STATE OF VERMONT
DEPARTMENT OF LABOR

Beth Farr

v.

Rite Aid Corporation

Opinion No. 24-16WC

By: Phyllis Phillips, Esq.
Administrative Law Judge

For: Anne M. Noonan
Commissioner

State File No. X-63385

OPINION AND ORDER

Hearing held in Montpelier on December 11, 2015
Record closed on March 23, 2016

APPEARANCES:

William Skiff, Esq., for Claimant
David Berman, Esq., for Defendant

ISSUE PRESENTED:

Did Claimantôs November 2014 surgery constitute reasonable medical treatment for her June 2006 compensable work injury?

EXHIBITS:

Joint Exhibit I: Medical records

Claimantôs Exhibit 1: *Curriculum vitae*, Joseph Phillips, M.D., Ph.D.

Defendantôs Exhibit A: *Curriculum vitae*, Leonard Rudolf, M.D.

CLAIM:

All workersô compensation benefits to which Claimant proves her entitlement as causally related to her November 2014 spine surgery

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 her employer as those terms are defined in Vermontôs WorkersôCompensation Act.

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

Claimant's 2006 Work Injury and Initial Treatment

3. Claimant worked for Defendant as a retail clerk. On June 19, 2006 she was reorganizing some boxes of liquor that had been delivered earlier in the day and placed in a cramped closet. While so engaged, she caught her foot between two boxes, twisted, fell and hit her back on a metal doorjamb. She heard and felt a pop in the area of her left hip, with pain radiating down her left leg.

4. Following a July 2006 MRI study, Claimant was diagnosed with a large left lateral disc herniation at L4-5 impinging on the L4 nerve root. Defendant accepted the injury as compensable, and began paying workersô compensation indemnity and medical benefits accordingly.

5. Initially Claimant treated conservatively for her injury, with physical therapy, pain medications and a course of epidural steroid injections. She continued to report symptoms consistent with the MRI findings, most notably constant low back and left hip pain, with pain, numbness and tingling radiating into her left leg, calf and foot. These were exacerbated by most activities, including prolonged standing, sitting and walking. Her sleep was impaired, and she reported falling occasionally due to her leg giving out.

6. Conservative treatment having failed to alleviate her symptoms, in October 2006 Claimant underwent surgery with Dr. Phillips, a neurosurgeon. This was a minimally invasive microsurgical procedure, the goal of which was to decompress the L4 nerve root by removing herniated disc material and widening the opening (in medical terms, the neural foramen) through which the nerve root traveled.

7. In the months following her 2006 surgery, Claimant experienced some symptom relief. Most notably, she reported that the radiating pains down her left leg had resolved. However, the numbness and tingling persisted, and ultimately came to include her right leg as well. By March 2007 she was reporting worsening pain radiating from her lower back into her hips and legs bilaterally. An MRI study documented findings consistent with ongoing L4 nerve root compression.

8. To treat her recurrent symptoms, Claimant underwent additional courses of physical therapy, epidural steroid injections and home exercise. In addition, her treating pain management specialist, Dr. Rauwerdink, discussed weight control, smoking cessation and increased physical activity as a means of addressing her discomfort on a long-term basis. From the evidence, it is unclear whether, to what extent and for how long she attempted these lifestyle changes. In any event, while her right-sided radicular symptoms abated, her low back pain persisted and her left leg symptoms steadily worsened. Her activities continued to be limited by discomfort.

9. In June 2007 Claimant underwent electrodiagnostic evaluation with Dr. Ayers, a neurologist. The results documented normal nerve conductions throughout her lower extremities, but also findings consistent with ongoing sensory nerve recovery, which would account for her continued paresthesias. Unfortunately, the process by which nerves heal is very slow, and with that in mind Dr. Ayers predicted that Claimantôs radicular symptoms would improve only gradually.

10. Over the ensuing months, Claimant continued to report low back and left leg pain. She rejected proposed interventional options (medial branch blocks, radiofrequency lesioning and/or additional epidural steroid injections) and also suggestions that she consider a psychological approach to managing her pain. She demonstrated fair to good endurance for activity during a work hardening program, but reported increased pain both before and after each session, to such an extent that she did not feel the program benefitted her. Instead, she continued her exercises at home.

Claimant's 2009 Surgery

11. In January 2008 Claimant returned to Dr. Phillips, again complaining of low back and left leg pain. An MRI study did not document any large disc herniations, but revealed some substantial narrowing of the spinal canal in the same location (L4-5 level on the left) as her 2006 surgery. It also showed degenerative changes at both L2-3 and L3-4, to a degree considered advanced for a patient of her age (29 at the time).

12. Dr. Phillipsô office note reflects that he discussed these findings with Claimant in depth. He explained that there likely was no reasonable surgical treatment option for her low back pain ï simply decompressing nerves is rarely beneficial, and fusions directed at controlling back pain *per se* are as likely to fail as they are to succeed. However, as to the radicular pain and weakness in her left leg, Dr. Phillips posited that surgically opening the spinal canal at the L3-4 and L4-5 levels on the left would create more room for the L4 and L5 nerve roots, which potentially would alleviate those symptoms. I find this analysis credible.

13. Dr. Phillips also engaged in a discussion of sorts with Dr. Chard, the orthopedic surgeon who examined Claimant at Defendantôs request in June 2008. Dr. Chard raised several concerns as to whether the surgery Dr. Phillips had proposed was medically indicated, all of which led him to conclude that Claimant was ñless likely than the average patient to have a satisfactory outcome.ò Nevertheless, he acknowledged that for Dr. Phillips to re-explore the L5 nerve root and remove residual disc fragments might be of some benefit. I concur, and find that Dr. Phillips adequately justified his decision to perform a second surgery.

14. Claimant underwent the second surgery, during which Dr. Phillips decompressed the left L4 nerve root by widening the spinal canal from L3 to L5, in January 2009. Defendant accepted the procedure as causally related to her work injury, and paid workersô compensation benefits accordingly.

15. As before, Claimant experienced some symptom relief following surgery, but it was incomplete. She continued to complain of numbness and pain radiating down her left leg, and localized low back pain as well. A September 2009 MRI did not reveal any dramatic interval change from her pre-surgical condition ï there was an appropriate degree of scarring, but no evidence of a fresh disc herniation. Dr. Phillips characterized these findings as ñvery assuring,ò adding that despite her residual complaints, the MRI showed ñno reason for additional intervention.ò He anticipated that she was approaching an end medical result.

16. In December 2009 Defendantôs independent medical examiner, Dr. Chard, determined that Claimant had reached an end medical result, with a 12 percent whole person permanent impairment attributable to her work injury. At her attorneyôs referral, in August 2010 Claimant underwent a second permanency evaluation with Dr. Banerjee, who concurred that she had reached an end medical result. In October 2010 the Department approved the partiesô Agreement for Permanent Partial Disability Compensation (Form 22), which established December 24, 2009 as the end medical result date and compromised the permanency at the midpoint between the two ratings.

17. The medical records corroborate that although Claimant had reached an end medical result by December 2009, functionally she remained significantly restricted. A February 2010 functional capacity evaluation documented limited tolerance for sitting, standing, lifting, carrying and bending. Later, in the context of his August 2010 permanency evaluation, Dr. Banerjee remarked that she remained ñseverely disabled with pain, unable to perform routine activities at home.ò

18. With the exception of a visit to her primary care provider in April 2012, between November 2009 and March 2014 Claimant did not seek any treatment for low back or left leg complaints. Nevertheless, she credibly testified that her symptoms steadily worsened during this time. The numbness down her left leg occurred with greater frequency, and the shooting pains became increasingly severe, to the point where by 2012 she felt she could hardly walk. She managed her symptoms as best she could with home exercise. She often cried in the bathroom so that her children would not see her.

19. Claimant credibly testified that she delayed seeking further treatment from Dr. Phillips while her children were younger, because she feared he would recommend fusion surgery and she did not want to burden them with what she anticipated would be an extended recovery. However, by 2014 her symptoms had become unbearable, so she sought an appointment.

Claimant's 2014 Surgery

20. Dr. Phillips examined Claimant in June 2014. In preparation for that visit, in March 2014 she had undergone another MRI. Upon review, Dr. Phillips reported that the findings depicted a new, ñfrankly recurrentò L4-5 disc herniation, which he described as ñquite substantial, [it] clogs up both the foramen and the origin of the L5 nerve.ò Dr. Phillips believed the resulting nerve root compression was the cause of Claimantôs intensified symptoms. As treatment, he recommended another minimally invasive surgery, much like the one she had undergone in 2006. As with both prior surgeries, Dr. Phillipsô intent was once again to decompress the L4 and L5 nerve roots by removing the encroaching material from the disc space.

21. Dr. Phillips did not testify at hearing, but his office notes were clear and thorough. In them, he credibly described an ñextensive discussionò with Claimant regarding the relative merits of another minimally invasive decompression surgery versus spinal fusion. Noting specifically that she felt the radicular symptoms in her buttock and left leg took precedence over her low back pain, he concluded that it was appropriate to proceed with decompression, notwithstanding the risk of yet another recurrence thereafter. Even with decompression, he anticipated that a future fusion surgery might still become reasonable in the event that her symptoms later gravitated more towards low back pain.

22. Claimant underwent the third surgery on November 12, 2014. Notably, although Dr. Phillipsô surgical findings did not document any free disc fragments in the area of the L4 and L5 nerve roots, there was significant bony overgrowth and scar tissue. Dr. Phillips described these as ñpotentiallyò compressive, and therefore carefully removed them.

23. As with her prior surgeries, Claimant realized some improvement following her November 2014 surgery, but it was short-lived, and not nearly as substantial as she had hoped. It has allowed her to remain off opioid pain medications, but functionally she remains severely restricted. She was in obvious physical distress at formal hearing. When asked to differentiate between low back and leg pain, her frustration was palpable ï ñI donôt differentiate, itôs all just pain to me, . . . it all links together.ò She was equally frustrated when asked if the surgery had made her symptoms more ñtolerable.ò ñOverall, Iôm living with it,ò she responded, but then credibly described feeling nauseous because ñI hurt so much.ò

Expert Medical Opinions regarding 2014 Surgery

24. Defendantôs medical expert, Dr. Rudolf, reviewed Claimantôs medical records and deposition testimony for the purpose of rendering an opinion whether her November 2014 surgery constituted medically necessary treatment causally related to her 2006 work injury. Dr. Rudolf is a board certified orthopedic surgeon with an active clinical practice. He issued a written report and also testified at formal hearing.

25. In Dr. Rudolfôs opinion, Dr. Phillipsô 2006 surgery had properly addressed the specific injury Claimant had suffered at work ï he removed the herniated disc material that likely had been compressing her L4 nerve root at the L4-5 level. In the years following, MRI studies documented spinal stenosis, a degenerative process that caused narrowing throughout her spinal canal. Noting that neither of her subsequent surgeries revealed any loose, soft disc material, Dr. Rudolf concluded that the likelihood of a recurrent disc herniation attributable to Claimantôs 2006 work injury was questionable, not only at the time of her 2014 surgery but dating back to her 2009 procedure as well. According to his analysis, a more probable cause for the worsening symptoms that precipitated both surgeries was ongoing deterioration related to spinal stenosis.

26. Dr. Rudolf acknowledged on cross examination that Claimantôs first (2006) and second (2009) surgeries both entailed removing some portion of the bone comprising her L4-5 facet joint. Scar tissue formed in the area as a result. The prior surgeries thus changed the normal anatomy of her spine at that level, further weakening a joint that likely was already undergoing degenerative changes. I find this aspect of his analysis credible.

27. As for whether Claimantôs 2014 surgery was medically necessary, given that two prior surgeries had failed to provide sustained symptom relief Dr. Rudolf believed the probability that she would improve with a third surgery was ñextremely low.ò He placed her in the category of patients suffering from ñfailed back surgery syndrome,ò meaning those for whom surgical treatments proved unsuccessful despite evidence-based indications on both clinical examination and imaging studies. The unfortunate result for such patients is a chronic pain condition that is unlikely to improve with either medical or surgical management.

28. Dr. Rudolf noted that as with Claimantôs prior surgeries, the stated intent of Dr. Phillipsô third surgery was to address the persistent complaints of radicular pain and numbness down her left leg by decompressing the involved nerves. Yet the electrodiagnostic testing she had undergone in 2007, Finding of Fact No. 9 *supra*, had documented essentially normal nerve conductions throughout her lower extremities. In Dr. Rudolfôs analysis, without evidence to confirm that Claimantôs symptoms derived from significant nerve dysfunction, it was unlikely that any of Dr. Phillipsôsurgeries would provide effective relief. I find this analysis credible.

29. Nevertheless, Dr. Rudolf stopped short of concluding that Dr. Phillipsôthird surgery failed to meet the standard of care for a patient in Claimantôs position. Had his intent been to alleviate her chronic low back pain, nerve decompression surgery would have been inappropriate. But the decision to treat her radicular symptoms surgically was a matter between her and her doctor.

30. Although he did not testify at formal hearing, Dr. Phillips responded to the opinions expressed in Dr. Rudolfôs report by letter to Claimantôs attorney. He confirmed that although her symptoms included some element of low back pain, ñthe ones that brought her to me [in 2014] were more in my mind related to the L4 nerve root.ò Moreover, in his opinion the pathology he treated, that is, the L4 nerve root in its foramen at the L4-5 level, resulted directly from her 2006 work injury, which had caused changes at that same location. I find this analysis credible.

CONCLUSIONS OF LAW:

1. In workersô 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, *see, e.g., Burton v. Holden & Martin Lumber Co.*, 112 Vt. 17 (1941), 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*, *supra* at 19; *Morse v. John E. Russell Corp*., Opinion No. 40-92WC (May 7, 1993).

2. The disputed issue in this claim is whether Claimantôs November 2014 surgery constituted reasonable treatment for her 2006 work injury, such that Defendant is obligated to pay the associated workersô compensation benefits under 21 V.S.A. §640(a).

3. Vermontôs workersô compensation statute requires an employer to provide ñreasonableò medical services and supplies to an injured employee. 21 V.S.A. §640(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). The Commissioner has discretion to determine whether a particular medical treatment is reasonable based on the circumstances of each case. *MacAskill v. Kelly Services,* Opinion No. 04-09WC (January 30, 2009).

4. The parties presented conflicting expert medical testimony regarding both aspects of the reasonableness determination. In such cases, the Commissioner traditionally uses a five-part test to determine which expertôs 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).

5. Considering the causal relationship question first, I conclude from the credible evidence that the required link between Claimantôs 2006 work injury and her treatment in November 2014 has been established. True, Defendantôs expert, Dr. Rudolf, sought to attribute her worsening symptoms to the degenerative processes at work throughout her spine. At the same time, however, he acknowledged that her prior surgeries had caused scar tissue to form and otherwise weakened the area in and around the L4-5 facet joint, and thus were contributing factors as well. Dr. Rudolf conceded that the 2006 surgery was directly related to Claimantôs work injury. Defendant having long ago accepted the 2009 surgery as causally related as well, Dr. Rudolfôs assertion to the contrary comes far too late in the game to be legally relevant. *See, e.g., Smith v. Fletcher Allen Health Care,* Opinion No. 51-08WC (December 15, 2008). The chain of causation thus runs directly from Claimantôs 2006 work injury through her first and second surgeries. It ends with the increasingly intolerable symptoms that prompted her to seek treatment again in the months prior to November 2014.

6. The question whether Dr. Phillipsô November 2014 surgery was medically necessary requires me to carefully weigh the conflicting expert medical evidence.[1] To prevail, Claimant must establish that as of the time the treatment was undertaken, it was likely to improve her condition, either by relieving symptoms and/or by maintaining or increasing functional abilities. *Shaffer v First Choice Communications*, Opinion No. 15-14WC (October 21, 2014).

7. Fairness dictates that the determination whether a treatment is or is not reasonably calculated to lead to further improvement must be made prospectively, at the time it is undertaken, not retrospectively and with the benefit of hindsight. *Luff v. Rent Way*, Opinion No. 07-10WC (February 16, 2010); *Lukic v. Rhino Foods*, Opinion No. 49-09WC (December 15, 2009). The practice of medicine is often inexact, and whether a particular treatment will prove efficacious cannot be known with certainty until it is attempted. A doctor need not guarantee success, but neither can he or she merely speculate that it might result in improvement. The standard is probability, not possibility.

8. Here, Dr. Rudolf conceded that for Dr. Phillips to treat Claimantôs radicular symptoms surgically was within the standard of care. He further acknowledged that the decision to do so was properly a matter between her and her doctor. As the treating physician, Dr. Phillipsô opinion is entitled to some deference. *See, e.g., Galbicsek v. Experian Information Solutions*, Opinion No. 51-09WC (December 22, 2009).

[1] Noting that Claimant did not offer Dr. Phillipsô testimony, either by deposition or at formal hearing, Defendant asserts that she has failed to provide the evidence necessary to sustain her burden of proof. *See, e.g., Lapan v. Berno's, Inc.*, 137 Vt. 393 (1979) (stating necessity for expert medical testimony to establish causal link between employment, injury and benefits sought). Such a rigid interpretation of the case law undermines both the spirit and intent of the workersô compensation formal hearing process, which is designed to be speedy, inexpensive and relatively informal, *Workers' Compensation Rule 17.1100.* Medical opinions routinely find expression in medical records and written reports. If cogently stated, they are entitled to be considered to the same extent as any other evidence.

9. Yet although Dr. Phillips clearly explained his rationale for undertaking a third surgery, his perspective seems to have been simply that it was worth trying. He has failed to convince me that it was likely to improve Claimantôs condition to any appreciable extent, which is the reasonableness standard I must impose.

10. In contrast, Dr. Rudolfôs opinion on the medical necessity issue was clear, thorough and objectively supported. Drawing both on the lack of objective findings on electrodiagnostic testing and on Claimantôs failure to realize sustained improvement from her prior surgeries, he concluded that the likelihood of success from a third surgery was ñextremely low.ò I concur.

11. I acknowledge that Claimant realized some benefit from her third surgery, however short-lived it proved to be. I must believe that Dr. Phillips was anticipating more sustained improvement; yet according to Dr. Rudolfôs credible analysis, he had no reasonable basis for doing so.

12. I conclude that Claimant has failed to sustain her burden of proving that Dr. Phillipsô November 2014 surgery was medically necessary. She therefore has failed to establish that the treatment was reasonable under §640(a). For that reason, I conclude that Defendant is not obligated to pay the associated workersô compensation benefits.

13. As Claimant has failed to prevail on her claim for benefits, she is not entitled to an award of costs and attorney fees.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Claimantôs claim for workersô compensation benefits causally related to her November 2014 surgery is hereby **DENIED**.

DATED at Montpelier, Vermont this 12th day of December 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 V.S.A. §§670, 672.