STATE OF VERMONT
DEPARTMENT OF LABOR

Bret Nelson

v.

Federal Express Freight

Opinion No. 19-16WC

By: Jane Woodruff, Esq.
Administrative Law Judge

For: Anne M. Noonan
Commissioner

State File No. EE-50898

OPINION AND ORDER

Hearing held in Montpelier, Vermont on March 15, 2016.
Record closed on June 20, 2016

APPEARANCES:

Claimant, *pro se*
James OøSullivan, Esq., for Defendant

ISSUES PRESENTED:

1. Is Claimantøs current neck condition causally related to his 2012 compensable work injury?

2. Does Claimantøs ongoing chiropractic care constitute reasonable medical treatment for his 2012 compensable work injury?

3. What is the extent of the permanent partial impairment referable to Claimantøs 2012 compensable work injury?

4. Has Claimantøs end medical result status changed since December 24, 2014?

EXHIBITS:

Joint Exhibit 1: Medical records dating from Dr. Templeøs July 16, 2012 note through Dr. Backusø August 4, 2015 medical report

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 Vermontøs Workersø Compensation Act.

2. Judicial notice is taken of all relevant forms and correspondence contained in the Departmentøs file relating to this claim.

3. Claimant is 55 years old. In 2012 he worked for Defendant as a route delivery driver.

4. In May or June 2012, while engaged in deliveries and pickups, Claimant had difficulty raising and lowering a truck door that often jammed. The door was readjusted but it remained very tight, and for about a two-week period Claimant had to push and pull on it to open and close it. During this period, he felt a strain in his neck, which progressed to numbness, tingling and pain radiating down his right arm.

5. Claimantøs description of his initial injury and onset of symptoms was generally consistent within various medical providersø and evaluatorsø records, including Dr. Temple (JME 229), Dr. Sengupta (JME 191), Dr. Presutti (JME 147), Dr. Stommel (JME 92), Colleen Olson, APRN (JME 99), physical therapist Traci Bergeron (JME 179), Dr. Hastings (JME 63), Dr. Ross (JME 45) and Dr. Backus (JME 14).[1]

6. Claimant sought treatment from Dr. Temple, a licensed chiropractic practitioner. Dr. Templeøs practice deals mostly with musculoskeletal cases. He has practiced for 35 years and has served as the president of the National Board of Chiropractic Examiners.

7. Dr. Temple treated Claimant regularly from his first post-injury visit on July 16, 2012 until shortly before the March 2016 formal hearing. Dr. Templeøs first impression included a diagnosis of õupper extremity cervical radiculopathy.ö

8. A November 2012 MRI (JME 198-202) revealed large disc osteophytes at the C5 level, worse on the right, which caused neural foraminal narrowing, and also a large right paracentral disc osteophyte complex at C6-7, which caused neural foraminal narrowing and mild central canal narrowing. Additional findings were suspicious for left paracentral and lateral disc herniation, which contributed to further neural foraminal narrowing at that level. The MRI also revealed a very small left paracentral area of disc protrusion at C4-5, with disc osteophyte complex and facet hypertrophic change.

9. Neural foraminal narrowing is a narrowing of the space through which nerves exit the spinal column. Disc osteophyte complex connotes a combination of both disc and osteophyte involvement of the spine.

10. Upon reviewing the November 2012 MRI, Dr. Temple concluded that there was a õdistinct clinical correlation between the [right] cervical thoracic [right] upper extremity pain and the [right] C5-C6 C6-C7 findings.ö In his opinion, the disc herniation was significant (JME 197).

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[1] All page number references here and following are to the medical records contained in the joint medical exhibit (Joint Exhibit 1).

11. Dr. Temple recommended that Claimant undergo an evaluation with an orthopedic or neurosurgical specialist. To that end, on November 23, 2012 Claimant presented to Dr. Sengupta, an orthopedic surgeon at the Dartmouth-Hitchcock Spine Center. Dr. Sengupta noted weakness in Claimantøs right wrist extension and flexion, and also in his right hand grip. In addition, Dr. Sengupta stated, õhe has definitive cervical spondylitis causing narrowing of the exit foramen for C6 and C7 nerve root with disc and osteophyte complex between C5-6 and C6-7. This can be treated with surgery.ö Given Claimantøs pain level, however, Dr. Sengupta stopped short of recommending surgery at the time, and instead offered Claimant physical therapy and possible steroid injections (JME 192).

12. Claimant continued to treat with Dr. Temple, but he also engaged in physical therapy with Traci Bergeron, P.T. He completed approximately seventeen visits with Ms. Bergeron between December 3, 2012 and February 21, 2013, at which time he was discharged from physical therapy.

13. Claimant presented to Dr. Presutti, an orthopedic surgeon, in January 2013. Dr. Presutti noted no whole person impairment (JME 150). He cleared Claimant to return to work with restrictions in January, and later released him to full duty work on February 22, 2013 (JME 116).

14. Claimant left Defendantøs employment in March or April of 2013. From approximately May through September 2013 he worked as a truck driver for Justin Co.

15. Even after being cleared for full duty work, Claimant continued to treat with Dr. Temple. Dr. Temple noted ongoing symptoms, including limited range of motion, right sided weakness, cold sensation at C6 dermatomes and radicular pain with foraminal compression tests (JME 70, 76, 104, 107 and 114).

16. Claimant underwent an evaluation with Dr. Stommel, a neurologist, in July 2013. Dr. Stommel diagnosed cervical radiculopathy (JME 95). As to causation, he stated:

> I suspect the patient has an irritated C6 or C7 nerve root secondary to degenerative changes of the cervical spine. The nerve root may well have been irritated by all the tugging and lifting he was doing while working for Fed Ex. It would not appear that he is a surgical candidate (JME 92).

17. In January or February 2014 Claimant began working as a fuel delivery driver for Irving Oil Co. This work included both driving and pulling on fuel hoses. As to the latter task, Claimant had the benefit of a power reel, but the work still involved pulling hoses across lawns and yards.

18. At Defendantøs request, in April 2014 Claimant underwent an independent medical evaluation with Dr. Hastings, a chiropractor. Dr. Hastings also reviewed Claimantøs pertinent medical records. He concluded as follows:

> All my findings, along with MRI and X-ray reports are consistent with a C5/C6 radiculopathy. X-ray findings of osteophyte formation suggest some level of degeneration prior to the injury, but described mechanism of action of trying to open a stuck door repetitively could certainly make an otherwise undetected and latent condition acute. Nothing in the [patientøs] history suggests there was a prior injury to the area (JME 64).

19. Dr. Hastings saw no signs of malingering and was of the opinion that past chiropractic treatments were reasonable.

20. Claimant underwent an evaluation with Dr. Ross, an orthopedic surgeon, in October 2014. Dr. Ross also reviewed his pertinent medical records. On exam, Dr. Ross noted some atrophy in the right bicep and right forearm (JME 46). He discerned no Waddelløs signs. His diagnosis was õdegenerative disc and joint disease of the cervical spine with foraminal stenosis [R greater than L] C5-C7ö and õsuggestion of chronic right C6 and C7 radiculopathy without clinical myelopathy (JME 47).ö

21. Dr. Ross concluded that further chiropractic care was not indicated and that past chiropractic care had been excessive. He reiterated this opinion in a November 2014 addendum, at which point he also rated Claimant with a six percent whole person impairment (JME 41).

22. On December 24, 2014 Dr. Temple wrote a two-page description of Claimantøs injury. He concluded that Claimant had reached an end medical result, with a fifteen percent whole person permanent impairment. Later, in January 2015 Dr. Temple supplemented his report and responded specifically to Dr. Rossø report (JME 36-37).

23. At Defendantøs request, in August 2015 Claimant underwent an evaluation with Dr. Backus, a board certified specialist in occupational and environmental medicine. Dr. Backus is a 1983 graduate of Dartmouth Medical School. Ninety-five percent of his medical practice concerns work-related injuries. He has undergone special, post-graduate training in the use of the *AMA Guides to the Evaluation of Permanent Impairment*. In addition to his clinical examination, Dr. Backus also reviewed Claimantøs medical records and assessed his response to various tests and questionnaires.

24. Dr. Backus diagnosed Claimant with õcervicobrachial syndrome.ö He added that there õcould be a right C6 radiculopathy involved . . . but the MRI was not impressive for verifying nerve root impingement of the right C6 nerve root (JME 21).ö

25. Consistent with both Dr. Rossø and Dr. Templeøs determinations, Dr. Backus concluded that Claimant had reached an end medical result (JME 22). As for permanency, he rated Claimant with a six percent whole person impairment. In his opinion, further chiropractic care was not necessary (JME 23).

26. As to causation, Dr. Backus concluded that after leaving Defendantøs employment, Claimantøs work with Irving Oil Company had caused an aggravation, which had worsened his condition (JME 23).

27. The three witnesses who testified at the hearing in this matter were Claimant, Dr. Temple and Dr. Backus.

28. Defendant has accepted Claimantøs 2012 injury as compensable, and in fact, has been paying permanency benefits in accordance with a six percent whole person impairment, as rated by both Dr. Ross and Dr. Backus.

End Medical Result

29. Both Dr. Ross and Dr. Temple concur that Claimant had reached an end medical result for his work injury as of December 24, 2014.

Causation of Current Condition

30. Dr. Backus and Dr. Temple both addressed the question whether Claimantøs current medical condition and symptoms are related to his 2012 injury. Dr. Backus asserted that Claimantøs work for Irving Oil as a fuel delivery driver was an aggravating cause of his symptoms, which worsened appreciably after he began that employment.

31. Dr. Temple, on the other hand, asserted that Claimantøs symptoms had never fully resolved, and that during his employment for Irving Oil no new injury or triggering work event ever specifically aggravated his condition. Moreover, Claimant testified that he was taking a break from chiropractic treatments when he first began working at Irving Oil, and both he and Dr. Temple felt it was the gap in chiropractic manipulations that caused his symptoms to worsen.

32. On this point, I find Dr. Templeøs conclusion to be the most persuasive. Having reviewed the medical records, and considering Claimantøs testimony, I find that his work at Irving Oil did not cause a separate injury or aggravation, but was merely normal physical work. From the credible evidence I further find that Claimantøs fluctuating levels of pain and numbness continued consistently from the time of his 2012 work injury forward, albeit with periodic increases and decreases from time to time.

Continued Chiropractic Care

33. Dr. Backus opined that continued chiropractic care was not reasonable or necessary as a treatment for Claimantøs 2012 injury. He was of the view that several chiropractic manipulations (up to twelve) might have been appropriate but that more such treatments after Claimant began working for Irving Oil were not necessary.

34. In contrast, Dr. Temple was of the opinion that chiropractic treatment had proven effective, and that during periods when Claimant did not undergo chiropractic care his condition had worsened (JME 49). He warned that there may well be events in the future that will increase Claimantøs 2012 injury-related symptoms, and these too might require chiropractic manipulations as treatment.

35. In Dr. Templeøs opinion, Claimantøs condition has not shifted significantly since his original injury in 2012. While it has occasionally improved and worsened since then, his symptoms have always been consistently related to the 2012 injury and have not been affected by any subsequent injury or aggravation through an intervening cause. According to Dr. Temple, chiropractic care continues to be reasonable and necessary treatment for Claimantøs injury-related symptoms, therefore.

36. Claimant had been prescribed gabapentin for his pain which had been effective (JME 25).

37. The medical records document Claimantøs report of various events that caused his pain to increase from time to time. He often reported that driving caused his neck pain to increase.[2] He reported neck pain while working for Defendant on the loading dock. He reported to APRN Olson that pulling on the fuel hoses with Irving Oil caused an increase in his symptoms (JME 25). He reported some increase in neck stiffness and soreness following a car repair in which he was on his back removing a fuel tank from the vehicle (JME 145).

Permanent Impairment Rating

38. The most important divergence between Dr. Backus and Dr. Temple was the extent of Claimantøs permanent impairment. With reference to the *AMA Guides to the Evaluation of Permanent Impairment* (5th ed.) (the *"AMA Guides"*), Dr. Backus assigned a six percent impairment rating, while Dr. Temple assigned a fifteen percent rating.

39. As noted above, Finding of Fact No. 24 *supra*, Dr. Backus diagnosed Claimant with õcervicobrachial syndrome.ö He testified that this is a diagnosis of neck pain, with attendant pain down the arm, but õwithout an identifiable cause.ö In his opinion, Claimant did not qualify for a diagnosis of cervical radiculopathy because there was not enough evidence to support that diagnosis to a reasonable degree of medical certainty. Thus, in his analysis, while cervical radiculopathy was considered õin the differentialö as a possible cause, the required indicators were inconsistent.

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[2] *See, e.g.,* Birget Ruppert 9/5/13 (JME 84); Dr. Temple 7/15/13 (JME 98), 5/13/13 (JME 109) and 9/8/14 (JME 52).

40. Dr. Backusø diagnosis sharply contrasts with those of Dr. Temple (õcervical radiculopathy,ö JME 76), Dr. Sengupta (right arm test õmay be diminished because of the radiculopathy,ö JME 192), Dr. Stommel (õcervical radiculopathy,ö JME 95), Dr. Hastings (õC5/C6 radiculopathy,ö JME 64), Dr. Ross (õsuggestions of chronic right C6 and C7 radiculopathy without myelopathy,ö JME 47) and APRN Olson (õfindings suggestive of impingement through the plexus as well as in the cervical spine,ö JME 25). Aside from Dr. Backus, no other treatment provider or evaluator diagnosed õcervicobrachial syndrome.ö

41. In Dr. Backusø opinion, Claimantøs MRI results did not provide imaging verification of the radicular complaints. He described the MRI as õunimpressive,ö and normal for a person of the Claimantøs age. Dr. Backus was of the view that if the MRI had shown nerve entrapment, then a category III impairment rating would have been appropriate and surgery would have been recommended. The EMG study did not establish nerve root impingement.

42. Again, none of the other treatment providers or evaluators concurred with Dr. Backusø analysis of the MRI as õunimpressive.ö To the contrary, several diagnosed radiculopathy based upon the MRI report.

43. Dr. Backus listed those tests which he characterized as õobjective,ö and therefore not affected by either the patientøs or the evaluatorøs subjective involvement, as MRI, EMG (although frequently inaccurate), reflex testing and muscle atrophy.

44. Dr. Backus used the *AMA Guides'* diagnosis related estimate (DRE) model to arrive at his six percent whole person impairment rating. On page 22 of his report, he stated:

> Dr. Temple does follow more specifically the impairment rating methodology in his report and provides a better explanation [than Dr. Ross] for his determination; however, the question that determines which is correct becomes whether or not [Claimant] has a true radiculopathy as defined in Box 15-1 to determine if he is in category II [5-8%] or III [15-18%]. At present he does have some signs of radiculopathy for which a category III can be considered, but he fits better with a DRE II criteria of signs and symptoms that might support radiculopathy but *which has not been verified by imaging studies or electrodiagnostic testing as in this case* (emphasis added).

45. õRadiculopathyö is defined in Box 15-1, *AMA Guides* at p. 382, as follows:

> [S]ignificant alteration in the function of a nerve root or roots and is usually caused by pressure on one or several nerve roots. The diagnosis requires a dermatomal distribution of pain, numbness, and/or paresthesias in a dermatomal distribution. A root tension sign is usually positive. The diagnosis of a herniated disc must be substantiated by an appropriate finding on an imaging study. The presence on an imaging study in and of itself does not make a diagnosis of radiculopathy. There must also be clinical evidence as described above.

46. The pertinent description for the category II level of impairment upon which Dr. Backus relied is as follows, *AMA Guides* at p. 392:

> **DRE Cervical Category II 5-8% Impairment of the Whole Person.**
> Clinical history and examination findings are compatible with a specific injury; findings may include muscle guarding or spasm observed at the time of the examination by a physician, asymmetric loss of range of motion or non-verifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity,
> **Or,**
> Individual had clinically significant radiculopathy and an imaging study that determined a herniated disc at the level and on the side that would be expected based on the radiculopathy, but has improved following non-operative treatment.

47. Dr. Temple, on the other hand, applied the same *AMA Guides'* criteria to Claimantøs condition and found him deserving of a fifteen percent whole person impairment. He determined that the subjective *and* objective tests showed a clear cervical radiculopathy. Such tests included: (1) the MRI, which showed a disc herniation with foraminal stenosis, especially at C5-6 and C6-7 on the right, and disc encroachment from a herniating disc; (2) muscle weakness on the right side as identified by Dr. Temple, Dr. Hastings, and Dr. Ross, including reduced grip strength; (3) atrophy on the right bicep and forearm as reported by Dr. Ross;[3] (4) hypoesthesia (lack of feeling) in some right digits (also noted by Dr. Backus); (5) occasionally positive Spurlingøs test (creation of radiating symptoms by compressing neck while neck is twisted);[4] (6) tingling in C6 dermatomes (skin areas associated with C6 nerve roots); and (7) reduced reflexes as found by Dr. Hastings. (*See generally* Dr. Templeøs impairment calculation, JME 36-40).

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[3] Dr. Backusø measurements showed equal circumference of the upper arms and a slightly larger right forearm (JME 18). These measurements are inconsistent with Dr. Rossø (JME 46).

[4] Dr. Backus did not administer a full Spurlingøs test, because he was unwilling to compress Claimantøs spine, as is usually included. Despite not having done the complete test, he nevertheless reported in his examination that õSpurlingøs maneuvers were negative (JME 18).ö Previously, Spurlingøs or compression tests had been positive intermittently when conducted by Dr. Temple (12/24/14; 10/20/14; 6/9/14; 3/10/14; 1/20/14; 7/15/13), APRN Olson (4/13/15) and physical therapist Birgit Ruppert (8/22/13).

48. According to Dr. Temple, it is inappropriate to consider just one test to determine the veracity of a cervical radiculopathy diagnosis. Rather, all tests and information must be considered in concert. More to the point, in Dr. Templeøs view, the MRI result provided the imaging confirmation (taken with all other test results and symptoms), which in turn were consistent with Claimantøs symptoms. I find this analysis persuasive.

49. The pertinent description for a category III cervical impairment reads as follows, *AMA Guides* at 392:

> **DRE Cervical Category III 15-18% Impairment of the Whole Person.** Significant signs of radiculopathy, such as pain and/or sensory loss in a dermatomal distribution, loss of relevant reflexes, loss of muscle strength, or unilateral atrophy compared with the unaffected side, measured at the same distance above or below the elbow, the neurologic impairment may be verified by electrodiagnostic findings
> **Or,**
> Individual had clinically significant radiculopathy, verified by an imaging study that demonstrates a herniated disc at the level and on the side expected from clinical findings with radiculopathy or with improvement of radiculopathy following surgery.

50. It is important to note several other facts in comparing the two expert opinions. First, Dr. Backus was quite clear that if Claimantøs MRI had shown nerve impingement, then surgery would have been suggested thereafter. According to his analysis, because surgery was not recommended, then the MRI must not have shown impingement. The medical evidence does not bear this analysis out, however. To the contrary, in his November 2012 evaluation Dr. Sengupta specifically stated that Claimant had õdefinitive cervical spondylitis causing narrowing of the exit foramen for C6 and C7 nerve root with disc and osteophyte complex between C5-6 and C6-7,ö and further that *"[t]his can be treated with surgery.*ö Finding of Fact No. 11 *supra* (emphasis added).

CONCLUSIONS OF LAW:

1. There was no persuasive evidence presented that Claimantøs end medical result status has changed since December 24, 2014, the date by which both his and Defendantøs experts agreed he had reached the point of maximum medical improvement. That issue is resolved, therefore.

2. In workersø compensation cases the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). The Claimant 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).

Extent of Permanent Impairment

3. By statute, any determination of the existence and degree of permanent partial impairment shall be made only in accordance with the whole person determinations as set out in the fifth edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment*. 21 V.S.A. §648(b). Generally, the *AMA Guides* are intended to provide a standardized, objective approach to evaluating medical impairment. They provide specific procedures so that objective tests should produce the same determinations of impairment by any doctor. *See R.J. v. Bourdeau International*, Opinion No 48-05 WC (August 9, 2005).

4. Where expert medical opinions are conflicting, 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 (Sept. 17, 2003). With these factors in mind, the key question is which expert medical opinion is the most credible? *M.B. v. Price Chopper*, Opinion No. 13-07WC (May 8, 2007).

5. Considering the above criteria, I note that Dr. Temple has been treating Claimant for his 2012 work injury since July of that year and has seen him regularly and often from the time of his first examination to the time of the hearing. Dr. Sengupta was also in a treating physician role. In contrast, Drs. Backus, Ross and Hastings were not treating physicians. This fact enhances Dr. Templeøs opinion in the case.

6. Both Dr. Temple and Dr. Backus had access to all the pertinent medical records.

7. Both expert witnesses have similar qualifications. However, Dr. Backusøqualifications are more extensive, and therefore they weigh in favor of his opinion.

8. Concerning the clarity, thoroughness and objective support underlying each expertøs opinion, I conclude that Dr. Templeøs has more objective support. His diagnosis of cervical radiculopathy is supported by almost all of the other providers and evaluators except for Dr. Backus. Dr. Templeøs conclusions are supported by objective observations and testing, including the MRI report, Dr. Hastingsøreflex testing and Dr. Rossøatrophy measurements.

9. Dr. Backus indicated in his analysis that Claimant õfits better with a DRE II criteria,ö Finding of Fact No. 44 *supra*. A simple reading of the category II and III criteria, Findings of Fact Nos. 46 and 49 *supra*, indicates that Claimant has more indicia of a category III impairment than a category II one. His condition has not appreciably improved; he has verifiable radicular complaints; there are objective findings of radiculopathy including unilateral atrophy; there is an imaging study that showed a herniated disc at the level and at the side expected from clinical findings. A category III finding does not require a positive EMG finding.

10. Dr. Templeøs opinion is supported in detail by Dr. Hastings with a full and complete description of Dr. Hastingøs calculation of a fifteen percent impairment. Dr. Backusø opinion was supported by Dr. Ross, but Dr. Ross did not explain how he derived his rating, thus reducing the persuasive effect of that opinion.

11. Finally, as noted above, Dr. Backusø õcervicobrachial syndromeö diagnosis was inconsistent with that of all of the other medical professionals who treated or evaluated Claimant. Finding of Fact No. 40, *supra*.

12. Considering all of the above, I conclude that Dr. Templeøs fifteen percent whole person permanent impairment is the most credible.

Causation of Current Symptoms and Condition

13. Dr. Backusøs opinion was that õthe new work [Irving Oil] rather than the lack of an ineffective treatment [was] the cause of his worseningö (JME 23). Dr. Temple believed that Claimantøs condition was subject to occasional recurrences and was not caused by any new injury or aggravation while he was employed by Irving Oil.

14. Under our law, in situations involving multiple employers, the first employer remains liable for the full extent of benefits if a second injury is solely a õrecurrenceö of the first injury and if subsequent accidents do not causally contribute to the claimantøs disability. *Pacher v. Fairdale Farms*, 166 Vt. 626 (1997).

15. The determination whether a condition is a õrecurrenceö or an õaggravationö caused by subsequent events is determined by applying the following criteria: (1) whether a subsequent incident or work condition destabilized a previously stable condition; (2) whether the worker had stopped treating medically; (3) whether the injured worker had successfully returned to work; (4) whether the worker had reached medical end result; and (5) whether the subsequent work contributed independently to the final disability. *Pacher v. Fairdale Farms*, 166 Vt. 626 (1997); *Trask v. Richburg Builders*, Opinion No. 51-98 (August 25, 1998).

16. In applying these criteria, I conclude that the weight of the evidence supports a conclusion of õrecurrenceö rather than õaggravation.ö There was almost no evidence that Claimantøs condition had become stable following the 2012 injury. He continued to receive medical treatments, evaluations and physical therapy for neck and arm complaints during the entire period. He had returned to work, but as Dr. Temple credibly noted, this was only because he worked through the pain and despite the fact that driving seemed to increase his symptoms. Claimant did not reach an end medical result until December 2014, well after he began working for Irving Oil. Finally, there was no specific incident, injury or clinically observed change in condition that was related to his work there. As Dr. Temple put it (JME 31), Claimant had pain and paresthesia aggravated by normal activities that prior to his 2012 injury he could perform without difficulty.[5]

17. I conclude that Claimantøs fluctuating medical condition, as manifested by neck pain and radiating pain and numbness into his arm represents a recurrence of his 2012 work injury, not an aggravation or new injury.

Reasonableness of Continued Chiropractic Treatment

18. When an employer seeks to terminate coverage for medical benefits, it has the burden of proving that the treatment at issue is not reasonable. *Richards v. Mack Molding*, Opinion No. 34-07WC (December 11, 2007).

19. Considering the conflicting medical evidence, I conclude that Defendant has not sustained its burden of proof on this issue. Specifically, I conclude that the opinions of Dr. Hastings, APRN Olson and Dr. Temple are more credible than that of Dr. Backus. Particularly convincing were both Dr. Templeøs and Claimantøs reports of good relief of symptoms with chiropractic manipulation, and worsening recurrence of symptoms during breaks in treatment. Thus, I conclude that unless and until an intervening event occurs to break the chain of causation back to the original injury, whether by new injury, aggravation or flare-up, Dr. Templeøs chiropractic treatments remain both causally related and medically necessary. Under 21 V.S.A. §640(a), they are Defendantøs responsibility to pay, therefore.

[5] I consider Dr. Templeøs use of the term õaggravationö to have been in its medical context, not its legal one. *See Gaboric v. Stratton Mountain, et al.,* Opinion No. 12-04WC (April 26, 2004).

ORDER:

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

1. Permanent partial disability payments based upon a fifteen percent whole person impairment referable to the spine, in accordance with 21 V.S.A. §648, with interest from the date when temporary disability benefits terminated, in accordance with 21 V.S.A. §664; and

2. Reasonable and necessary medical benefits, including chiropractic treatments, as causally related to Claimantøs 2012 work injury.

DATED at Montpelier, Vermont this 1st day of November 2016.

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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 VSA Sec. 670, 672.