STATE OF VERMONT
DEPARTMENT OF LABOR AND INDUSTRY

Robert Liscinsky	)	State File No. H-20159
	)	
v.	)	By: Margaret A. Mangan
	)	Hearing Officer
Temporary Payroll Incentives, Inc.	)	For: R. Tasha Wallis
	)	Commissioner
	)	
	)	Opinion No. 09R-01WC

RULING ON DEFENDANT'S MOTION FOR RECONSIDERATION OF ORDER AND MOTION TO STAY ORDER PENDING OUTCOME OF APPEAL

Defendant by and through its attorneys, Kiel Ellis & Boxer, moves the Commissioner to reconsider and reverse her decision of March 22, 2001 in the matter. Alternatively, defendant, pursuant to 21 V.S.A. §675(b) moves to stay the enforcement of her Order pending disposition of defendant's appeal to the Rutland Superior Court. Claimant by and through his attorney, Keith Kasper, submitted written opposition to both motions.

I. THRESHOLD CONSIDERATIONS:

In the previous decision, the Department found that Mr. Liscinsky's back surgery led to a foot drop in his right leg, necessitating a foot brace. The brace, which did not fit properly, caused a blood blister to form on his right foot, eventually becoming a non-healing ulcer requiring a vascular graft.

Defendant has made a supplemental motion dated April 27, 2001 to admit newly discovered evidence. Specifically, defendant submits a March 20, 2001 medical report indicating a new ulcer on the claimant's left heel. Since the record is closed, defendant moves to admit the March 20, 2001 medical report under either 21 V.S.A. §668, modification of awards, or alternatively V.R.C.P. 60(b)(2), motion for a relief based on newly discovered evidence.

Title 21 V.S.A. §668 empowers the Commissioner to modify an award on the basis of a change in conditions. Defendant argues that the March 20, 2001 report demonstrates that the theory of causation adopted by the Commissioner is incorrect. The defendant argues that if the left foot evidence had been available at the formal hearing, it would have been dispositive and persuaded the hearing officer that the right plantar ulcer was unrelated to the work injury. To support, defendant argues that the claimant has the burden of proving each link in the causation chain.

Defendant's argument is misleading. Due to the unusual circumstances linking claimant's various injuries, claimant proved causation through expert testimony. See *Lapan v. Berno's Inc.*, 1372 Vt. 393 (1979). But, it remained the defendant's burden to prove that its theory was the more likely because the defendant had already accepted Mr. Liscinsky's original claim. *See Merrill v. U.V.M.*, 133 Vt. 101, 105 (1974)(defendant must prove it is justified in terminating a claim).

Defendant aptly points out several differences and similarities between the claimant's left and right foot. The left foot does not suffer from foot drop and at no time required a brace. Yet, it spontaneously formed an ulcer requiring similar treatment to the right. The supporting arguments, however, highlight the weakness of the position. The defense relies on a passage from expert testimony that says any trauma can cause a foot ulcer in a patient such as Mr. Liscinsky. Such evidence could equally explain the right plantar ulcer forming under the claimant's theory and the left heel ulcer from any number of independent causes, without contradiction. Defendant fails to demonstrate why a newly formed left heel ulcer found years after the first makes its theory of causation more likely. Therefore, claimant's newly formed left heel ulcer does not conflict with or change the prior conditions and overwhelming medical testimony, accepted by the Commissioner, establishing a line of causation from Mr. Liscinsky's work injury to his right plantar ulcer.

The defendant in the alternative makes a motion to allow relief from the Commissioner's Order based on V.R.C.P. 60(b)(2), relief from judgment. V.R.C.P. 60(b)(2) is intended to provide the sole means of obtaining relief from a judgment after the time for a motion under V.R.C.P. 59(b). *Kotz v. Kotz*, 134 Vt. 36 (1975). Additionally, for newly discovered evidence to warrant relief, it must 1) affirmatively appear that the evidence is such as will probably change the result if a new hearing is granted, 2) that the evidence is material to the issue, and 3) it is not merely cumulative or impeaching. *Bonfanti v. Ayers*, 134 Vt. 421 (1976). Defendant states that the left heel ulcer was not discovered until March 20, 2001 and that the defendant did not receive the report until April 6, 2001, eight months after the formal hearing. Thus, it could not have been discovered by due diligence in time for the formal hearing or a V.R.C.P. 59(b) motion. Nothing in the record contradicts the late nature of the diagnosis and subsequent report. As evidence, however, the report is inadmissible because it does not affirmatively appear more probable to change the original decision. Defendant's arguments notwithstanding, the evidence does not prove or disprove the issue at hand, namely whether Mr. Liscinsky's work injury and successive surgeries caused his foot drop, and right plantar ulcer. Coupled with defendant's testimony, the newly discovered evidence is merely cumulative, but *Bonafanti* clearly states that cumulative or impeaching purpose is not a basis for the introduction of newly discovered evidence. *See Id.*, 423.

Even if the March 20, 2001 records were admitted, it would not dissuade in the face of abundant medical evidence for claimant's position. Defendant's burden is to prove that it is more probable than not that the diabetic neuropathy and the right plantar ulcer arose independently of the 1995 work injury and resultant back surgeries. Claimant succeeded in the hearing because the facts and testimony adequately demonstrate that the 1995 back surgery began a series of reactions that led to a foot ulcer. While the cumulative effect of the newly discovered evidence affects the issue of whether the brace caused the ulcer, it stands on an unstable foundation. As claimant notes, the six-year span between the right foot ulcer and the left heel ulcer, stretches the defendant's claim of causal relation. Without further evidence, the evidence is too tenuous.

Accordingly, defendant's motion to modify the award pursuant to 21 V.S.A. §668 and requesting relief under V.R.C.P. 60 (b)(2) is DENIED.

II. DEFENDANT'S MOTION FOR RECONSIDERATION:

Defendant argues that the original holding is erroneous in two ways. First, the evidence is clearly against the claimant's theory of causation. Secondly, defendant asserts, diabetic neuropathy, arising independent of work-related injuries, combined with the injuries to cause the claimant's permanent total disability. Thus, defendant argues, the Commissioner erroneously ignored the holding of *Yefchak v. Orange Supervisory Union*, Opinion No. 09-00WC (May 31, 2000) as precedent. Claimant opposes the use of *Yefchak* as precedent and argues that Commissioner's findings of fact and findings of law are correct.

Defendant's first factual challenge centers on the relationship between the March 30, 1995 back injury and the successive foot drop. Briefly, the defense musters the testimony regarding the independent cause of the foot drop, uncertainty regarding the surgery as source, and the lack of connection between the stress of surgery and changes in the diabetic condition. Defendant especially narrows in on Dr. Upton's theory that Dr. Harbaugh dinged the L-5 nerve root during surgery. Specifically, defendant argues that temporal relationships alone do not justify causal relationships. While Dr. Upton's conclusions, may be circumstantial, they are based on expert opinion, credible cause and effect relationship, and corroborating evidence. Along with Dr. White's strongly stated opinion, Dr. Bucksbaum and Dr. Levy's admittance that claimant's theory was possible, the claimant created a strong theory of causation supported by the evidence. As claimant notes, the chain of causation may be longer than usual, but the evidence is clear and sufficiently strong. More importantly, the facts and testimony coupled together make the defendant's theory of diabetic neuropathy less than probable. Thus the defendant fails to carry its burden and prove its theory as more probable.

The second factual conclusion defendant questions concerns the relationship between the foot brace and the right foot ulcer. Defendant questions the factual basis for Dr. Wilks's letter, which blames the foot brace as the cause of claimant's foot blister. Defendant also cites Dr. Walsh's testimony that such ulcers are typical for diabetic neuropathy and can have any number of causes, common and uncommon, including a bone infection. However, the testimony of Dr. Walsh is quite clear as to the cause of the blister on claimant's right foot. Along with the claimant's wife who provided connective testimony between the initial blister and brace, his testimony is persuasive. Moreover, defendant's arguments while neatly illustrating the lack of definitive evidence do not prove that the complaint's theory is less likely than not. In this case, causation is a reasonable function of common sense, direct observation, and clear medical documentation.

The defendant's remaining argument for reconsideration, the application of *Yefchak* as precedent, relies on an acceptance of the diabetic neuropathy independently arising in the claimant after his work-related injuries. Defendant argues that *Yefchak* holds that where a non-work related condition develops subsequent to a work-related condition and combines with it to result in a permanent total disability, the PTD is not compensable. While the fact sensitive nature of *Yefchak* raises questions to its precedential value, the defendant's use of *Yefchak* begs the question, what caused the claimant's diabetic neuropathy?

The defendant argues that diabetic neuropathy is the only cause of complaint's foot drop and right plantar ulcer. Furthermore, Defendant argues, such conditions arose after and independently of the work injury. While defendant rallies a significant amount of medical testimony from several of the testifying experts, it fails to break the claimant's chain of causation. Contrary to the defendant's conclusion, the testimony of Dr. Levy, Dr. Shoemaker, Dr. Turco, Dr. Walsh, Dr. Upton and Dr. Bucksbaum, all admit the claimant's theories of causation to varying degrees as possible or probable causes. As well, defendant's evidence beyond Dr. Bucksbaum's testimony fails to establish the causal onset of the diabetic neuropathy as independent of claimant's work-related injuries and stress. In lieu of any other compelling reason to reconsider the Department has no choice but to sustain its initial assessment of the case.

Accordingly, the defendant's motion to reconsider is DENIED.

DEFENDANT'S MOTION TO STAY:

Defendant moves the Commissioner in the alternative to issue a stay of judgment pursuant to 21 V.S.A. §675(b). The test for a stay of judgment under §675(b) must be met in all four parts. Defendant must demonstrate that 1) it is likely to succeed on the merits, 2) it would suffer irreparable harm if the stay were not granted, 3) a stay would not substantially harm the other party, and 4) the best interests of the public would be served by the issuance of a stay. *In re Insurance Services Office, Inc.*, 537 A.2d 134 (1987). If all four prongs of the test are not satisfied, then defendant's motion cannot succeed. *See* Id. Defendant argues that it will succeed on the merits based on its motion to reconsider. Claimant points out, however, that the defendant failed to prevail in its initial claim, that more than enough information exists to support the Department's decision, and that there is no evidence that defendant will fare any better on trial before a Rutland jury of Mr. Liscinsky's peers. Claimant makes a strong argument and despite defendant's tenacious persistence, it fails to adequately demonstrate why it will succeed in the next level of hearing.

Furthermore, the defendant's second prong that it would suffer irreparable harm is based upon a secondary source and a Vermont case regarding tariffs. As claimant notes through primary case law, the Department does not equate payment by an insurance carrier on appeal with irreparable harm. *Durand v. Okemo Mountain*, Opinion No. 41S-98WC (September 1, 1998).

The fourth prong requires that a stay serve the public interest. Contrary to the defendant's arguments, the Commissioner's findings in the original decision do not exceed the established standard of causation. Claimant is a textbook example of an "eggshell claimant" whose relatively minor work injuries have led to permanent total disability. It is in the interest of the public that the Department, without special treatment to either side, upholds black letter law such as employers taking employees as they are found. *Petit v. No. Country Union High Sch.*, Op. No. 20-98WC (Apr. 28, 1998).

In keeping with the purpose of worker compensation to provide expedient and consistent payments without proof of fault while limiting employer liability, the Commissioner rejects the defendants motion for stay based on its failure to meet all four elements of the established test for a stay of judgement.

Accordingly, defendant's motion for stay is DENIED.

ORDER:

Defendant's motions for reconsideration and stay are hereby DENIED.

Dated at Montpelier, Vermont this 26th day of June 2001.

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R. Tasha Wallis
Commissioner

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Hearing Held in Montpelier on July 24, 2000.
Record Closed on September 25, 2000.

APPEARANCES:

Keith Kasper, Esq. for the Claimant.
Andrew Goodger, Esq for the Defendant.

ISSUES:

1. Is the claimant entitled to payment of outstanding medical bills?

2. Is the claimant permanently and totally disabled as a result of his March 30, 1995 work-related injury?

EXHIBITS ADMITTED:

Joint Exhibit I:	Medical Records in 3 volumes totaling 2,215 pages.
Joint Exhibit II:	Stipulation.
Claimant's Exhibit 1:	List of medications.
Claimant's Exhibit 2:	Bills.
Claimant's Exhibit 3:	Transcript of deposition of Eric White, M.D.
Claimant's Exhibit 4:	Curriculum vitae of Paul Langevin.
Claimant's Exhibit 5:	Curriculum vitae of Daniel Walsh, M.D.
Claimant's Exhibit 6:	Curriculum vitae of Peter Upton, M.D.
Claimant's Exhibit 7:	Attorney's affidavit (a); Fee agreement (b); and Worksheets (c)
Defendant's Exhibit A:	Curriculum vitae of Richard Levy, M.D.
Defendant's Exhibit B:	Curriculum vitae of Mark Bucksbaum, M.D.

DEPARTMENT FORMS

Form 1, Employers' First Report of Injury	March 5, 1995.
Form 25, Wage Statement	April 7, 1995.
Form 21, Agreement for TTD Compensation	October 12, 1995.
IWRP, Individual Written Rehabilitation Plan	February 29, 1996.
Forms 13, Affidavits of Payment of Compensation	July 15, 1996, Sept. 24, 1998.
Form VR5, VR Closure Report	January 1, 1997.
Form 27, Notice of Intention to Discontinue Payments	March 5, 1999.

STIPULATION:

1. Claimant was an employee of defendant within the meaning of the Vermont Workers' Compensation Act (Act) at all relevant times.

2. Defendant was an employer within the meaning of the Act at all relevant times.

3. CNA Insurance Company was the workers' compensation insurance carrier for defendant at all relevant times.

4. On March 30, 1995, claimant suffered a personal injury by accident arising out of and in the course of his employment with defendant.

5. At the time of the injury claimant had an average weekly wage of $457.40 resulting in an initial compensation rate of $304.93.

6. At the time of the injury and thereafter, claimant has had no dependents within the meaning of the Act.

7. On March 3, 1999 a Form 27 was filed alleging that claimant had reached a medical end result for his work-related injuries with a permanent partial impairment rating of 33% whole person for his spinal injury. The Department approved the Form 27 on March 5, 1999.

8. The parties agree to the admission of a Joint Medical Record Exhibit.

9. The parties agree that the Department may take judicial notice of any and all forms or agreements between the parties in its files in this matter.

10. There is no dispute as to the qualifications of any of claimant's treating or examining health care professionals.

FINDINGS OF FACT:

1. The claimant was born on September 2, 1934. From 1948 to 1952 he worked on a farm. Following his discharge from the Army in 1963 he opened a bar where he worked until he sold it in 1989. In 1990 he began working at the Cortina Inn where he tended bar as the manager until he was injured on March 30, 1995.

2. On the day of his injury, the claimant was moving a keg of beer that slipped out of its container and started to go over the edge. When he reached over and grabbed for it, he immediately felt a sharp pain in the center of his back above the buttocks.

3. Prior to this incident, the claimant had a history of heart problems, back problems and diabetes mellitus. In 1993 he had open-heart surgery. In 1994 he had surgery on his back for pain that radiated down his left leg. Although he had diabetes, he was not taking insulin. Despite these pre-existing physical problems, he was able to work and do his physically demanding job every day.

4. Before the injury at issue in this case, the claimant had last seen his back surgeon, Dr. Harbaugh, on August 1, 1994 when Dr. Harbaugh released him from his care. Claimant had no problems with his right foot, and significantly, no signs indicative of foot drop.

Post Injury Medical Care

5. After the March 30, 1995 work-related accident, the claimant initially sought treatment at Rutland Regional Medical Center, (RRMC) then was referred to the Dartmouth Hitchcock Medical Center (DHMC) where Dr. Harbaugh saw him again.

6. Dr. Harbaugh determined that surgery would be necessary. He performed a laminectomy on May 17, 1995. The operative note indicates that the area from the third lumbar (L3) vertebra to first sacral (S1) vertebra was directly observed or palpated. Stenosis, but no free fragment disc material, was found during that procedure. However, after the surgery the claimant's pain was no different than before. A post operative MRI revealed a ruptured disc that had not been removed at the time of the operation.

7. Therefore, two days later, on May 19, 1995 Dr. Harbaugh again operated and removed a disc at the L3-4 level. After the second surgery, it was noted that the claimant significantly improved. He was discharged on May 22, 1995.

8. The claimant was seen at RRMC later in May and in June of that year for right leg pain and numbness. The May 30th note indicated that his pain developed after an active day.

9. After the second (May 19th) surgery, the claimant complained of symptoms in his right lower extremity.

10. By June of 1995 the claimant was having difficulty with his right leg. On June 5th, Dr. Harbaugh noted that he had a "question of subtle weakness if the extensor hallucis and dorsiflexors on the right" and that he had slight diminution in sensation in the right great toe. A MRI disclosed a swollen right L5 root. The assessment at that time was probable diabetic neuritis. The claimant was treated in the hospital for a few days, then discharged on June 8th with a diagnosis of diabetic neuritis.

11. A June 6, 1995 consultation report from DHMC notes that the claimant walked with an antalgic gait and that he had decreased sensation in the right foot. The diagnosis was radiculopathic back pain with L5-S1 distribution.

12. On July 7, 1995, Dr. James Wepsic performed an examination for the defendant. He stated that it was unlikely that there was any difference in the claimant's outcome based on the need for the second surgery on May 19, 1995.

13. When his surgeon, Dr. Robert Harbaugh, saw the claimant on July 10, 1995, he noted that the claimant continued to have persistent lower extremity pain, and peripheral numbness, despite postoperative imaging that demonstrated good decompression of the nerve roots. In the note for that visit, Dr. Harbaugh's also stated specifically, "I believe that he has an underlying diabetic neuritis which is his present problem. This problem was, however, exacerbated by a work-related disc herniation requiring surgery."

14. An August 10, 1995 physical therapy note from RRMC states that the claimant was water walking with and without a cane.

15. On a referral, the claimant began physical therapy at Vermont Sports Medicine (VSM) in the summer of 1995. On August 21 and August 28, notes from VSM stated that the claimant was "starting to get stronger" and was "feeling better." An October 5, 1995 note indicated that the claimant's functional status had improved and that he had increased his endurance and strength, although he did not have a significant change in his pain.

16. A VSM note of November 7, 1995 reported that the claimant's gait pattern included a toe drag on the right.

17. On November 14, 1995 the claimant presented to DHMC with a spine pattern of numbness and duskiness of the right forefoot.

18. When Dr. Seddon Savage saw the claimant at the Hitchcock Clinic on November 15, 1995, he diagnosed right leg pain caused by several contributing factors, including possible epidural scarring, although that had not been documented, and diabetic neuropathy.

19. DHMC notes from November 1995 indicate that the claimant also complained of pain in his left lower extremity.

20. On November 16, 1995 the claimant gave the physical therapist a referral for a right leg brace.

21. On November 24, 1995, the claimant was fitted with an orthotic brace for his right foot to compensate for the previously documented foot drop. The therapist noted that the claimant had been unable to walk safely on uneven terrain.

22. Dr. Kerri Wilks, neurologist, saw the claimant for a pain consultation at DHMC on January 10, 1996. She noted that he had not made the improvement he should have at that point. Among other things, she noted that he had " a blister on the bottom of his foot from his AFO for the foot drop."

23. When the claimant was seen at DHMC on January 10, 1996 for a physical therapy re-evaluation, a nickel size ulcer was noted on the plantar surface of his right foot, in an area covered by the orthotic brace. He was then referred to his primary care physician, Dr. William O'Rourke. Because of the diminished sensation associated with diabetic neuropathy, the claimant was unable to feel the blister as it developed.

24. A Functional Capacity Evaluation (FCE) at Vermont Sports Medicine on May 30, 1996 assessed the claimant's work capacity at sedentary to light.

25. On May 31, 1996 Dr. Bagley at RRMC commented that the claimant's last back operation left him with a foot drop that he thought was permanent.

26. An angiogram at RRMC indicated that the claimant has severe atherosclerotic disease. A radiology report of June 6, 1996 revealed vascular calcification consistent with diabetes.

27. Claimant developed cellulitis in the right forefoot, and gangrenous necrosis of the skin and soft tissue. On July 2, 1996, a consultant at RRMC diagnosed a diabetic foot infection and probable diabetic neuropathy. Bone destruction in the right great toe consistent with osteomyelitis was seen on x-ray.

28. Because of compromised circulation to the right foot, Dr. Daniel Walsh, a vascular surgeon at DHMC, performed a vein graft bypass to revascularize the right foot.

29. Claimant was discharged from DHMC on July 19, 1996 with several diagnoses including peripheral vascular disease, diabetes mellitus, history of hypertension, multiple discectomies in the lumbar region and a history of foot drop.

30. In the first two months after the surgery, Dr. Walsh noted that the claimant was doing well and that the foot was well revascularized. However, on October 29, 1996, the claimant presented with a swollen leg and some petechiae (pinpoint red spots). Because, the vein graft was intact and the pulses to the claimant's foot were good, Dr. Walsh opined that while the etiology of the claimant's symptoms was unclear, it did not appear to be related to the graft.

31. The claimant was readmitted to DHMC at the end of October 1996 for aspiration for what turned out to have been an abscess in the right leg. He progressed well post operatively with Dr. Walsh pronouncing that the foot was "essentially healed" on January 6, 1997.

32. Although the medical records indicate that the claimant had a severe diabetic problem, he was not taking insulin. His treatment was glyburide, tablets prescribed for type II (non-insulin dependent) diabetes.

33. On April 21, 1997 Dr. Robert Shoemaker evaluated the claimant for the defendant. He assessed the claimant with a 25% whole person impairment (33% spine) for his work-related injury. Dr. Shoemaker was unable to comment on permanency related to the claimant's circulatory problems, although he opined that those problems were primarily related to the claimant's diabetes. In a subsequent letter dated November 17, 1997, Dr. Shoemaker confirmed his opinion that the claimant had reached medical end result for his back condition.

34. Dr. Shoemaker described the process involved in the claimant's problems as: "since March 30, 1995, I would compare his impairments to a train, the engine of which was the March 30, 1995 event."

35. In November of 1997 the claimant had left leg numbness and vascular tests indicating mild lower extremity arterial occlusive disease on the left, with significant deterioration since the previous study.

36. In 1998 the claimant sought medical care from the RRMC emergency department as well as from Dr. Walsh at the Lahey-Hitchcock Clinic. Dr. Walsh noted that the right foot continued to do well, that the bypass was functioning nicely and that his foot remained healed. Emergency department notes indicate that the claimant complained of cramps in his calves that were due to severe peripheral vascular disease.

37. In March of 1999 the claimant returned to RRMC emergency department complaining of severe low back pain that had been increasing over the previous two weeks. He was admitted to the hospital where he was treated for two weeks. He was placed on bedrest and provided with pain relieving medications "without substantial improvement ensuing," according to Dr. David Austin's discharge summary. Neurologist Dr. Stephen Brittain, orthopedist Dr. Joseph Vargas and physiatrist Dr. Michael Kenosh then evaluated him. Dr. Austin assessed the claimant's pain as both neuropathic and mechanical. MRI of the lumbosacral spine showed evidence of degenerative disk disease, stenosis at the L1-L2 and L3-L4 levels attributed to degenerative disk osseous changes, some scar tissue, but no evidence of herniated disc. At discharge, the etiology of the back pain remained undetermined. Other diagnoses were: diabetes, arteriosclerotic and hypertensive cardiovasvular disease, peripheral vascular disease, hyperlipidemia, and a history of graft procedure of the foot.

38. On March 5, 1999 this Department approved CNA's Form 27 to discontinue temporary total disability benefits based on Dr. Shoemaker's report that claimant had reached a medical end result with a 33% permanency of the spine.

39. On April 12, 1999 the claimant was admitted to the Dartmouth Hitchcock Medical Center with complaints of escalating low back pain. After the four-day hospitalization, Dr. John Turco identified the claimant's principal diagnoses as intractable low back pain and left sciatica. Secondary diagnoses were coronary artery disease, diabetes, history of hypertension, history of high cholesterol and history of right foot drop. The hospital admission was for pain management. In his discharge summary, Dr. Turco wrote, "At this time, the etiology of his pain was felt to be consistent with a post-laminectomy phenomenon with contributing factors of degenerative disc disease and diabetic neuropathy." He was discharged on numerous medications and with a recommendation for aggressive physical therapy.

40. When Dr. Walsh saw the claimant again on August 16, 1999, he performed several tests, then determined that the graft to the right foot had stenosed, decreasing the blood supply, a problem for which further vascular surgery was necessary. On September 14, 1999, Dr. Walsh performed a vein patch angioplasty that resulted in improvement in the blood supply to the claimant's right foot.

41. At the Hitchcock Clinic on October 11, 1999, Dr. Comi documented bilateral retinopathy, a complication of diabetes. He recommended careful monitoring of medications and meticulous foot care to avoid more complications.

42. On October 11, 1999 Dr. Walsh noted that the claimant had some swelling in his foot, palpable pulses and a healing ulcer. He debrided that ulcer.

43. On January 13, 2000, Dr. Walsh opined, "to the extent that his initial foot lesion was related to his brace then this was a workman's compensation issue though his diabetes and consequent art[er]ial disease are dominant factors."

44. On February 14, 2000 the claimant was admitted to DHMC with a new area of ulceration on his right foot. Studies revealed progressive destruction of bone at the great toe. On February 17th, Dr. Sparks noted that the cellulitis from the ulcer on the claimant's foot was resolving on intravenous antibiotics. On February 23rd the claimant's foot ulcer was surgically debrided and bone in the right great toe removed.

Claimant's Testimony

45. Claimant described his current medical condition as constant back pain, sometimes going down his right leg, pain that severely limits what he can do. He has little movement of his right foot and walks with a quad cane.

46. He described a typical day in which simple activities of daily living are prolonged because of his instability. Both the distance and time involved in activities are limited because of pain. For example, he tries to walk down his 70-foot driveway; he sometimes needs a ride back up. He testified that he is unable to stand at church. He moves slowly. He cannot bend over to do things. His sleep is restless.

47. According to the claimant, he is not able to do any of the jobs he did in the past, including farm work and tending bar.

48. Claimant is sixty-five years old. He said that he does not travel or go out socially because he cannot negotiate steps safely.

Claimant's wife's testimony

49. Mrs. Licinsky testified that she and the claimant have been married for thirty-eight years and have five children. She described her husband's condition prior to the March 1995 injury as healthy. Although he had pre-existing health conditions, he was able to work everyday, often long hours and seldom with a day off.

50. From her lay perspective, Mrs. Licinsky testified that the claimant recovered fully from his 1994 back surgery. He returned to work, continued to work long days and did not exhibit signs of pain.

51. Mrs. Liscinsky was with her husband after his May 17, 1995 surgery when she observed that he was in a great deal of pain. That pain seemed to have been relieved somewhat after the second surgery two days earlier.

52. Although she could not be precise about dates, Mrs. Liscinsky recalls noticing a blood blister on her husband's foot after he started wearing the foot brace. The claimant could not see the blister because he could not bend over far enough. And he could not feel it. At first, Mrs. Liscinsky thought the blister would go away on its own. However, one day when she took off her husband's sock, she noted that it was full of blood. In her opinion, his right foot has not been the same since then.

53. Mrs. Liscinsky never saw her husband walk barefoot, nor could she remember anything other than the leg brace that would account for the blister.

54. Mrs. Liscinsky corroborated her husband's description of his physical limitations.

55. Mrs. Liscinsky testified that it is she who handles the household finances. She explained that after her husband's work-related injury in 1995, CNA paid all the medical bills until April 1999. Since March 23, 1999 they have been billed for $64, 251.74, for services including ambulance transportation, emergency department care, surgery and prescriptions for pain medications. Charges for those services are listed in Claimant's Exhibit 2 with supporting documentation.

Vocational Rehabilitation

56. Paul Langevin is a vocational rehabilitation counselor hired by CNA work with the claimant in 1995 and 1996. After an initial vocational assessment, Mr. Langevin determined that the claimant was entitled to vocational rehabilitation services. He then developed an Individual Written Vocational Rehabilitation Plan (IWRP) which he and a representative from CNA signed. The IWRP suggested "maybe part-time employment" was a goal. But the claimant

did not sign that form because he believed a number of medical conditions prevented him from engaging in work activity that could return him to suitable employment. At that time, the claimant was in the process of securing social security disability benefits.

57. In 1996, Mr. Langevin and the claimant decided to suspend vocational rehabilitation benefits. Although the claimant was clearly "entitled," they decided it was unlikely that he would be successful given his multiple medical conditions. Officially, the services were closed, but with the understanding that could be re-opened in the future. This Department agreed.

58. At the hearing Paul Langevin testified that there was nothing in Dr Bucksbaum's report to alter his opinion about the claimant's work ability. In Langevin's opinion, the same barriers to the claimant ability to become gainfully employed exist today as when the vocational rehabilitation benefits were suspended.

59. In response to CNA's suggestion that the claimant could perform a business manager job, Mr. Langevin countered that the claimant's limited mobility, with severe limitations on his ability to travel would restrict realistic access to a sedentary job. Furthermore, Langevin opined that the claimant medical conditions would limit home employment or self-employment.

Expert Medical Opinions

60. Dr. Levy testified for CNA. He reviewed the claimant's records, but never examined him. Dr. Levy agreed that the claimant had pre-existing diabetes at the time of his work-related injury. He acknowledged that the claimant had back surgery in 1994, but had not seen a doctor from August 1994 until March of 1995.

61. Dr. Levy did not dispute that the claimant had a work-related injury in March of 1995 and agreed that it was likely he herniated a disc at the time of the lifting incident, with the onset of severe pain. When Dr. Harbaugh operated in May of 1995, he explored the claimant's back from L2 to S1 during the two procedures two days apart. And he agreed that exploration of the L5 nerve root could be a cause of the claimant's foot drop and that it is possible that the surgeon dinged the nerve root.

62. Dr. Levy agreed that persons with diabetes are more vulnerable to problems than those without this chronic disease. When such a patient has surgery, he is stressed to the point that a pre-existing diabetic neuropathy can worsen. In this case, it is possible that the diabetic process caused the claimant's foot drop. At the same time, it is equally possible that the surgeon damaged a nerve that led to the foot drop. The surgery itself would be a physiological stress that could result in foot drop.

63. Dr. Levy went on to agree that the claimant has a foot drop as a result of the surgery, then developed an ulcer on his foot. He wore a foot brace as a result of the foot drop, a brace that did not fit well, as noted by a physical therapist. An ulcer developed on the metatarsal as a result of the foot brace, the location where osteomyelitis later developed. Complications from the osteomyelitis required surgeries from July 1996 through 1999.

64. Dr. Levy was referred to Dr. Harbaugh's July 10, 1995 note stating, "I believe that he has an underlying diabetic neuritis, which is his present problem. This problem was, however, exacerbated by a work-related disc herniation requiring surgery." Dr. Levy agreed that this causation mechanism asserted by Dr. Harbaugh is possible. The claimant's diabetic condition set him up for these problems and the stress of the surgery itself caused the exacerbated diabetic neuritis.

65. Dr. Levy concluded the cross-examination questioning by agreeing that it is possible that but for the work injury, the claimant would not have had the back surgery, which then exacerbated the diabetic neuropathy, which led to the foot drop, and the ongoing surgeries. It is a much more complex web of causation than the norm, but he could not rule any of that out. He could not state that such a web of causation was more probable than not, but testified that it is entirely possible.

66. Next, Dr. Mark Bucksbaum testified for the employer. On direct examination, he testified that the claimant's foot brace could not have contributed in any manner to the development of his foot ulcers. Yet he also testified that with diabetes, a small nick or cut can result in a limb-threatening situation. In Dr. Bucksbaum's opinion, an incidental nick and the claimant's vascular disease would be the most significant factors contributing to the claimant's foot problems. He testified that the "brace itself cannot be held at fault."

67. Dr. Bucksbaum agreed that the claimant had only a sedentary work capacity. He opined that it would be possible to find a job for him, although it could not involve lifting or any exertions.

68. Dr. Bucksbaum agreed that the claimant's work-related injury resulted in a disc herniation, which resulted in the first surgery and a 25% whole person impairment. Because this injury occurred before April 1, 1995, the 25% WP permanency equates to 41.5% of the spine under WC Rule 11. Therefore, Dr. Shoemaker's 33% spine rating is incorrect.

69. Given the claimant's limitations in range of motion, Dr. Bucksbaum opined under the range of motion model that the claimant's permanency would be 33% WP or 55% of the spine.

70. If Dr. Bucksbaum were to rate the permanency of the claimant's vascular problems, it would be a Class 2 on page 198 of the Guides, with an additional 10% whole person rating.

<u>Daniel Walsh, M.D.</u>

71. Dr. Walsh, the claimant's treating vascular surgeon, testified for the claimant. Dr. Walsh has specialized in vascular surgery since he began practicing in 1983 and has been treating the claimant from 1996 through to the present. He had been provided with all of the claimant's medical records. Dr. Walsh testified that he had sufficient information to render his opinions with a reasonable degree of medical certainty.

72. When Dr. Walsh first performed surgery, the venous graft, in July of 1996 the claimant had a non-healing ulcer on the metatarsal or ball of the large or great toe on his right foot, a common occurrence in patients with diabetes. From the medical records linking the development of the ulcer to the brace the claimant had been wearing, Dr. Walsh concluded that the brace caused a blister that led to an ulcer. There is nothing in the medical records to suggest another cause for the development of the ulcer. Once the foot is traumatize in some way and a lesion develops one with diabetes lacks the circulation necessary to provide oxygen to heal it. Therefore, a bypass is the only way to supply the area with the necessary oxygen.

73. Unfortunately the claimant needed additional surgery in 1999 where the bypass had been sewn. If it had not been for the ulcer none of the three surgeries Dr. Walsh performed would have been necessary.

74. Dr. Walsh testified that his treatment has been reasonable, necessary and causally related to the ulcer that was due to the brace.

Peter D. Upton, M.D.

75. Dr. Upton, board certified neurosurgeon, testified for the claimant. He had received all the medical records and treated him in April and May of 1995. Based on his own education and experience and the materials he reviewed, Dr. Upton stated that he could render his opinions within a reasonable degree of medical certainty.

76. When Dr. Upton first saw the claimant on April 1, 1995 in the RRMC emergency department, the claimant presented with severe pain in his right low back and right leg. Because the pain could not be controlled in the emergency department, the claimant was admitted to the hospital in an effort to get the pain under control. At that time Dr. Upton suspected a ruptured disc at the 3rd and 4th lumbar vertebrae on the right (L3-L4). He was aware that the claimant had surgery in 1994, but that was on the left side.

77. The Rutland Regional Medical Center discharge summary from April 1995 did not include a confirmatory diagnosis because the MRI had not yet been done. Dr. Upton opined that the claimant's problems were probably a disc, but could have been a neuropathy. Given the MRI results, Dr. Upton was satisfied that it was a herniated disc had had nothing to do with the claimant's diabetes.

78. Dr. Upton was puzzled by the May 17, 1995 operative report from Dr. Harbaugh (the first of the two surgeries in 1995). The operative report does not mention a herniated disc at L3-4. It suggests that the surgeon was looking for a disc at L4-5, rather than L3-4, although palpation was done throughout. The surgeon did an operation for spinal stenosis, and stated that he did not find a ruptured disc. Dr. Upton explained that the potential problem with palpating nerve roots, which was done on May 17, was to irritate and damage them.

79. Dr. Upton noted that after a post operative MRI revealed a ruptured disc at L3-4, Dr. Harbaugh operated again, found the rupture and took it out. When the claimant was discharged, he was significantly improved. The preoperative pain he had on his right thigh and shin was much better, although he still had back pain from the surgery itself.

80. Dr. Upton noted that the records at DHMC are not completely consistent. He was able to determine what the actual surgical procedure was from reading the report, not by relying on statements by others about what the procedure was.

81. After reviewing the follow-up note by Dr. Harbaugh dated June 5, 1995 documenting a question of subtle weakness on the right, Dr. Upton opined that the claimant evidenced problems with the L-5 nerve root which would have been in the area palpated during the surgery. Palpation in that area can cause swelling which in turn can cause foot drop. Dr. Upton reasoned that independent diabetic neuritis is too much of a coincidence to be the cause of the foot drop when compared to the fact that initial symptoms followed two extensive surgical procedures in two days, one of which involved palpation of the involved nerve root.

82. Although Dr. Harbaugh attributed his post surgical problems to diabetic neuritis, his July 10, 1995 note reveal his opinion that the work-related injury and concomitant surgery exacerbated that neuritis. Dr. Upton agrees that surgery would exacerbate the underlying condition, he believes a direct answer is more probable. According to Dr. Upton's reasoning, the claimant's problems were more mechanical or physical in origin. What began as a ruptured disc at the 4^{th} lumbar vertebra led to surgery that involved nerves at several vertebral levels. That led to the foot drop that Dr. Upton believes would not have occurred had the first surgery simply removed the ruptured disc.

83. Dr. Upton opines that the surgery caused direct trauma to the nerve, which affected the foot drop, either directly or indirectly. Yet stress, including surgery, is also enough to alter one's chemistry levels and increase the blood sugar. In Dr. Uptons' opinion, it is highly unlikely that the claimant's foot drop would have occurred spontaneously.

84. Dr. Upton agreed with Dr. Shoemaker's train analogy when he concluded that all of the claimant's problems go back to the March 1995 injury. The herniated disc necessitated the surgery that damaged a nerve that caused a foot drop that necessitated a brace that caused a blister that led to an ulcer that compromised the circulation that necessitated vascular surgical procedures.

Eric White, M.D.

85. Dr. White testified on behalf of the claimant. He is an orthopedic surgeon who reviewed a complete set of the claimant's medical records. Dr. White opined that the March 30, 1995 work injury caused the disc herniation necessitating the surgery in May of 1995. In his opinion, the foot drop was the result of that surgery. Dr. White supported his opinion with a comparison of the claimant's pre and postoperative clinical signs. He was able to heel-toe walk in April 1995 prior to the surgery which shows that he had no preoperative nerve root involvement, yet he had absent reflexes in the right ankle on May 22, after the surgery which he did not have before.

86. Dr. White recognized that the claimant had diabetic neuropathy that may have predisposed him to injury. However, it was the surgical exploration necessitated by the ruptured disc itself and the scar tissue that caused the swollen fifth nerve root. He agreed that it was theoretically possible for a diabetic condition to cause foot drop, but testified that such an occurrence would be unusual, particularly in the face of a disc herniation and surgical exploration. In his opinion, the diabetes was a contributing cause, but not the primary one. Alternately, he opined the surgery necessitated by the work injury exacerbated the diabetic neuropathy. Dr. White concurred that the ill-fitting brace would lead to an ulcer, which led to the claimant's vascular surgeries. The April 1999 hospitalizations were all related to the work injury, in Dr. White's opinion that he said is in concurrence with Dr. Turco's opinion.

Permanency Benefits

87. The defendant suggests that the claimant is entitled to 108.9 weeks of permanency benefits based on Dr. Shoemaker's permanency evaluation of 33% of the spine (25% whole person). However, Dr. Bucksbaum agreed that such a calculation would be erroneous and that the proper calculation would be 41.5 % or 136.95 weeks.

88. The claimant maintains that he is permanently totally disabled. William A. O'Rourke, M.D. internist in Rutland who coordinated the claimant's medical care for years, opined in a January 3, 2000 letter that the claimant is 100% disabled.

Attorney Fees and Costs

89. The claimant submitted evidence of his contingency fee agreement with his attorney, worksheet for attorney time and documentation supporting necessary costs totaling $5,332.45. Hours total 97.1 in lawyer time and 80.7 in paralegal time according to the attorney's affidavit and supporting documentation.

CONCLUSIONS OF LAW:

1. In workers' compensation cases, there must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden Lumber Co.,* 112 Vt. 17 (1941). Where the causal

connection between an accident and an injury is obscure, and a layperson would have no well-grounded opinion as to causation, expert medical testimony is necessary. *Lapan v. Berno's Inc*., 137 Vt. 393 (1979).

2. Therefore, the party bearing the burden of proof in this complex case must support its position with medical evidence and prove that its position is the more probable hypothesis.

3. It is not disputed that the claimant suffered a compensable work-related injury in March of 1995. CNA entered into an appropriate Form 21 with the claimant for that injury and paid for all work-related medical bills until April of 1999, after which it denied responsibility for any of the claimed medical bills. Because CNA seeks to terminate benefits for a claim it had accepted, it has the burden of proving it is justified to do so. "Where the injury and resultant disability are unquestioned, the burden of proof is on the employer who seeks to terminate compensation upon the grounds that the disability has ceased." *Merrill v. U.V.M.*, 133 Vt. 101, 105 (1974). "Similarly, when the employer seeks to terminate coverage for medical benefits, it has the burden of proving that the treatment is not reasonable." *Rolfe v. Textron, Inc*., Opinion No. 8-00WC (May 16, 2000). Both procedurally and substantively, CNA has failed to meet its burden.

4. Because CNA never filed a Form 27 to discontinue medical benefits, it must continue to cover them until an adequately supported form is filed. *Gilbeau v. CEPCO, Inc*., Opinion No. 24-95WC (May 23, 1995); *Thiverge v. Groleau*, Opinion NO. 67-94WC (April 20, 1995).

5. Also, given the medical facts in this case, CNA cannot meet its burden. As a direct result of the accepted and clearly compensable back injury, the claimant underwent two surgical procedures on his back. He had lower extremity losses after that surgery and developed foot drop, a deficit associated with a lumbar 5 injury. Dr. Upton opined that palpation in the lumbar area of the claimant's back caused the foot drop or aggravated the neuropathy that led to foot drop. Dr. Bagley linked the foot drop to the nerve root injury when he stated that the last back operation left him with a foot drop that Dr. Bagley thought was permanent.

6. Neither Dr. Bucksbaum nor Dr. Levy can wholly discount the premise that the work-related surgery led to the foot drop, although neither believes it probable. In light of the strong medical testimony from Dr. Upton and Dr. White who opined that the causation from surgery to foot drop is the more probable explanation, the defendant's "possible but no probable" argument cannot support its burden.

7. The alternative theory for compensability for the foot drop is that it was caused by diabetic neuropathy, which was exacerbated by the two surgeries. Dr. Levy concedes that it is possible. Dr. White and Dr. Upton agree that it is a potential cause of the claimant's condition. The claimant's treating surgeon, Dr. Harbaugh, stated that the work-related injury and its treatment exacerbated the diabetic neuropathy.

8. Once the train was in motion, as Dr. Shoemaker stated, it kept moving. After the injury, surgery and foot drop came the brace. Common sense, direct observations and clear medical documentation support the claimant's position that an ill-fitting brace created a blister on the claimant's foot that he could not feel. That blister became an ulcer that eventually compromised the circulation to his foot, necessitating vascular surgery.

9. With the causal connection between the brace and the ulcer, the reasonableness, necessity and causal connection between the claimant subsequent surgeries and his foot problems is well established.

10. While unusual and complex, the causal chain has been established between the claimant's March 1995 work-related injury and his subsequent medical treatment through to the present. The injury necessitated the two May 1996 back operations. The surgery led to neurological changes and then to full-blown foot drop, which required a brace that unfortunately did not fit properly. That brace caused a blister that developed into an ulcer that compelled ongoing medical care.

11. The defendant contends that the claimant's diabetes, unrelated to the work-related injury, is the only logical explanation for the claimant's current condition. The diabetes is clearly a part of this complex causal web, which is why this claimant has had complications that one without diabetes might not have had. But the claimant's medical vulnerability does not negate compensability. It is "black letter law that an employer takes each employee as is, and is thus responsible under our workers' compensation law for an accident or trauma which disables one person but which might not disable another." *Petit v. No. Country Union High Sch.*, Opinion No. 20-98WC (Apr. 28, 1998); "[C]ompensation is not based on any implied warranty of perfect health or immunity from latent and unknown tendencies to disease which may develop into positive ailments if incited into activity by accidental injury received in the performance for the work for which he is hired." *Morrill v. Bianchi*, 107 Vt 80, 87-88 (1935). As long as the work injury accelerates or exacerbates an underlying condition, the claim is compensable, even if the condition would inevitably lead to the same result. *Marsigli Estate v. Granite City Sales*, 124. Vt. 95, 103 (1964).

Degree of Impairment

12. The claimant argues that he is entitled to permanent total disability pursuant to 21 V.S.A. § 644. Because his injury predates the 2000 amendment to § 644, to qualify, his injury must either fit into one to categories enumerated in § 644 or his work injury must have as severe an impact on his earning capacity as one of the scheduled injuries. See, *Bishop v. Town of Barre,* 140 Vt. 565 (1982). On this issue, the claimant bears the burden of proof.

13. Injuries enumerated in § 644 include total and permanent loss of sight in both eyes, the loss of both feet at or above the ankle, the loss of both hands at or above the wrist, the loss of one hand and one foot, a spinal injury resulting in permanent and complete paralysis of both legs or both arms or of one leg and one arm, and a skull injury resulting in incurable imbecility or insanity.

14. The claimant must prove that he is disabled for gainful employment and that he is not able to "uninterruptedly do even light work due to physical limitations." *Gravel v. Cabot Creamery*, Opinion No. 15-90WC (July 10, 1991) (citing *Buttler's Dairy v. Honeycutt*, 452 So.2d. (Fla. App.1984)).

15. Claimant's primary physician found him to be totally disabled. Dr. Bucksbaum, the employer's expert, agreed to the proposition that the claimant is unable to perform uninterrupted work. Claimant's work history, obvious physical limitations and the totality of the medical opinions combine to convince me that this claimant, like the claimant in *Fleury*, is "totally disabled for gainful employment." *Fleury v. Kessel/Duff Constr*. Co., 148 Vt. 415, 419 (1987).

Attorney Fees and Costs

16. Having prevailed in this case on all matters, the claimant is entitled to an award of costs as a matter of law and attorney's fees as a matter of discretion." 21 V.S.A. § 678(a); Workers' Compensation Rule 10(a). He is therefore awarded 20% of the amount of the permanency award, not to exceed $7,000 and costs in the amount of $5,332.45.

ORDER

Based on the Foregoing Findings of Fact and Conclusions of Law, the defendant is ORDERED to pay the claimant:

1. Medical benefits as outlined in Claimant's Exhibit 2;

2. Permanent total disability benefits;

3. Attorney fees and costs as outlined above.

Dated at Montpelier, Vermont this 22nd day of March 2001.

Clerical errors corrected this 30th day of March 2001.

_____

R. Tasha Wallis
Commissioner

Appeal:

Within 30 days after copies of this opinion have been mailed, either party may appeal questions of fact or mixed questions of law and fact to a superior (county) court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§ 670, 672.