Fecto v. Speciality Paperboard (March 31, 1996)

STATE OF VERMONT
DEPARTMENT OF LABOR AND INDUSTRIES

Clayton Fecto	*)*	*File #: E-23505*
	)	*By: Barbara H. Alsop*
v.	*)*	*Hearing Officer*
	)	*For: Mary S. Hooper*
Specialty Paperboard	*)*	*Commissioner*
	)	
	)	*Opinion #: 9-96WC*

Hearing held at Montpelier, Vermont, on January 11, 1996.
Record closed on January 31, 1996.

APPEARANCES

David A. Gibson, Esq., for the claimant
Glen L. Yates, Jr., Esq., for the defendant

ISSUE

What is the amount of permanent partial disability compensation to which the claimant is entitled?

THE CLAIM

1. Permanent partial disability compensation pursuant to 21 V.S.A. §648 for 34% of the spine and 78% of the left lower extremity.

2. Medical and hospital benefits pursuant to 21 V.S.A. §640.

3. Attorneys fees and costs pursuant to 21 V.S.A. §678(a).

STIPULATIONS

1. On June 17, 1992, the claimant was an employee within the meaning of the Workers Compensation Act.

2. On June 17, 1992, the defendant was an employer within the meaning of the Workers Compensation Act.

3. On June 17, 1992, the claimant suffered a compensable injury while in the employ of the defendant.

EXHIBIT

Joint Exhibit 1 Medical records notebook

FINDINGS OF FACT

1. The above stipulations are accepted as true and the exhibit is admitted into evidence. Notice is taken of all forms filed with the Department in this matter.

2. The claimant worked for the defendant for a period of approximately 26 years. In 1988, he suffered a severe injury to his left shoulder, which resulted in two surgeries and a permanent partial impairment to the left upper extremity, as well as a permanent restriction to light duty work.

3. On June 17, 1992, the claimant was moving some carton stock. The boxes of stock were on skids, and each box weighs about 104 pounds. As he picked up the boxes on the arms of a forklift and began to back out of the area, an action that required turning the stack, one of the boxes caught on the upright pole that demarked the shelf on which the boxes had been sitting and twisted. The claimant alit from the forklift and bent over to push the box back onto the forks in a straight line. In leaning over, he felt a sharp pain and heard a popping noise in his lower back. He finished the job, and then went to report the injury to the office.

4. The claimant went home, and then went to see Dr. Idelkope on the same day. Dr. Idelkope assessed the problem as a muscle strain of the leg, specifically the quadricep, and lower back, and placed the claimant on a muscle relaxer with a recommendation of no lifting or standing for a prolonged time. The claimant did not respond well to the medication, and a CT scan was ordered for the spine. The CT scan showed very minor changes of facet joint arthroplasty at L3-4 on the left, and at L4-5 bilaterally. The balance of the scan was normal.

5. At the request of the employer, the claimant was seen by Dr. Bresnahan,

who confirmed the diagnosis. As a result of the finding that the injury was in all likelihood a muscle strain, the claimant was referred to physical therapy. The claimant then was referred to Dr. Chard in August of 1992.

6. Dr. Chard found that the claimant was severely impaired by his back pain, although he could not find an explanation for the extent of the claimant s complaints. He found that the claimant seemed to have hypersensitive muscles, with a tendency for muscle spasm, and that he would expect that physical therapy would be effective in dealing with this problem. Thereafter, at Dr. Chard s direction the claimant received a local anesthetic injection, which provided some brief relief. The claimant continued in physical therapy, and began to show some improvement.

7. In September, the claimant reported an increase in symptoms, apparently due to overexertion. Dr. Chard began to believe that there might be some disc involvement in the claimant s symptoms, but expressed concern about the possibility of an MRI, as the claimant was severely claustrophobic. He was referred for a neurological consultation to Dr. Kerri Wilks.

8. Dr. Wilks took a history from the claimant that indicated that the injury to the quadricep may have occurred at some point prior to May 19, 1992, and may not have been related to work. Thereafter he told the story of the work injury as being one to his back. She found that the pain pattern was strange, in that the primary indication was of a high lumbar disc problem, with an unexplainable lower lumbar weakness. She ordered an MRI with precautionary valium premedication due to his claustrophobia.

9. The MRI was performed on October 13, 1992, and indicated a minimal posterior bulge at the L4-5 disc, with no evidence of HNP, presumably a herniated nucleus pulposus. Based on this finding and the claimant s continued pattern of muscle spasm related to pain in his sciatic notch, Dr. Wilks referred the claimant for an epidural block to assist with the pain syndrome. He had two epidural blocks, with some improvement after the first one.

10. The claimant was referred by his rehabilitation counselor from the insurer to Work Hardening of New Hampshire, Inc., for a work capacity evaluation on December 2, 1992. The claimant did not complete the evaluation, complaining of a serious setback in his symptoms after the first day of the evaluation. The report of the evaluation indicated that, while

the tests to evaluate the consistency of the effort shown by the test subject were passed, the claimant participated without enthusiasm in the testing, and that results in the portion of the testing that was completed did not correlate with his diagnosis. The testers reported that the claimant left the facility after the examination in no apparent discomfort, reporting that he felt fine. Other medical records reflect that the claimant reported that he was returned to square one by the testing, and that he refused to return to complete the testing.

11. The claimant was seen by Dr. A. Douglas Lilly on February 11, 1993, at the request of the insurer. Dr. Lilly reviewed the claimant s history, treatment record and process and determined that the claimant had made substantial progress in recovering from his work injury, described as a bulging disc at L4-5. According to Dr. Lilly, the claimant reported to him that he was greatly improved after the epidural cortisone injections. Dr. Lilly opined that the claimant would continue to improve with a likely end medical result of April 1, 1993, with a permanency of 5% to the lumbar spine,
according to the AMA Guides to the Evaluation of Permanent Impairment, Third
Edition Revised.

12. The claimant began to treat with a chiropractor, Dr. Loyall Allen, on May 3, 1993. Dr. Allen is certified in the use of thermography for diagnosis and assessment. He is also certified in the use of the AMA Guides, and has been qualified as an expert witness in Wisconsin and New Hampshire. On May
3, 1993, he determined that the claimant was suffering from a subluxation complex of the lumbosacral spine. His impression at that time was that the damage he observed was consistent with a sprain/strain type of injury as described by the claimant.

13. Dr. Allen treated the claimant with a number of modalities over a period of a year and a half, and has placed the claimant at an end medical result. He indicates that the claimant will continue to need supportive care in the future to prevent further deterioration. Over the course of his treatment of the claimant, he has noted that the claimant has had increased symptoms on a
number of occasions associated with certain activities, such as golf, yard work, vacuuming and slipping on ice. In one particular incident, the claimant was struck in the face by a closing door at a Rich s Store, which resulted in an exacerbation of his condition, although it had no cumulative effect on his permanency.

14. Dr. Allen performed a permanency evaluation of the claimant on January

4, 1995. He testified to his basis for concluding that the claimant had suffered a 45% impairment to the whole person, or a 20% impairment to the whole person attributable to the spine, a 32% impairment to the left lower extremity and a 2% impairment to the right lower extremity. He based his calculations on the diagnosis related estimate of the impairment of the spine, and the range of motion and sensory loss model for the lower extremities. He testified extensively to his calculations, but also testified that all of the problems that he found in the lower extremities were caused by the radiculopathy attributable to the impairment of the spine.

He found no evidence of muscular atrophy or of loss of bowel control, which would suggest a greater degree of impairment to the spine.

15. Dr. Allen combined the numbers from the DRE for the spine with the range of motion model for the lower extremities. There is no support in the AMA Guides for this procedure. He has mixed the two models together, resulting in duplicative compensation for the same radiculopathy. Therefore, his opinion is not accepted.

16. The claimant was also evaluated for permanency by Dr. Wilks on August 4, 1993. At that time, she found that he had suffered a 14% impairment to the whole person which equates to a 24% impairment of the spine. Her evaluation was based on the third edition, revised, of the AMA Guides. When later asked to convert to the fourth edition, she pointed out that he reached an end medical result at a time when the third edition was in effect, and that conversion to the fourth edition would result in a lower rating for the claimant, which was inappropriate in this case. She also indicated that the AMA Guides did not provide a way to evaluate the peculiar spasm of the left quadricep nor a way to assess the trigger points in the sciatic notch. Accordingly, she felt the appraisal was low. She recommended the continuation of the as- needed chiropractic adjustments, as these were the most effective treatment the claimant received.

17. The claimant was seen by Dr. Lilly again on December 5, 1994. Based on his evaluation on that date, using the fourth edition of the AMA Guides, Dr. Lilly found that the claimant had suffered a 17% impairment to the lumbar spine. He based his calculation on Table 75, which is a table applicable to the Range of Motion Model in the Guides. Dr. Lilly made no allowance for any

changes in the claimant s range of motion in reaching his conclusion. Dr. Lilly confirmed the propriety of ongoing chiropractic care for palliative purposes.

18. The carrier has advanced the sum of $22,735.81 to the claimant as permanency in this matter. That sum reflects a payment of 67.65 weeks of compensation. This equals 20.5% of the maximum award for a spinal injury,
and reflects a compromise between Dr. Wilks and Dr. Lilly s assessments.

19. The claimant has produced evidence that his attorney has spent 69 hours
and 40 minutes in his representation of the claimant and expenses of $1,274.19, including the sum of $550.00 for the impairment report of Dr. Allen and $400.00 for the testimony of Dr. Allen.

20. On February 6, 1996, the attorney for the defendant filed by facsimile what purports to be a Supplemental Memorandum Regarding Attorneys [sic] Fees.
This memorandum has not been considered in this decision, as having been filed in an untimely manner.

CONCLUSIONS OF LAW

1. In workers compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. Goodwin v. Fairbanks, Morse Co., 123 Vt. 161 (1963). The claimant must establish by sufficient credible evidence the character and extent of the injury as well as the causal connection between the injury and the employment. Egbert v. The Book Press, 144 Vt. 367 (1984).

2. 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 & Martin Lumber Co., 112 Vt.
17 (1941). Where the causal connection between an accident and an injury is
obscure, and a lay-person would have no well grounded opinion as to causation, expert medical testimony is necessary. Lapan v. Berno s Inc., 137
Vt. 393 (1979).

3. The sole issue for decision here is which doctor s permanency rating, if

any, is to be accepted as the measure of the claimant s impairment. The claimant has produced two opinions, seriously divergent, both from treating physicians. Although Dr. Allen claims to be familiar with and trained in the use of the AMA Guides, his performance in this regard was seriously lacking in this case. By his own testimony, he indicated that he was combining the Injury Model and the Range of Motion Model in determining the claimant s impairment pursuant to the fourth edition of the Guides. The Guides states: All persons evaluating impairments according to Guides criteria are cautioned that either one or the other approach should be used in making the final impairment estimate. If one component were used according to Guides recommendations, then a final impairment estimate using the other component usually would not be pertinent or germane. Guides, p. 3/94. Because of Dr. Allen s lack of comprehension of the importance of this principle and his duplication of benefits by his mixture of the two components, his analysis cannot be accepted in any material way.

4. Similarly, Dr. Lilly s analysis of the claimant s disability is also flawed by a misuse of the Guides. His reliance on Table 75 is comparable to that disapproved in Eric Beauregard v. Grand Union, Opinion No. 71-95WC. As was indicated there, Table 75 applies to the Range of Motion Model for determining permanency, and requires combination with range of motion impairment estimates and with whole-person impairment estimates involving sensation, weakness, and conditions of the musculoskeletal, nervous, or other organ systems. Table 75, fn 2. Since Dr. Lilly found limitations in the claimant s range of motion and issues of loss of sensation and weakness, his failure to include these findings in his rating is fatal to his opinion in this case.

5. The only remaining opinion is that of Dr. Wilks, who appears to have used the edition of the Guides at her disposal in an appropriate and conscientious way. Her opinion is troublesome in that it does not account for the peculiar cramping of the claimant s thigh, and in that the fourth edition of the Guides was available at the time she performed her permanency evaluation. However, given that the fourth edition was published only two months prior to the evaluation, I cannot find that it was inappropriate to use the older version at that time. Therefore, I find that the evaluation of Dr. Wilks is the best estimate of the claimant s permanent partial impairment, and becomes the most probable hypothesis of the claimant s permanency. The claimant is therefore entitled to permanency in the amount of 24% of the spine. As he has already been advanced 20.5%, he is entitled

to an additional payment reflecting 3.5% of the spine.

6. An award of attorney s fees is discretionary. In this case, where the bulk of the case involved the request for compensation based on Dr. Allen s testimony and report, and where that testimony and report have been rejected as the basis for an award, the claimant cannot be said to have prevailed in a substantial way. Accordingly, an award of attorney s fees for the bulk of the dispute would be inappropriate. On the other hand, the offer of compromise by the insurer did not reflect the amount to which the claimant was actually entitled, and hence an award of some amount is warranted. The claimant will be awarded the sum of $700.00 in attorney s fees, reflecting 20 hours of attorney s time, which is a reasonable estimate of the amount of time necessary to obtain the result here.

7. A prevailing claimant is entitled as a matter of law to his costs. However, the Department has adopted Rule 40, the Workers Compensation Fee Schedule, which deals with the payments to health care providers for their involvement in the workers compensation system. Pursuant to Rule 40.021(A), the maximum allowable payment for an unscheduled charge is 90% of the charge for the service. In this case, Dr. Allen has charged $950.00 for his impairment assessment and participation in the hearing. 90% of that amount is $855.00, which is the amount to be awarded. The claimant s other expenses, in the amount of $324.19, are also awarded. It should be noted that health care providers are not allowed to balance bill claimants for amounts not awarded under Rule 40. See Rule 40.021(B).

ORDER

THEREFORE, based on the foregoing findings of fact and conclusions of law, it is hereby ORDERED that:

1. Kemper Insurance, or in the event of its default Specialty Paperboard, pay the claimant additional permanency benefits in the amount of 3.5% of the spine, in accordance with the terms of this opinion; and

2. Kemper Insurance, or in the event of its default Specialty Paperboard, pay attorney s fees in the amount of $700.00 and expenses in the amount of $1,179.19.

DATED at Montpelier, Vermont, this 31st day of March 1996.

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Mary S. Hooper
Commissioner