ALASKA WORKERS' COMPENSATION BOARD

P.O. Box 115512 **Juneau, Alaska 99811-5512**

JOSEPH TRAUGOTT, Employee, Claimant,	)	INTERLOCUTORY DECISION AND ORDER
v.	)	AWCB Case No. 201309316
ARCTEC ALASKA, Self-Insured Employer, Defendants.	)	AWCB Decision No. 16-0018
	)	Filed with AWCB Fairbanks, Alaska on March 10, 2016

Joseph Traugott's July 16, 2015 and November 10, 2015 claims were heard on February 18, 2016 in Fairbanks, Alaska. This hearing date was selected on January 18, 2016. Attorney Chancy Croft appeared and represented Joseph Traugott (Employee). Attorney Robert Bredesen appeared and represented Arctec Alaska (Employer). Witnesses included Employee; Marilyn Yodlowski, M.D., Lynn Palazzatto, and Katie Weimer, who appeared in person, and Jerry Grimes, M.D., who testified by video deposition. The record closed at the hearing's conclusion on February 18, 2016.

ISSUES

Employee contends his work for Employer was the substantial cause of his osteomyelitis, and consequently his resulting disability and need for medical treatment are compensable under the Alaska Worker's Compensation Act (Act). Employer contends Employee's disability and need for medical treatment are due to Charcot arthropathy, a consequence of his preexisting diabetes, and, as a result, he is not entitled to benefits under the Act.

1. Was Employee's employment with Employer the substantial cause of his disability or need for medical treatment, and, if so, to what benefits is he entitled?

In the course of deliberating the merits of this case, the hearing panel noted both gaps in the medical record and its own lack of understanding of the medical evidence. In order to best ascertain the rights of the parties, the panel therefore decided to order a Second Independent Medical Evaluation (SIME) records review.

2. Should an SIME be ordered?

FINDINGS OF FACT

The following facts are based on the evidence in the record as of February 18, 2016 and are limited to those facts necessary to resolve the limited issues presented. The following facts and factual conclusions are established by a preponderance of the evidence:

1. Employee was diagnosed with diabetes in 2002. (Employee Deposition).
2. On August 9, 2004, Employee reported a sore on his toe that was healing. A photograph of what appears to be an open sore on Employee's right big toe has a notation stating "old blister from shoes." (AK Kidney & Diabetes, Chart Note, August 8, 2004).
3. On February 7, 2005, it was noted that Employee's toe had "completely healed over from 8/04." (AK Kidney & Diabetes, Chart Note, February 7, 2005).
4. On April 25, 2005, Employee reported an infection on his left big toe. (AK Kidney & Diabetes, Chart Note, April 25, 2005).
5. On September 22, 2005, Employee complained of a right big toe infection, which began five days earlier, and was placed on oral antibiotics. (AK Kidney & Diabetes, Chart Note, September 22, 2005).
6. On October 3, 2005, Employee was seen by Patrick Crawford, D.P.M. Dr. Crawford reported that while working in Alaska, Employee had a callus that broke down developing a neurotrophic ulcer on his right big toe. There was no evidence of bony involvement. (Dr. Crawford, Chart Notes, October 3 and 17, 2005).
7. An October 26, 2005 chart note indicates Employee's right big toe was better, but needed debridement. (AK Kidney & Diabetes, Chart Note, October 26, 2005).
8. On January 5, 2006, Employee's right big toe ulcer was found to be infected with streptococcus. (Dr. Crawford, Chart Note, January 5, 2006).
9. On January 9, 2006, Employee was seen for follow up of his right big toe after someone had stepped on it. The toe appeared infected, and Employee was placed on oral antibiotics. (AK Kidney & Diabetes, Chart Note, January 9, 2006).

10. By March 8, 2006, Employee's right big toe had healed. (Dr. Crawford, Chart Note, March 8, 2006).
11. On September 6, 2006, Dr. Crawford diagnosed possible Charcot foot (Charcot neuroarthopathy) in Employee's right foot.
12. On August 11, 2007, Employee was diagnosed with neuropathy. (Texas Tech University, Patient Information Sheet, August 11, 2007).
13. Neuropathy, or peripheral neuropathy, is a disruption in the function of peripheral nerves, commonly due to diabetes. It most often involves nerves related to sensation or proprioception. (Dr. Yodlowski, EME Report, January 5, 2016).
14. When a person develops neuropathy, their skin stops producing the oils that lubricate the skin and they don't sweat. Because they don't feel damage to the skin, they are at risk of skin ulcers. (Dr. Grimes, Deposition Testimony, February 6, 2016).
15. On October 15, 2008, Employee reported continued pain in both feet, some of which was determined to be nerve-related. (AK Kidney & Diabetes, Chart Note, October 15, 2008).
16. On February 4, 2010, an x-ray revealed evidence of joint destruction in Employee's right foot. Dr. Crawford diagnosed Charcot neuroarthopathy in Employee's right midfoot. It was noted that the second toe on Employee's right foot was a hammer toe (Dr. Crawford, Chart Note, February 10, 2010).
17. Charcot neuropathy or Charcot foot is a condition that occurs in a small percentage of individuals with neuropathy. It appears as inflammation in a joint or bone, and the foot gets red, swollen, and looks like it's infected, but there's no organism present. During the inflammation stage, the bones begin to crumble and fall apart. It is unknown why Charcot foot occurs. A flare of Charcot may lead to a deformity causing an abnormal weight-bearing surface. These abnormal weight-bearing surfaces are at additional risk of ulceration because the skin breaks down very easily. (Dr. Grimes, Deposition Testimony, February 6, 2016).
18. Hammer toe can develop as a result of neuropathy. The damage to the nerve causes an imbalance in the muscles of the toe, causing the toe to curl. (Yodlowski).
19. On May 2, 2011, it was noted that Employee had decreased sensation to touch in both legs. (Amarillo Family Physicians Clinic, Chart Note, May 2, 2011).

20. May 2, 2011, Dr. Crawford noted Employee's hammer toe had become infected and recommended surgery to correct the hammer toe condition. (Dr. Crawford, Chart Note, May 2, 2011).
21. On May 5, 2011, the infection in Employee's toe was determined to be a staphylococcus infection. (Dr. Crawford, Chart Note, may 5, 2011).
22. On May 16, 2011, Dr. Crawford stated he would schedule surgery to correct Employee's hammer toes. (Dr. Crawford, Chart Note, May 2, 2011).
23. Because of unrelated medical complications, the surgery on Employee's toes was not performed until May 29, 2012, when Dr. Crawford fused the joints in the second and third toes on Employee's right foot using internal fixation. (Dr. Crawford, Chart Notes, August 17, 2011 to May 29, 2011).
24. On May 21, 2012, Employee reported the lesions on his toe had increased in size. He was diagnosed with a diabetic ulcer and bone infection (osteomyelitis). (Amarillo Family Physicians Clinic, Chart Note, May 21, 2012).
25. On June 21, 2012, the infection in Employee's second toe was found to be staphylococcus. (Dr. Crawford, Chart Note, June 21, 2012).
26. On July 23, 2012, Employee was released to work after the hammer toe surgery. (Dr. Crawford, Work Release, July 31, 2012).
27. On August 3, 2012, Employee was found to have a staphylococcus infection in his right third toe. (PPL Laboratory, Microbiology Report, August 4, 2012).
28. Employee was hired by Employer in March 2013. At the time of hiring, he was given a physical examination. He was approved for work without restriction, but was notified he should consult his doctor because a pulmonary function test had been abnormal. Employee worked about three weeks at the Indian Mountain site, and was transferred to Tin City. While at Tin City, Employee primarily worked replacing heating and cooling systems. The work was six days per week, at least 10 hours per day. Most of the work was overheard, requiring Employee to spend significant time standing on ladders. Standing on the ladders caused pressure on the middle of his feet. (Employee Deposition, October 16, 2015; Beacon Occupational Health, Hiring Physical, March 11, 2013; Employee).
29. In the middle of May 2013, Employee developed a blister, smaller than the size of a dime, located on the outside of his right foot, near the middle of the arch. Employee believed the

blister was caused by the pressure on his foot while standing on ladders. Employee did not seek medical attention, and did not report the injury. He treated the blister himself by keeping it clean; he did not use any antibiotics. The blister healed and went away within a couple of weeks. (Employee Deposition, October 16, 2015).

30. On July 5, 2013, the skin on the sole of Employee's right foot cracked open about an inch away from where the blister was in May. There was a fetid discharge. Because there are no medical facilities at Tin City, Employee was flown to Nome the next day. (Employee Deposition, October 16, 2015).
31. Employee was hospitalized in Nome with an initial diagnosis of cellulitis of the foot, secondary to diabetes. He reported that while he had no recent injury to the foot, he had been experiencing foot problems for about a week. (Norton Sound Regional Hospital, Inpatient Admission Form and Admission History, July 6, 2013).
32. On July 9, 2013, Employer filed a report of occupational injury or illness. (Report of Injury, July 8, 2013). It is Employer's practice to report all injuries, whether it believes they are compensable or not. (Palazzatto).
33. Employee was discharged from Norton Sound Regional Hospital on July 11, 2013 with a diagnosis of moderately severe cellulitis. X-ray and CT scans had shown a soft tissue ulcer with no evidence of osteomyelitis, although the possibility of osteomyelitis remained a concern. Wound and blood cultures were negative, suggesting an anaerobic infection. The wound was debrided, and Employee was to receive follow-up care when he returned home to Texas. (Norton Sound Regional Hospital, Discharge Summary, July 11, 2013).
34. On July 15, 2013, Employee was seen by Dr. Crawford. Dr. Crawford reported Employee had developed a blister on his right foot in May 2013, which had cracked open and become infected. Dr. Crawford diagnosed a diabetic ulcer, cellulitis, and Charcot foot. Another wound culture was done, and Employee was to continue on antibiotics. An MRI was scheduled for July 23, 2013. (Dr. Crawford, Chart Note, July 15, 2013).
35. Employee's foot improved initially, but by August 1, 2013, he was hospitalized when osteomyelitis was suspected, and the wound was drained and debrided. Cultures revealed a Staphylococcus epidermis infection, and Employee was started on a broad-spectrum antibiotic. (BSA Health System, Discharge Summary, August 5, 2013).

36. On August 12, 2013, Employer controverted all benefits noting that Employee had been diagnosed with diabetic foot cellulitis, and there was no evidence the condition was work-related. (Notice of Controversion, August 8, 2013).
37. On December 8, 2013, Employee was found to have a Staphylococcus aureus infection in his foot. (PPL Laboratory, Microbiology Report, December 8, 2013). He received a prolonged course of intravenous antibiotic therapy. (BSA Health System, Infectious Disease Consultation, December 26, 2013).
38. Employee received wound care three times per week, and slowly improved. By June 20, 2014, the wound was nearly closed. (Dr. Crawford, Chart Note, June 20, 2014).
39. In September 2014, Employee wound was found to be infected with methicillin resistant Staphylococcus aureus (MRSA). (PPL Laboratory, Microbiology Report, September 27, 2014).
40. By December 2, 2014, cultures showed no infection in Employee's foot. (BSA Health System, Laboratory Report, December 2, 2014).
41. By December 17, 2014, the wound had healed, although there was still some swelling and warmth. (Dr. Crawford, Chart Note, December 17, 2014).
42. On January 5, 2015, Employee returned to Dr. Crawford with a swollen right foot and ankle. An x-ray revealed partial dislocation of the right ankle, and Dr. Crawford diagnosed Charcot right foot and ankle, possible aggravated by gout. (Dr. Crawford, Chart Note, January 5, 2015).
43. On January 20, 2015, Employee was seen by Mark Drew, M.D., at BSA Health System. Dr. Drew diagnosed severe right foot and ankle Charcot arthropathy. Dr. Drew noted that the ulcer on the sole of Employee's foot had not recurred, but he had a thick callus at the site. (BSA Health System, Chart Note, January 20, 2015).
44. On February 9, 2015, Dr. Drew noted the deformity in Employee's right ankle was worsening due to Charcot arthropathy. The sole of his foot remained intact with no ulceration. (BSA Health System, Chart Note, February 9, 2015).
45. On March 18, 2015, Dr. Drew referred Employee to an orthopedic surgeon, Dr. Risko, at Amarillo Bone and Joint Clinic. (BSA Health System, Chart Note, March 18, 2015).
46. By March 30, 2015, Employee had developed a small ulceration between the third and fourth toe of his right foot. (BSA Health System, Chart Note, March 30, 2015).

47. On March 23, 2015, Employee met with Dr. Risko. Dr. Risko concluded Employee was not a candidate for corrective Charcot surgery and recommended a below the knee amputation. (BSA Health System, Chart Note, April 8, 2015).
48. On July 6, 2015, Dr. Crawford filed a Physician's Report stating Employee's right foot condition was work related. He explained "stress to right foot caused blister/open area leading to infection and ulcer." (Dr. Crawford, Physician's report, July 16, 2015).
49. On November 4, 2015, Employee met with Jerry Grimes, M.D., an orthopedic surgeon. Dr. Grimes noted that midfoot radiographs of Employee's ankle were consistent with Charcot neuroarthropathy, but the talus was essentially gone and did not show significant fragmentation. Dr. Grimes concluded the lack of fragmentation could be secondary to infection, Charcot, or an avascular necrotic process. Based on blood tests, Dr. Grimes concluded Employee did not have active osteomyelitis. Dr. Grimes noted a below the knee amputation was reasonable, but given Employee's aversion to amputation, an ankle fusion was a reasonable alternative. (Dr. Grimes, Chart Note, November 4, 2015).
50. On November 12, 2015, Dr. Grimes performed the fusion surgery on Employee's right ankle using internal hardware. (University Medical Center, Surgical Documentation, November 12, 2015). Because of the unusual appearance of the talus during surgery, Dr. Grimes sent biopsy samples for pathology and microbiology evaluation. (Dr. Grimes, Deposition, February 5, 2016).
51. The pathology tests took several days to complete. On November 24, 2015, the pathologist reported to Dr. Grimes that the bone destruction could be consistent with Charcot, but it was more likely that osteomyelitis was an initiating or complicating factor. (Pathology Report, November 24, 2015). The microbiology reports subsequently confirmed osteomyelitis in Employee's talus. (Dr. Grimes, Deposition, February 5, 2016).
52. Determining whether the damage to a bone was caused by osteomyelitis or Charcot neuroarthropathy is very difficult using imaging such as x-rays, MRIs, and CT scans. The best way to distinguish is through a bone biopsy. (Dr. Grimes, Deposition, February 5, 2016).
53. While osteomyelitis can develop from a blood borne infection, the infection is most commonly acquired through a break in the skin, such as a blister, cut, or ulcer. It is one of the most frequent infections of a diabetic foot. (Dr. Grimes, Deposition, February 5, 2016).

54. After receiving the pathology and microbiology reports, Dr. Grimes revised his diagnosis, concluding the collapse of Employee's talus was due to osteomyelitis rather than Charcot foot. He was convinced the osteomyelitis infection originated with the May 2013 blister on Employee's foot. Dr. Grimes stated that while Employee was at a higher risk than someone with a healthy foot, Employee would probably not have developed the ulceration and osteomyelitis with normal activities. Dr. Grimes relied, in part, on Dr. Crawford's July 16 2015 report which stated stress to right foot caused a blister or open area leading to the infection and ulcer. (Dr. Grimes, Deposition, February 5, 2016).
55. On January 25, 2016, Dr. Yodlowski performed an employer's medical evaluation (EME). Because Employee was unable to travel, Dr. Yodlowski's evaluation was limited to a review of the medical records. While Dr. Yodlowski had Employee's medical records dating to 2002, she did not have records from the November 2015 surgery. Dr. Yodlowski noted Employee had been diagnosed with both Charcot foot and osteomyelitis well before the work injury. She opined the loss of bone in Employee's ankle was most likely due to Charcot foot, but could be due to a combination of Charcot and osteomyelitis. She explained the underlying cause of Charcot foot was the peripheral neuropathy due to Employee's diabetes, and the Charcot foot develops with normal activities of living, and was not due to trauma. She further explained that MRSA was often found on a person's skin, and Employee was not at a higher risk of infection because of his work activities. In response to a question asking her to identify the substantial cause of "the diagnosed condition," Dr. Yodlowski responded the cause of the Charcot and the infections was Employee's diabetes, not his employment. (Dr. Yodlowski. EME Report, January 5, 2016).
56. At the February 18, 2016 hearing, Dr. Yodlowski testified about causation: "countless people climb ladders every day . . . and it doesn't cause a diabetic ulcer;"; "what causes a diabetic ulcer is having these underlying abnormalities . . . in your foot structure and then doing activities that people do every day without sustaining injury." She noted that "if you climb ladders and get a blister, you don't get hospitalized unless you have other pathology." She did note, however, that if an individual "didn't follow medical advice on prevention, substantial pressure on middle of foot could likely cause him to develop an ulcer." She did not know how much of the day Employee spent on a ladder, but she had not seen nor read about ulcers as a result of standing on ladders. (Dr. Yodlowski).

57. Employee testified that prior to the 2013 infection, no doctor had recommended he wear orthotic or diabetic shoes, although he had been prescribed orthotic wedges he could use in work shoes. (Employee; Employee, Deposition, October 15 2015).
58. On February 16, 2016, Employee's attorney filed an affidavit detailing$104,072.00 in attorney fees. On February 22, 2016, Employee's attorney filed a supplemental affidavit detailing an additional $11,646 in fees and $7,933.30 in costs. (Fee Affidavits, February 6, 2016 and February 22, 2016,

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter**. It is the intent of the legislature that
> (1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;
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> . . . .
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> (4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

The board may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987). An adjudicative body must base its decision on the law, whether cited by a party or not. *Barlow v. Thompson*, 221 P.3d 998 (Alaska 2009).

> **AS 23.30.010. Coverage.**
> (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for

> medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

In *City and Borough of Juneau v. Olsen*, AWCAC Decision No. 11-0185 (August 21, 2013), the commission explained the application of "the substantial cause" in cases where a work injury "aggravates or accelerates" or "combines" with a preexisting condition. When an employee asserts a work injury caused the aggravation or acceleration of a preexisting condition, the board must evaluate the relative contribution of both the preexisting condition and the work injury. To establish causation, the employee must show the work injury played a greater role in the disability or need for medical treatment than did the preexisting injury. *Olsen, 17-18.* When an employee asserts his disability or need for medical treatment arose as a result of a combination of his work injury and a preexisting condition, the employee must establish two additional facts to prevail, first, that the disability or need for treatment would not have happened "but for" the work injury, and second that reasonable persons would regard the work injury as the substantial cause of the disability or need for medical treatment. *Olsen, 18-19.*

> **AS 23.30.110. Procedure on claims**
> . . .
> (g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician which the board may require.

Subsection AS 23.30.110(g) has long been considered procedural in nature, not substantive, for the reasons outlined in *Deal v. Municipality of Anchorage*, AWCB Decision No. 97-0165 (July 23, 1997) at 3; *see also Harvey v. Cook Inlet Pipe Line Co*., AWCB Decision No. 98-0076 (March 26, 1998) at 4. Wide discretion exists under AS 23.30.110(g) to consider any evidence available when deciding whether to order an SIME to assist in investigating and deciding medical issues in contested claims, to best protect the rights of all parties. *See, e.g., Hanson v. Municipality of Anchorage*, AWCB Decision No. 10-0175 (October 29, 2010) at 18; *Young v.*

Brown Jug, Inc., AWCB Decision No. 02-0223 (October 28, 2002) at 3; AS 23.30.135(a); AS 23.30.155(h).

The Alaska Workers' Compensation Appeals Commission (Commission) in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008) at 5 addressed the board's authority to order an SIME. Referring to § 110(g), the Commission stated "the board has discretion to order an SIME when there is a significant gap in the medical or scientific evidence and an opinion by an independent medical examiner or other scientific examination will help the board in resolving the issue before it. . . ." In denying Mr. Bah's request for a board-ordered SIME, the Commission noted: "Ordering an SIME is not proper if it serves no purpose to the board by advancing its understanding of the medical evidence or by filling in gaps in the medical evidence, where that gap in the evidence, or lack of understanding of the medical evidence, prevents the board from ascertaining the rights of the parties in the dispute before the board." *Id.* at 5.

Bah further noted "the purpose of ordering an SIME . . . is to assist the board…" *Id.* Citing *Olafson v. State, Dep't of Trans. & Pub. Facilities*, AWCAC Decision No. 061 (October 25, 2007) at 23, *Bah* reiterated the SIME physician is the *board's expert*, not the employee's or employer's expert. *Id.*, emphasis in original.

> **AS 23.30.120. Presumptions.**
> (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
> (1) the claim comes within the provisions of this chapter . . ..

Under AS 23.30.120, benefits sought by an injured worker are presumed to be compensable, and the burden of producing evidence is placed on the employer. *Sokolowski v. Best Western Golden Lion Hotel*, 813 P.2d 286, 292 (Alaska 1991). The Alaska Supreme Court held the presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996); *Carter* at 665. An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski* at 292.

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some" "minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.*, 262 P.3d 613, 620 (Alaska 2011); *Smith v. Univ. of Alaska, Fairbanks*, 172 P.3d 782, 788 (Alaska 2007); *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Kramer* at 473-74, quoting *Smallwood* at 316. If the employer can present substantial evidence demonstrating that "a cause other than employment played a greater role in causing the [need for medical treatment], etc., the presumption is rebutted." *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (Mar. 25, 2011) at 7. "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-612 (Alaska 1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after a determination whether the employer has produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994); *Wolfer* at 869-870.

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065, 1075 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381. At this last step of the analysis, evidence is weighed and credibility considered. To prevail, the claimant

must “induce a belief” in the minds of the fact finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

A fundamental principle in workers' compensation law is the “eggshell skull doctrine,” which states an employer must take an employee “as he finds him.” *Fox v. Alascom, Inc.*, 718 P.2d 977, 982 (Alaska 1986), citing *S.LW, v. Alaska Workmen's Compensation Board*, 490 P.2d 42, 44 (Alaska 1971); *Wilson v. Erickson, All* P.2d 998, 1000 (Alaska 1970). A pre-existing condition does not disqualify a claim if the employment aggravated, accelerated or combined with the pre-existing condition to produce the disability or need for medical treatment for which compensation is sought. Under the Act, there is no distinction between the aggravation of symptoms and the aggravation of the underlying condition. *DeYonge v. NANA/Marriott*, 1 P.3d 90, 96 (Alaska 2000); *Peek v. SKW/Clinton*, 855 P.2d 415, 416 (Alaska 1993).

> **AS 23.30.135. Procedure before the board.**
> (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .
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> **AS 23.30.155. Payment of compensation.**
> . . .
> (h) The board may upon its own initiative at any time in a case . . . where right to compensation is controverted . . . make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly protect the rights of all parties.
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> **AS 23.30.395. Definitions.**
> . . . .
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> (16) "disability" means incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment;

ANALYSIS

The cause of Employee’s disability or need for medical treatment is a factual issue subject to the presumption analysis. Relevant to the presumption analysis here is the “eggshell skull doctrine,”

under which an employer takes an employee as he finds him. It is undisputed that Employee had pre-existing pathologies, such as peripheral neuropathy and Charcot foot as a result of his diabetes, which predisposed him to diabetic ulcers. Nevertheless, his injury may compensable if his work activities aggravated, accelerated, or combined with the pre-existing condition to cause the diabetic ulcer that resulted in osteomyelitis leading to Employee's disability and need for medical treatment. *Fox; DeYonge; Olsen.* On the other hand, if the pre-existing pathologies themselves are ultimately found to be the substantial cause of the disability or need for medical treatment, then Employer would prevail. AS 23.30.010(a).

At the first step of the analysis, Employee was required to show a preliminary link between his osteomyelitis and the employment. Employee's testimony that the significant amount of work on ladders resulted in a blister combined with the testimony of Dr. Grimes that the blister was the most likely portal of entry for the bacteria causing the osteomyelitis is sufficient to attach the presumption

Because Employee raised the presumption, Employer was required to rebut it. It did so through the testimony of EME physician Dr. Yodlowski. Dr. Yodlowski testified that Employee's diabetes was the cause of his Charcot foot, which was, in turn, the cause of the diabetic ulcer on his foot. She stated that climbing ladders does not cause diabetic ulcers, and Employee was not at a higher risk of infection because of his work activities.

Because Employer rebutted the presumption, the analysis proceeded to the third step, in which Employee must prove by a preponderance of the evidence that the employment was the substantial cause of his disability or need for medical treatment. At this step, however, the hearing panel was hampered by both gaps in the medical evidence and its own lack of understanding of the evidence produced.

Both Dr. Crawford and Dr. Grimes opined Employee's July 2013 foot ulcer lead to the osteomyelitis in his midfoot, and Dr. Grimes opined the ulcer was also the source of the osteomyelitis in Employee's talus. However, both doctors appear to understand that the earlier blister on Employee's foot became infected and developed into an ulcer. That appears to be

contrary to Employee's testimony that the May 2013 blister healed without antibiotic treatment before the ulcer appeared. The panel is unclear as to whether a blister that healed without infection could be the source of the infection in the subsequent ulcer.

Dr. Yodlowski's statements that "countless people climb ladders every day . . . and it doesn't cause a diabetic ulcer" and "what causes a diabetic ulcer is having these underlying abnormalities . . . in your foot structure and then doing activities that people do every day without sustaining injury" suggest she is not accounting for the fact an employer must take an employee as he finds him. In her written report, she answered Employer's question about the substantial cause of "the diagnosed condition." When the issue is whether work aggravated a preexisting condition, Employer's question is ambiguous and misleading. By definition, the preexisting condition was not caused by the work injury. Under the Act, the relevant question is whether the employment was the substantial cause of *the disability or need for medical treatment*, the cause of the preexisting condition is irrelevant.

Given Employee's preexisting condition, the test for causation becomes whether work aggravated the preexisting condition and the aggravation was the substantial cause of the disability or need for treatment. Dr. Yodlowski acknowledged that pressure on the middle of Employee's foot could likely cause him to develop an ulcer, but she did not know how much of the day Employee spent on a ladder, and she was unaware of any cases where standing on a ladder had caused an ulcer.

Due to these evidentiary gaps and its lack of understanding, the panel was unable to decide the key legal issue of what caused the osteomyelitis in Employee's midfoot, and what caused the collapse of Employee's talus. Specifically, the panel was unable to determine:

1. How likely it is that a blister that healed within a couple of weeks without treatment, including antibiotics, would be the portal of entry for the infection in a diabetic ulcer on employee's foot that occurred about five weeks later.
2. If the blister was not the portal of entry for the infection in Employee's subsequent midfoot ulcer, whether such an ulcer developed because Employee's preexisting diabetic

neuropathy and Charcot foot were aggravated by significant time spent standing on ladders.

3. The likelihood Employee would have developed the midfoot ulcer had he not been engaged in work activities – in other words, how it likely it was the ulcer would have developed if Employee had only engaged in his normal activities of daily living.
4. Whether the collapse of Employee's talus was more likely due to Charcot neuroarthropathy or to osteomyelitis.
5. If the collapse of Employee's talus was due to Charcot neuroarthropathy, whether the osteomyelitis aggravated the collapse.
6. The probability that the source of the osteomyelitis in Employee's talus was his midfoot osteomyelitis, or whether another source was more likely.

The hearing panel therefore decided it needed more medical evidence before rendering a decision on the compensability of Employee's claim. In order to be fair and impartial to all parties, the presumption analysis was halted at the third step, and the decision was made to order an SIME records review.

An SIME may be ordered when there is a significant gap in the medical evidence or a lack of understanding of the medical evidence, and the opinion of an independent medical examiner will help ascertain the parties' rights. AS 23.30.110(g); *Bah*. This is a highly complex medical case with conflicting medical opinions, and the panel lacks the understanding necessary to properly evaluate those opinions. As discussed above, the hearing panel's deliberations were thwarted at the third step of the presumption analysis both its lack of understanding and by apparent gaps in the medical evidence produced.

An SIME records review with orthopedic surgeon, Carol Frey, M.D., a foot and ankle specialist, will be ordered under AS 23.30.110(g), subject to the board's designee's conflict of interest inquiry. Employer will be ordered to provide a transcript of the August 19, 2014 hearing for inclusion in the SIME binders, along with a copy of this Decision and Order, and all depositions, medical records and medical opinions expressed in any format, including letters, are also to be

included. In addition to the standard questions posed by the board designee, the following questions will be posed to the SIME physician:

1. How likely is it that a blister that healed within a couple of weeks without treatment, including antibiotics, would be the portal of entry for the infection in the diabetic ulcer on Employee's foot that occurred about five weeks later?
2. If the blister was not the portal of entry for the infection in Employee's subsequent midfoot ulcer, could such an ulcer develop because Employee's preexisting diabetic neuropathy and Charcot foot were aggravated by significant time spent standing on ladders?
3. What is the likelihood Employee would have developed the midfoot ulcer had he not been engaged in work activities – in other words, how likely was it the ulcer would have developed if Employee had only engaged in his normal activities of daily living?
4. Was the collapse of Employee's talus was more likely due to Charcot neuroarthropathy or to osteomyelitis?
5. If the collapse of Employee's talus was due to Charcot neuroarthropathy, did the osteomyelitis aggravate the collapse?
6. Is it probable that the source of the osteomyelitis in Employee's talus was his midfoot osteomyelitis, or was there another, more likely, source?

CONCLUSIONS OF LAW

1. The issue of whether Employee's employment with Employer the substantial cause of his disability or need for medical treatment, is not ripe.

2. An SIME will be ordered.

ORDER

1) Workers' Compensation Officer Susan Reishus-O'Brien is directed to schedule a records review SIME with orthopedic surgeon, Dr. Carol Frey, subject to her availability and the lack of any potential conflict of interest.

2) The parties shall schedule a prehearing conference to address deadlines and instructions for compilation of the SIME binders.

3) Employer is ordered to provide a transcript of the February 18, 2016 hearing for inclusion in the SIME binders, along with a copy of this Decision and Order. All depositions, medical records and medical opinions expressed in any format, including letters, are also to be included.

4) In addition to the standard questions posed by the board designee, the following questions will be posed to the SIME physician:

1. How likely is it that a blister that healed within a couple of weeks without treatment, including antibiotics, would be the portal of entry for the infection in the diabetic ulcer on Employee's foot that occurred about five weeks later?
2. If the blister was not the portal of entry for the infection in Employee's subsequent midfoot ulcer, could such an ulcer develop because Employee's preexisting diabetic neuropathy and Charcot foot were aggravated by significant time spent standing on ladders?
3. What is the likelihood Employee would have developed the midfoot ulcer had he not been engaged in work activities – in other words, how t likely it was the ulcer would have developed if Employee had only engaged in his normal activities of daily living?
4. Was the collapse of Employee's talus was more likely due to Charcot neuroarthropathy or to osteomyelitis?
5. If the collapse of Employee's talus was due to Charcot neuroarthropathy, did the osteomyelitis aggravate the collapse?
6. Is it probable that the source of the osteomyelitis in Employee's talus was his midfoot osteomyelitis, or was there another, more likely, source?

5) Jurisdiction over the employee's claim is retained, pending receipt of the SIME report.

6) Upon receipt of the SIME report, the parties shall request a prehearing conference to schedule additional briefing and determine the necessity of further oral testimony.

Dated in Fairbanks, Alaska on March 10, 2016.

ALASKA WORKERS' COMPENSATION BOARD

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Ronald P. Ringel, Designated Chair

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Jacob Howdeshell, Member

PETITION FOR REVIEW

A party may seek review of an interlocutory other non-final Board decision and order by filing a petition for review with the Alaska Workers' Compensation Appeals Commission. Unless a petition for reconsideration of a Board decision or order is timely filed with the board under AS 44.62.540, a petition for review must be filed with the commission within 15 days after service of the board's decision and order. If a petition for reconsideration is timely filed with the board, a petition for review must be filed within 15 days after the board serves the reconsideration decision, or within 15 days from date the petition for reconsideration is considered denied absent Board action, whichever is earlier.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accordance with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accordance with 8 AAC 45.150 and 8 AAC 45.050.

CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Interlocutory Decision and Order in the matter of JOSEPH TRAUGOTT, employee / claimant; v. ARCTEC ALASKA, self-insured employer; Case No. 201309316; dated and filed in the Alaska Workers' Compensation Board's office in Fairbanks, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on March 10, 2016.

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Elizabeth Pleitez, Office Assistant