V. P. v. Heritage Ford (September 28, 2007)

STATE OF VERMONT
DEPARTMENT OF LABOR

V. P.

v.

Heritage Ford

Opinion No. 26-07WC

Jane Dimotsis, Esq.
Hearing Officer

Patricia Moulton Powden
Commissioner

State File No. S-21982

OPINION AND ORDER

Hearing held in Montpelier on May 2, 2007

APPEARANCES:

Richard Goldsborough, Esq. for Claimant
John Valente, Esq. for Defendant

ISSUE PRESENTED:

Whether the fusion surgery proposed by Claimant's treating physicians constitutes reasonably necessary and causally related treatment for her work-related low back injury.

EXHIBITS:

Joint Exhibits:

Joint Exhibit I: Medical Records

Claimant's Exhibits:

Exhibit 1: Curriculum Vitae of Michael A. Horgan, M.D.

Defendant's Exhibits:

Exhibit A: Deposition of Dr. Victor Gennaro taken on June 11, 2007

CLAIM:

1. Workers' compensation benefits associated with proposed fusion surgery, including payment of medical bills and both temporary and/or permanent disability benefits, as proven following the procedure.

2. Attorney's fees and costs under 21 V.S.A. §678.

FINDINGS OF FACT:

1. At all times relevant to this proceeding Claimant was an employee of Defendant, and Defendant was Claimant's employer, within the meaning of Vermont's Workers' Compensation Act.

2. On June 10, 2002 Claimant suffered a work-related injury to her right shoulder and left low back. She was in the process of lifting one end of a truck axle onto a delivery truck when the person holding the other end dropped it. Claimant felt a snap in her shoulder and an immediate, stabbing pain in her low back.

3. Claimant reported her injury to Defendant, which accepted the claim and paid benefits accordingly.

4. Claimant began treating for her injury on June 19, 2002 with Kathleen Campbell, a physician's assistant, and Tim Fitzgerald, D.O., an osteopath, both at Champlain Valley Urgent Care. Dr. Fitzgerald diagnosed right shoulder and low back strains. Treatment was conservative, consisting of heat, ice, anti-inflammatory medications and restricted work duties.

5. At Dr. Fitzgerald's referral, Claimant underwent physical therapy, including both pain modalities and stretching and strengthening exercises, from June 28, 2002 through August 26, 2002, a total of 17 sessions.

6. Claimant's low back pain persisted throughout the summer and fall of 2002.[1] Dr. Fitzgerald did not report any radicular pain or parasthesias during this time.

7. In December 2002 Dr. Fitzgerald referred Claimant for a therapeutic steroid injection and further evaluation with Pierre Angier, D.O., and his associates.

8. Evan Musman, D.O., Dr. Angier's associate, treated Claimant regularly from December 2002 until August 2003, at which point he left the practice and Dr. Angier assumed responsibility for Claimant's care. Claimant treated regularly with Dr. Angier from August 2003 until December 2005.

[1] Claimant's right shoulder pain also persisted. The course of treatment and ultimate resolution of that injury is not at issue here and therefore will not be discussed.

9. Dr. Musman's diagnosis was lumbosacral sprain/strain, possible spondylolisthesis at L5-S1 and possible pars defect at L5. The latter diagnoses were based on Dr. Musman's review of lumbar spine x-rays taken in January 2003.

10. Dr. Musman's treatment consisted of osteopathic manipulation, trigger point injections, massage therapy and anti-inflammatories. He also referred Claimant for another course of physical therapy, which she underwent from January through March 2003.

11. Dr. Musman did not report any radicular component to Claimant's low back pain, although he did note some ipsilateral buttock tenderness. The physical therapy evaluation reported some intermittent left lower extremity paresthesias, but no other radicular symptoms.

12. Claimant made slow progress with physical therapy. She became independent with her home exercise program, and demonstrated excellent compliance. However, she continued to experience low back pain, though there was no progression of any neurologic symptoms in her lower extremities. Her sleep was disturbed due to pain, and in April 2003 Dr. Musman noted that she was suffering from "low grade depression from pain."

13. In March 2003 Dr. Musman referred Claimant to Dr. Michael Horgan, a neurosurgeon, for a surgical consult. Dr. Horgan examined Claimant in April 2003. He described her as "straightforward and pleasant." Dr. Horgan reported that Claimant described pain predominantly in the low back itself, but also radiating down the left buttock into the left thigh. As to treatment recommendations, Dr. Horgan reported back to Dr. Musman as follows:

> I have discussed with [Claimant] in detail the conservative strategies which I know you have gone over with her versus operative management. This is typically a lifestyle type issue and a pain issue and although I do not think she is at particular risk for nerve damage, the decision is one of pain control. I think she stands a good chance of pain control with surgery, although it is a significant undertaking. I discussed with her and described the risks in general and she would like to most likely pursue this course.

14. Prior to making a final decision as to surgery, Dr. Horgan recommended that Claimant obtain a lumbar spine MRI. Claimant did so on May 3, 2003. With the results in hand, Dr. Horgan re-evaluated Claimant on May 13, 2003. The MRI revealed no disc herniations, but evidence of a "very mild grade" spondylolisthesis. Dr. Horgan again discussed surgical intervention versus ongoing conservative management with Claimant. Claimant elected to forego surgery and continue with conservative treatment.

15. Claimant continued to treat with Dr. Musman through the summer of 2003. She underwent two sacroiliac joint injections and also resumed physical therapy. Her low back pain persisted.

16. On June 24, 2003 Dr. Horgan re-evaluated Claimant. He reported that she had experienced slight pain relief following Dr. Musman's joint injection, but without prolonged effect. Dr. Horgan again discussed with Claimant the rationale for conservative versus operative management, and reported that she was "very against" any type of surgical intervention. Dr. Horgan stated that Claimant's decision to continue with conservative treatment was "completely appropriate given her normal neurologic state," but also stated that she should "call me at any time if her symptoms change or if she reconsiders."

17. From August 2003 until December 2005 Claimant treated regularly with Pierre Angier, D.O., Dr. Musman's associate. Like Dr. Musman, Dr. Angier's treatment consisted of osteopathic manipulation, trigger point injections, massage and anti-inflammatories. At various times Dr. Angier reported that Claimant's low back pain was improved. At other times, however, Dr. Angier reported that Claimant's pain was worsened, and included occasional pain and paresthesias into her buttocks and left leg as well.

18. At Dr. Angier's referral, in April 2005 Claimant returned to Dr. Horgan for another surgical consult. Dr. Horgan reported that Claimant's low back pain had persisted despite prolonged conservative management, and that she now suffered from bilateral lower extremity pain as well, left greater than right. Dr. Horgan noted that Claimant was "quite uncomfortable" and concluded that she was a "reasonable surgical candidate."

19. Claimant underwent additional MRI scanning in August 2006. Among the findings, consistent with earlier scans, were degenerative disc changes at L4-5 and L5-S1, a small herniation at L4-5 and neural foraminal narrowing at L5-S1. X-rays taken in April 2007 also showed findings consistent with earlier films, notably a bilateral pars defect of L5, grade 1 anterolisthesis of L5 over S1 and mild disc space narrowing from L3 to S1.

20. Dr. Horgan testified on Claimant's behalf at the formal hearing. Dr. Horgan has been an attending neurosurgeon at Fletcher Allen Health Care since 2000, and has been board-certified in neurosurgery since 2005. Approximately 80% of his practice involves evaluating and treating patients, with the remaining 20% spent on teaching and research.

21. Dr. Horgan defined spondylolisthesis as a fracture through a portion of the vertebrae. The fracture separates the surrounding facet joints and at L5-S1 leads to slippage of the bone on the sacrum. Often, the fracture occurs in childhood, but remains asymptomatic and therefore can go unnoticed for years. Then, a "sentinel event" occurs that causes the fracture to become painful. The actual pathology that triggers the pain to arise is not clearly understood. Thus, the diagnosis of spondylolisthesis as the cause of a patient's back pain is often one of exclusion – the rest of the patient's spine is in good condition, and the fracture presents the only significant abnormality.

22. Dr. Horgan testified that the fracture in Claimant's spine was very clearly seen on x-ray. In addition, once Claimant began to complain of pain traveling down her legs, Dr. Horgan became concerned about possible nerve entrapment and damage. This occurs when the slippage of the bone on the sacrum causes scar tissue to form and build up in the foramen, the hole through which the spinal nerves travel. The involved nerves become stretched, sensitized and pinched, which causes radicular symptoms.

23. Dr. Horgan testified that Claimant's May 2003 MRI scan revealed "solid findings" confirming both the slippage of bone at L5 onto S1 and also a pinched nerve at L5. The L5 nerve was more pinched on the left side than on the right, which coincided with Claimant's report of more radicular symptoms on that side.

24. Dr. Horgan testified that his review of Claimant's x-rays and MRI scans showed "very little" degenerative disc disease for a woman of her age. Thus, the only significant abnormality he detected was the spondylolisthesis at L5-S1. In Dr. Horgan's opinion, the injury Claimant suffered on June 10, 2002 was the "sentinel event" that most likely triggered the spondylolisthesis to become symptomatic.

25. Dr. Horgan testified that the course of treatment Claimant had undergone up until the time he first evaluated her was entirely appropriate and reasonable. In his opinion, Claimant has been a "good patient," who has taken her condition seriously and has engaged actively in all attempts at conservative management. With persistent pain after more than three years, however, Dr. Horgan believes it is reasonable to conclude that she has failed conservative management. He now recommends spinal fusion surgery as the treatment most likely to relieve her pain and improve her function.

26. Dr. Horgan has found no evidence of symptom magnification in Claimant's behavior, nor has he observed any other "red flags" for possible secondary gain issues. Such red flags might have included a patient desperate for surgery notwithstanding the doctor's strong recommendation against it, a patient who was not working, or a patient who exhibited symptoms and pain behaviors discordant with objective findings. Were a patient to exhibit such behaviors, Dr. Horgan would consider obtaining a psychological evaluation prior to recommending surgery. Claimant has exhibited no such behaviors here, however. She has been reluctant to pursue surgery as a treatment option, has continued to work and does not exhibit extraordinary pain behavior. Therefore, Dr. Horgan does not believe a psychological evaluation is necessary.

27. Dr. Horgan performs thirty to forty surgeries annually of the type he is proposing for Claimant and an additional thirty to forty surgeries annually involving other types of lumbar fusion. His success rate, which he described as a good to excellent result, though not necessarily pain free, is 70-80%.

28. At Defendant's request, in September 2003 Dr. Christopher Brigham performed a review of Claimant's medical records. This was followed by an independent medical evaluation performed by Dr. Brigham's associate, Dr. William Boucher, in August 2004. In contrast to Dr. Horgan's opinion, both doctors concluded that Claimant's L5-S1 spondylolisthesis was clinically insignificant. Both found that Claimant's subjective complaints were more marked than her objective findings, and both concluded that this might be an indication of symptom magnification behavior. Both recommended that Claimant undergo an analysis of potential psychosocial, behavioral, personality and psychological contributants to her delayed recovery. Both counseled against surgery or other invasive treatment options. Last, as of August 2004 Dr. Boucher concluded that the lumbar strain Claimant suffered on June 10, 2002 most likely had long since resolved and that Claimant required no further treatment.

29. At Defendant's suggestion, in October 2003 Dr. Verne Backus evaluated Claimant for the purposes of rendering a second opinion/consultation. Dr. Backus diagnosed chronic mechanical low back pain. He reported that the low back pain Claimant experienced after the June 2002 accident had resolved by September 2002. Dr. Backus stated that he did not know what caused Claimant's symptoms to increase after that, but that there was no causal relationship between any of her current complaints and the June 2002 injury.

30. At Defendant's request, in January 2005 Claimant underwent an independent medical evaluation with Dr. John Johansson, an osteopath. Dr. Johansson diagnosed Claimant with "standard, run-of-the-mill mechanical low back pain," which he felt was causally related to her June 2002 injury. Dr. Johansson did not comment specifically on the efficacy of fusion surgery as a treatment option, but did state that his only treatment recommendation would be a home exercise program involving "classic" lumbar stabilization exercises.

31. In December 2005, again at Defendant's request, Claimant underwent an independent medical evaluation with Dr. Victor Gennaro, an osteopath and orthopedic surgeon. Dr. Gennaro diagnosed chronic low back pain and strain. He could not conclude that Claimant's symptoms were attributable to her spondylolisthesis. He opined that the increase in Claimant's symptoms might be due to age-related disc deterioration, but he could not state this with certainty.

32. Dr. Gennaro agreed with Dr. Brigham that surgery was not indicated in Claimant's case, at least in part because she had not undergone a comprehensive psychological evaluation to identify possible secondary gain issues. Instead, Dr. Gennaro opined that the primary treatment for Claimant's back pain should be smoking cessation, mild aerobic exercise, weight loss and abdominal strengthening.

33. According to Dr. Gennaro, smoking hinders blood circulation and can cause a patient's spondylolisthesis to become increasingly unstable and more symptomatic. It also significantly decreases the likelihood of successful fusion. Aerobic exercise helps increase blood circulation to the spine and strengthens both abdominal and lower back muscles. Dr. Gennaro testified that if Claimant were to quit smoking, engage in aerobic exercise and lose weight, there was a better than 50% chance that her pain would be relieved.

34. In Dr. Gennaro's opinion, the positive indications for surgery in a case such as Claimant's would include verifiable radiculopathy in the lower extremities, MRI results documenting significant encroachment on the nerve roots or foramen and a negative response to conservative treatment measures. As contraindications against surgery, Dr. Gennaro listed significant or severe obesity, heavy smoking, significant unresolved psychological issues and severe narcotic use.

35. Dr. Gennaro testified that he performs fewer than ten spinal fusion surgeries yearly. He stated that although he agreed with Dr. Brigham's recommendation that Claimant undergo psychological testing, he did not often have his own patients undergo such screening. He did not find any evidence of malingering or symptom magnification in the course of his examination of Claimant.

36. Dr. Gennaro acknowledged that Claimant has permanent symptoms in her low back arising from her June 2002 injury. He testified that he could not share Dr. Horgan's optimism as to the likelihood that fusion surgery would result in a decrease in Claimant's symptoms, though he could not rule out the possibility that it might.

37. Claimant testified credibly at the hearing as to the nature and extent of her back pain and its impact on her daily activities. Her low back aches, and she experiences sharp, shooting pains into her buttocks and down her left leg. When seated, her back "pulls" and her legs fall asleep. Stepping off a curb or bending down might cause pain so severe it "takes my breath away." Prior to the June 2002 injury, she walked for exercise, as much as 2 miles daily, but she is unable to do so now. She feels limited in her ability to play with her grandchildren or go shopping. She can no longer mow her lawn, make the beds or vacuum. She tries to strengthen her abdominal muscles by holding her stomach in when she walks, but any other exercise makes her back ache "terrible."

38. Aside from a period of temporary total disability following shoulder surgery, Claimant has continued to work since the June 2002 accident. Her job responsibilities have changed, so that she no longer is required to do any heavy lifting, and her work station has been adjusted ergonomically. Claimant testified that she enjoys her job and does not like being out of work.

39. Claimant currently smokes 4-5 cigarettes daily. She testified that she intends to quit prior to undergoing fusion surgery. Claimant currently stands 4'11" tall and weighs 135 pounds. None of the various medical providers who have treated or examined her have described her as overweight or obese.

40. Claimant had suffered a prior low back injury in 1994, when she slipped while descending a ladder. Her symptoms fully resolved after a few months. Aside from occasional back aches, Claimant had not experienced any low back pain in the intervening years prior to the June 10, 2002 accident, and certainly nothing of the type and degree she experienced following that event.

CONCLUSIONS OF LAW:

1. Under Vermont's Workers' Compensation Act, the employer must furnish "reasonable surgical, medical and nursing services to an injured employee." 21 V.S.A. §640(a). In determining what is reasonable, "the decisive factor is not what the claimant desires or what she believes to be the most helpful. Rather, it is what is shown by competent expert evidence to be reasonable to relieve the claimant's back symptoms and maintain her functional abilities." *J.H. v. Therrien Foundations*, Opinion No. 53-05WC (August 19, 2005); *P.F. v. Ethan Allen*, Opinion No. 50-05WC (August 9, 2005); *Quinn v. Emery Worldwide*, Opinion No. 29-00WC (September 11, 2000).

2. When an employer seeks to terminate coverage for medical benefits, it has the burden of proving that the treatment at issue is not reasonable. *S.S. v. The Book Press*, Opinion No. 06-07WC (February 21, 2007); *Liscinsky v. Temporary Payroll Incentives, Inc.*, Opinion No. 9-01WC (March 22, 2001), *citing Rolfe v. Textron, Inc.*, Opinion No. 8-00WC (May 16, 2000). A treatment may be unreasonable either because it is not medically necessary or because it is not related to the compensable condition or injury. *S.S. v. The Book Press, supra; see, e.g., Morrisseau v. State of Vermont, Agency of Transportation*, Opinion No. 19-04WC (May 17, 2004).

3. In this case, therefore, two issues must be addressed. First, are Claimant's current low back symptoms causally related to her June 10, 2002 work injury? Claimant argues that they are, because they are generated by her underlying spondylolisthesis, which became symptomatic as a result of the work injury. Defendant argues that they are not, either because Claimant's spondylolisthesis is clinically insignificant or because it became symptomatic as a result of the natural degenerative aging process and not because of the June 2002 work injury.

4. If the first issue is resolved in Claimant's favor, then the second issue is whether spinal fusion surgery is a reasonable treatment. Claimant argues that it is, because it offers a favorable success rate and will likely relieve her symptoms and improve her functional abilities beyond what she has been able to accomplish with conservative treatment. Defendant argues that it is not.

5. As to the first issue, it is true, as the leading workers' compensation commentator has stated, that all of the medical consequences and sequelae that flow from an injured worker's primary compensable injury are themselves compensable as well. 1 *Larson's Workers' Compensation Law* §10.01. Determining which medical consequences flow from the primary injury and which do not, however, requires expert medical testimony. *Lapan v. Berno's, Inc.*, 137 Vt. 393 (1979). Establishing the requisite connection, furthermore, requires more than mere possibility, suspicion or surmise. Rather, the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden & Martin Lumber Co.*, 112 Vt. 17 (1941).

6. In claims involving conflicting medical evidence from expert witnesses, 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. Dr. Horgan testified that the June 2002 injury was the "sentinel event" that triggered Claimant's underlying spondylolisthesis to become symptomatic. Although he could not explain the specific pathology that causes the dormant condition to light up and produce symptoms, his testimony as to causal relationship was credible. Dr. Horgan has been one of Claimant's treating physicians since 2003. He has witnessed the progression of Claimant's symptoms over time. His interpretation of Claimant's x-rays and MRI scans provide objective support for his opinion that Claimant's pain is being generated by her L5-S1 spondylolisthesis. Dr. Horgan is trained as a neurosurgeon, and has treated numerous patients with conditions similar to Claimant's.

8. None of the medical experts who hold conflicting opinions as to causation have treated Claimant, and therefore none of them have been able to evaluate either her symptoms or her response to conservative treatment over time. None of them have neurosurgical training or experience. Most significantly, none of them have provided an explanation for Claimant's current symptoms that is as cogent and persuasive as Dr. Horgan's. To state that there is no explanation for Claimant's current symptoms, as Dr. Backus did, or simply to conclude that the lumbar strain suffered in June 2002 "has long since resolved," as Dr. Boucher did, is patently insufficient to negate Dr. Horgan's finding of causal relationship. Even Dr. Gennaro, who provided the most thoughtful testimony in support of Defendant's position, could not rule out the possibility that Claimant's spondylolisthesis became symptomatic because of the June 2002 injury, and could not posit any alternative theory of causation to the required degree of medical certainty.

9. I find, therefore, that Dr. Horgan's expert opinion as to the causal relationship between Claimant's current symptoms and her June 2002 injury is the most credible.

10. Turning to the second issue, whether spinal fusion surgery is a reasonable treatment option, again Dr. Horgan's expert opinion merits the greatest weight. As noted, Dr. Horgan has been one of Claimant's treating physicians and therefore has witnessed her commitment to conservative treatment measures, none of which have proven successful. As a neurosurgeon, Dr. Horgan has performed many surgeries of the type he proposes to perform on Claimant, on patients with similar objective findings and subjective complaints. His post-surgical prognosis for Claimant may be optimistic, but it is borne out by his own surgical experience and success rate.

11. Defendant's medical experts do not share Dr. Horgan's optimism. The factors they point to as contraindications against surgery, however – the lack of verifiable findings of radiculopathy, morbid obesity, heavy smoking and unresolved psychological issues, for example – are not present here. Claimant has exhibited radicular symptoms at times, as is well documented in her treatment records. She is not morbidly obese and is not a heavy smoker. Most notably, she has not behaved in any was as to indicate that unresolved psychological or secondary gain issues are motivating her to seek surgery.

12. Claimant testified credibly as to the impact her condition has had on her life, the pain she experiences and the functional limitations she endures. She committed herself to conservative treatment measures, but these have failed. The surgical treatment option Dr. Horgan has proposed is at least reasonably likely to be successful at ameliorating her symptoms and improving her quality of life. Under these circumstances, Claimant is entitled to the benefit of any doubt as to whether in fact this will occur. *See J.H. v. Therrien Foundations, supra; P.F. v. Ethan Allen, supra*.

13. The burden of proof is on Defendant to establish that the proposed surgery does not constitute reasonable treatment for Claimant's condition. I find that Defendant has not done so. The most credible evidence establishes that surgery is an appropriate option for Claimant to pursue. She has earned the right to attempt it.

14. Having prevailed on her claim, Claimant is be entitled to recover reasonable attorney's fees and costs pursuant to 21 V.S.A. §678(a) and Workers' Compensation Rule 10. The Attorney's fees are reasonable. However, the cost for the expert exceeds the amount of $300.00 per hour in the Rules. The Defendant has objected to costs on this basis. Therefore, Claimant's attorney has thirty days to file an amended list of costs for consideration.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Defendant is ORDERED to pay:

1. Workers' compensation benefits associated with proposed fusion surgery, including payment of medical bills and both temporary and/or permanent disability benefits, as proven following the procedure.

2. Claimant's request for attorney's fees in the amount of $5,157.00.

3. An amended itemized list of Claimant's costs should be forwarded to the Department within 10 days with appropriate hourly rates for expert deposition testimony and hearing testimony pursuant to Rule 40.1. Upon receipt and a determination of reasonableness, these costs will be awarded.

Dated at Montpelier, Vermont this 28th day of September 2007.

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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.