STATE OF VERMONT
DEPARTMENT OF LABOR

David Brown

v.

Casella Waste Management

Opinion No. 19-15WC

By: Phyllis Phillips, Esq.
Administrative Law Judge

For: Anne M. Noonan
Commissioner

State File No. Y-00301

OPINION AND ORDER

Hearing held in Montpelier on March 9, 2015
Record closed on April 24, 2015

APPEARANCES:

Christopher McVeigh, Esq., for Claimant
J. Justin Sluka, Esq., for Defendant

ISSUES PRESENTED:

1. Is Claimant entitled to temporary total disability benefits retroactive to July 23, 2014 as a consequence of his July 13, 2006 compensable work injury?

2. Does Claimant's current course of physical therapy constitute reasonable medical treatment causally related to his July 13, 2006 compensable work injury?

3. Does Claimant's current use of Suboxone constitute reasonable medical treatment causally related to his July 13, 2006 compensable work injury?

4. Did Claimant's July 13, 2006 compensable work injury aggravate or exacerbate his preexisting anxiety and depression?

EXHIBITS:

Joint Exhibits I-III:	Medical records
Claimant's Exhibit 1:	Deposition of Brian Erickson, M.D., February 12, 2015
Defendant's Exhibit A:	Preservation deposition of John Johansson, D.O., March 18, 2015

CLAIM:

Temporary total disability benefits retroactive to July 23, 2014 pursuant to 21 V.S.A. §642
Medical benefits pursuant to 21 V.S.A. §640
Interest, costs and attorney fees pursuant to 21 V.S.A. §§664 and 678

FINDINGS OF FACT:

1. At all times relevant to these proceedings, Claimant was an employee and Defendant was his 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 for Defendant as a recycling truck driver, collecting curbside recycling buckets with a side-loading truck. His prior employment history includes experience in construction, roofing and truck driving. Claimant earned his GED while in the military, and also possesses a commercial driver's license.

4. Claimant has an extensive prior medical history. He has suffered from chronic low back and bilateral knee pain for more than a decade, which he treats with Advil and Soma, a muscle relaxant. He has undergone multiple shoulder surgeries. As a consequence of the functional limitations associated with these various injuries and conditions, a 2005 functional capacity evaluation documented only a sedentary to light work capacity.

5. Claimant also has a long history of treatment for anxiety, depression, insomnia and substance abuse; as to the latter condition, he has been abstinent since 2004.

Claimant's July 2006 Work Injury and Subsequent Medical Course

6. On July 13, 2006 Claimant was operating a garbage truck when one of the recycling bins got stuck in the loader. He climbed up to dislodge it, and as he did so he slipped and fell against the loader. He hit his right hip against the side of the loader, reached back to grab a bar with his right arm and lowered himself to the ground.

7. Claimant injured his right hip and right upper extremity in this incident. Defendant accepted these injuries as compensable and began paying workers' compensation benefits accordingly.

8. Initially Claimant treated conservatively for his injuries, with physical therapy, diagnostic injections and modified-duty work restrictions. His symptoms, which

included pain, weakness and limited range of motion in his hip, and pain and sensory deficits in his forearm, hand and fingers, failed to resolve, however. Later, diagnostic studies revealed a labral tear in his hip and cubital tunnel syndrome in his right elbow, and later still, ligament tears in his right wrist. Ultimately, these injuries all required surgical treatment. For the right hip, Claimant underwent arthroscopic surgery in 2006, and then a total hip replacement in February 2008. For the elbow, he underwent ulnar nerve transposition surgery in August 2008. For the right wrist, he underwent surgical repair in April 2010.

9. After his 2008 hip replacement surgery, Claimant underwent a course of physical therapy focusing on postural restoration, which employs a whole-body approach to maximizing function. With the use of heel lifts in his shoes to correct a possible leg length discrepancy, by June 2008 his gait pattern had improved. Although he applied himself diligently to both physical therapy and home exercise, his hip continued to ache and the musculature remained weak, however. Neither a specialist evaluation (Dr. Kain) nor further diagnostic testing (Dr. Benjamin) clearly identified the etiology of these lingering symptoms – the joint hardware remained stable and appropriately positioned, there was no evidence of infection, and no apparent neurologic component to his weakness.

10. Claimant also suffered complications after his 2008 elbow surgery, most significantly lymphedema, or fluid collection and swelling, in his arm. This he treated with a combination of physical therapy and compression garments.

11. Following a course of evaluation and treatment with Dr. Backus, by December 2010 Claimant was determined to have reached an end medical result. Noting that he still experienced moderate pain even at rest, walked with a moderate to severe limp, used a cane at times for support and now had a measurable leg length discrepancy, Dr. Backus rated him with a 30 percent whole person impairment referable to the hip. Considering both his elbow and wrist injuries, Dr. Backus found an additional 23 percent whole person impairment referable to the right upper extremity.

12. Defendant's medical expert, Dr. Johansson, an osteopath, also rated Claimant's permanent impairment. Following an independent medical examination in May 2009, he found only a 20 percent impairment referable to the hip, and no ratable impairment at all for the upper extremity. However, following a second examination in January 2011, he amended his rating to 30 percent for the hip and 13 percent for the upper extremity. In September 2011 the Department approved an agreement for permanent partial disability benefits in accordance with a compromise rating of 30 percent referable to the hip and 20 percent referable to the upper extremity, which Defendant subsequently paid.

13. In their respective permanency evaluations, both Dr. Backus and Dr. Johansson agreed that upon reaching an end medical result, and despite his residual deficits,

Claimant had a work capacity. According to Dr. Johansson, he was capable of sedentary to light work, with additional restrictions against repetitive upper extremity activities, sitting for more than four to six hours, standing for more than two to four hours and lifting more than ten pounds occasionally. Dr. Backus' opinion was somewhat more restrictive; he limited Claimant to sedentary work only, with no repetitive use of his right arm and no commercial driving.

Claimant's Move from Vermont and Subsequent Employment

14. In April 2011 Claimant moved to Florida with his adult daughter. Shortly thereafter, they relocated to South Dakota. Later still, he moved to Wyoming, and then back to South Dakota before returning to Vermont in December 2013. Claimant held the following jobs during this period:

    - Driving a tanker truck for a small trucking company, hauling wastewater from the North Dakota oil fields; Claimant's employment terminated after three or four months because the trucking company lost its contract;

    - Driving a rear-loader garbage truck for a waste management company; Claimant left this job after two months; although he testified that this was due to pain in his hip and arm, contemporaneous medical records reference his "old back injury" and document only low back and radiating leg pain as the cause of his difficulties;

    - As a long-haul trucker for a furniture manufacturing company; Claimant left this job after six months due to a conflict with his dispatcher.

15. Claimant's ongoing symptoms during this time included pain in his groin and hip flexor and a persistent limp, for which he often used a cane. Nevertheless, and despite Dr. Backus' admonition against commercial driving, he acknowledged that he was able to perform the duties associated with both the tanker truck job and the long-haul trucking job without disabling pain. I find that Dr. Backus' prior opinion as to work capacity, Finding of Fact No. 13 *supra*, was rendered less credible as a result of this admission.

16. Claimant treated for chronic pain, related to both his hip and his lower back, while in South Dakota and Wyoming. Aside from undergoing a bone scan to rule out infection or loosening of the prosthesis as possible causes for his hip pain and instability, his treatment during this period consisted almost exclusively of prescribing and monitoring his use of prescription medications. These included Soma and Suboxone for chronic low back and hip pain, Klonopin for anxiety and Zoloft for depression. At no time did any of his treating providers determine that he was disabled from working, either totally or partially, as a consequence of his hip, right upper extremity or psychological conditions.

17. After quitting his long-haul trucking job, Finding of Fact No. 14 *supra,* Claimant was unemployed from February 2013 until January 2014. I find no credible evidence establishing that his unemployment during this time was causally related to his work injury.

18. Claimant returned to Vermont in December 2013. In January 2014 he began working as an installer for Twin State Signs. Claimant credibly testified that the work was less physically demanding than the jobs he had held in Wyoming and South Dakota, but more mentally taxing, because it involved working with electricity, with which he had no experience. In addition, the job offered only part-time hours. For these reasons, Claimant continued to seek alternative employment.

19. In March or April 2014 Claimant began working full time for Milton Building Supply. He anticipated that his job there would primarily entail driving a boom truck to deliver materials to construction sites. In fact, however, he spent most of his time working in the yard, helping customers load lumber into their trucks. These duties required much more time on his feet, which was problematic and painful for him. Overall, the job offered far less flexibility than the jobs he had held while out west had allowed with respect to sitting and taking stretch breaks. Claimant experienced pain in his lower back, hip, legs and arms; by the end of the day, he was both physically and mentally exhausted.

Claimant's Current Medical Treatment and Work Capacity

20. Throughout the spring of 2014, Claimant reported increased pain with work activities to Dr. Erickson, the chronic pain specialist/psychiatrist to whom he had been referred upon his return to Vermont earlier in the year. Both in his office notes and in his deposition testimony, Dr. Erickson reported that Claimant described pain "from multiple sources," including not only his right hip and arm, but also his lower back, neck, right shoulder and left knee. As noted above, Finding of Fact No. 4 *supra,* Claimant's prior medical history includes injuries to all of the latter areas.

21. In his July 23, 2014 office note, Dr. Erickson reported that Claimant was having an increasingly difficult time at work, as follows:

> David describes his "brain is catching up at my body." He described having increasing problems at work, noting that he had never told anybody about his pain problems, but they could tell by midday, he was slowing down. He eventually went to his boss who told him he needs to take time off work. He feels that his hip is "trashed;" his whole right side is having problems. He feels like his left knee is having problems compensating for the right side. He describes after his surgery 8 or 9 years ago being told he would need to consider hip replaced [sic] again in the future. He

> describes taking some time off work doing a lot of thinking, telling his boss he needs to take time off to be more aggressive with therapy. He describes he does "not like to admit defeat." He notes it is now hard to walk up stairs.
>
> . . .
>
> He notes his left arm is having more problems with tendinitis as he has to do more lifting. He has a history of right ulnar nerve surgery and now is more swollen. He describes when he wakes up he is bent over; it takes a long time to understand [sic] up.

22. As treatment for Claimant's worsening pain, Dr. Erickson made two referrals – one to an orthopedist "to review his hip," and another for postural restoration physical therapy. In Dr. Erickson's opinion, the latter referral was necessary to correct gait abnormalities that had developed as a consequence of Claimant's hip injury. These in turn were affecting his posture, the rotation of his pelvis and the manner in which he used his other leg. I find this analysis credible.

23. Also in the context of his July 23, 2014 evaluation, Dr. Erickson provided Claimant with a handwritten note recommending that he "take time off work for intensive treatment of a medical problem," adding that it was "unclear" when he would be capable of returning. Claimant has not worked since that date.

24. In his deposition testimony, Dr. Erickson acknowledged that he has no training in orthopedics and has never physically examined Claimant. He admitted that he did not consider whether Claimant might be capable of at least sedentary work prior to providing him with a note totally disabling him from work. He recalled that one reason why he wrote the note was because he hoped it would safeguard Claimant against losing his job while undergoing what Dr. Erickson understood would be an "intense" course of physical therapy, one that would require several sessions each week. Considering this testimony, it is difficult to discern the specific medical evidence upon which Dr. Erickson relied in concluding that Claimant was totally disabled from working. For that reason, I find it unpersuasive.

25. In accordance with Dr. Erickson's first referral, in October 2014 Claimant underwent an evaluation with Dr. Blankstein, an orthopedist. As had been the case in prior orthopedic evaluations, x-rays revealed that Claimant's hip prosthetic was in good position, with no hardware complications, no "concerning signs" and no change from its previous position. Having found no significant pathology, either radiologically or on physical examination, Dr. Blankstein suspected that Claimant's increased symptoms "might be due to his recent increase in activities," (an apparent reference to his job duties at Milton Building Supply), and likely would subside over time. In the meantime, he recommended physical therapy focused on muscle strengthening.

26. Notably, Dr. Blankstein did not address Claimant's work capacity in the course of his evaluation, either to determine that he was capable of working or that he was totally or partially disabled from doing so.

27. In November 2014 Claimant began a course of physical therapy with Leslie Bell. Ms. Bell holds a doctorate in physical therapy and as such, qualifies as a direct access provider, meaning that she does not need a referral from another medical professional before commencing treatment. Ms. Bell counts among her areas of specialization therapies for lymphedema, and in fact she and others in her practice had treated Claimant for this complication following his 2008 right elbow surgery, Finding of Fact No. 10 *supra*. Ms. Bell has never reviewed Claimant's medical records from other providers.

28. Ms. Bell's treatment has focused on addressing the pain and weakness in Claimant's hip, as well as instability and poor balance. Although she attributes all of these deficits to his work-related injury, the notes from her initial evaluation reference as well his job duties at Milton Building Supply as having precipitated a "severe exacerbation" of symptoms.

29. Contrary to Dr. Erickson's understanding, Finding of Fact No. 24 *supra*, Ms. Bell's physical therapy is not so "intense" as to involve several sessions each week; she typically sees Claimant on a twice-weekly basis. It is unclear from her treatment notes whether she is employing the postural restoration techniques Dr. Erickson had suggested in July 2014, Finding of Fact No. 22 *supra*. In fact, according to both her office notes and her testimony, the most significant improvements in Claimant's ability to move about with better balance and less pain have resulted from the use of heel lifts to correct his leg length discrepancy, and a stability strap to support his right hip and leg. By decreasing the constant irritation in his hip, these devices have helped to increase Claimant's strength and tolerance as well.

30. Ms. Bell credibly testified that Claimant is continuing to progress in therapy. His gait control is 75 percent improved, though his tolerance for walking and standing is still limited by pain to about ten minutes; the functional goal is for him to increase his tolerance to at least thirty minutes. Ms. Bell anticipates another eight to twelve weeks of therapy in order to reach this goal. With that in mind, in her opinion Claimant has not yet reached an end medical result.

31. Ms. Bell testified that Claimant's current limitations with respect to walking and standing preclude him from returning to work at this time. In stating this opinion, it does not appear that she considered whether and to what extent Claimant might be capable of work similar to the jobs he held while in Wyoming and South Dakota, however. According to Claimant's own testimony, those jobs offered greater flexibility in terms of alternating sitting, standing, walking and stretching, and thus he was able to manage them without disabling pain, *see* Finding of Fact

No. 15 *supra*. With that in mind, I find Ms. Bell's opinion on this issue unpersuasive.

32. At Defendant's request, in September 2014 Claimant underwent a third independent medical examination with Dr. Johansson. As noted above, Finding of Fact No. 12 *supra*, Dr. Johansson previously had examined Claimant in May 2009 and then again in January 2011. At the latter evaluation, Dr. Johansson had concluded that Claimant was at end medical result for his work injuries, and had a sedentary to light work capacity, with restrictions against, *inter alia*, sitting for more than four to six hours and standing for more than two to four hours, *see* Finding of Fact No. 13 *supra*. This time he was asked to reevaluate whether Claimant remained at end medical result, whether further treatment was now warranted and whether he still was capable of working.

33. In answering these questions, Dr. Johansson differentiated between the specifically work-related injuries Claimant had suffered to his right hip, elbow and wrist, and the more diffuse chronic myofascial pain from which he had suffered for many years in his lower back and bilateral joints throughout his body, Finding of Fact No. 4 *supra*. In Dr. Johansson's opinion, to the extent Claimant reported worsening right hip pain, this most likely represented a manifestation of his more generalized pain condition, and not a change in the underlying physiology itself. Thus, considering just the work-related injuries, Dr. Johansson concluded that Claimant was still at end medical result.

34. Using the same analysis, Dr. Johansson concluded that Claimant remained capable of working to the same extent as previously. He acknowledged that at least in part as a result of his work-related injuries, Claimant now suffers from chronic pain in his right hip. However, given his more generalized chronic pain condition, it is impossible to isolate that specific area of pain as the cause of any current inability to work. I find this analysis credible.

35. To the extent that a specific cause for Claimant's worsening pain could be identified, Dr. Johansson theorized that his job duties at Milton Building Supply were likely responsible. As noted above, Finding of Fact Nos. 25 and 28 *supra*, both Dr. Blankstein and Ms. Bell posited the same causal connection. Claimant himself testified that the Milton Building Supply job was harder on his body than any of the jobs he had held in Wyoming and South Dakota, and as Dr. Johansson correctly noted, his work there was physically demanding to an extent that far exceeded the sedentary to light work capacity he had been given in 2011.

36. As for Claimant's current treatment, Dr. Johansson testified that undergoing another course of physical therapy was not unreasonable given his worsening pain. Again, however, he attributed the need for any such treatment to the increased physical demands of Claimant's job at Milton Building Supply. This analysis ignores the primary focus of Ms. Bell's therapy – to decrease the constant irritation in Claimant's hip by addressing the leg length discrepancy caused by his

hip replacement, and thereby facilitate gains in strength, tolerance, balance and instability. For this reason, I find Dr. Johansson's opinion on this issue unpersuasive.

37. In his own testimony, Claimant credibly described his pattern since leaving Vermont in 2011 – finding a job, tolerating it as best he could notwithstanding his chronic pain, and if he could not do so, moving on to another, in the hopes that it would be easier on his body. While this testimony helps to establish that Claimant is physically incapable of performing certain work, I find that it also demonstrates that he is not totally disabled from performing any work at all.

Claimant's Use of Suboxone

38. As noted above, Finding of Fact No. 5 *supra*, Claimant has a history of substance abuse dating back to grade school. He has been abstinent since 2004, when he was admitted into a methadone program.

39. When prescribed as treatment for opioid addiction, methadone can only be dispensed through a federally monitored clinic. Dispensing typically occurs on a daily basis at first, and if the patient is compliant he or she may be permitted to move to a weekly "take home" dispensing schedule. In either case, the drug can only be dispensed in person, which means that the patient must travel to the clinic, on either a daily or weekly basis, to receive it.

40. In contrast, any licensed physician can prescribe methadone to treat chronic pain, albeit typically at a lower dosage, and if prescribed for that purpose, it need not be dispensed in person.

41. Following his 2006 work injury Claimant's use of methadone served a dual purpose. As a recovering addict, he required it to reduce the possibility of relapse. But the drug also served as an effective substitute for the narcotic pain medications he otherwise might have been offered as treatment for his chronic right hip pain. Given his substance abuse history, Claimant was understandably reluctant to consider any such alternatives.

42. Following his first hip surgery in 2006, Claimant inquired of his primary care provider, Dr. Koutras, whether she would assume responsibility for administering his methadone prescription. Dr. Koutras acknowledged that Claimant used methadone for both narcotic avoidance and pain management, but advised that she could not prescribe it for the latter purpose unless he was able to taper his usage down to the appropriate dosage for chronic pain, 60 milligrams per day.

43. Claimant worked hard over the next five years to reduce his methadone dosage. By February 2011 he had tapered to 55 milligrams per day. Dr. Koutras still declined to assume responsibility for his prescription, however. Instead, she recommended that he either taper off the drug completely or consider a referral to

a pain management clinic for future monitoring. Shortly thereafter, Claimant moved to South Dakota and Wyoming, *see* Finding of Fact No. 14 *supra*.

44. During his time out west, Claimant was unable to access a methadone program, so instead his treating physicians prescribed Suboxone. Like methadone, Suboxone can be prescribed both for narcotic avoidance and for pain control. Unlike methadone, however, it need not be dispensed at a clinic, and for that reason many patients consider it a more convenient option.

45. I find from the contemporaneous medical records that Claimant's treating physicians in both Wyoming and South Dakota were prescribing Suboxone for the dual purpose of addiction control and chronic pain management. As to the latter, Claimant's use of the drug helped to address both his low back and right hip symptoms, *see* Finding of Fact No. 16 *supra.*

46. Upon his return to Vermont, in early 2014 Claimant reestablished care with Dr. Koutras' practice. Shortly after that, he was referred to Dr. Erickson for evaluation and treatment of his chronic pain, *see* Finding of Fact No. 20 *supra*.

47. A primary component of Dr. Erickson's involvement in Claimant's care has been to assume responsibility for prescribing and monitoring his use of Suboxone. As reflected in his initial evaluation, Dr. Erickson specifically asserted that he was prescribing the drug both "to help with [Claimant's] pain" and to provide "straightforward office-based management of [his] opioid addiction." "This is pertinent," his note added, "as he apparently has an active workers' compensation case." Although not entirely clear, the latter notation likely was alluding to the fact that unless the prescription was covered by workers' compensation, Claimant would have to pay out of pocket for it.[1]

48. Dr. Erickson had no opinion whether Suboxone provides Claimant with better pain relief than methadone did; in his experience, each drug's effectiveness varies from patient to patient. For his part, Claimant credibly testified that he found both Suboxone and methadone to be equally effective at maintaining his pain at a level he considers tolerable. Were neither drug available to him, he would have to ask for other narcotic pain medications, as ibuprofen alone provides insufficient relief. I find this testimony credible.

49. Dr. Erickson also could not state with certainty whether Claimant likely would still be taking either Suboxone or methadone for narcotic avoidance even had he not been injured; over time some patients are able to maintain their sobriety without pharmaceutical intervention, while others cannot.

50. At Defendant's request, Dr. Johansson also addressed the question whether Claimant's current use of Suboxone is required solely for addiction control or whether it also serves as a means of managing his chronic hip pain. In his

[1] Apparently Claimant's prior use of methadone had been funded entirely through the dispensing clinic.

experience, Suboxone is rarely prescribed for pain relief. With that in mind, and noting that Claimant's current Suboxone dosage is essentially equivalent to the amount of methadone he was taking even before his work injury, in Dr. Johansson's opinion the drug is serving primarily as a deterrent against relapse. While this may be true, Dr. Johannson's response begs the question whether given Claimant's addiction history and consequent reluctance to consider other narcotic pain relievers, Suboxone offers a suitable and effective means of addressing both issues. For that reason, I find his analysis unpersuasive.

Claimant's Anxiety and Depression

51. As noted above, Finding of Fact No. 5 *supra*, Claimant has a long history of anxiety and depression, dating back to his childhood years. Dr. Koutras' 2004 office notes document various episodes of depression causally related to family issues and chronic low back and knee pain, and for which he was prescribed Prozac as treatment. For his anxiety-related issues, Dr. Koutras and others prescribed Klonopin, which Claimant has been taking since 2004.

52. Claimant continued to report symptoms of anxiety and depression following his July 2006 work injury as well. The medical records document stressors related to family issues (September 2006 and April 2014), social anxiety (April 2007 and November 2011), an attempt to taper off methadone (November 2008), and Claimant's move back to Vermont (August 2014). The cumulative effect of dealing with chronic pain has been a likely stressor as well, though at least until 2014 this did not appear to impact Claimant's psychological wellbeing to any greater extent than it had in the years prior to his injury.

53. More recently, Dr. Erickson has pointed to financial stressors as significantly increasing Claimant's levels of anxiety and depression, a conclusion that Claimant strongly corroborated in his testimony. Dr. Erickson acknowledged that to the extent these stressors are tied to the pending dispute over Claimant's alleged inability to work and entitlement to workers' compensation benefits, his psychological state would "improve tremendously" if he were to return to work. For that reason, Dr. Erickson agreed, and I find, that Claimant's anxiety and depression are not themselves disabling to any extent.

54. Claimant continues to take Klonopin as treatment for his anxiety. Despite Dr. Erickson's recommendation, he has declined to pursue psychotherapy, and also has refused anti-depressant medications.

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. Claimant here presents four issues for review: (1) whether he is entitled to a resumption of temporary total disability benefits as of July 23, 2014, the date when he stopped working at his Milton Building Supply job; (2) whether his current course of physical therapy constitutes reasonable treatment for his July 2006 work-related injury; (3) whether his use of Suboxone constitutes reasonable treatment for that injury; and (4) whether his work injury has aggravated his preexisting anxiety and depression.

Claimant's Entitlement to Temporary Disability Benefits

3. Temporary disability benefits are awarded on the basis of an injured worker's incapacity for work. *Bishop v. Town of Barre*, 140 Vt. 564 (1982). Unlike permanency benefits, which are intended to compensate for a probable future reduction in earning power, temporary disability benefits are designed to counteract the injured worker's immediate or present loss of wages during a period of physical recovery referable to a compensable work injury. *Orvis v. Hutchins*, 123 Vt. 18, 22 (1962). Once the worker either regains full earning power or reaches an end medical result, his entitlement to temporary disability benefits, whether total or partial, ends. *Id.* at 24; 21 V.S.A. §§643 and 647. This limitation on temporary disability benefits applies equally to both the initial period of disability following an injury and to any subsequent periods of disability.

4. 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.[2] The date of end medical result marks an important turning point in an injured worker's progress. 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.[3]

5. In the workers' compensation context, expert medical testimony has long been required to establish whether a particular course of treatment should be considered curative or palliative, *compare Brace v. Vergennes Auto, Inc.*, 2009 VT 49 (treatment deemed curative, therefore prior end medical result

[2] Effective August 1, 2015 this rule has been re-codified as Rule 2.2000.
[3] Effective August 1, 2015 this rule has been re-codified as Rule 2.3400.

determination negated), *with Coburn v. Frank Dodge & Sons*, 165 Vt. 529 (1996) (treatment deemed palliative, therefore prior end medical result determination still effective). Expert medical testimony also is required to establish the extent, if any, to which an injured worker is incapable of working. *See, e.g., Maluk v. Plastic Technologies of Vermont*, Opinion No. 06-13WC (February 5, 2013); *Pfalzer v. Pollution Solutions of Vermont*, Opinion No. 23A-01WC (October 5, 2001).

6. The parties here submitted conflicting medical opinions on both of these issues. 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).

(a) <u>*End Medical Result*</u>

7. I conclude that Ms. Bell's opinion is the most persuasive on the question whether her current treatment should be deemed to have negated Claimant's prior end medical result determination. Claimant already has recognized gains in both strength and tolerance as a result of her therapy. These results offer objective support for Ms. Bell's prediction that Claimant likely will realize even further improvement over the course of the next eight to twelve weeks. For the same reason, they render Dr. Johansson's opinion on the issue less persuasive.

8. I recognize, as Defendant asserts, that Ms. Bell's treatment will not correct Claimant's leg length discrepancy or otherwise alter the physiology of his hip. However, as already has occurred to some extent, if the current course of physical therapy is continued to its conclusion it is reasonable to expect significant functional improvement. In keeping with the remedial nature of Vermont's workers' compensation law, *see Montgomery v. Brinver Corp.*, 142 Vt. 461, 463 (1983), such gains have consistently been held to negate a finding of end medical result. *See, e.g., Marsh v. Koffee Kup Bakery, Inc.*, Opinion No. 15-15WC (July 6, 2015) (participation in pain management program); *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).

9. I further conclude that the lingering deficits attributable to Claimant's July 2006 work injury, and not his more recent employment at Milton Building Supply, have necessitated his current course of therapy. Much of Ms. Bell's success has come about as a result of her use of heel lifts and stability straps to address the chronic irritation in Claimant's hip, which had persisted at least since his 2008 hip replacement surgery and resulting leg length differential. As Dr. Backus noted in

his 2010 permanency evaluation (with which Dr. Johansson ultimately concurred), the latter condition came about as a direct result of Claimant's 2006 work injury, and is not in any way related to his more recent employment at Milton Building Supply. Treatment directed at minimizing its impact is therefore causally related.

10. Last, as for Defendant's assertion that because Ms. Bell is not a medical doctor, her opinion is therefore less credible, I disagree. As a doctorate level physical therapist, Ms. Bell has the requisite training and expertise to render an opinion, and her status as Claimant's direct treatment provider adds to, rather than detracts from, her credibility.

(b) Causally Related Total Disability

11. I thus conclude that Claimant's ongoing therapy with Ms. Bell negates his prior determination of end medical result. However, in order to determine his entitlement to temporary total disability benefits, I also must conclude not only that he is currently totally disabled from working, but also that this disability is a consequence of his 2006 work injury rather than any intervening activity.

12. I conclude that Claimant has failed to sustain his burden of proving either of these facts. As to his alleged total disability, although both Dr. Erickson and Ms. Bell stated opinions to the effect that he is currently unable to work, neither offered sufficient grounds in support. Dr. Erickson did not even conduct a physical examination, and neither provider reviewed Claimant's prior medical records. Nor did either of them consider whether and to what extent Claimant might be capable of performing less strenuous work than what was required of him at Milton Building Supply. These gaps in analysis are so substantial as to render their opinions unpersuasive.

13. The evidence is similarly lacking with respect to proving the required causal relationship between Claimant's current inability to work, whether total or partial, and his 2006 work injury. The work restrictions attributable to that injury were essentially the same as the ones he previously had been given in 2005. Even with those, Claimant was able to work at a variety of jobs while in Wyoming and South Dakota. In fact, as both Dr. Blankstein's and Ms. Bell's office notes reflect, it was not until he took on the more physically demanding job duties at Milton Building Supply that his symptoms became disabling.

14. Dr. Johansson also posited that Claimant's Milton Building Supply job was responsible for the exacerbated symptoms that preceded his current inability to work. Whether the facts are sufficient to establish an aggravation or flare-up, as Dr. Johansson has suggested, is not directly before me now. For now, I conclude only that the evidence is insufficient to establish that any disability from which Claimant now suffers is attributable to his 2006 injury.

15. I thus conclude that Claimant has failed to sustain his burden of proving his entitlement to temporary total disability benefits for the period from July 23, 2014 forward.

Compensability of Claimant's Current Course of Physical Therapy

16. 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).

17. Having already concluded that Ms. Bell's current course of treatment is causally related to his 2006 work injury, Conclusion of Law No. 9 *supra*, the only remaining question is whether it is medically necessary. To fulfill this requirement, the evidence must establish that the treatment is likely to improve Claimant's condition, either by relieving his symptoms and/or by maintaining or increasing his functional abilities. *Shaffer v. First Choice Communication*, Opinion No. 15-14WC (October 21, 2014); *Quinn v. Emery Worldwide*, Opinion No. 29-00WC (September 11, 2000).

18. From the credible evidence here, I conclude that Claimant has met this standard. Defendant's own expert, Dr. Johansson, agreed that it was reasonable for him to undergo another course of physical therapy, and Ms. Bell's treatment already has produced measurable improvements in strength, tolerance and gait control. These in turn have precipitated functional gains in terms of both walking and standing. Claimant is entitled to see the treatment through to its conclusion, and Defendant is obligated to pay for it.

Compensability of Claimant's Suboxone Prescription

19. Defendant's obligation to pay for Claimant's Suboxone prescription is complicated solely by the fact that it serves a dual purpose, only one of which is referable to his compensable injury. Defendant argues that because Claimant likely would have continued on either Suboxone or methadone even had his July 2006 work injury never occurred, it should be relieved of responsibility for paying for the drug now. If Claimant cannot comfortably bear the expense himself, Defendant further asserts, he should forego Suboxone completely and return to a methadone clinic, where presumably he can obtain the drug for free.

20. Defendant cites no law in support of its position. To the contrary, its argument flies in the face of a core principle of Vermont's workers' compensation law –

that when an employee is injured at work, the employer assumes full responsibility for the consequences, notwithstanding any preexisting injuries or conditions. *See, e.g., Campbell v. Heinrich Savelberg, Inc.*, 139 Vt. 31 (1980); *see also,* 5 Lex K. Larson, *Larson's Workers' Compensation* §90.01 (Matthew Bender Rev. Ed.) (discussing full responsibility rule in context of disability benefits).

21. That Claimant already was treating for a preexisting condition – his narcotics addiction – at the time he was injured does not change Defendant's responsibility to pay for causally related, medically necessary treatment. What matters is simply that, as currently prescribed, Suboxone is an effective treatment for the injury-related chronic hip pain from which he now suffers. At least until the drug ceases to be helpful for that purpose, under §640(a) Defendant is obligated to pay for it.

22. Defendant's argument that Claimant could obtain the same pain relief with methadone is similarly unpersuasive. While both drugs might be equally effective, Suboxone offers a more convenient dispensing protocol, which is understandably important to those who must plan their daily lives around its use. So long as both alternatives are reasonable, and I conclude that they are, the statute does not prohibit Claimant from choosing to direct his own medical care in this fashion. *Cahill v. Benchmark Assisted Living*, Opinion No. 13-12WC (April 27, 2012), citing *Lackey v. Brattleboro Retreat*, Opinion No. 15-10WC (April 21, 2010).

23. I conclude that Claimant's use of Suboxone constitutes reasonable medical treatment for his July 2006 work injury, and therefore that Defendant is obligated to pay for it.

Aggravation of Claimant's Preexisting Anxiety and Depression

24. Last, I consider whether Claimant has sustained his burden of proving that his July 2006 work injury has aggravated his preexisting anxiety and depression. It is axiomatic that when a work injury aggravates or exacerbates a pre-existing condition, be it physical or psychological, the result is compensable. *Marsigli's Estate v. Granite City Auto Sales, Inc.*, 124 Vt. 95 (1964). This is simply an extension of the well-settled rule that an employer takes its employees as it finds them. *Lydy v. Trustaff, Inc.*, Opinion No. 05-12WC (February 8, 2012); *Brace v. Jeffrey Wallace, DDS*, Opinion No. 28-09WC (July 22, 2009); *Petit v. North Country High School*, Opinion No. 20-98WC (April 28, 1998).

25. The credible evidence here establishes that Claimant has long struggled with anxiety and depression. These conditions have always been multi-factorial in origin, both before and after his July 2006 work injury. Stressors have included family relationships, narcotics addiction and chronic pain from multiple sources. At no time has either condition disabled Claimant from working.

26. I acknowledge that more recently Claimant's anxiety and depression have worsened. However, as Dr. Erickson's credible testimony establishes, this has been due primarily to financial stressors related to his extended period of unemployment. Having concluded that Claimant's inability to work, if any, is not causally related to his July 2006 work injury, the required nexus between those stressors and that injury is lacking. *See, e.g., Farnham v. Shaw's Supermarkets*, Opinion No. 11-13WC (March 29, 2013); *Blais v. Church of Christ of Latter Day Saints*, Opinion No. 30-99WC (July 30, 1999); *see also* 3 Lex K. Larson, *Larson's Workers' Compensation* §56.03 (Matthew Bender, Rev. Ed.) and cases cited therein. For that reason, his aggravation claim must fail.

Summary

27. To summarize, I conclude that Claimant has failed to establish his entitlement to temporary disability benefits from July 23, 2014 forward, or to workers' compensation benefits generally on account of his exacerbated anxiety and depression. I conclude that he has established his entitlement to medical benefits covering both Ms. Bell's current course of physical therapy and his ongoing use of Suboxone as treatment for his injury-related chronic hip pain.

28. As Claimant has only partially prevailed, he is entitled to an award of only those costs that relate directly to the claims he successfully litigated. *Hatin v. Our Lady of Providence*, Opinion No. 21S-03 (October 22, 2003), citing *Brown v. Whiting*, Opinion No. 7-97WC (June 13, 1997). As for attorney fees, in cases where a claimant has only partially prevailed, the Commissioner typically exercises her discretion to award fees commensurate with the extent of the claimant's success. Subject to these limitations, Claimant shall have 30 days from the date of this opinion to submit evidence of his allowable costs and attorney fees.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Claimant's claim for temporary disability benefits from July 23, 2014 forward is hereby **DENIED**. Claimant's claim for workers' compensation benefits referable to the aggravation or exacerbation of his preexisting anxiety and depression is also **DENIED**. Defendant is hereby **ORDERED** to pay:

1. Medical benefits in accordance with 21 V.S.A. §640(a), covering (a) Claimant's current course of physical therapy with Leslie Bell; and (b) Claimant's ongoing use of Suboxone as treatment for his injury-related chronic hip pain; and

2. Costs and attorney fees in amounts to be determined, pursuant to Conclusion of Law No. 28 above and in accordance with 21 V.S.A. §678.

DATED at Montpelier, Vermont this ____ day of _____, 2015.

_____
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.