Mandi Marsh v. Koffee Kup Bakery Inc (July 6, 2015)

STATE OF VERMONT
DEPARTMENT OF LABOR

Mandi Marsh

v.

Koffee Kup Bakery, Inc.

Opinion No. 15-15WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Anne M. Noonan
Commissioner

State File No. CC-02256

OPINION AND ORDER

Hearing held in Montpelier on February 13, 2015
Record closed on March 18, 2015

APPEARANCES:

Frank Talbott, Esq., for Claimant
David Berman, Esq., for Defendant

ISSUES PRESENTED:

1. Did Claimant reach an end medical result for her September 20, 2010 compensable work injury as of November 20, 2013, the date on which Defendant discontinued her temporary disability benefits?

2. If not, did Claimant reach an end medical result for her September 20, 2010 compensable work injury at some later date?

EXHIBITS:

Joint Exhibit I:	Medical records
Claimant's Exhibit 1:	Preservation deposition of Brian Erickson, M.D., February 10, 2015
Defendant's Exhibit A:	*Curriculum vitae*, George White, Jr., M.D.

CLAIM:

Temporary total disability benefits pursuant to 21 V.S.A. §642
Costs and attorney fees pursuant to 21 V.S.A. §678

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 and correspondence contained in the Department's file relating to this claim.

3. Claimant worked on Defendant's doughnut packaging and production line for approximately nine years. She was on her feet for virtually all of her eight-hour shift, and often worked overtime as well. Her job responsibilities required her at times to lift heavy bags of sugar and other ingredients. Some of these weighed 50 pounds or more.

Claimant's Work Injury and Subsequent Medical Course

4. On September 20, 2010 Claimant was helping a co-employee lift a 100-pound barrel of flour overhead so that they could pour it into a mixer. As they lifted the barrel, the co-employee dropped his end, leaving Claimant to bear the entire weight herself. She immediately felt a sharp, burning pain in her right shoulder and arm, and into her neck, chest and back as well. She reported the injury to her supervisor and, as it was towards the end of her shift, completed her work day.

5. Initially Claimant treated conservatively for her injury, which Defendant accepted as compensable. When her right shoulder symptoms failed to improve, her primary care provider, Molly Backup, a physician assistant, referred her to Dr. Lawlis, an orthopedic surgeon, for further evaluation. MRI findings suggested a small labral tear. As treatment, Dr. Lawlis recommended aggressive physical therapy aimed at stabilizing and strengthening her shoulder joint. At the same time, Ms. Backup prescribed various medications for pain control. This proved challenging; Claimant did not tolerate non-steroidal anti-inflammatories, and other medications were either ineffective or caused discomforting side effects.

6. Claimant participated fully in physical therapy, and was diligent with her home exercise program as well. Unfortunately, although she gained both range of motion and strength, she continued to experience limiting shoulder pain. Nor was she able to return to work, as Defendant proved unable to accommodate the modified duty restrictions her treating providers had imposed.

7. In September 2011 Claimant underwent arthroscopic surgery to repair tendon and tissue tears in her shoulder. Thereafter, she participated in another course of physical therapy. As before, her shoulder strength and range of motion improved, but her pain persisted.

8. With her return to full duty work in March 2012, Claimant's shoulder pain increased, and after only a few weeks Dr. Lawlis again disabled her from working. Claimant has not worked since. In May 2012 she underwent a functional capacity evaluation, in which she demonstrated a light work capacity, with significantly less lifting ability than what her regular job with Defendant required. Again, the evaluator noted that she had "reasonable" function in her right shoulder and arm, with good range and strength, but questioned whether she was prepared to tolerate the level of pain that likely would be associated with performing her previous job.

9. In her formal hearing testimony, Claimant credibly described her shoulder pain during this period as "terrible," such that it was "almost impossible" to wash or dress herself, make meals or do even light housework. Dr. Lawlis did not believe her ongoing symptoms were due to any persisting issue with her shoulder *per se*, but questioned whether she might be suffering from a right-sided thoracic outlet syndrome. With that in mind, in July 2012 he referred her to Dr. Steinthorsson for further evaluation.

10. Dr. Steinthorsson first evaluated Claimant in October 2012, and diagnosed pectoralis minor syndrome, a variant of thoracic outlet syndrome. Following a course of both physical therapy and diagnostic injections, as treatment for this condition Claimant underwent rib resection surgery in May 2013.

11. Claimant's pain did not abate with surgery. Ms. Backup's attempts to control it with medication were similarly ineffective, as had been the case from the outset. The list of prescriptions Claimant had tried previously was already lengthy – Robaxin, Ultram, Tylenol, Neurontin, Vicodin, Relafen, Klonopin, Cymbalta, Lyrica and Celexa; following her second surgery, she underwent trials of Effexor and Dilaudid as well. Some of these medications were prescribed specifically for pain, while others were meant to address comorbid issues, including depression, stress, anxiety and disturbed sleep. None of them provided adequate pain relief for a sustained period of time without intolerable side effects.

12. In her formal hearing testimony, Claimant credibly described the period following her second surgery as extremely frustrating. Her pain was "horrendous." Most days she felt unable even to get out of bed, as a result of which she missed physical therapy and other medical appointments. She could not wash her hair or get dressed without assistance. She had difficulty driving her standard shift car. She was angry and irritable, and this adversely affected her relationship with both her spouse and her children.

13. Dr. Steinthorsson could not offer any additional surgical remedies. At his September 2013 follow-up, he recommended only continued physical therapy and home exercise, and advised Claimant that her ongoing symptoms might simply be something she would have to live with.

14. At her September 20, 2013 follow-up, Ms. Backup as well discussed "accepting limits" as part of her treatment plan for Claimant's condition. To that end, she made two referrals. The first was for an updated functional capacity evaluation, which Claimant underwent in October 2013. The results established only a sedentary work capacity, a marked reduction from the light capacity she had demonstrated in her May 2012 evaluation, Finding of Fact No. 8 *supra*.

15. Ms. Backup's second September 2013 referral was to the Fletcher Allen Health Care Center for Pain Medicine, so that Claimant could be assessed "for better pain control." Claimant's subsequent treatment in this regard is discussed in depth *infra*, Finding of Fact Nos. 28-36.

Dr. White's End Medical Result Determination

16. At Defendant's request, on November 11, 2013 Claimant underwent an independent medical examination with Dr. White, an occupational medicine specialist. Dr. White previously had examined Claimant in June 2012, and initially had concluded that she had reached an end medical result for her work injury, with a three percent whole person permanent impairment referable to her shoulder. However, upon learning that Dr. Lawlis had referred her to Dr. Steinthorsson for evaluation of possible thoracic outlet syndrome, in August 2012 Dr. White withdrew that determination and concluded instead that ongoing treatment was reasonable.

17. In conjunction with his November 2013 examination, Dr. White reviewed Claimant's medical records up through the October 2013 functional capacity evaluation, but excluding Ms. Backup's September 20, 2013 office note. He thus incorrectly understood that Claimant had been referred for "pain management counseling," rather than the more comprehensive pain control assessment encompassed by Ms. Backup's referral. Dr. White anticipated that pain management counseling would not alter Claimant's physical condition but might still result in "some improvement in her coping mechanisms."

18. Dr. White concluded that Claimant had reached an end medical result as of the date of his November 2013 examination. As grounds for this opinion, he observed that following her most recent surgery Claimant's "situation" now appeared static, with no indication for further invasive treatment and little probability of substantial change in the foreseeable future.

19. Dr. White rated Claimant with a seven percent whole person permanent impairment referable to her shoulder, based on limitations he measured in her residual range of motion. This was in accordance with the upper extremity chapter of the *AMA Guides to the Evaluation of Permanent Impairment (5th ed.)*.

20. In formulating his opinion regarding the extent of Claimant's permanent impairment, Dr. White did not include any additional rating for pain. In his experience, when an individual exhibits range of motion limitations these typically are not mechanical in origin, but rather occur because more extensive movement is painful. According to his analysis, therefore, an impairment rating based on range of motion already incorporates pain as a factor, such that in most cases no additional consideration is necessary.

21. Dr. White acknowledged that under the *AMA Guides* it is permissible to increase an impairment rating such as the one he calculated by as much as three percent to account for pain. The specific provision to which he was referring suggests that an adjustment may be required in situations where an individual "appears to have pain-related impairment that has increased the burden of his or her condition *slightly*," such that a rating based solely on range of motion limitations would not adequately reflect the permanent consequences of the injury. *AMA Guides*, Chapter 18.3d at p. 573 (emphasis in original). Dr. White declined to make any such adjustment in Claimant's case.

22. In some situations, the *AMA Guides* recognize that even a three percent increase in an individual's impairment rating may be insufficient to account for the impact of chronic pain. In cases where a person "appears to have pain-related impairment that is *substantially* in excess of the impairment determined [according to a specific body or organ rating system]," the *Guides* suggest that the examiner "should perform a formal pain-related impairment assessment." *AMA Guides*, Chapter 18.3d at p. 573 (emphasis in original). That assessment should enable the examiner to classify the individual's pain-related impairment into one of four categories: mild, moderate, moderately severe or severe. *Id.*

23. As with any impairment assessment performed under the *AMA Guides*, *see id.*, Chapter 2.4 at p. 19, in applying the protocol for performing a pain-related impairment assessment, it is "particularly important" for the examining physician to determine first whether the individual has reached the point of maximum medical improvement. *Id.*, Chapter 18.3f at p. 577. This requires consideration not only of interventions aimed primarily at the injured body part or system itself, but also of appropriate pain management interventions, which potentially might "reduce all the components of impairment, with reduced pain severity, functional restoration, and mood normalization." *Id.* To determine whether "potentially useful treatments" are available, the *Guides* conclude, it may be necessary to consult with a pain medicine specialist. *Id.*

24. As noted above, Finding of Fact No. 20 *supra*, because Dr. White concluded that Claimant's pain presentation was adequately reflected in the impairment rating derived from her range of motion deficits alone, he did not perform a formal pain-related assessment. Nor did he determine whether or when she reached the point of maximum medical improvement for any pain-related condition separate and distinct from her shoulder injury. To the contrary, notwithstanding what he understood to be Ms. Backup's referral for "pain management counseling," Finding of Fact No. 17 *supra*, in his formal hearing testimony Dr. White restated his opinion that because there was no indication for further invasive treatment directed at her shoulder, Claimant had reached an end medical result.

25. Dr. White correctly characterized the *Guide's* system for rating pain-related impairments as controversial. Its central premise is that, as recent research has documented, in some circumstances the pathophysiology of pain can induce changes at a cortical level. These findings, the *Guides* assert, are highly significant. "They demonstrate that pain need not be symptomatic of a disease or injury but, in fact, can become a disease unto itself." *AMA Guides,* Chapter 18.2c at p. 568. Phrased alternatively, the *Guides* acknowledge that sometimes it is appropriate to consider pain as a separate medical condition.

26. I find Dr. White's analysis of Claimant's pain presentation somewhat lacking, both as reflected in his November 2013 independent medical examination report and in his formal hearing testimony. His description of the extent to which Claimant's pain limited her functional status is at odds with the pain levels she reported in conjunction with her functional capacity evaluation just weeks earlier, and also as reflected in contemporaneous medical records from Ms. Backup, Dr. Steinthorsson and the treating physical therapist. Against that backdrop, I find his assertion at formal hearing that Claimant's pain-related impairment did not merit separate consideration under Chapter 18 of the *Guides* unpersuasive. For the same reason, and more germane to the specific dispute at issue here, his end medical result determination is also suspect.

27. With Dr. White's end medical result determination as support, effective November 20, 2013 Defendant terminated Claimant's temporary disability benefits.

Claimant's Pain Management Treatment

28. In opposing Dr. White's end medical result determination, Claimant points to subsequent treatment and/or evaluations with Cheryl Gagnon, a physician assistant at the UVM Medical Center (formerly Fletcher Allen Health Care) Center for Pain Medicine, and Dr. Erickson, Ms. Gagnon's supervising physician. Both practitioners became involved in Claimant's care as a result of Ms. Backup's September 20, 2013 recommendation that she be assessed for "better pain control," *see* Finding of Fact No. 15 *supra*.

29. Before committing to pain management treatment, Claimant first sought confirmation that she had exhausted all treatment options aimed specifically at her shoulder. To that end, in February 2014 she underwent an evaluation with Dr. Nichols, an orthopedic surgeon. Dr. Nichols noted that Claimant's symptoms had remained unchanged despite two surgical procedures, multiple medication trials and other non-operative therapies. Stating that he was uncertain whether it would ever be possible to clearly identify the source of her ongoing pain, he concluded that pain management was the more appropriate avenue to pursue. He thus referred her to Dr. Erickson at the Center for Pain Medicine, the same pain management practice group to which Ms. Backup had referred her.

30. In March 2014 Claimant began treating with Ms. Gagnon at the Center for Pain Medicine. Ms. Gagnon has a master's degree in physician assistant sciences and has undergone extensive training in palliative medicine at Harvard University. She specializes in pain and psychiatry, and has been practicing in this area for more than ten years.

31. Ms. Gagnon is a strong adherent to the school of thought from which much of the *AMA Guides'* pain chapter is derived, *see* Finding of Fact No. 25 *supra*, that is, that pain of the type Claimant now experiences is a medical condition in itself, entirely separate from her underlying shoulder injury. Thus, while she agreed that Claimant's shoulder injury had been thoroughly treated, she disagreed that this was the case with respect to her chronic pain. According to Ms. Gagnon, at the time of her first evaluation, the latter condition had been poorly treated, was severely impacting Claimant's ability to function and was not yet stable. I find this analysis credible.

32. In her formal hearing testimony, Ms. Gagnon credibly described the range of treatment modalities she might consider in order first, to stabilize and then hopefully, to alleviate a patient's pain experience. Depending on the individual, these might include narcotic and/or non-narcotic medications, various types of physical therapy, interventional anesthetic procedures, massage, acupuncture and/or other adjunct modalities, and therapies to address the psychosocial and emotional aspects of chronic pain.

33. In Claimant's case, Ms. Gagnon's treatment has primarily been pharmacological. As documented at monthly visits over the past two years, by way of trial and error she has identified a combination and dosage of long- and short-acting morphine that effectively alleviates at least a portion of Claimant's pain without intolerable side effects. In her formal hearing testimony, Ms. Gagnon acknowledged that as of her last evaluation on February 10, 2015 Claimant had reached "somewhat of a plateau," and that her pain was now "fairly stable." She described the plan going forward as "a slow process of negotiating with the pain," one that might still yield some progress but will likely fall short of "substantial improvement." I find these statements are equivalent to a declaration of end medical result with respect to Claimant's pain condition.

34. Ms. Gagnon's supervising physician, Dr. Erickson, testified in full support of her pain management treatment plan. Dr. Erickson is board certified in psychiatry, with a qualification in psychosomatic medicine. At Ms. Gagnon's request, in October 2014 he evaluated Claimant in order to assess her chronic pain condition and to offer additional treatment recommendations.

35. Like Ms. Gagnon, Dr. Erickson acknowledged that pain management treatment is designed not to change an underlying medical condition, but rather to help a person function better by alleviating his or her chronic pain on a long-term basis. On the question whether Claimant had reached an end medical result for her underlying shoulder injury, he deferred to both Dr. Steinthorsson and Dr. Nichols, agreeing that from their perspective Claimant's condition was stable, with no further medical interventions likely to substantially improve it.

36. I find that by deferring to Drs. Steinthorsson and Nichols' end medical result determination with respect to Claimant's shoulder injury, Dr. Erickson did not necessarily intend to imply that as of his October 2014 evaluation she had reached an end medical result for her pain condition as well, however. As Ms. Gagnon did, Dr. Erickson viewed the two as separate and distinct medical conditions. As to the latter, in his October 2014 evaluation Dr. Erickson made specific treatment recommendations, including continued pharmacological management by Ms. Gagnon and also a variant of physical therapy involving postural restoration techniques, which Claimant apparently declined to pursue.

37. For her part, although her physical symptoms have not changed Claimant credibly testified to a dramatic improvement in her attitude, outlook, and at least to some extent, her functional abilities as well, all as a direct result of Ms. Gagnon's pharmacological treatment. She can now wash her hair, get dressed and tie her shoes independently. She can make meals and wash dishes. She can sleep. Whereas before her pain was so excruciating that she just wanted to be left alone, now she has more patience, is more communicative and is better able to work through the "little problems" that arise in the ordinary course of her family relationships. Thus described, the before-and-after picture Claimant painted was compelling.

CONCLUSIONS OF LAW:

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 a 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 probable hypothesis. *Burton v. Holden Lumber Co.*, 112 Vt. 17 (1941); *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. As framed by the parties, the disputed issue in this case is whether Defendant appropriately terminated Claimant's temporary disability benefits in November 2013. Underlying this issue is a more important one, however – whether the pain management treatment Claimant underwent subsequently should be deemed to negate the end medical result determination upon which Defendant's discontinuance was based. As with many disputes in the workers' compensation arena, resolving this question requires consideration of both legal and medical concepts.

3. Vermont's workers' compensation rules define end medical result as "the point at which a person has reached a substantial plateau in the medical recovery process, such that significant further improvement is not expected, regardless of treatment." Workers' Compensation Rule 2.1200. The date of end medical result marks an important turning point in an injured worker's progress, both medically and legally. Medically, it signals a shift in treatment from curative interventions, the goal of which is to "diagnose, heal or permanently alleviate or eliminate a medical condition," to palliative ones, which aim instead to "reduce or moderate temporarily the intensity of an otherwise stable medical condition." Workers' Compensation Rule 2.1310.

4. Legally, because temporary disability benefits are only payable "for so long as the medical recovery process is ongoing," once an injured worker reaches an end medical result his or her entitlement to temporary indemnity benefits ends, and the focus shifts instead to consideration of permanent disability. *Bishop v. Town of Barre,* 140 Vt. 564, 571 (1982).

5. In discerning the line between curative and palliative treatments, two Vermont Supreme Court decisions are instructive. In the first case, *Coburn v. Frank Dodge & Sons*, 165 Vt. 529 (1996), the Court was asked to reject an employer's discontinuance of temporary disability benefits on end medical result grounds because the injured worker was continuing to undergo chiropractic treatments designed to relieve his persistent upper back pain. The treatments improved his ability to walk, restored his sleep patterns, and enabled him to work part time, perform simple household chores and decrease his use of pain medication. For these reasons, the Court determined that the treatments were medically necessary. Nevertheless, the Court concluded that because ongoing chiropractic care was not "reasonably expected to bring about significant medical improvement" in the worker's underlying condition, the employer's discontinuance of his temporary disability benefits was proper. As the Court explained, "The fact that some treatment, such as physical or drug therapy, continues to be necessary does not preclude a finding of medical end result if the underlying condition causing the disability has become stable and if further treatment will not improve that condition." *Id.* at 533-34.

6. The disputed issue in the second case, *Brace v. Vergennes Auto, Inc.*, 2009 VT 49, was very similar to the one presented here, that is, whether "pain management treatment" can negate a finding of end medical result. The claimant in *Brace* had undergone right shoulder surgery. When she declined further surgery, her treating orthopedic surgeon referred her to a pain clinic for rehabilitation and pain management, stating that "although there was nothing more for *him* to do," the referral 'might improve her ability to function.'" *Id.* at ¶12 (emphasis in original). Upon receiving the referral and first evaluating the claimant, the rehabilitation physician determined that she "had the potential [with therapy and treatment] to improve her overall function, whether that be daily activities, potentially vocational activities as well." This prediction proved accurate, as with better pain management the claimant's range of motion improved and she became able "to engage more fully in various activities and tasks." *Id.* at ¶13. These facts amply supported a finding that she did not reach an end medical result until her pain management treatment concluded, the Court held.

7. In cases decided since *Brace*, the Commissioner has ruled that a defined course of treatment that (a) offers long-term symptom relief rather than just a temporary reprieve; and (b) is reasonably expected to provide significant functional improvement can, in appropriate circumstances, negate a finding of end medical result. *Luff v. Rent Way*, Opinion No. 07-10WC (February 16, 2010) (trial implantation of spinal cord stimulator); *Cochran v. Northeast Kingdom Human Services*, Opinion No. 31-09WC (August 12, 2009) (participation in functional restoration program). Interpreting the concept of the "medical recovery process," *Bishop, supra*, in this way is in keeping with the benevolent objectives and remedial nature of Vermont's workers' compensation law. *Luff, supra*, citing *Montgomery v. Brinver Corp.*, 142 Vt. 461, 463 (1983).

8. Applying those principles here, I conclude that the pain management treatment Ms. Gagnon provided Claimant through February 10, 2015 was sufficiently curative in nature to negate Dr. White's prior end medical result determination. Its purpose was not merely "to offer improvement in [Claimant's] coping mechanisms," as Dr. White characterized it, but rather to alleviate and stabilize her pain condition. It thus was directed at long-term symptom relief, with a reasonable expectation of significant functional restoration as a result. And although Ms. Gagnon's treatment plan was not as finite as the treatments at issue in either *Luff* or *Cochran*, neither was it so open-ended as to lack a defined goal aimed at permanently improving rather than just maintaining function, *see N.C. v. Kinney Drugs*, Opinion No. 18-08WC (end medical result not negated by chiropractic treatment that provided only temporary pain relief and maintained "decidedly low" level of function).

9. I stress the limited nature of my determination in this case. Defendant is legitimately concerned that a finding of end medical result not be delayed indefinitely merely because an injured worker continues to receive treatment for pain or other symptoms after curative interventions have concluded. Certainly, as Defendant contends, it is not unusual for an injury to cause pain, and it is not unusual for a treating provider to prescribe pain medications or other palliative measures for temporary symptom relief. However, as the *AMA Guides* acknowledge, not all pain rises to the level of becoming "a disease unto itself," *AMA Guides*, Chapter 18.2c at p. 568, and therefore not all pain qualifies as a separate medical condition. In most cases, ongoing symptoms do not merit consultation with a pain specialist or treatment at a pain clinic. Nor do they increase the burden of an individual's injury beyond what would ordinarily be expected, either "slightly" or substantially," *AMA Guides*, Chapter 18.3d at p. 573. In most cases, therefore, the mere fact that a claimant continues to experience and treat for lingering pain or other symptoms once curative treatment for the primary work-related injury has concluded likely will not negate a finding of end medical result.

10. In sum, I conclude that Dr. White's determination of end medical result in November 2013 was erroneous, and therefore that Defendant's termination of temporary disability benefits as of November 20, 2013 was inappropriate. In accordance with Ms. Gagnon's determination that as of February 10, 2015 Claimant's pain condition had become stable, such that substantial further improvement in function was unlikely, I conclude that Claimant reached an end medical result as of that date. Claimant is therefore owed temporary total disability benefits for the intervening period.

11. As Claimant has prevailed on her claim for benefits, she is entitled to an award of costs and attorney fees. She has submitted a request under 21 V.S.A. §678 for costs totaling $2,646.81 and attorney fees totaling $8,901.00. Defendant shall have 30 days from the date of this decision within which to file its objection to all or any portion of the costs and fees requested, following which an award shall issue.

ORDER:

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

1. Temporary total disability benefits from November 20, 2013 through February 10, 2015 in accordance with 21 V.S.A. §642, with interest as calculated in accordance with 21 V.S.A. §664; and

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

DATED at Montpelier, Vermont this 6th day of July 2015.

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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.