STATE OF VERMONT
DEPARTMENT OF LABOR

Pamela Darby

v.

W.E. Aubuchon Co., Inc.

Opinion No. 03-18WC

By: Phyllis Phillips, Esq.
Administrative Law Judge

For: Lindsay H. Kurrle
Commissioner

State File No. FF-58467

OPINION AND ORDER

Hearing held in Montpelier on June 5, 2017 and July 26, 2017
Record closed on November 13, 2017

APPEARANCES:

Christopher McVeigh, Esq., for Claimant
Oliver Abbott, Esq., for Defendant

ISSUES PRESENTED:

1. Was Claimantôs August 27, 2016 fall and resulting hip injury causally related to her November 2013 compensable work injury?

2. Does Claimantôs current regimen of prescription opioid medications constitute reasonable medical treatment for her November 2013 compensable work injury?

3. Is Claimantôs depression causally related to her November 2013 compensable work injury, and if so, does individual psychotherapy constitute reasonable medical treatment?

4. Is Claimant permanently and totally disabled as a consequence of her November 2013 compensable work injury?

EXHIBITS:

Joint Exhibit I:	Medical records through April 8, 2014
Joint Exhibit II:	Medical records, April 8, 2014 ï June 8, 2017
Joint Exhibit III:	Vocational rehabilitation records
Claimantôs Exhibit 1:	Deposition of James Dougherty, M.D., August 8, 2017

CLAIM:

Medical benefits pursuant to 21 V.S.A. §640
Permanent total disability benefits pursuant to 21 V.S.A. §645

Any additional workersô compensation benefits to which Claimant proves her entitlement as a consequence of her August 27, 2016 fall and subsequent hip injury
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 the Vermont WorkersôCompensation Act.

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

3. Claimant began working for Defendant in 2009, first as a part-time retail sales associate at its South Burlington store and later as an assistant manager at its Essex Center store. Her prior work history included stints as a bartender, as a local public housing authority maintenance worker, in various retail sales positions and, for sixteen years, alongside her husband in their own custom cabinetry and remodeling business. Some of her duties in the latter position were very physical, for example, planing, sanding and staining wood, laying ceramic tiles and helping her husband to assemble and install cabinets.

4. In 2008, Claimant and her husband closed their business and semi-retired. Claimant credibly described herself as in ñexcellent shapeò at that time; she mowed and raked her yard, worked in her flower garden, walked her dogs and helped her husband to scrape and paint their house. In her spare time, she enjoyed tole painting,[1] and sometimes exhibited her work at local craft shows.

5. Claimantôs work for Defendant was also somewhat physical. She checked in freight, shelved cases of paint and other inventory, moved ladders, washed windows and drove a forklift, all with no major episodes of low back pain or other physical complaints.

6. After leaving semi-retirement, Claimantôs husband also worked for Defendant, as the manager of its South Burlington store.

Claimant's 2010 Work Injury and Subsequent Medical Course

7. On June 29, 2010 Claimant fell and twisted awkwardly while moving some heavy steel shelving components at work. She experienced the immediate onset of severe low back pain. At the hospital emergency room four days later, she reported radiating numbness, tingling and pain into her right leg as well. An MRI revealed a large L3-4 foraminal disc herniation, with compression of the exiting right L3 nerve root.

8. Defendant accepted Claimantôs injury as compensable and began paying workersô compensation benefits accordingly.

[1] Tole painting is a form of folk art that involves painting decorative patterns on wooden objects.

9. Claimant treated initially for her symptoms with Dr. Dougherty, her primary care provider, who subsequently referred her to Dr. Binter, a neurosurgeon. On examination, Dr. Binter documented sensory deficits and ñprofound weaknessò in Claimantôs right lower extremity, all consistent with right L3 radiculopathy. *Joint Exhibit I at p.000170.* As treatment, she recommended a bilateral L3-4 laminotomy and discectomy, which Claimant underwent on August 4, 2010.

10. Claimant began to feel better almost immediately following her surgery and progressed well with physical therapy. Nevertheless, her symptoms did not fully resolve; at an October 2010 functional capacity evaluation (FCE), she reported both a nagging low back ache and occasional numbness and swelling in her right leg with increased activity. Despite these complaints, Dr. Binter concluded that she was able to return to work, first part-time and then full-time, in a light to medium work capacity, but with various lifting, carrying and positional restrictions. In November 2010 Dr. Binter determined that Claimant had reached an end medical result, and later rated her with an eleven-percent whole person permanent impairment referable to her work injury.

11. Gradually Claimant was able to resume her non-work activities as well, including gardening, housework and tole painting.

Claimant's November 2013 Work Injury and Subsequent Medical Course

12. Upon resuming her assistant manager duties, Claimant found it difficult to abide by the functional restrictions Dr. Binter had endorsed. She had to climb ladders, bend, lift and carry to the same extent that she had prior to her injury. Claimant performed these tasks as best she could. Over time, her pain began to worsen again, so she stopped doing as much.

13. Claimant credibly testified that by September 2013 she had experienced a few flares of severe low back pain, which she described as a ñwhite flashò of ñnerve painò that caused her right leg to feel numb and tingly, ñlike itôs not there.ò On a couple of occasions, she lost her balance and fell during these episodes.

14. In late October 2013 Defendantôs district manager assigned Claimant to inventory duties. By this time, she was working as a full-time assistant manager in the South Burlington store, with her husband as her manager. Her inventory duties required her to travel to a different store each day, breaking down and verifying pallet counts of bagged goods (sand, concrete, mulch, soil, etc.) weighing 40 to 50 pounds each. The work was strenuous; over a ten- to twelve-hour day, she had to climb stairs, move ladders and lift and carry heavy loads with far greater frequency than what her post-2010 functional restrictions allowed.

15. The inventory assignment lasted for 14 days, from October 28th to November 19th, 2013. Claimant managed to complete it, but experienced recurrent episodes of severe, sharp pains in her lower back, which radiated into her right lower extremity. She treated these with Advil.

16. On December 4, 2013 Claimant sought treatment for her worsening low back and right leg pain with Dr. Dougherty. Dr. Doughertyôs medical record reports the following history, *Joint Exhibit I at p.000278*:

> Ongoing back ache: [patient] had back surgery 2 years ago and a dull back pain is [sic] been there ever since and *the right leg goes numb off and on, which is making her lose balance, [patient] fell twice since October 28th.*
>
> She notes 6 months or so of increasing lumbar and right buttock pain across right upper anterior thigh ï upper lateral to lower medial. *No routine weakness but on two occasions she's fallen – leg didn't lift as she expected when stepping up.* Not clear that standing or weight bearing makes the pain worse. She has seated and night pain as well. *Pain is similar to that noted prior to her 2010 surgery.* She notes some muscle spasms also. [Emphasis added].

17. As Claimantôs symptoms were suggestive of right L3-4 nerve root irritation, Dr. Dougherty posited that they were due to a recurrent disc herniation at that level. A subsequent MRI study confirmed his suspicion.

18. Initially Dr. Dougherty treated Claimantôs symptoms conservatively, with non-steroidal anti-inflammatories, tramadol (an opioid analgesic) and gabapentin (a neuropathic pain medication). As of January 10, 2014, he determined that Claimant was temporarily totally disabled.

19. On January 17, 2014 Defendant filed a new First Report of Injury (Form 1), in which it reported that Claimant had suffered a low back injury on November 19, 2013 while ñclimbing stairs repeatedlyò and ñlift[ing] and carry[ing] tall laddersò during her inventory assignment. Defendant accepted this injury as compensable and resumed paying workersô compensation benefits accordingly.

20. Claimantôs symptoms continued to worsen. In mid-January 2014, she reported to Dr. Dougherty that her low back and right thigh and leg pain was ñsevere.ò She recounted that she had fallen once when her pain ñabruptlyò became much more severe and her leg gave out, which she described as ñlike the leg just disappears.ò *Joint Exhibit I at p.000299*. Dr. Dougherty anticipated that she would require surgical treatment, and to that end, he referred her to Dr. Tranmer for a neurosurgical consult.

21. In February 2014 Claimant underwent an evaluation with Melissa Naef, a physicianôs assistant in Dr. Tranmerôs practice. As Dr. Dougherty had anticipated, Ms. Naef recommended surgical treatment of Claimantôs L3 disc herniation to address her acute symptoms.

22. Dr. Tranmer concurred that the right L3-4 disc herniation visible on MRI was the cause of Claimantôs pain. In April 2014 he surgically removed hard, chronic disc fragments from underneath her L3 nerve root.

23. Claimantôs recovery from this surgery did not proceed nearly as well as it had following her 2010 surgery. Initially she reported decreased pain and numbness in her right leg, but these improvements were short-lived. She made limited progress in physical therapy. By July 2014 she was complaining of increased pain, swelling, tingling and numbness in her right lower extremity. As she had before her surgery, she reported ñnot knowing where her [right] foot is,ò and falling ñabout once every other day.ò She was observed to lose her balance often; the physical therapistôs testing indicated that she was at ñhigh riskò for falls. *Joint Exhibit II at p.000879.* Notably, her symptoms at this time were more suggestive of L5-S1 radiculopathy, or possibly sacroiliac (SI) joint dysfunction. The symptoms referable to the L3-4 level had largely resolved.

24. Claimantôs progress since mid-2014 has been steadily downhill. She continues to report decreased sensation and severe weakness in her right lower extremity, to the point where she began using first a cane, and then crutches, to assist with ambulation. She cannot sit, stand, walk or drive for prolonged periods, and cannot sleep for more than a few hours at a time. Her right leg often buckles unexpectedly, so to guard against falls her husband has installed grab bars throughout the house. She requires assistance with bathing and dressing. She cannot do most household chores, cannot mow her lawn or tend to her flower garden and has not tole painted since her re-injury in 2013. Sometimes she just sits in her chair and cries.

25. Imaging studies have revealed some foraminal narrowing at the L4-5 level, but with no evidence of nerve root compression these findings do not completely explain Claimantôs current symptoms. Because she could not tolerate electrodiagnostic testing, it was impossible to either confirm or rule out SI joint involvement as a pain generator, as both Dr. Tranmer and Dr. Lunardini, the orthopedic surgeon to whom she was referred for further evaluation, suspected. Targeted injections failed to provide any relief, and no surgical options have presented themselves.

26. Following an independent medical examination with Dr. Johansson, an osteopath, in August 2015 Claimant was determined to have reached an end medical result for her November 2013 injury. With the Departmentôs approval, Defendant discontinued her temporary total disability benefits effective August 17, 2015. In April 2016, the Department approved payment of permanent partial disability benefits in accordance with a 15.5 percent whole person impairment.

Claimant's August 2016 Hip Injury

27. On August 27, 2016 Claimant was standing at the top of a ramp at her home, having just accompanied her dogs outside to play in the back yard. As she took a step with her right leg, it went numb and gave out. Claimant fell and then tumbled down the ramp, landing on her left side. She went by ambulance to the hospital emergency room, where imaging studies revealed multiple hip fractures. The contemporaneous medical records consistently report her account that she fell because her right leg, which she described as chronically weak, unexpectedly buckled beneath her.

28. Fortunately, Claimantôs hip fractures were non-displaced and did not require surgical treatment. By mid-January 2017 she reported that she felt fully recovered; in February 2017 Dr. Dougherty reported that she was back to her ñusualò pain level. *Joint Exhibit II at pp.001453, 001479*.

29. As to the causal relationship, if any, between Claimantôs November 2013 work injury and her August 2016 fall and resulting hip fractures, the partiesô medical experts disagree. In his deposition testimony, Dr. Dougherty asserted that the August 2016 event was ñof a pieceò with other falls Claimant had reported since her November 2013 injury. *Dougherty deposition (Claimant's Exhibit 1) at p.31*. Both the medical records and Claimantôs credible testimony support this assertion. *See* Finding of Fact Nos. 16, 20, 23 and 24, *supra*. Having ruled out any structural disease of either the knee or the hip, Dr. Dougherty posited that Claimantôs right leg pain, weakness and give-way episodes were likely due to nerve dysfunction or pain signals causally related to her work injury. *Id. at pp.30-31*. I find this analysis credible.

30. Defendantôs independent medical examiner, Dr. Johansson, disagreed with this analysis. Dr. Johansson is a board-eligible osteopath, with significant experience in non-operative treatment of patients suffering from low back pain. Dr. Johansson personally evaluated Claimant in August 2014, March 2015 and, relative specifically to her hip injury, December 2016.

31. In Dr. Johanssonôs opinion, Claimantôs subjective report that her right leg sometimes ñgave outò was insufficient to support a conclusion, to the required degree of medical certainty, that her fall was causally related to her work injury. Lacking any definitive diagnosis, according to his analysis an injury-related neurological deficit was just one of many possible causes.

Claimant's Use of Prescription Opioid Medications

(a) Initial Oxycodone and Fentanyl Prescriptions

32. Aside from a brief regimen of Percocet immediately following her 2010 injury, Claimant effectively managed her symptoms without any need for narcotic pain medications. This changed dramatically after her 2013 re-injury.

33. Claimant was first prescribed oxycodone for her pain symptoms in February 2014, in anticipation of Dr. Tranmerôs surgery. Post-surgery, her dosage tapered down for a time, but when her low back and right leg pain began to worsen again it tapered back up. By February 2015 she was using 25 milligrams daily, as prescribed by Dr. Dougherty.

34. At Ms. Naefôs referral, in February 2015 Claimant underwent a pain management consult with Kristie Oliver, a physicianôs assistant at UVM Medical Centerôs Pain Medicine clinic. Claimant reported only short-lived pain relief from oxycodone ï less than 45 minutes after taking it, she was back to her baseline pain level. With that in mind, Ms. Oliver concluded that it would be appropriate either to discontinue the medication altogether or to transition to a longer-acting narcotic. I find this analysis reasonable.

35. Defendantôs independent medical examiner, Dr. Johansson, also expressed concern about Claimantôs use of narcotic medications to treat her chronic pain. Following his March 2015 evaluation, he described her as ñvery pain reactive,ò *Joint Exhibit II at p.001111*, and suggested that she might be developing hyperalgesia (a heightened sensitivity to pain) secondary to her prolonged use of oxycodone. He too recommended moving towards a longer-acting medication.

36. With Ms. Oliverôs and Dr. Johanssonôs suggestions in mind, in March 2015 Dr. Dougherty adjusted Claimantôs medication regimen, decreasing her oxycodone dosage and adding Fentanyl, a longer-acting opiate. After some experimentation, he settled on a dosage level of 20 milligrams of oxycodone daily (down from 25 milligrams previously) and 50 micrograms of Fentanyl, delivered via 72-hour transdermal patch.[2]

(b) Dosage Taper Attempts

37. Except for two brief taper attempts, Dr. Dougherty has maintained Claimant on the same Fentanyl and oxycodone dosage levels since May 2015. The first taper occurred in November 2015. While maintaining Claimant on the same oxycodone dosage, Dr. Dougherty reduced her Fentanyl dosage from 50 to 25 micrograms. Claimantôs pain rapidly increased, and after two weeks he returned her to her prior dosage.

38. The second taper occurred in April 2017. Upon reviewing her medical records, Dr. Johansson had reiterated his concern that Claimantôs continued use of narcotic analgesics had proven ineffective and was likely contributing to both hyperalgesia and depression. He therefore recommended that she taper off both Fentanyl and oxycodone. Dr. Johansson suggested first decreasing Claimantôs Fentanyl dosage by 20 percent per week, while maintaining or even increasing her oxycodone as needed to compensate for any increased pain. He anticipated that it might take two or three weeks for Claimant to reduce her Fentanyl dosage to zero, perhaps longer depending on her response. At that point, she could begin tapering her oxycodone, again by a factor of 20 percent per week, until that too was reduced to zero.

39. Dr. Dougherty proceeded along somewhat different lines. As with the first taper attempt, he maintained Claimant on the same dosage of oxycodone and reduced her Fentanyl dosage, albeit by a lesser amount than before ï from 50 to 37.5 micrograms. Once again, Claimant was unable to tolerate the decrease without significant worsening of both pain and function. After two months, Dr. Dougherty returned her to her prior dosage levels, where she has remained since.

40. Dr. Dougherty has not recommended increasing Claimantôs current dosage of either Fentanyl or oxycodone. Doing so would increase the risk of adverse side effects and would be unlikely to result in any appreciable decrease in her pain.

[2] According to the Centers for Disease Control and Prevention opioid dosage calculator, this equates to a morphine milligram equivalent (MME) dosage of 150 milligrams per day. *See* https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html, [PDF-1M].

(c) Treatment Effectiveness; Hyperalgesia

41. I find that Dr. Doughertyôs narcotic medication regimen has proven only marginally effective at managing Claimantôs pain, much less improving her function. His medical records reflect ongoing complaints of ñrelatively constant moderate to severe pain,ò with brief, unpredictable yet periodic episodes of ñsevere intolerable pain.ò *Joint Exhibit II at p.001203*. Although Dr. Dougherty has encouraged Claimant to be as active as she is able, ñher impression is that the more she does, the worse things get for pain.ò *Id. at p.001227*. Even at her current dosage levels, on two occasions she has reported to Dr. Dougherty that over all she is worse. *Id. at pp.001208, 001227*. Nevertheless, I accept as credible Claimantôs testimony that her pain is somewhat less intolerable at her current dosage levels than it was during either of her failed tapers. What relief it affords is nevertheless meaningful to her.

42. As for whether it is appropriate for Claimant to continue with her current opioid regimen, the experts disagree. Dr. Dougherty believes the medications have offered ñsome benefitò in terms of pain relief, and therefore ñmore comfortò in her daily life. *Dougherty deposition (Claimant's Exhibit 1) at p.45*. She has tolerated them well, and there have been no red flags for abuse. In his opinion, therefore, because the positive aspects of using narcotics to treat her chronic pain outweigh the negatives, it is appropriate to continue them.

43. Contrary to Dr. Johanssonôs opinion, *see* Finding of Fact No. 35 *supra*, Dr. Dougherty has not identified any ñspecific indicationò that Claimantôs prolonged opioid use has triggered hyperalgesia. *Dougherty deposition (Claimant's Exhibit 1) at p.27*. In his analysis, the ñsignificant diseaseò in her spine has clearly demonstrated an organic basis for her pain, which was severe even before her opioid regimen began. *Id. at pp.27, 50*. Viewed in that context, hyperalgesia is not ña default conclusion;ò it requires supporting evidence, which Dr. Dougherty found lacking. *Id. at p.27*. Thus, while acknowledging that it remains hard to determine ñwhy the pain continues to be as severe as it is,ò *id. at p.52*, in Dr. Doughertyôs opinion the medications themselves are not the cause. I find this analysis credible.

44. Dr. Johansson disagrees with this reasoning. In his opinion, Claimantôs heightened pain reactivity is directly related to her prolonged use of narcotic medications ï in effect, the drugs are causing her to feel *more* pain rather than less. They also might be playing a role in her depression, *see* Finding of Fact No. 53 *infra*. They have not triggered any functional improvements, and in fact, her quality of life has worsened. In Dr. Johanssonôs opinion, the balance of negatives versus positives thus weighs strongly against the reasonableness of ongoing opioid treatment.

(d) Defendant's Discontinuance of Payment for Opioid Medications

45. Upon reviewing Claimant's medical records, in April 2017 Dr. Johansson voiced concern that Dr. Dougherty had failed to comply with the Vermont Department of Health's recently promulgated *Rule Governing the Prescribing of Opioids for Chronic Pain*. Specifically, Dr. Dougherty's medical records did not adequately document that he had obtained a written opiate contract and informed consent from Claimant, conducted random urine drug screens or appropriately queried the Vermont Prescription Monitoring System. As a consequence of these deficiencies, in May 2017 the Department's specialist approved Defendant's Notice of Intention to Discontinue Payments (Form 27) for Claimant's ongoing Fentanyl and oxycodone prescriptions, effective June 9, 2017.

46. Although not well documented in his medical records, Dr. Dougherty credibly testified that he complied with those aspects of the Vermont Department of Health rule upon which Defendant's discontinuance was based. He required Claimant to sign an opiate contract, obtained her informed consent to treatment, conducted random urine screens and queried the Vermont Prescription Monitoring System. He physically examined Claimant at appropriate intervals and appropriately documented both dosages and refills. As discussed *infra*, Finding of Fact No. 49, he also made an appropriate referral to Dr. Naylor, a psychiatrist, for consideration of psychologically-based treatment options for Claimant's chronic pain. I find that Dr. Dougherty thus substantially complied with the rule's requirements.

Claimant's Depression and Associated Treatment

47. Following her 2010 work injury, and barely three weeks after her first surgery, Dr. Binter noted in passing that Claimant was depressed because she had not yet returned to work. Claimant did not undergo any psychological treatment at the time, and aside from this brief reference, there is no indication of any history of, or treatment for, depression prior to her November 2013 injury.

48. With her failure to progress following her 2013 injury and subsequent surgery, Claimant became increasingly discouraged. Her mood worsened appreciably in November 2014, after Defendant terminated her employment. In January 2015 Dr. Dougherty diagnosed her with moderately severe depression. As treatment, he prescribed duloxetine (Cymbalta), for the dual purpose of addressing both her pain and her mood issues.

49. In May 2016 Dr. Dougherty referred Claimant to Dr. Naylor, a psychiatrist and pain management specialist, for possible entry into the University of Vermont Medical Center's Mind-Body Medicine Clinic. The clinic offers a 13-week chronic pain management program, in which participants receive training, in a group setting, in pain perception, relaxation, cognitive restructuring and other cognitive behavioral techniques for addressing their pain and related psychological symptoms.

50. Dr. Naylor diagnosed Claimant with major depression and chronic pain syndrome. At her recommendation, in July 2016 Claimant enrolled in the Mind-Body chronic pain management program. Although she expressed frustration with some aspects of the program, she actively participated in each weekly session, and was committed to completing it. Unfortunately, her August 2016 hip injury precluded her from doing so. The medical record reflects that after she returned to her baseline level of pain and functioning, a representative from the Mind-Body program requested that Defendant approve her participation in a new 13-week session beginning in February 2017. It is unclear from the record whether Defendant responded. In any event, Claimant did not attend.

51. Separate and apart from the Mind-Body program, Dr. Dougherty also has recommended individual psychotherapy as treatment for Claimantôs depression. In his opinion, as part of a comprehensive treatment plan it is reasonable to address the thought patterns that contribute to depression in either a group setting and/or on a one-to-one basis. For her part, Claimant credibly testified that she was unable to master the meditation and relaxation techniques taught in the Mind-Body program but would avail herself of individualized therapy if it was offered. Given her stated preference, I find Dr. Doughertyôs analysis entirely persuasive.

52. In Dr. Doughertyôs opinion, Claimantôs depression is causally related to her November 2013 injury. Having known her both before and after, he has had ample occasion to observe the changes in her affect and presentation, as well as the frustration and hopelessness she has expressed in reaction to her ongoing pain and diminished capabilities. Both Claimant and her husband also testified regarding the psychological toll that her injury has exacted from her. I find their testimony, as well as Dr. Doughertyôs causation opinion, credible in all respects.

53. In Dr. Johanssonôs analysis, Claimantôs psychological condition is more likely due to her use of opioids, which are known to cause significant depression and anxiety when taken for prolonged periods. The most reasonable treatment, therefore, would be for her to taper off the narcotics and move instead towards other pain management techniques. Dr. Johansson did not address the likelihood that Claimantôs chronic pain itself has contributed to her depression, such that even tapering off narcotics might not entirely restore her psychological well-being. For this reason, I find his analysis overly simplistic.

54. Dr. Johansson acknowledged that Dr. Naylorôs Mind-Body program might be a medically necessary substitute for narcotics, in that it teaches both physical and psychological coping skills. He asserted that talk therapy was not a good pain management tool, and thus did not endorse individualized psychotherapy as a reasonable treatment option. In doing so, he failed to address whether one-on-one therapy might assist Claimant in working through her depressive symptoms. For this reason, I find his analysis somewhat incomplete.

Claimant's Work Capacity, Vocational Rehabilitation Efforts and Alleged Permanent Total Disability

55. Claimant has not worked since January 2014, when Dr. Dougherty determined that she was temporarily totally disabled.

(a) Functional Capacity Evaluations

56. Claimant has undergone three FCEs since her November 2013 work injury. At her attorneyôs request, Charles Alexander conducted the first two, in July 2015 and January 2017. Mr. Alexander is an occupational therapist; as such, his job entails evaluating an individualôs function in a variety of settings and providing training to improve functional abilities. He also conducts FCEs, and is certified in the Matheson system, which utilizes a versatile methodology for obtaining objective, verifiable data as to an individualôs functional work capacity. Mr. Alexander estimates that he has performed 30 to 50 FCEs annually since 2003.

57. Although conducted a year and a half apart, Claimantôs two FCEs with Mr. Alexander yielded substantially the same results. Generally, she exhibited good effort throughout testing, her subjective reports matched well with Mr. Alexanderôs objective findings, and there was no evidence of symptom magnification. She was consistently limited by her low back and right hip and leg symptoms, and her pain increased over the course of each evaluation, both of which lasted for approximately five hours.

58. More specifically, in both evaluations Claimant demonstrated limited tolerance for sitting, standing, walking and lifting. She needed to change positions ï from sitting to standing or vice versa ï every ten to 20 minutes. This significantly limited her ability to complete tasks at a competitive speed. She could not lift any weight from floor to waist. She had difficulty climbing and descending stairs, and exhibited poor balance, both with testing and with general mobility. She was unable to perform any carrying tasks safely and had difficulty assuming or standing from low level positions.

59. Based on Claimantôs objective test results, in both evaluations Mr. Alexander concluded that she had a less than sedentary work capacity according to the *Dictionary of Occupational Titles (DOT)*. This determination was based on (a) her inability to lift any weight from floor to waist; and (b) her inability to tolerate sustained sitting on at least an occasional (up to one-third of a day) basis. Both of these are requirements for sedentary work, which is the *DOT*ôs least strenuous work capacity category.

60. Although Mr. Alexander determined that Claimant did not meet the *DOT* criteria for even sedentary work, he concluded that she retained some residual work capacity nonetheless. In his estimation, if she could perform tasks in either a sitting or standing position as necessary to manage her symptoms, she might be able to work part-time, two to four hours per day. Even with that, however, Mr. Alexander questioned whether she would be able to tolerate a five-day work week, as her ability to attend to work tasks would depend on her pain levels, and therefore would likely be inconsistent from day to day. Self-paced tasks, such as part-time work from home, might be Claimantôs best vocational option, therefore. I find this analysis credible in all respects.

61. Defendantôs functional capacities evaluator, occupational therapist Mark Coleman, reached a similar conclusion after evaluating Claimant in February 2017. During this evaluation, she demonstrated limited tolerance for sustained sitting or standing ï five to ten minutes on average. Her lifting capacity was limited to ten pounds occasionally from knee to chest and only rarely from floor to waist. Her low back and right hip and leg pain were her primary limiting factors.

62. Based on his testing, Mr. Coleman determined that Claimant was functioning at a ñconditional sedentary (10 pounds)ò work capacity for an estimated four-hour work day. *Joint Exhibit III at p.001484*. He noted several limiting factors, however, including her limited tolerance for sustained sitting or standing, her slow work pace, cautious manner and generally guarded posture, and her history of falls and demonstrated ñwobblinessò on occasion. Considering these limitations, Mr. Coleman concluded that Claimant would need a job in which she could self-pace and change positions frequently. I find this analysis, which is identical to Mr. Alexanderôs in most respects, credible.

(b) <u>Vocational Rehabilitation</u>

63. Claimant was found entitled to vocational rehabilitation services in June 2015. Shortly thereafter she began working with Tammy Parker, a certified vocational rehabilitation counselor with more than 20 yearsô experience in the field. Since initiating vocational rehabilitation services, Ms. Parker has met with Claimant monthly to discuss progress and offer assistance.

64. As Claimant has only an eleventh-grade education, Ms. Parkerôs vocational rehabilitation efforts have focused primarily on assisting her to complete high school and earn her diploma. To that end, in March 2016 Claimant enrolled in the Vermont Adult Learning essential skills program. This program provides basic instruction in math, reading and writing. Progress is measured by periodic testing, which the student must pass in order to move on to high school-level classwork.

65. Claimant has made good effort, but very little progress in the essential skills program. Attending classes in person was physically taxing ï it required more driving, walking and sitting than she could easily manage, and it left her extremely fatigued. Both Claimant and her husband credibly testified to her difficulties with memory, concentration and retention, such that she has been equally unsuccessful doing online coursework from home. Her limited tolerance for sustained sitting or standing means that she must constantly interrupt her studies to move about, and when she returns she has forgotten what she has just read and has to start over. After a year and a half, she still has not been able to score high enough on the essential skills test to advance to the high school completion program.

66. Ms. Parker credibly testified to the extent of Claimantôs engagement in the vocational rehabilitation process. She has sought out volunteer opportunities on her own initiative. She has pursued job leads. She has taken online courses to improve her computer skills. Unfortunately, none of these efforts have yielded any success. As the process has continued, Claimant has become increasingly discouraged and depressed.

67. Ms. Parker credibly testified that she has now explored and exhausted all reasonable vocational rehabilitation avenues for Claimant. In her analysis, Claimant needs new skills to return to any type of work, even part-time. Yet despite her best efforts, after a year and a half she still has been unable either to obtain her high school diploma or to increase her computer proficiency. Her pain and physical limitations create additional barriers, as do her depression and diminished mental acuity. Her age ï 59 as of the formal hearing ï is also problematic; in Ms. Parkerôs experience, age discrimination still exists, making it more difficult for a person of Claimantôs age to obtain work. Considered together, in Ms. Parkerôs opinion these obstacles render it unlikely that Claimant will be able to find and maintain regular gainful work. I find this analysis credible.

68. I find corroboration for Ms. Parkerôs conclusions regarding Claimantôs employability in Iris BanksôMarch 2017 vocational assessment. Ms. Banks is a certified vocational evaluator. As part of her assessment, she reviewed the medical records pertinent to Claimantôs functional capacities, conducted a personal interview and administered various tests to assess her interests, aptitudes and temperament.

69. Ms. Banks identified several challenges to Claimantôs ability to return to work, including chronic pain, disrupted sleep, depression and a history of work in occupations whose physical demands were beyond her current functional capacities. On the plus side, she presented as personable, competent, conscientious and diligent, displayed initiative and an ability to work independently and had significant experience in supervision, training and customer service.

70. From the vocational profile she constructed of Claimant, Ms. Banks considered ï and ultimately discarded ï a number of vocational avenues. For example, while Claimant has significant and relevant retail experience, jobs in that field often involve a fast, variable or unpredictable pace, which is incompatible with her need for self-pacing. A telephonic customer service job in a call center might accommodate her need for frequent positional changes, but likely would not allow for the frequent breaks she requires. Working from home on a self-paced schedule, as in a self-employment venture, might offer more flexibility, but even there, her inability to complete tasks consistently or within a prescribed time frame would likely be a barrier to success. I find this analysis credible.

71. ñBarring a change in status that would include an increase in stamina and decrease in pain level and current limitations,ò Ms. Banks concluded that the occupations she considered in her report ñwould likely not be a matchò for Claimant. *Iris Banks' report at p.10 (Joint Exhibit III)*. I find this conclusion credible.

72. In April 2017, Defendant retained Fran Plaisted to conduct an independent vocational evaluation. Ms. Plaisted has been a vocational rehabilitation counselor since 1989. She holds a masterôs degree in vocational rehabilitation counseling and has earned certifications as a rehabilitation counselor, disability management specialist and vocational expert. As part of her evaluation, Ms. Plaisted reviewed Claimantôs medical and vocational rehabilitation records, conducted an in-person interview,[3] analyzed her transferable skills and undertook a labor market survey. Her goal was to determine whether additional vocational rehabilitation services will assist Claimant to become employable or alternatively, whether she is permanently and totally disabled.

73. Ms. Plaisted acknowledged at formal hearing that Ms. Parker ñhas done a good jobò working with Claimant. She agreed that Claimantôs best return to work option will mostly likely involve working from home in a job that allows for self-pacing, frequent breaks and an adjustable work station. Even at that, she faces numerous barriers, including her reliance on narcotic medications, her deficient keyboarding and computer skills and, most notably, her lack of a high school diploma. As to the last, Ms. Plaisted admitted that none of the occupations she identified that might fit Claimantôs transferable skills and need to telecommute will likely be available to her until she completes high school, which, so far, she has been unable to accomplish. This too is consistent with Ms. Parkerôs analysis.

[3] At Claimantôs request and expense, Ms. Parker attended and silently observed Ms. Plaistedôs interview. Defendant alleges that by doing so, Ms. Parker violated her professionôs code of ethics. Whether this is so is not for me to decide. Even if Defendantôs interpretation is correct, I do not consider Ms. Parkerôs alleged violations to have any effect whatsoever on either her credibility or the strength of her stated conclusions in this matter.

74. Whereas Ms. Parker believes Claimant is unlikely to make further vocational rehabilitation progress, Ms. Plaisted believes additional measures should be taken to assist her, however. Among her suggestions:

- An adjustable, ergonomically correct work station, which might make it easier for Claimant to study and improve her productivity at home;
- One-to-one tutoring, which might facilitate her ability to earn her diploma more expeditiously; and
- Renewed efforts, possibly including in-patient rehabilitation, to wean her off narcotic medications, which might improve her cognitive capabilities.

75. Ms. Plaisted admitted that Claimantôs employment outlook is at best ñguardedò at this point. Without a high school diploma, she testified, it is ñvery difficult to do anything in todayôs world.ò That said, the vocational rehabilitation counselorôs job is to identify barriers and then develop a plan to overcome them, and in Ms. Plaistedôs analysis, Ms. Parker has not yet done so. Until she does, according to Ms. Plaisted, it would be premature to declare Claimant unemployable.

76. I find reason in the record to doubt whether Ms. Plaistedôs recommendations are likely to have any measurable effect on Claimantôs employability. As Claimant credibly testified, because much of her pain derives from her limited tolerance for both sitting and standing, having access to an adjustable work station likely would not benefit her. As for one-to-one tutoring, the difficulties she has encountered with her class studies stem mostly from her inability to focus on and retain information, not from her failure to understand the subject matter. While this might improve were she to wean off narcotic medications, to date her efforts to do so have proven unsuccessful. No medical professional has yet recommended in-patient rehabilitation and for Ms. Plaisted to suggest it is well beyond her professional expertise.

(c) Expert Medical Opinions regarding Permanent Total Disability

77. In his August 2014 independent medical evaluation, Dr. Johansson determined that Claimant was capable of returning to full-time, light duty work with various restrictions, including that she not lift more than ten pounds and that she be allowed to change positions frequently. Dr. Johansson acknowledged at hearing that he did not conduct any formal functional capacities testing during his evaluation. Rather, his determination was based primarily on what he perceived to be significant discrepancies between his physical exam findings and Claimantôs subjective reports of pain.

78. At formal hearing, Dr. Johansson testified that while he does not doubt that Claimant suffers from chronic pain, he does not believe it is serious enough to keep her fully out of work forever. For that reason, in his opinion she is not permanently and totally disabled. I find this analysis, which relies on a subjective estimate of the extent of another personôs pain rather than on objectively verifiable functional capacities testing results, wholly unpersuasive.

79. In Dr. Doughertyôs opinion, Claimant has no current work capacity, and the probability of her returning to regular gainful employment in the future is very small. This conclusion is based both on his observations of her over the course of the past four years and on the results of the various FCEs she has undergone. He acknowledged that Claimantôs pain is the primary barrier to her ability to work, but identified her immobility, weakness, balance issues and other physical difficulties as disabling factors as well. 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, 20 (1941), as well as the causal connection between the injury and the employment. *Egbert v. The Book Press,* 144 Vt. 367, 369 (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,* 112 Vt. at 20; *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

Compensability of Claimant's August 2016 Fall and Resulting Hip Injury

2. As to the first disputed issue ï whether Claimantôs August 2016 fall and resulting hip injury was causally related to her November 2013 compensable work injury ï the parties presented conflicting medical evidence. Where expert medical opinions are conflicting, 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).

3. I conclude here that Dr. Doughertyôs opinion is the most credible. As Claimantôs primary care provider since her first work injury in 2010, he was well-positioned to understand the progression of her right leg symptoms. His medical records after November 2013 consistently report her complaints of weakness, numbness, a feeling that her leg ñjust disappearsò and most notably, increasingly frequent falls. Dr. Dougherty aptly described her August 2016 fall as ñof a pieceò with this history.

4. Dr. Johansson correctly noted that there has been no definitive diagnosis for Claimantôs right lower extremity symptoms. Medicine is an inexact science, however; so too is medical decision-making, as to both diagnosis and treatment. *See, e.g., Veillette v. Pompanoosuc Mills Corp.*, Opinion No. 23-12WC (September 14, 2012). The fact that Dr. Dougherty cannot pinpoint the precise pathology that is causing Claimantôs right hip and leg to feel weak and numb does not fatally undermine his conclusion, which he asserted to the required degree of medical certainty, that the symptoms are causally related to her work injury.

5. I conclude that Claimant has sustained her burden of proving that her August 2016 fall and subsequent hip injury was causally related to her November 2013 work injury and is therefore compensable.

Reasonableness of Prescription Opioid Medications as Treatment for Claimant's November 2013 Work Injury

6. As to the second disputed issue ï whether Claimantôs current use of prescription opioid medications constitutes reasonable treatment for the chronic pain associated with her November 2013 work injury ï the parties again offered conflicting expert medical opinions.

7. Vermontôs workersô compensation statute obligates an employer to furnish ñreasonableò medical services and supplies to an employee who has suffered a compensable work-related injury. 21 V.S.A. §640(a). The Commissioner has discretion to determine what constitutes ñreasonableò medical treatment given the particular circumstances of each case. *MacAskill v. Kelly Services*, Opinion No. 04-09WC (January 30, 2009). 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); *Brodeur v. Energizer Battery Manufacturing, Inc.,* Opinion No. 06-14WC (April 2, 2014).

8. Although once hailed as both safe and effective, in recent years the use of opioid medications to treat chronic pain has come under increasing scrutiny. In 2015, the Vermont Department of Health (VDOH) published its first *Rule Governing the Prescribing of Opioids for Chronic Pain*.[4] The rule established various ñbest practicesò for opioid prescribers, including those discussed in Finding of Fact Nos. 45-46 *supra*.

[4] Code of Vermont Rules 13-140-076 (2015). The rule has since been amended, effective July 1, 2017, and now governs opioid prescriptions for acute pain as well.

9. In keeping with a legislative directive to adopt rules governing ñclaim adjudication for patients prescribed opioids for chronic pain,ò 21 V.S.A. §640c(b), in 2016 this Department incorporated the VDOH rule as its best practices guideline for determining the reasonableness of treatment in the workersô compensation context. The amended rules now create a rebuttable presumption that allows an employer to deny or discontinue payment for opioid pain medications if the prescribing physician cannot justify his or her failure to comply with the VDOH rule. *See* Workersô Compensation Rules 11.1400 and 12.1730.

10. Claimant questions the extent to which the amended Workersô Compensation rules can be applied to her claim. Because her date of injury preceded their effective date, if the amendments are deemed substantive rather than procedural, arguably they should not apply. *Sanz v. Douglas Collins Construction*, 2006 VT 102. Under the circumstances of this claim, I need not decide this question. I have already found that Dr. Dougherty provided sufficient evidence to overcome the rebuttable presumption, Finding of Fact No. 46 *supra*. Whether Defendantôs discontinuance was proper at the time, I now conclude that the grounds it alleged in support no longer justify its action.

11. The inquiry does not end there, however. The VDOH ñbest practicesò rule covers the nuts and bolts of prescribing opioid medications to treat chronic pain ï how to inform, involve and monitor the patient, how to appropriately document the medical decision-making process, when to consider a specialist referral, how often to re-evaluate. But the ultimate determination ï whether the treatment is medically appropriate under the circumstances ï remains in the physicianôs hands alone, as it should.[5]

12. Dr. Dougherty weighed the benefits of continuing Claimant on opioid medications ï no improvement in function, but meaningful pain relief ï against the risks ï intolerable side effects, potential for abuse, evidence of hyperalgesia ï and determined that it was appropriate to continue. This was the correct approach, and having known and treated Claimant for some years, I appreciate his ability to strike the right balance. I accept his opinion as credible, and thus conclude that Claimantôs current opioid medication regimen is medically appropriate and necessary.

[5] Regarding its opioid prescribing rule, the Vermont Department of Healthôs ñFrequently Asked Questions: For Prescribersò includes the following question ï ñWill [the rule] prevent a health care provider from prescribing opioids to a patient in pain?ò ï and answer ï ñNo, nothing in the rule prevents a provider from prescribing opioids as a part of the treatment of pain.ò
http://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_Opioid%20Prescribing_Rules%20FAQs.pdf.

13. I do not reach this conclusion without some trepidation, however, and I caution anyone who assumes the balance will always be so. In accordance with the VDOH rule, I assume that Dr. Dougherty will regularly re-evaluate the efficacy of Claimantôs medication regimen (Rule 6.4.2), continue to evaluate alternative treatment options (Rule 6.4.3.1) and determine and document the need for additional pain management consultations (Rule 6.4.3.2). Given the high dosage level at which Claimant is currently being maintained, I am hopeful that the latter step in particular will yield both a successful taper plan and a more effective treatment approach.

Causal Relationship between Claimant's Depression and her November 2013 Work Injury, and Individual Psychotherapy as Reasonable Treatment

14. As to the third disputed issue ï whether Claimantôs depression is causally related to her November 2013 work injury, and if so, whether individual psychotherapy is reasonable treatment ï again the parties presented conflicting expert testimony, and again I side with Dr. Dougherty. I accept as credible his testimony, which both Claimant and her husband corroborated, that the increased pain and decreased function she has suffered since her work injury have inflicted a significant emotional toll. Given Claimantôs inability to master the meditation and relaxation techniques she was taught in the Mind-Body program, for Dr. Dougherty to suggest individual psychotherapy as either an alternative or an adjunct is entirely reasonable.

15. Dr. Johanssonôs opinion rests on his assumption that Claimantôs depression is wholly related to her use of opioids. In his analysis, therefore, the most reasonable treatment is to taper her off the medications. Dr. Johansson thus endorsed Claimantôs further participation in the Mind-Body program, but only as a tool to assist her during the tapering process. In his experience, individual psychotherapy is ineffective for this purpose.

16. Dr. Johanssonôs analysis was couched entirely in general terms and seemed not to account for Claimantôs particular circumstance. He failed to address the likelihood that, separate and apart from her opioid use, her underlying chronic pain itself is contributing to her depression. Given her previous frustration with the Mind-Body program, he also failed to consider whether individual psychotherapy might now prove more beneficial, not only by supporting her during any future taper attempts but also by teaching her how to manage her pain more effectively.

17. Though I acknowledge Defendantôs right to contest its obligation to pay for treatment it believes is unreasonable, I am dismayed nonetheless at its response to Claimantôs request for psychotherapy in this case. I share Defendantôs concern that opioid medications have neither decreased her pain nor increased her function as effectively as anyone would hope. But to advocate for removal of the only pain management tool she currently has at her disposal, while simultaneously refusing to embrace a reasonable alternative, is callous and inhumane.

18. In accordance with Dr. Doughertyôs analysis, I conclude that Claimant has sustained her burden of proving that her depression is causally related to her November 2013 work injury. I further conclude that individual psychotherapy is a reasonable treatment option for her to pursue.

Permanent Total Disability

19. The final disputed issue is whether Claimantôs November 2013 work injury has rendered her permanently and totally disabled. Under Vermontôs workersô compensation statute, a claimant is entitled to permanent total disability benefits if he or she suffers one of the injuries enumerated in §644(a), such as total blindness or paraplegia. In addition, §644(b) provides:

> The enumeration in subsection (a) of this section is not exclusive, and, in order to determine disability under this section, the commissioner shall consider other specific characteristics of the claimant, including the claimantôs age, experience, training, education and mental capacity.

20. The workersô compensation rules provide further guidance. Rule 10.1700 states:

> Odd lot doctrine. An injured worker shall be considered permanently and totally disabled in accordance with the odd lot doctrine if a compensable injury causes a physical and/or mental impairment that renders him or her unable to perform regular, gainful work. In evaluating whether or not an injured worker is permanently and totally disabled under this rule, his or her age, experience, training, education, occupation and mental capacity shall be considered, in addition to physical or mental limitations and/or pain.
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> . . .
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> 10.1720 For the purposes of this Rule, ñregular, gainful workò refers to regular employment in any well-known branch of the labor market. Work that is so limited in quality, dependability or quantity that a reasonably stable market for such work does not exist does not constitute ñregular, gainful work.ò

21. In this case, both partiesô functional capacities evaluators determined that Claimant has at best a part-time capacity for limited sedentary work. Both concluded that to accommodate her physical restrictions, she would need a job that would allow her to self-pace and change positions frequently.

22. Relying on this information, both partiesô vocational rehabilitation experts determined that Claimantôs best vocational option would likely involve working from home. Claimant having failed to graduate from high school, both experts further agreed that the first step to any vocational rehabilitation plan would have to be for her to obtain her high school diploma or equivalency. Both experts agreed that if she was unable to do so, her prospects for regular, gainful employment would be dim.

23. Unfortunately, despite her best efforts Claimant has failed to progress towards the goal of completing her high school education. The experts disagree as to whether she can reasonably be expected ever to do so. Claimantôs vocational rehabilitation counselor, Ms. Parker, believes she cannot, that vocational rehabilitation resources have been exhausted and that she is therefore permanently and totally disabled. Defendantôs vocational rehabilitation expert, Ms. Plaisted, believes there are additional steps that, if taken, might enable Claimant to obtain her high school diploma and progress in her return to work planning. In Ms. Plaistedôs opinion, until those options are pursued it is premature to declare Claimant permanently and totally disabled.

24. From the credible evidence, I have already found that Ms. Plaistedôs recommendations are unlikely to have any measurable effect on Claimantôs employability. To the extent that her analysis is based on their success, I conclude that it is inadequately supported and therefore unpersuasive.

25. Ms. Parkerôs opinion was informed by her experience as Claimantôs vocational rehabilitation counselor for the past two and a half years. Both Dr. Dougherty and Ms. Banks credibly corroborated her analysis. I accept it as persuasive.

26. I agree, as Ms. Plaisted testified, that a vocational rehabilitation counselorôs job is to identify barriers to employment and then develop a plan to overcome them. In doing so, the counselor is limited by the realities of the injured workerôs situation, however ï the education and experience he or she brings to the table, the physical and psychological ramifications of his or her injury, and the functional limitations that any job will have to accommodate. Speculative reasoning might allow for a conclusion that any obstacle can be overcome, but that is not the standard by which an injured workerôs employability is measured. The standard is what is reasonably to be expected, not what is remotely possible. *Hawley v. Webster Trucking Corp.*, Opinion No. 18-13WC (August 9, 2013), citing *Moulton v. J.P. Carrera, Inc.*, Opinion No. 30-11WC (October 11, 2011).

27. Professor Larson has described the essence of the odd lot test as ñthe probable dependability with which [the] claimant can sell his or her services in a competitive labor market, undistorted by such factors as business booms, sympathy of a particular employer or friends, temporary good luck or the superhuman efforts of the claimant to rise above crippling handicaps.ò 4 Lex K. Larson, *Larson's Workers' Compensation* §83.01 at p. 83-3 (Matthew Bender, Rev. Ed.), quoted with approval in *Moulton, supra*. As the commissioner observed in *Moulton*, it would be a harsh result to deny an injured workerôs claim for permanent total disability benefits solely because the possibility exists, however slight, that he or she might someday find a job.

28. Here, Claimant has already demonstrated her inability to accomplish the most preliminary step in her vocational rehabilitation ï obtaining her high school diploma. That she would somehow develop the capacity to do so, and then successfully compete for and secure regular, gainful employment notwithstanding her age, functional restrictions and physical and psychological limitations, is too speculative for me to accept.

29. I conclude that Claimant has sustained her burden of proving that her November 2013 work injury has rendered her unable to successfully perform regular, gainful work. This circumstance is unlikely to change even with the provision of further vocational rehabilitation services. Claimant is permanently and totally disabled, therefore.

Costs and Attorney Fees

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

ORDER:

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

1. All workersô compensation benefits to which Claimant proves her entitlement as causally related to her August 27, 2016 fall and resulting hip injury;

2. Medical benefits associated with Claimantôs currently prescribed opioid pain medications, in accordance with 21 V.S.A. §640(a);

3. Medical benefits associated with individual psychotherapy for Claimantôs causally related depression, in accordance with 21 V.S.A. §640(a);

4. Permanent total disability benefits commencing on the date when temporary disability benefits ended, August 17, 2015, in accordance with 21 V.S.A. §645, with credit for any permanent partial disability benefits paid thereafter, in accordance with 21 V.S.A. §648(a)[6];

5. Interest on the above amounts as appropriate and as calculated in accordance with 21 V.S.A. §664; and

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

DATED at Montpelier, Vermont this 13th day of February 2018.

_____
Lindsay H. Kurrle
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.

[6] *See Harmon v. Central Vermont Council on Aging*, Opinion No. 01-17WC (February 1, 2017).