STATE OF VERMONT
DEPARTMENT OF LABOR

Violet Veillette

v.

Pompanoosuc Mills Corp.

Opinion No. 23-12WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Anne M. Noonan
Commissioner

State File No. U-52073

OPINION AND ORDER

Hearing held in Montpelier on May 4, 2012
Record closed on July 10, 2012

APPEARANCES:

Charles Powell, Esq., for Claimant
Keith Kasper, Esq., for Defendant

ISSUE PRESENTED:

Is Defendant obligated to pay for various medical services and supplies, including prescription pain medications, injections, physical therapy, chiropractic treatment and/or proposed cervical fusion surgery, as reasonable treatment for Claimant's compensable March 4, 2004 work injuries?

EXHIBITS:

Joint Exhibit I:	Medical records (Volume 1)
Joint Exhibit II:	Medical records (Volume 2)
Joint Exhibit III:	Stipulation
Claimant's Exhibit 1:	*Curriculum vitae*, Melynda Wallace, MSN, CRNA
Claimant's Exhibit 2:	*Curriculum vitae*, Sara Young-Xu, MD
Claimant's Exhibit 3:	*Curriculum vitae*, Joseph Phillips, MD, Ph.D.
Claimant's Exhibit 4:	DVD of Dr. Boucher examination, January 11, 2011
Claimant's Exhibit 5:	6/29/2010 MRI, sagittal image #8
Claimant's Exhibit 6:	6/29/2010 MRI, axial image #8
Claimant's Exhibit 7:	6/29/2010 MRI, axial image #9
Defendant's Exhibit A:	*Curriculum vitae*, William Boucher, MD
Defendant's Exhibit B:	*Curriculum vitae*, Herbert Cares, MD

CLAIM:

Medical benefits pursuant to 21 V.S.A. §640(a)
Costs and attorney fees pursuant to 21 V.S.A. §675

FINDINGS OF FACT:

1. At all times relevant to these proceedings, Claimant was an employee and Defendant was her employer as those terms are defined in Vermont's Workers' Compensation Act.

2. Judicial notice is taken of all relevant forms contained in the Department's file relating to this claim.

3. Claimant worked at Defendant's furniture manufacturing facility. Her duties included sanding, spraying and staining pieces of furniture, and also carrying them to and from various locations within the building.

4. On March 5, 2004 Claimant tripped over a piece of metal at work while carrying a drawer. She fell sideways, still holding the drawer. Her right shoulder and the right side of her neck hit the drawer as it in turn hit the floor. Claimant suffered contusions and pain in her left leg, lower back, neck and right arm. Defendant accepted these injuries as compensable and began paying workers' compensation benefits accordingly.

5. Claimant treated initially with Dr. Young-Xu, her primary care provider. Over the course of time her symptoms, which included primarily right-sided neck pain radiating into her shoulder blades as well as low back pain radiating into her right hip, have become chronic, and somewhat diffuse as well. Prior to her work injury Claimant had no previous medical history of any such symptoms.

6. As to her cervical and upper extremity symptoms, Claimant has undergone various diagnostic studies, including both MRI imaging and electrodiagnostic testing. The earliest studies, completed in the first few months following her injury, revealed advanced degenerative disc disease at the C5-6 level as well as a large disc herniation on the left at C6-7. Subsequent MRI studies in 2005, 2006 and 2010 yielded similar findings. However, electrodiagnostic studies failed to reveal any focal peripheral nerve involvement or dermatomal distribution to account for the radicular symptoms in Claimant's right shoulder and arm.

7. Various diagnostic studies of Claimant's lumbar spine have likewise failed to reveal a clear-cut source for her radicular complaints, with no evidence of disc herniation or nerve root involvement apparent.

8. Although the degenerative disc disease in Claimant's cervical spine probably preexisted her injury, it was entirely asymptomatic. The C6-7 disc herniation, which was an acute injury caused by her work-related fall, likely affected the biodynamics of the spine at the adjacent C5-6 level as well. Over time, bone spurs continued to grow at both levels. Bone spurs sometimes represent a chronic reaction to an acute injury – they are the body's way of "fixing" a painful area of the spine by immobilizing it even further.

9. It also is likely that at least some of Claimant's now chronic pain is neuropathic in nature. Neuropathic pain occurs when the neural processors in the brain become hypersensitive following a primary injury. As a result, the threshold for generating pain falls at the same time that its duration, amplitude and spatial distribution increase.[1] Unlike nociceptive pain (pain that results directly from sensing noxious stimuli) or inflammatory pain (tenderness that activates the body's immune system to help damaged tissues heal), neuropathic pain is a separate, maladaptive disease of the nervous system.[2] Curing such pain is very difficult; rather, the best hope is often simply to manage it.

Treatment with Prescription Pain Medications

10. Claimant has undergone several conservative therapies for her chronic pain, beginning with narcotic pain medications prescribed by Dr. Young-Xu only weeks after her injury. Currently her pain medication regimen includes fentanyl (a synthetic morphine), gabapentin (for nerve pain), Flexeril (a muscle relaxant), amtriptyline (a sleep aid) and Zoloft (an anti-depressant).

11. Claimant testified credibly that the fentanyl patches she currently uses provide noticeable pain relief with few if any side effects. As such, they are more effective than any of the other narcotic pain medications she attempted previously, including Vicodin and oxycodone. On those rare occasions when she forgets to apply a patch, her pain markedly worsens and her ability to perform such basic activities as showering, washing her hair and doing the dishes is impaired.

12. The goal of prescription pain control in chronic pain patients is not to eliminate the pain altogether, but rather to allow for some increased function and improved quality of life. Research suggests that it is often efficacious to rotate a patient's narcotic medications, and also to titrate dosages to the lowest level possible without sacrificing adequate pain control. According to Dr. Young-Xu, the medications she currently prescribes, including fentanyl, maintain Claimant's pain at a tolerable level, but still not to the point where it should be considered well controlled. For that reason, and also because there is no evidence that Claimant has ever misused or abused any of the drugs she has been prescribed, Dr. Young-Xu does not believe it would be appropriate either to reduce her dosage or to taper her off of them. I find this analysis persuasive.

Injections

[1] Woolf, CJ, "What is this thing called pain?", *J.Clin.Invest.* 2010; 120(11):3742-3744 at p. 3744; Joint Exhibit II at 674.

[2] *Id.* at p. 3742; Joint Exhibit II at 672.

13. In addition to prescription pain medications, Claimant has at various times undergone different types of injections in an effort to manage her cervical and lumbar pain. Initially these were administered by Dr. Frazer; since June 2006 Melynda Wallace, a certified nurse anesthetist, has been the treating provider. Ms. Wallace holds a master's degree in anesthesia and is certified as a fellow of the American Academy of Pain Management. She is an experienced pain practitioner, whose current focus is on chronic pain management.

14. The injections Ms. Wallace has administered in Claimant's case involve the use of epidural steroids. Their purpose is not to fix the pain generator in either the cervical or lumbar spine *per se*, but rather to provide some measure of extended pain relief. Epidural steroid injections reduce inflammation in the structures of the spine on a cellular level, such that the structures cease sending constant pain signals to the brain, at least for a time.

15. The medical records document that Claimant derived measurable pain relief from the cervical injections Ms. Wallace administered. She underwent a series of three injections between June 2006 and February 2007, a single injection in March 2009 and then another in May 2010. In Ms. Wallace's opinion, which I find credible, an injection ought to provide at least 30 to 45 days of pain relief in order to justify regularly repeating the procedure. The interval pain relief Claimant realized more than met this standard.[3]

16. Ms. Wallace also has significant experience with managing chronic pain pharmaceutically. She fully endorsed Dr. Young-Xu's medication regimen, including the use of both fentanyl and gabapentin. She noted that while Claimant's dosage levels have not decreased, they have not increased in many years either. This is an indication of their ongoing effectiveness in controlling Claimant's symptoms.

Physical Therapy and Chiropractic Manipulation

17. Claimant has at various times undergone courses of physical therapy as well as chiropractic manipulations as treatment for both her cervical and lumbar symptoms. According to the medical records, the last course of physical therapy occurred in 2006, and the last chiropractic treatment was in 2010. The medical records do not document any currently pending prescription or referral for ongoing treatment in either discipline.

18. Ms. Wallace testified in general terms as to the benefits of physical therapy as a means of maintaining function, and also as to the reasonableness of chiropractic manipulation directed at Claimant's lumbar spine. The extent of Ms. Wallace's specific expertise in these areas is unclear, and therefore I find her opinion on this issue of limited value.

[3] The medical records document similar relief of Claimant's lumbar pain as a result of Ms. Wallace's injections.

Surgery

19. Claimant first considered the possibility of treating her cervical symptoms surgically in September 2004. At Dr. Young-Xu's referral, she underwent an evaluation with Dr. Phillips, a neurosurgeon. Dr. Phillips determined at that time that surgery was "definitely an option" in the event that non-surgical interventions failed. As Claimant preferred continued conservative management of her symptoms, she opted against this approach.

20. Dr. Phillips next examined Claimant in April 2006. Both her symptoms and her MRI findings were essentially unchanged from his prior exam, and again he offered Claimant the same surgical option he had previously. Again, Claimant opted to continue with conservative management of her symptoms.

21. Dr. Phillips again evaluated Claimant in October 2010. As before, he found her MRI findings essentially unchanged from prior studies, and again he offered the same surgical option.

22. The surgery Dr. Phillips has proposed, a C5-6 and C6-7 discectomy and fusion, is designed to address Claimant's axial pain, that is, the pain she feels in her neck itself. It likely will not alleviate her radicular pain, that is, the pain she describes as radiating into her shoulder and arm. Radicular pain can often be localized to a particular nerve root, which allows the surgeon to identify the specific pain generator with greater confidence. The source of axial pain is more difficult to pinpoint. In Claimant's case, however, given that she has been followed over a long period of time with no new complaints or developments, and also given that her symptoms correlate well with her MRI findings, Dr. Phillips is confident that he will be able to do so.

23. Claimant has now decided that she would like to undergo surgery. While she understands that it likely will not cure her pain completely, Dr. Phillips anticipates that it will alleviate her symptoms enough to provide long-term improvement in both her quality of life and her ability to function.

24. Claimant will need medical clearance to undergo Dr. Phillips' proposed surgery, as she has a history of coronary artery blockage. An updated MRI study also will be necessary prior to surgery.

25. Dr. Phillips testified that both Dr. Young-Xu's medication regimen and Ms. Wallace's injection therapies were consistent with conservative management of chronic pain problems such as Claimant's.

Defense Expert Medical Opinions

26. At Defendant's request, Claimant has undergone two independent medical examinations, one with Dr. Boucher in January 2011 and another with Dr. Cares in January 2012. At issue in both evaluations was whether Claimant's ongoing treatment, consisting of prescription pain medications, injections and possibly fusion surgery, is medically necessary and causally related to her compensable work injury.

(a) Dr. Boucher

27. Dr. Boucher is board certified in occupational medicine. In the past 15 years he has focused increasingly on chronic pain management, though he is not board certified in that specialty. His current practice consists primarily in performing medical records reviews, permanency evaluations and independent medical examinations; only ten percent involves direct patient care.

28. As part of his evaluation of Claimant, Dr. Boucher conducted a physical examination and also reviewed her medical records. Based on that, he concluded that Claimant's physical injuries have never been so severe as to warrant the type and extent of treatment she has received. Rather, in his opinion her condition is largely psychogenic, or psychologically rather than physically driven.

29. I find specific reason in the record to question this assertion. For example, although Dr. Boucher stated that Claimant was "clearly" depressed, this was based solely on her demeanor during his examination, not on any formal screening tool. Notably, based on Claimant's periodic self-reports on a validated screening questionnaire, Dr. Young-Xu has concluded that her depression is in remission and under control. Having used a far more precise evaluative technique, I find Dr. Young-Xu's conclusion in this regard more persuasive than Dr. Boucher's.

30. Dr. Boucher's conclusion that Claimant exhibited evidence of symptom magnification is also suspect. In appropriate circumstances, symptom magnifying behavior may indicate a strong psychological component to a patient's presentation. In Claimant's case, Dr. Boucher found such behavior in the inconsistent responses she demonstrated on repeat cervical range of motion testing. However, as Ms. Wallace credibly noted after viewing the video of Dr. Boucher's evaluation, his examination technique may itself have induced the inconsistencies upon which he relied, and therefore I must discount them.

31. Dr. Boucher found fault in virtually all of the treatment that Claimant's providers have rendered since her work injury. In his opinion, the objective findings have never been sufficient to justify narcotic pain medications, and recent research suggests that chronic use of opiate analgesics may actually increase rather than decrease a patient's perception of pain. According to his review of the medical records, Claimant's response to Ms. Wallace's epidural steroid injections provided only temporary relief and likely represented a placebo effect rather than truly effective treatment. As for Dr. Phillips' proposed surgery, Dr. Boucher strongly discouraged it, on the grounds that absent clear evidence of radiculopathy cervical fusion likely would not be successful at relieving Claimant's symptoms.

32. Again, I find reason to question these assertions. While it is true that long term use of narcotic pain medications may be contraindicated in many chronic pain patients, even Dr. Boucher acknowledged that anecdotally there are those who appear to function well on them. The American College of Occupational and Environmental Medicine (ACOEM) guidelines recommend their use for select patients. Presumably as a safeguard against abuse, the ACOEM guidelines also recommend routine urine drug screening to identify aberrant use, a procedure to which Dr. Young-Xu adheres and which Claimant has never failed. Notably, both Ms. Wallace and Dr. Phillips also supported Dr. Young-Xu's medication regimen as consistent with proper management of chronic pain patients.

33. As noted previously, furthermore, Finding of Fact No. 15 *supra*, I already have found from the credible medical evidence that Claimant derived sufficient benefit from injection therapy to justify its ongoing use. Ms. Wallace's credentials in this area are impressive, and her explanation as to how injections are used to manage both acute and chronic pain was persuasive. Viewed against this backdrop, I find little evidence to support Dr. Boucher's conclusion that the only benefit Claimant has derived from injection therapy is as a placebo.

34. Dr. Boucher's opinion as to fusion surgery comports generally with that of Dr. Cares, which is discussed in greater detail below.

(b) *Dr. Cares*

35. Dr. Cares is a board certified neurosurgeon at Massachusetts General Hospital. His clinical practice includes cervical spine surgeries. Dr. Cares was one of Dr. Phillips' mentors during the latter's residency. Each holds the other in high regard.

36. Dr. Cares diagnosed Claimant with a remote cervical strain causally related to her work injury, but attributed her current symptoms solely to somatoform disorder. He based this conclusion on what he perceived to be a lack of objective findings, coupled with evidence of symptom magnification. His observations in this regard were similar to Dr. Boucher's.

37. As for Dr. Phillips' proposed surgery, Dr. Cares was strongly opposed. In his opinion, Claimant's symptoms did not correlate with either her MRI studies or his findings on examination. Absent sufficient correlation, in Dr. Cares' opinion it would be impossible to identify and address the source of her pain surgically. Thus, while he acknowledged that some surgeons will operate on axial pain, in his opinion to do so is not "scientific behavior." He does not anticipate that Claimant will derive much, if any, benefit from surgery. Were she his patient, it is not an option he would offer.

38. Dr. Cares also expressed concern about the inherent risks associated with a two-level fusion surgery such as the one Dr. Phillips has proposed. Fusing two joints places added stress on the discs directly above and below, thus increasing the risk of excessive degeneration from overuse.

39. In his testimony, Dr. Phillips directly addressed Dr. Cares' misgivings as to fusion surgery. As noted above, Finding of Fact No. 22 *supra*, notwithstanding that Claimant's pain is primarily axial rather than radicular in nature, Dr. Phillips is confident that surgery will alleviate her symptoms enough to improve function. Her complaints have been consistent throughout and to his view correlate well with her imaging studies. Dr. Phillips noted in this regard that although Claimant's MRI studies have documented more left- than right-sided abnormalities, this does not mean that her predominantly right-sided symptoms are inconsistent. The key is how the various structures of the spine move in relation to one another. Thus, the fact that on a static MRI scan a disc herniation appears to predominate on the left does not negate the possibility of nerve root irritation on the right.

40. As for the risk of further degeneration above and below the fusion site, in Dr. Phillips' opinion this is overstated. As discussed *supra*, Finding of Fact No. 8, bone spurs already have formed at the levels to be fused, which is the body's own attempt to immobilize the area. Even without surgical fusion, the risk of adjacent segment disease already exists, therefore. I find this analysis persuasive.

Procedural History

41. At Defendant's request, in May 2006 Claimant underwent an independent medical examination with Dr. Davignon. This evaluation followed her second surgical consultation with Dr. Phillips. Claimant having at that time opted against surgery, Dr. Davignon determined that she had reached an end medical result for her compensable neck and lower back injuries. With that opinion as support, in June 2006 the Department approved Defendant's discontinuance of temporary total disability benefits. Thereafter, Defendant continued to pay for physical therapy, chiropractic treatments, injections and prescription pain medications as before.

42. In December 2006 the Department approved a full and final (Form 14) settlement of Claimant's claim for indemnity benefits causally related to her compensable neck and lower back injuries. Claimant's entitlement to ongoing medical benefits was unaffected by this settlement.

43. With Dr. Boucher's January 2011 independent medical examination as support, in February 2011 the Department approved Defendant's discontinuance of both chiropractic manipulations and/or injections as treatment for Claimant's compensable injuries. The Department rejected Defendant's discontinuance of pain medications absent evidence of a safe taper plan.

CONCLUSIONS OF LAW:

1. The disputed issue in this claim is whether Defendant is obligated to pay for various medical services and supplies, including prescription pain medications, injections, physical therapy, chiropractic treatment and/or proposed cervical fusion surgery, as reasonable treatment for Claimant's compensable neck and low back injuries. Defendant asserts that it is not, both because her current complaints are unrelated to her work injuries and because the treatments at issue are not medically necessary.

2. Vermont's workers' compensation statute obligates an employer to pay only for those medical treatments that are determined to be both "reasonable" and causally related to the compensable injury. 21 V.S.A. §640(a); *MacAskill v. Kelly Services,* Opinion No. 04-09WC (January 30, 2009). The commissioner has discretion to determine what constitutes "reasonable" medical treatment given the particular circumstances of each case. *Id.* A treatment can be unreasonable either because it is not medically necessary or because it is not related to the compensable injury. *Baraw v. F.R. Lafayette, Inc.*, Opinion No. 01-10WC (January 20, 2010).

3. The parties presented conflicting expert testimony on both of these factors. In such cases, the commissioner traditionally uses a five-part test to determine which expert's opinion is the most persuasive: (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 (September 17, 2003).

Causal Relationship

4. Considering the causal relationship question first, I conclude from the more credible evidence that Claimant's current symptoms and need for ongoing treatment are related to her compensable injuries. I accept the opinions of her treating providers – Dr. Young-Xu, Ms. Wallace and Dr. Phillips – as persuasive in this regard. All have benefitted from the opportunity to evaluate and observe Claimant over an extended period of time. Beyond that, Ms. Wallace cogently explained the extent to which some of Claimant's more diffuse symptoms likely represent neuropathic pain, and Dr. Phillips credibly connected the dots between her consistent complaints and the objective findings documented on MRI studies.

5. Drs. Boucher and Cares both characterized Claimant's condition as driven primarily by psychological factors, but I find lacking the evidence in support. As to both depression and symptom magnification, Dr. Boucher's observations were particularly suspect given his examination technique. Dr. Cares' opinion was largely conclusory, and therefore difficult for me to evaluate. Neither expert provided sufficient justification for the premise that at some point Claimant's neck and lower back symptoms, the treatment for which Defendant had long accepted as compensable, suddenly became psychogenically caused instead. Defendant bore the burden of proof on this issue, *Merrill v. University of Vermont*, 133 Vt. 101 (1974), and I conclude that it has failed to sustain it.

Medical Necessity

6. Having concluded that Claimant's need for ongoing treatment is causally related to her compensable work injuries, I next consider whether the treatments at issue are medically necessary. This determination is based on evidence establishing the likelihood that they will improve the patient's condition, either by relieving symptoms and/or by maintaining or increasing functional abilities. *Cahill v. Benchmark Assisted Living*, Opinion No. 13-12WC (April 27, 2012); *Quinn v. Emery Worldwide*, Opinion No. 29-00WC (September 11, 2000).

(a) Prescription Pain Medications and Injection Therapy

7. I conclude from the more credible evidence here that both Dr. Young-Xu's prescription pain medications and Ms. Wallace's injection therapy meet this standard. The intent of these treatments is not to "cure" Claimant's pain, but rather to make it more manageable on a daily basis. As Ms. Wallace aptly described the chronic pain practitioner's goal, "We don't measure success by pain score. We measure success by function."

8. With this goal in mind, I accept as credible Claimant's testimony that she functions better with her pain medications, particularly fentanyl, than without them. I therefore conclude that the medications are continuing to serve the purpose for which they were prescribed and are thus medically necessary.

9. It is true, as Dr. Boucher noted, that recent research studies caution against the long term use of opiate analgesics as treatment for chronic pain. Given his limited association with Claimant, however, he is ill positioned to evaluate effectively whether such long-term use might still be appropriate in her case, a possibility that the ACOEM guidelines themselves acknowledge. As Claimant's primary treatment provider, Dr. Young-Xu is more capable of making that determination, and also ensuring that proper safeguards against abuse are maintained. Both Dr. Phillips and Ms. Wallace fully endorsed the medication regimen she has prescribed, furthermore. Considered together, I conclude that the opinions of Claimant's three treatment providers on this issue are more persuasive than Dr. Boucher's.

10. I also accept as credible Ms. Wallace's assertion that Claimant derives sufficient benefit from injections to justify their continued periodic use. Claimant credibly testified to that effect, and the relief she claimed was adequately documented in the medical records. In contrast, Dr. Boucher's conclusion that the injections were effective only as a placebo lacked objective support, and therefore I find it unpersuasive.

(b) *Physical Therapy and Chiropractic Treatment*

11. I conclude that the evidence was insufficient to establish that either physical therapy or chiropractic treatment constitute medically necessary treatment for Claimant's symptoms at this point. There is no currently pending referral for physical therapy, and thus there is no basis for me to evaluate its current role, if any, in addressing her work-related condition. As for chiropractic, I will not give carte blanche approval for treatment that Claimant has not recently pursued absent more persuasive evidence regarding its efficacy in this case.

(c) *Surgery*

12. Finally, I must determine whether Dr. Phillips' proposed cervical fusion surgery constitutes medically necessary treatment for Claimant's work-related neck injury. Both Dr. Phillips and Dr. Cares rendered carefully considered opinions on this issue. If nothing else, their debate presents an instructive example of how two similarly trained and experienced medical professionals might present diametrically opposed yet equally persuasive views regarding how best to manage their own patients. It is a forceful reminder that medical decision-making is an inexact science, and that rarely is there only one right answer. *Cahill, supra; Lackey v. Brattleboro Retreat*, Opinion No. 15-10WC (April 21, 2010).

13. I conclude here that Dr. Phillips' opinion is the most persuasive. I am confident that he conducted an appropriate risk-benefit analysis as to the efficacy of fusion surgery in Claimant's case. I accept as credible his conclusion that it represents a reasonable opportunity to improve both function and quality of life in ways that will make a significant difference to her. Conservative treatment having failed to accomplish this result, I agree that she deserves this opportunity.

14. I am mindful that Dr. Cares' risk-benefit analysis weighed against surgery as an appropriate treatment option in Claimant's case, such that were Claimant his patient, it is not a choice he would have offered. However, the benefit side of his analysis was based on what he perceived to be evidence of symptom magnification and somatoform disorder, evidence I already have rejected, *see* Finding of Fact No. 37 *supra*. As for his risk analysis, I have accepted Dr. Phillips' interpretation instead, *see* Finding of Fact No. 40 *supra*.

15. I conclude that Claimant has sustained her burden of proving that Dr. Phillips' proposed fusion surgery is medically necessary.

Summary

16. I conclude that Claimant has sustained her burden of proving that prescription pain medications, injection therapy and proposed fusion surgery constitute causally related, medically necessary and therefore reasonable treatment for her March 2004 work injuries. Under 21 V.S.A. §640(a), Defendant is obligated to pay for them.

17. I conclude that Claimant has not sustained her burden of proving that either physical therapy or chiropractic treatment is medically necessary at this time.[4]

18. As Claimant has substantially prevailed on her claim for benefits, she is entitled to an award of costs and attorney fees. In accordance with 21 V.S.A. §678(e), Claimant shall have 30 days from the date of this opinion within which to submit her itemized claim.

ORDER:

Based on the foregoing Findings of Fact and Conclusions of Law, Defendant is hereby **ORDERED** to pay:

1. Medical benefits covering ongoing chronic pain management of Claimant's current cervical and lower back conditions with appropriately prescribed pain medications and/or injection therapies, in accordance with 21 V.S.A. §640(a);

2. Medical benefits associated with Dr. Phillips' proposed cervical fusion surgery, in accordance with 21 V.S.A. §640(a); and

3. Costs and attorney fees in amounts to be established, in accordance with 21 V.S.A. §678.

DATED at Montpelier, Vermont this 14th day of September 2012.

_____
Anne M. Noonan
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.

[4] My conclusion in this regard should not be interpreted as precluding a finding of medical necessity for these treatments in the future, based on a treatment provider's appropriate and credible recommendation or referral.