M. B. v. Price Chopper (May 8, 2007)

STATE OF VERMONT
DEPARTMENT OF LABOR

Opinion No. 13-07WC

M. B.

v.

Price Chopper

By: Phyllis Severance Phillips, Esq.
Hearing Officer

For: Patricia Moulton Powden
Commissioner

State File No. L-03387

OPINION AND ORDER

Hearing held in Montpelier on November 8, 2006

APPEARANCES:

Thomas Bixby, Esq. for Claimant
Keith Kasper, Esq. and David Berman, Esq. for Defendant

ISSUES PRESENTED:

1. Whether Claimant's neck and/or right shoulder symptoms are causally related to her compensable August 1, 1997 low back injury;

2. Whether Claimant is entitled to temporary disability benefits retroactive to May 14, 2006: and

3. Whether the medical treatment proposed by Claimant's treating chiropractor is reasonably necessary and causally related to her compensable August 1, 1997 injury.

EXHIBITS:

Joint Exhibits:

Joint Exhibit I: Medical Records (CD format)
Joint Exhibit II: Medical Records supplement

Claimant's Exhibits:

Claimant's Exhibit 2: Form 22 Agreement for Permanent Partial Disability Compensation
Claimant's Exhibit 4: Claimant's Paycheck for week ending 1/15/06 and Form 21 Agreement for Temporary Total Disability Compensation

CLAIM:

Temporary total disability benefits under 21 V.S.A. §642;
Medical benefits under 21 V.S.A. §640(a);
Attorney's fees and costs under 21 V.S.A. §678.

FINDINGS OF FACT:

1. Claimant has worked as a cashier for Defendant since 1995. On August 1, 1997 she suffered a low back strain when she "turned just right" while scanning a heavy item. Defendant accepted the injury as compensable and paid benefits accordingly.

2. Prior to this date, Claimant had never suffered any injuries to her low back. She elected to treat with Brenda Davis, D.C., a chiropractor. Claimant experienced stiffness while standing and her left leg was sore, but she was able to continue working.

3. On August 19, 1997 Claimant tripped while going up the stairs at work. She caught her fall by reaching for the railing, but in doing so bent her right hand and forearm back. She was diagnosed with a right forearm strain/sprain, which appeared to resolve fairly quickly.

4. Claimant treated conservatively for her low back strain. Dr. Davis prescribed a lumbar support and recommended that she not lift heavy objects at work. Radiological studies conducted in December 1997 showed a central herniation at L4-5 but with no nerve root encroachment and therefore questionable clinical significance.

5. In February 1998 Claimant underwent a course of physical therapy with Julie Emond, R.P.T. Ms. Emond reported that Claimant presented with symptoms consistent with her diagnosis of low back strain with herniation at L4-5 as well as weakness in her trunk and lower extremities due to disuse. Claimant made good progress with both physical therapy and home exercise. Upon her discharge from therapy in April 1998 Ms. Emond noted that there had been good improvement, although some symptoms did remain.

6. Neither Dr. Davis nor Julie Emond noted any pain, discomfort, reduced range of motion or other symptoms in Claimant's neck or right shoulder related either to the August 1, 1997 work injury or to the August 19, 1997 fall on the stairs.

7. In June 1998 Claimant's low back pain recurred and she returned to Dr. Davis for treatment. As a result of this recurrence, Claimant was temporarily disabled from working from June 18, 1998 until November 2, 1998.

8. Dr. Davis' treatment notes during this time reflect that Claimant experienced muscle spasms in her lumbar, dorsal and cervical spine. This is the first mention of any symptoms in Claimant's neck and/or shoulders.

9. Claimant also underwent another course of physical therapy with Ms. Emond during this time. Ms. Emond noted pain in the central lower back area as well as aching in the legs, arms and shoulder blades.

10. In October 1998 Defendant referred Claimant to Jon Thatcher, M.D. for a second opinion regarding her chronic low back pain. Dr. Thatcher diagnosed chronic low back pain presumably from degenerative L4-5 discs, or perhaps chronic muscle injury. For treatment, he advised Claimant to continue her home exercise program and also prescribed a lumbo-sacral corset for her to wear if necessary. Dr. Thatcher released Claimant to return to work with lifting restrictions. Last, he determined that Claimant had reached an end medical result and rated her with a 5% whole person permanent impairment.

11. Dr. Thatcher's report made no mention of any shoulder or neck symptoms, either subjectively reported or objectively observed.

12. In February 1999 the parties executed a Form 22 Agreement for Permanent Partial Disability Compensation and Defendant paid permanency benefits in accordance with Dr. Thatcher's 5% impairment rating.

13. Claimant did reasonably well with her return to work. Her symptoms waxed and waned, and she often experienced increased pain at the end of her shift, particularly on busy days. Presumably these symptoms were not severe enough to warrant medical attention. Claimant did not treat for any low back, leg, upper extremity or neck pain from December 1998 until February 2000.

14. On February 18, 2000 Claimant returned to Dr. Davis for chiropractic treatment relating to pain in her back, neck, legs and arms. Dr. Davis noted that Claimant gradually had stopped doing her home exercise program, and that her arms ached, especially in the morning. On examination, Dr. Davis found that Claimant was very stiff and tender in her neck and anterior shoulders.

15. Dr. Davis did not provide any ongoing treatment beyond the single visit on February 18th, but she did issue a written recommendation to Defendant that Claimant have a bagger to assist her for the next month, and thereafter "as often as possible." In June, Dr. Davis supplemented this recommendation, advising that Claimant should alternate sitting and standing at the cash register.

16. There are no records of any medical treatment for Claimant's low back, shoulder or neck from February 2000 until January 2002. In January 2002 Claimant began another course of physical therapy with Julie Emond, R.P.T., apparently at the referral of Tony Blofson, M.D. Ms. Emond reported that Claimant presented with a two-month history of increased cervical pain and limitation "without specific cause." According to Ms. Emond, x-rays taken in November 2001 revealed degenerative disc disease of the cervical area. Ms. Emond noted that Claimant exhibited poor postural alignment and decreased range of motion in her neck and right shoulder. She was tender and tight throughout her right upper extremity.

17. Ms. Emond reported in her January 11, 2002 treatment note that Claimant "feels that working at both jobs which requires increased arm movement has been part of the aggravation." I find that the second job to which this note refers most likely was the part-time work Claimant performed for a time at a local dry cleaner. During this time Claimant worked 5 days per week for Defendant, and the other 2 days per week at the dry cleaner. Her duties there included marking, ironing and organizing shirts, all activities that would have required increased use of her right arm.

18. Claimant improved with physical therapy. Her pain decreased, her shoulder range of motion returned to normal and she was able to perform activities of daily living without difficulty. Claimant was discharged from physical therapy in February 2002. According to Ms. Emond, her prognosis for maintenance of improvements was good so long as she continued with her home exercises and self-care program.

19. Claimant did not treat for low back, neck or shoulder pain from February 2002 until May 2003. In February 2003 she presumably was examined by Denise Paasche, M.D., who issued a prescription pad note recommending that "due to a diagnosis of degenerative disc disease in her neck" Claimant should have a bagger to assist her with heavy lifting at work.

20. In May 2003 Claimant resumed chiropractic treatment with Dr. Davis. Dr. Davis reiterated her prior recommendations as to necessary workplace accommodations – that Claimant be provided with both a bagger to assist with heavy lifting and a stool so that she could alternate sitting and standing as necessary.

21. Claimant treated with Dr. Davis until October 2003, although the records do not reflect specifically what area(s) of pain, reduced range of motion or other symptoms were addressed.

22. In July 2004, at Defendant's request, Claimant underwent an independent medical evaluation with Terrance Ryan, D.C. Dr. Ryan noted Claimant's complaints of low back pain with occasional spasms and mild numbness into the tops of her legs, but did not mention any complaints of pain, limitation or reduced range of motion in Claimant's neck, shoulder or upper extremities. Dr. Ryan diagnosed chronic recurrent L4-5 discopathy and rated Claimant with an 8% whole person permanent impairment referable to her lumbar spine. As for job accommodations, Dr. Ryan recommended that Claimant avoid heavy lifting and repetitive bending or twisting. Last, in an addendum to his initial report, Dr. Ryan advised that further treatment should focus on an active spinal stabilization program, either supervised or at home, to reduce the need for more passive, in-office treatments.

23. On her attorney's advice, in November 2004 Claimant obtained another impairment rating, this time performed by John Chard, M.D., an orthopedic surgeon. Dr. Chard's report was consistent with Dr. Ryan's, particularly in that there was no mention of any complaints of pain, reduced range of motion or other symptoms in Claimant's neck, shoulders or upper extremities. Dr. Chard diagnosed a midline herniation of the L4-5 disc and concurred with Dr. Ryan's 8% permanent impairment rating. Dr. Chard recommended against further chiropractic treatment, as it did not appear to be helpful. Instead, he suggested that Claimant might try pharmaceutical medications for pain relief.

24. Claimant elected not to follow Dr. Chard's treatment recommendations, and opted instead for further chiropractic care, this time with Elizabeth Gillespie, D.C. In sharp contrast to the complaints she reported to both Dr. Ryan and Dr. Chard, the pain diagram Claimant completed upon her initial evaluation with Dr. Gillespie, just 2 weeks prior to Dr. Chard's examination, reflected her complaints of moderately intense pain from her mid-back down through both lower extremities, as well as pain in her neck, shoulders and forearms.

25. Claimant has treated regularly with Dr. Gillespie from November 2004 until the present time. Her complaints have waxed and waned, and Dr. Gillespie's treatments – manipulations, soft tissue massage, ultrasound and other passive modalities – have been directed at symptoms in her low back, legs, neck and right shoulder. In Dr. Gillespie's opinion, all of Claimant's symptoms are directly related to her August 1, 1997 work injury. According to Dr. Gillespie, the disc herniation in Claimant's lower back causes pressure on her sciatic nerve. To relieve the pressure, Claimant has altered her posture by leaning forward. This altered postural pattern has caused increased stress to her neck and shoulders. Cumulative trauma related to the repetitive arm movements necessitated by Claimant's work as a cashier also has contributed. Over time, bone spurs have formed in Claimant's neck.

26. On January 13, 2006 Claimant reported to Dr. Gillespie that she was going to see her medical doctor because she was unable to raise her right arm. On January 14, 2006 Claimant presented to the Brattleboro Memorial Hospital Emergency Room with a chief complaint of right shoulder pain. She was tearful and extremely anxious. On examination, both paraspinal and trapezius muscle spasms were noted, as well as decreased range of motion due to pain. She was prescribed valium for pain and advised to follow up with her physician.

27. On January 16, 2006 Claimant followed up with Dr. Blofson. Dr. Blofson noted low back pain and both weakness and reduced range of motion in the right shoulder. He reported that Claimant advised that her pain was not changed by working. Dr. Blofson stated that although Claimant ascribed her shoulder pain to her long-standing chronic low back problem, he disagreed with that assessment. Dr. Blofson determined that Claimant was unable to work due to her right shoulder problem. He advised her to stop chiropractic treatment and referred her to Dr. Kinley for an orthopedic assessment of her right shoulder.

28. Donald Kinley, M.D., an orthopedist, examined Claimant on January 17, 2006. He diagnosed right shoulder calcific tendonitis. Dr. Kinley treated Claimant with a corticosteroid injection. Immediately thereafter Claimant reported 90% pain relief and was able to both raise her arm overhead and rotate it as well. Dr. Kinley advised that Claimant would be able to return to work within the next day or two.

29. At her attorney's suggestion, Dr. Chard evaluated Claimant on February 13, 2006 specifically for the purpose of determining whether her shoulder problems were causally related to her August 1, 1997 low back injury. Dr. Chard reviewed the available medical records and also examined Claimant. Having done so, he found no evidence that her current problem, right shoulder calcific tendonitis, was in any way related to her 1997 low back injury.

30. In March 2006 Claimant underwent another orthopedic evaluation, this time at Dr. Blofson's referral, with Elizabeth McLarney, M.D. Dr. McLarney's diagnosis, consistent with Drs. Kinley and Chard, was right shoulder calcific tendonitis. Dr. McLarney noted that Claimant had some radicular pain, particularly in her right arm, but could not determine whether this represented cervical radiculopathy or not.

31. At Defendant's request, on April 3, 2006 Claimant underwent an independent medical evaluation with George White, M.D., an occupational medicine specialist. Dr. White concurred with the diagnosis of right shoulder calcific tendonitis. He stated that this was a separate problem, unrelated to Claimant's low back pain or lumbar disc disease. In Dr. White's opinion, although it is common for patients who suffer from degenerative disc disease in their lower backs to suffer from a similar degenerative process in their upper backs and/or necks as well, one does not in any way cause the other.

32. Dr. White did not observe any symptoms consistent with cervical radiculopathy in his examination of Claimant. He admitted, however, that the focus of his examination was on Claimant's lumbar spine, not her cervical spine. At the formal hearing, Dr. White testified that Claimant did not exhibit or complain of the muscle weakness or pattern of sensory loss that most commonly is associated with cervical radiculopathy.

33. As to treatment of the low back, Dr. White strongly urged consideration of a multidisciplinary rehabilitation program, particularly one with a strong educational component, as he found that Claimant lacked understanding as to the nature of her low back condition and the symptoms it might (and might not) cause. Dr. White's treatment approach would emphasize active rather than passive modalities, and would include strength training, walking and aerobic conditioning in addition to biofeedback and pain management strategies. Dr. White strongly advised against any type of cervical spine manipulation for fear that it might cause further injury.

34. Dr. Gillespie's treatment approach stands in sharp contrast to Dr. White's recommendations. In addition to the passive modalities she has been providing since 2004 – chiropractic manipulations, soft tissue massage and ultrasound – most recently Dr. Gillespie has recommended a course of treatment with a spinal decompression unit. The goal of this treatment is to enlarge the disc spaces and relieve nerve pressure, thereby reducing the extent of any herniations and allowing the outer ligaments to be strengthened. At the time of the formal hearing, Dr. Gillespie had been using the unit on some of her patients for more than three months, and had observed excellent results.

35. It is not clear to what extent treatment with the decompression unit proposed by Dr. Gillespie is effective on patients whose pain is caused by bone spurs rather than those who suffer from disc herniation and/or nerve root impingement.

36. Drs. Gillespie and White also disagree as to Claimant's current work capacity. Consistent with his belief that the best way to treat chronic low back pain is to encourage more rather than less activity, Dr. White has recommended that Claimant return to work in a light duty capacity, with restrictions against heavy lifting, bending or twisting. In contrast, Dr. Gillespie maintains that due to the combination of symptoms in her lower back, neck, arms and shoulders Claimant is unable to work at all.

37. In June 2006 Claimant underwent both cervical and lumbar spine MRI evaluations. The cervical spine MRI revealed degenerative discs and bone spurs at both C4-5 and C5-6. The lumbar spine MRI showed a central disc bulge at L4-5 and a rupture of the annulus fibrosis, but with no evidence of any significant impingement on the thecal sac or exiting nerve roots.

38. It is unclear to what extent Defendant has or has not complied with the various work restrictions and accommodations suggested by Claimant's treatment providers since her August 1, 1997 injury. On several occasions Dr. Davis accused Defendant of aggravating Claimant's condition by failing to provide necessary accommodations. Claimant admitted, however, that on many occasions she chose not to ask for accommodations for fear of upsetting her manager.

39. In May 2006 Defendant filed a Form 27 Notice of Intention to Discontinue Payments. Defendant argued that Claimant had failed to accept modified-duty work in accordance with Dr. White's IME recommendations, thus terminating her right to ongoing temporary disability benefits. Defendant further argued, again on the basis of Dr. White's report, that Claimant was not entitled to medical benefits for treatment of her right shoulder as that condition was not related causally to her compensable low back injury. The Department approved the Form 27 on May 16, 2006.

40. That Claimant is a poor historian and that she is notably inconsistent with respect to the nature and extent of her symptoms is well documented in the medical records. At times she recalled that she first injured her shoulder when she tripped going up the stairs at work on August 19, 1997, although the medical records reflect only a minor forearm strain. At times she reported debilitating neck and shoulder pain, and then only days later failed to report any pain at all in these areas. At the formal hearing she testified to a specific event at work – lifting and then dropping a gallon container of milk – that caused her shoulder to become frozen on January 14, 2006. There is no such history reported in the medical records, however, and in fact Claimant already had advised her chiropractor on the day before that she planned to see her medical doctor because she could not lift her arm. These discrepancies make it difficult to determine when various symptoms arose and to what extent, if any, they were related to work activities.

CONCLUSIONS OF LAW:

Compensability of Neck and/or Shoulder Injury

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). He or she 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). There must be created in the mind of the trier of fact something more than possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the resulting disability, and the inference from the facts proved must be the more probably hypothesis. *Burton v. Holden Lumber Co.*, 112 Vt. 17 (1941); *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. The trier of fact may not speculate as to an obscure injury which is beyond the ken of laymen. *Laird v. State Highway Department*, 110 Vt. 981 (1938). Where the Claimant's injury is obscure, and a layman could have no well grounded opinion as to its nature or extent, expert testimony is the sole means of laying a foundation for compensability. *Lapan v. Berno's, Inc.*, 137 Vt. 393 (1979); *Jaquish v. Bechtel Corp.*, Opinion No. 30-92WC (Dec. 29, 1992).

3. In this case, Claimant has alleged a variety of possible work-related causes for her neck and/or right shoulder symptoms, including (a) a traumatic injury caused when she tripped going up the stairs at work on August 19, 1997; (b) a traumatic injury caused when she dropped a gallon jug of milk at work on January 14, 2006; (c) cumulative trauma caused by the altered posture that resulted from her August 1, 1997 compensable low back injury; and/or (d) cumulative trauma caused by the repetitive arm movements involved in performing the job-related functions of a supermarket cashier.

4. As to the first possible cause, there is no evidence in any of the medical records to substantiate a neck or shoulder injury occurring on August 19, 1997. Dr. Davis was Claimant's treating physician at the time, and her notes reflect only a minor forearm strain that resolved within a week's time.

5. As to the second possible cause, there is no medical evidence to connect Claimant's neck and/or right shoulder injury to any specific incident occurring at work on January 14, 2006. In fact, Dr. Gillespie's treatment notes reflect that Claimant was exhibiting signs of a frozen shoulder *on the day before* the alleged incident at work. The subsequent records relating to Claimant's frozen shoulder, including those from the hospital emergency room and from Drs. Blofson, Kinley, Chard and Gillespie, make no mention of any incident at work involving a dropped gallon jug of milk. Without any such support in the medical records, Claimant's account of this incident must be rejected as unreliable.

6. As to the possibility that cumulative trauma, related either to the August 1, 1997 low back injury or to her job as a cashier, has caused Claimant's neck and/or shoulder injury, the expert medical opinions are conflicting. In these instances, the Commissioner traditionally uses a five-part test to determine which expert's opinion is the most persuasive, considering (1) the nature of treatment and the length of time there has been a patient-provider relationship; (2) whether the expert examined all pertinent records; (3) the clarity, thoroughness and objective support underlying the opinion; (4) the comprehensiveness of the evaluation; and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (Sept. 17, 2003).

7. In this case, a wide variety of medical practitioners have voiced opinions as to the cause of Claimant's neck and shoulder pain. Some are chiropractors, some are orthopedists, some have examined Claimant only once and some have enjoyed a long-standing treatment relationship with her, some can be identified as her own experts and some are Defendant's. With this array of expert opinions to consider, analyzing each of the above factors individually will yield no clear-cut result. Simply put, the key question is which expert medical opinion is the most credible?

8. I conclude that the most credible medical evidence establishes that Claimant suffers from calcific tendonitis in her right shoulder and degenerative disc disease in her neck. Both of these conditions are degenerative biochemical processes. They can be caused or aggravated by numerous factors, including aging, repetitive stress, altered posture or reduced activity. To puzzle out which of these factors are at play in Claimant's case requires more than supposition or hypothesis. It requires close scrutiny and scientific examination of all of the available evidence.

9. Dr. Gillespie's theory of causation does not withstand such scrutiny. There was no evidence that she ever visited Claimant at her work site, or that she performed any kind of functional analysis of Claimant's cashiering job. Had she done so, her conclusion that Claimant's neck and shoulder problems were caused by repetitive arm movements at work might have been persuasive. Without such evidence, they are just one of many possible hypotheses, not the most probable one.

10. Dr. Gillespie's theory that Claimant's neck and shoulder problems are most likely the result of altered posture due to her low back injury is also unconvincing. It must be noted, first of all, that Dr. Gillespie stands alone in this opinion, Drs. Blofson, Kinley, Chard, McLarney and White all having concluded that Claimant's neck and right shoulder complaints were unrelated to her low back injury. More importantly, there is no basis for concluding that the degeneration in Claimant's neck and shoulders is most probably due to this cause as opposed to the myriad of other possible causes for degeneration to occur.

11. I conclude, therefore, that Claimant has not sustained her burden of proving that her neck and shoulder complaints were caused or aggravated either by her work for Defendant or by her compensable low back injury.

Temporary Total Disability

12. It is important to note that Claimant's most recent period of disability, which began in January 2006, stemmed not from her low back injury, but from her frozen right shoulder. Given my conclusion that Claimant's neck and right shoulder complaints are not compensable, the only way she can qualify for temporary disability benefits is if her current inability to work, whether total or partial, is due at least in part to her compensable low back injury.

13. I find Dr. White's opinion as to work capacity to be more credible than Dr. Gillespie's in this regard. Even according to Dr. Gillespie's description, Claimant does not appear to be so debilitated as to be incapable of performing even the lightest duty work, so long as appropriate accommodations are provided and proper precautions against re-injury are taken. Should a formal functional capacities evaluation be necessary in order to determine how best to proceed in this regard, then Defendant is well-advised to take that step.

Appropriate Medical Treatment

14. Last, I must determine which is the most appropriate treatment path for Claimant's chronic low back injury – the spinal decompression approach advocated by Dr. Gillespie, or the multidisciplinary rehabilitation program recommended by Dr. White.[1]

[1] It is unclear from either the parties' pre-hearing statements or their post-hearing briefs whether Defendant is contesting the efficacy of the proposed spinal decompression unit solely with respect to treatment of Claimant's neck and/or shoulder symptoms or with respect to treating her compensable lower back injury as well. Dr. Gillespie testified at the formal hearing that she planned to use the unit to treat both the cervical and lumbar spine. Dr. White testified that a multidisciplinary rehabilitation program would be a more effective treatment for Claimant's low back injury, and that it offered benefits for her neck and upper extremity complaints as well. Given the testimony presented as to the appropriate treatment for Claimant's cervical spine complaints as well as her lumber spine injury, I find there is sufficient evidence from which to determine the extent to which the proposed spinal decompression treatment is likely to be efficacious in either area.

15. Dr. Gillespie's treatment plan is problematic in two respects. First, it centers on a spinal decompression unit that is new, experimental and largely untested. Although Dr. Gillespie testified to having witnessed largely positive results in the three months since she began using the unit, this is too short a time frame within which to evaluate fully the merits of such a treatment, and particularly whether it produces long-lasting or merely temporary relief of symptoms.

16. Secondly, to the extent that Dr. Gillespie's treatment plan incorporates the same type of passive treatment modalities that Claimant has long been receiving, clearly these have proven ineffective in terms of controlling her pain or improving her functional capacities. Will adding the spinal decompression unit to this mix of passive modalities produce better results? From the evidence presented, I cannot so conclude.

17. I find that the multidisciplinary rehabilitation approach advocated by Dr. White is more likely to lead Claimant back to an active life and productive work. It incorporates such elements as active physical therapy, strengthening and aerobic conditioning. As such, its focus is similar to the physical therapy and home exercise programs Claimant underwent in the past, both of which proved effective in controlling her pain and maintaining her functional abilities.

18. In addition, by providing education as to the anatomical bases for Claimant's symptoms as well as training in biofeedback and other pain management strategies, a multidisciplinary approach offers a more realistic way of dealing with the type of chronic pain from which Claimant suffers, whether the source of that pain is in her low back or in her neck or shoulders. As such, Dr. White's approach is more likely to lead to functional restoration of Claimant's "whole person."

19. For these reasons, I find that the spinal decompression treatment program proposed by Dr. Gillespie does not constitute reasonably necessary treatment under 21 V.S.A. §640(a).

ORDER:

1. Claimant's claim for workers' compensation benefits associated with her neck and/or right shoulder symptoms is DENIED;

2. Claimant's claim for temporary total disability benefits retroactive to May 14, 2006 is DENIED;

3. Claimant's claim for medical benefits in accordance with the treatment program proposed by Dr. Gillespie is DENIED;

4. Because Claimant has not prevailed, she is not entitled to an award of attorney's fees or costs under 21 V.S.A. §678.

DATED at Montpelier, Vermont this 8th day of May 2007.

_____
Patricia Moulton Powden
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 court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§670, 672.