STATE OF VERMONT
DEPARTMENT OF LABOR

Jasmina Omerovic

v.

University of Vermont Medical Center

Opinion No. 18-19WC

By: Stephen W. Brown
Administrative Law Judge

For: Michael A. Harrington
Interim Commissioner

State File No. HH-54558

OPINION AND ORDER

Hearing held in Montpelier on March 25 and 26, 2019
Record closed on July 8, 2019

APPEARANCES:

Christopher McVeigh, Esq., for Claimant
Jennifer Moore, Esq. and Jennifer Meagher, Esq. for Defendant

ISSUES PRESENTED:

1. Did Claimant suffer post-traumatic stress disorder (PTSD) or other psychological injury as a result of her accepted October 14, 2015 workplace injury?

2. Are cervical spinal injections reasonable and necessary medical treatment related to Claimant's accepted workplace injury?

3. Is physical therapy reasonable and necessary medical treatment related to Claimant's accepted workplace injury?

EXHIBITS:

Joint Exhibit 1	Transcript of Deposition of Ayla Valjevac-Juhl, R.N. [1]
Joint Exhibit 2	Joint Medical Exhibit ("JME")
Joint Exhibit 3	Transcript of Deposition of Stephen Mann, Ph.D.
Claimant's Exhibit 1	October 14, 2015 Security Services Incident Report
Claimant's Exhibit 2	Claimant's Performance Reviews
Claimant's Exhibit 3	Diagram of McClure 6 layout drawn by Nicole Karadza, R.N.
Claimant's Exhibit 4	October 14, 2015 Employee Report of Event
Defendant's Exhibit 1	Curriculum Vitae of Nancy E. Binter, M.D.
Defendant's Exhibit 2	Curriculum Vitae of Steven B. Mann, Ph.D.
Defendant's Exhibit 3	Curriculum Vitae of Phillip J. Davignon, M.D.

[1] Ms. Valjevac-Juhl's surname appears in several spellings in the record. Some documents and witnesses also refer to her as Ms. Juhl-Valjevac. I use the spelling that she provided in her deposition.

Defendant's Exhibit 4	Curriculum Vitae of Andrea Solomon, P.A.
Defendant's Exhibit 5	October 14, 2015 Employee Report of Event (same as Claimant's Exhibit 4)

FINDINGS OF FACT

1. I take judicial notice of all relevant forms in the Department's file for this claim.

2. Claimant is a forty-year-old woman with a history of psychological conditions related to childhood trauma from the Bosnian War, as well as an extensive history of chronic neck and shoulder pain.

3. On October 14, 2015, she was employed as a licensed nursing assistant ("LNA") at Defendant's hospital in Burlington, Vermont, when an agitated dementia patient physically attacked her, causing physical injuries.

Claimant's Experiences and Baseline Prior to Her October 2015 Workplace Incident

A. Experiences During the Bosnian War of the 1990s

4. Claimant grew up in Zvornik, a small town in Bosnia and Herzegovina.[2] The Bosnian War began when she was approximately eleven years old. Around that time, Serbian militants occupied her town and forcibly relocated her and her family to a middle school in another city. She lived in that middle school with her family for about a year and a half, after which Serbian militants bussed her and her family to yet another city.

5. In approximately 1995, when Claimant was about sixteen years old, she was visiting her sister's home, where she slept on a sofa with her sister-in-law. One night, someone threw a grenade into the room where they were sleeping. The explosion killed Claimant's sister-in-law and seriously injured Claimant. Claimant's injuries from the explosion included a broken arm, shrapnel lodged into her lung, and significant facial lacerations. She woke up in transit to a hospital, where she underwent lung and arm surgery. She still has scarring and shrapnel in her body from the explosion.

6. Claimant never received any psychological treatment in Bosnia.

B. Resettlement, Work History, and Medical History in the United States

7. Claimant left Bosnia in 1999, when she was about twenty years old. Initially she moved to Germany, but later that year settled in Barre, Vermont through a refugee resettlement program. Her medical records from the three-year period following her arrival in Vermont are sparse but reflect chronic neck and shoulder pain. (JME 003-006).

[2] Prior to March 1992, Zvornik was part of Yugoslavia.

8. Between approximately 1999 and 2008, she held various jobs in Northfield, Berlin, and Montpelier, Vermont. She sustained at least two work-related injuries during this time, and her medical records following both injuries reflect persistent shoulder, back, and neck pain. (JME 018, 022, 030, 035, 048, 050, 064, 089-212). They also show that she suffered from depression and that several of her providers were concerned that she may have been suffering from PTSD related to the grenade explosion. (JME 050, 060, 075, 081, 083, 084, 098, 160). However, there is no recorded diagnosis of PTSD from this time period.

9. Notwithstanding her workplace injuries and ongoing psychological difficulties, Claimant completed training to become an LNA during her time in central Vermont and obtained that certification in 2006. She has worked as an LNA since that time.

10. She moved to Burlington in 2008 to work at a nursing home but left that position in 2010 to work as an LNA at Defendant's hospital.

11. Shortly after moving to Burlington, she began treating with the Community Health Center of Burlington ("CHCB"). Her initial primary care provider there was Jennifer Willingham, MD, who treated her for anxiety and depression. In January 2011, Dr. Willingham formally diagnosed her with PTSD related to her Bosnian wartime experiences. (JME 209-211).

12. In July 2015, Dr. Willingham transferred Claimant's primary care to Andrea Solomon, PA, who has been Claimant's primary care provider ever since. Dr. Willingham left Ms. Solomon a memorandum indicating that Claimant had PTSD and summarizing her traumatic experiences in Bosnia. That memorandum also noted that Claimant's "PTSD contributes to a lot of her physical symptoms and she is aware of that." (JME 262).

13. Based on Claimant's medical history, I find that as of the early fall of 2015, her baseline condition was marked by chronic neck pain and psychological conditions including depression, anxiety, and PTSD. However, her psychological conditions at that time were stable and generally well-managed with her then-current medications. (*See* JME 259-267). Additionally, her psychological conditions at that time did not materially interfere with her ability to perform her LNA duties, as evidenced by Defendant's consistent evaluations of her job performance as "Successful" or "Excellent" during this period. (*See* Claimant's Exhibit 2).

The October 2015 Workplace Incident

14. In the early morning of October 14, 2015, Claimant was working on the sixth floor of the McClure building at Defendant's hospital ("McClure 6"). A woman brought her husband with dementia to Defendant's emergency room because of his aggressive behavior. Emergency room staff advised the staff on McClure 6 that the patient would likely be admitted to that floor and that he was highly aggressive.

15. When the dementia patient arrived on McClure 6, he was admitted to a room where Claimant provided LNA care. Defendant also assigned him a one-on-one "sitter" in accord with its practices for particularly difficult or aggressive patients. At approximately 6:00 a.m., the patient soiled himself, and Claimant attempted to clean him and change his clothes.

16. What happened next is disputed. Based on Claimant's testimony, her contemporaneous written report of the incident (Claimant's Exhibit 4 and Defendant's Exhibit 5), Defendant's Security Services Incident Report (Claimant's Exhibit 1), Claimant's medical records from shortly after the event (JME 268-271), and the testimonies of Charge Nurse Nicole Karadza, R.N. and Nurse Ayla Valjevac-Juhl, R.N., I find that the following occurred:

17. The patient reacted aggressively to Claimant's efforts to change his clothes by swinging his arms violently at her. Claimant screamed for help, and Mses. Karadza and Valjevac-Juhl came to assist her. Ms. Karadza called a "Code 8," a security protocol for physically aggressive patients that alerts security and other personnel to assist. Ms. Valjevac-Juhl left the room to obtain an injectable sedative.

18. While Ms. Valjevac-Juhl was out of the room, the patient advanced aggressively toward Ms. Karadza, who Claimant knew to be pregnant at the time. Claimant positioned herself to protect Ms. Karadza. The patient then grabbed Claimant by her neck and shoulder with considerable force, resulting in physical injuries. In that moment, Claimant feared for her life.

19. Eventually, security professionals arrived and restrained the patient. He struggled with them, but they eventually pinned him down long enough for Ms. Valjevac-Juhl to administer the sedative injection that she had left the room to retrieve.

20. Ms. Valjevac-Juhl credibly described the dementia patient as small in stature but surprisingly strong. Ms. Karadza credibly described him as one of the most aggressive patients she had ever encountered. Defendant accepted Claimant's neck and shoulder injuries from the attack as compensable.

Medical Treatment and Employment History After the October 2015 Workplace Incident

21. Shortly after the incident, Claimant went home, where her pain increased throughout the day. Her daughter later drove her to Defendant's emergency room, where she received treatment for neck injuries. (JME 268-275). Two days later, a nurse practitioner diagnosed her with a right trapezius strain and took her out of work, noting her "extreme and worsening condition." (JME 278).

22. Approximately six weeks after the attack, Claimant presented to Ms. Solomon with increased anxiety and depression, leading Ms. Solomon to increase her antidepressant dosage. (JME 315-316).

A. Return to Work in 2017

23. In early 2017, Claimant was released to work at her own request but with physical limitations. She initially returned to work as a unit secretary on McClure 6, where she performed sedentary functions at a station where she would not regularly be within a direct line of sight with the room where she was attacked. (*See generally* Claimant's Exhibit 3).

24. She initially tolerated this secretarial position well, but continued to experience depressed mood, anxious thoughts, fatigue, difficulty sleeping, and headaches. (JME 359-363). Nonetheless, by February 2016, she expressed an interest in returning to her full LNA duties. (JME 342).

1. Improvement of Musculoskeletal Conditions, But with Ongoing Pain

25. John Peterson, DO, one of Claimant's treating physicians, released her back to her full duties in March 2016 after finding that her cervical strain had "essentially resolved." (JME 366). He noted that her posture and gait were normal and that she could safely lift fifty pounds as required for her LNA duties. (*Id.*). Claimant told Dr. Peterson the following week that she was glad to be back to her regular duty because her secretarial work was not nearly as satisfying as patient care. (JME 367).

26. Later, however, Claimant began experiencing unexplained worsening of her neck and shoulder pain. She told Dr. Peterson in April 2016 that things were "not good" and that she was experiencing significant pain particularly when dealing with heavy or uncooperative patients. Dr. Peterson noted, however, that Claimant could rise easily from her chair and walk with a normal gait. He found her cervical range of motion somewhat decreased but symmetrical. He referred her for pain management injections and recommended that her working time be split between LNA duties and secretarial work. (JME 375-376).

27. On Dr. Peterson's recommendation, Claimant saw Dr. Michael Borrello of Vermont Interventional Spine in May 2016. He diagnosed her with degenerative spinal changes typical for someone of her age. In August and October of that year, he administered two kinds of epidural steroid injections into her cervical spine. Neither injection resulted in any significant pain relief, so he referred her for a neurosurgical consultation. (JME 394-397, 409-410, 416-419).

28. Ryan Jewell, M.D. performed a neurosurgical evaluation in August 2017, and found no structural problem for which surgery would be appropriate. Accordingly, he referred Claimant to physical therapy with a postural restoration specialist, which Claimant began in September 2017. (JME 522, 533-536, 566, 574).

29. In November 2017, occupational medicine physician Phillip Davignon, M.D. concluded that Claimant was at end medical result and that ongoing physical therapy was no longer medically necessary. (JME 572). Defendant sought to discontinue payment for physical therapy that month based on Dr. Davignon's opinion, and the

Commissioner approved that request on December 1, 2017. However, Claimant continued to undergo physical therapy after that time. (*E.g.*, JME 588-589, 677-678).

2. Psychological Difficulties Following Return to Work

30. Meanwhile, Claimant continued to experience significant psychological difficulties after her return to work, including panic attacks, nightmares, and flashbacks. She had trouble putting on her uniform in the morning knowing she had to go to work, and she often thought of the patient attacking her. She saw Ms. Solomon with complaints of fatigue, difficulty concentrating, headaches, and sleepiness in October 2016, and saw her again in February 2017 with complaints of anxious thoughts triggered by traumatic memories. (JME 411-415, 462-467).

31. In June 2017, she presented to Ms. Solomon with complaints of chest pain so severe that she thought she might have a heart condition. Ms. Solomon noted that her recent stress test and electrocardiograms had been normal and told Claimant that she had most likely experienced a panic attack related to her PTSD. She prescribed additional medications and referred her to weekly counseling sessions. (JME 502-507).

32. In September 2017, Claimant underwent a psychological evaluation at CHCB with psychiatric nurse practitioner Sarah Morse, who noted among other things that Claimant's past depression was always manageable until she was attacked in October 2015 but that she "[l]ikely developed PTSD from this experience in 2015/or [*sic*] possibly exacerbated PTSD from her experience during war in Bosnia (?)." [*sic*]. (JME 537-539).

33. The following month, Claimant began attending psychotherapy sessions for her PTSD with licensed clinical social worker Crystal Fisher (*e.g.*, JME 685, 692), but continued to manage her psychiatric medications with Ms. Morse (*e.g.*, JME 592, 705-708).

34. Claimant's work performance declined during this period as well, as evidenced by her performance evaluation for the year ending in September 2017, in which Defendant rated her performance for the first time as "Meeting Many Expectations," the level below "Successful." (*See* Claimant's Exhibit 2).

B. Cervical Spinal Injections and Radiofrequency Ablation in 2018

35. In January 2018, Defendant preauthorized one consultation with Dr. Borrello without prejudice to determine the appropriate treatment for Claimant's neck pain. It then filed a denial of benefits for proposed cervical injections in March 2018, relying on a medical records review prepared by neurosurgeon Nancy Binter, M.D.

36. Notwithstanding that denial, Claimant presented to Dr. Borrello in April 2018 for a new series of injections to treat her neck and upper extremity pain. Based on Claimant's prior non-response to epidural injections and her description of her pain pattern, he suspected the source of Claimant's pain may have been her spinal facet joint.

37. He administered two facet steroid injections into her cervical spine in April and May of 2018, and these treatments provided some modest pain relief. However, Claimant continued to experience right-sided neck pain with radiation into her trapezius and tingling in her right arm. (*See* JME 734-736, 781, 793-795, 811).

38. Based on her limited response to these facet injections, Dr. Borrello administered two medial branch block injections in June and August 2018 as a diagnostic measure to evaluate the appropriateness of radiofrequency ablation ("RFA"). A positive response to these injections would indicate a reasonable likelihood that Claimant would respond well to RFA; a negative response would indicate that RFA would be unlikely to provide relief.

39. Claimant responded well to the medial branch block injections, and Dr. Borrello administered RFA therapy in September 2018. However, RFA provided such marginal relief that Dr. Borrello considered it inappropriate to continue that treatment. (JME 858-860, 864, 872-873, 915-916, 923-925). He noted in December 2018 that Claimant was unlikely to benefit from further interventional treatment. (JME 924).

C. Claimant's Declining Psychological Condition, Suicidality, and Psychological Evaluations at CHCB

40. Through this same period, Claimant's psychological conditions continued to seriously deteriorate. By April 2018, she was expressing thoughts of death and suicide. (JME 781-786).

41. In June 2018, she underwent a behavioral health evaluation with Paul Brewer, a licensed clinical social worker at CHCB (JME 816-825). He noted Claimant's relevant "trauma history" as including both the 1995 grenade explosion and her October 2015 workplace incident. He also indicated that Claimant was experiencing suicidal ideation and had a past suicide plan that she had never acted on. (JME 820) ("Plan/attempt description: 'I can't recall the date exactly but I never did anything.'").

42. Mr. Brewer noted as one of Claimant's "imminent" stressors that her employer had informed her that if she did not return to her job full time, she risked losing it. (JME 821). He confirmed Claimant's diagnosis of PTSD based on the applicable diagnostic criteria and began a treatment regimen involving eye movement desensitization and reprocessing ("EMDR"). (JME 817, 822). Claimant found that treatment difficult to tolerate as it forced her to repeatedly confront her memories of the October 2015 attack. (*E.g.*, JME 893).

43. During subsequent sessions with Mr. Brewer, Claimant expressed self-blame for the October 2015 attack and reported fear of saying things that might upset her coworkers because of her experience being assaulted. (JME 902-903, 932).

44. In July 2018, Claimant also expressed thoughts of death and suicide to Ms. Solomon, who noted that while Claimant had PTSD before October 2015, "it was the assault at

the hospital that was triggering and causing her not be able to work full time." (JME 838-843).

45. Later that same month, Ms. Morse noted that Claimant was continuing to experience nightmares, flashbacks, and panic attacks related to her workplace trauma, but that her PTSD symptoms were more manageable after a recent break from work. She stated that "[i]n my opinion pt did develop PTSD from the work related incident and that is why she has been struggling since then w/ panic, fb's nightmares. [*sic*] This is also why when she returns to work she is more triggered, etc. and when she is able to take time away from work the symptoms have some are [*sic*] dampened down." (JME 846).

46. Later in January 2019, Claimant presented to Adam Greenlee, M.D. of CHCB for a psychiatric evaluation. (JME 941-946). He noted that her symptoms following her October 2015 workplace incident included hypervigilance, fear avoidance, flashbacks, and nightmares. He also noted that she had become much less social than prior to the incident, and that her relationships with family members had become more distanced. He described her as having a "passive Death Wish[.]" (JME 942).

47. In Dr. Greenlee's opinion, Claimant's PTSD resulted solely from her 2015 workplace incident. While he acknowledged that her "past trauma in Bosnia may have primed her for a pathological response to the work place trauma," he believed that she "clearly did not have PTSD prior to this incident." (JME 945). He increased her antidepressant dosage and indicated that it was "ok for PCP to co-manage pt's medications at this time." (*Id.*).

Expert Opinion Testimony

A. Ms. Solomon's Opinions Concerning Claimant's Psychological Conditions

48. Claimant presented Ms. Solomon as an expert witness in support of her contention that her October 2015 attack aggravated her preexisting psychological conditions including PTSD.

49. Ms. Solomon is a licensed physician's assistant with a Master of Science in Physician Assistant Studies. She has passed the Physician Assistant National Certifying Exam and holds a license to prescribe controlled medications. Since 2009, she has provided direct patient care at CHCB, where she is authorized to treat patients independently under the general supervision of a medical doctor. She generally only goes to a supervising physician with questions about unusual situations.

50. Ms. Solomon has experience treating patients with psychological disorders including depression, anxiety, and PTSD, and can recognize the hallmarks of such disorders. She is able to diagnose PTSD if she knows a patient has experienced a trauma and demonstrates the hallmark symptoms of that condition, although that condition is more often diagnosed by a professional from CHCB's behavioral health department.

51. Ms. Solomon was not directly involved in diagnosing Claimant with PTSD, as Dr. Willingham had rendered that diagnosis several years before Ms. Solomon ever saw Claimant. However, Ms. Solomon has treated Claimant's PTSD and other psychological conditions continuously for approximately four years, and thus has had ample opportunity to hear her complaints and observe her symptoms. I find Ms. Solomon competent to testify as to both the fact of and reasons for Claimant's worsening psychological symptoms from July 2015 through the present.

52. Ms. Solomon credibly testified that it is possible for psychological conditions like PTSD to be stable and well-managed but subsequently become destabilized after a patient is retraumatized by a subsequent event. In her opinion, that is what happened with Claimant after the October 2015 workplace incident. Before the attack, Claimant's psychological conditions were stable and well-managed on medications. After the attack, these conditions significantly worsened and interfered with her ability to function.

53. She acknowledged that Claimant's mood appeared stable during some of her interactions with Claimant after the attack, and that occasionally her condition improved. However, she credibly explained that it is common for a patient's mental health symptoms to wax and wane, and this does not mean that the patient is not suffering psychologically.

54. She also acknowledged that some of Claimant's psychological concerns related to her experiences in Bosnia. She credibly explained that it is possible for multiple triggers to give rise to the need for therapy, and that Claimant's October 2015 workplace incident "absolutely contributed" to her present need for psychotherapy.

55. Ms. Solomon demonstrated familiarity with CHCB's extensive treatment records for Claimant, which comprise the vast majority of her psychological treatment records. While she had not reviewed Claimant's medical records from certain other providers such as Concentra, and had not reviewed Claimant's independent medical examinations, I do not find that this materially hampered her testimony.

56. I find Ms. Solomon's testimony credible, persuasive, and well-supported by the weight of Claimant's other psychological treatment records.

B. Dr. Stephen Mann's Opinions Concerning Claimant's Psychological Conditions

57. Defendant presented Stephen Mann, Ph.D. as an expert witness in support of its contentions that Claimant does not have PTSD and that the October 2015 attack did not exacerbate any of her preexisting psychological conditions.

58. Dr. Mann is a psychologist licensed to practice in Vermont. Defendant hired him to perform an Independent Behavioral Medicine and Pain Experience Evaluation on Claimant. His evaluation included both an interview and psychometric testing and was completed over two days in early 2018. (JME 611-676). He also conducted an extensive review of Claimant's medical records. (JME 620-635).

59. Dr. Mann concluded that Claimant could not have PTSD because her October 2015 workplace incident did not constitute exposure to actual or threatened death, serious injury or sexual violence, as required by Criterion A of the DSM-V.[3]

60. Dr. Mann generally disbelieved Claimant's account of the October 2015 attack, noting that her description was "dramatic." I find this unpersuasive; all credible evidence indicates that the event was, in fact, dramatic.

61. He did not believe that Claimant could have feared for her life because the man who attacked her was old and small. While he was aware of witness reports from nurses Karadza and Valjevac-Juhl, he was not aware of their descriptions of the attacker as surprisingly strong and unusually aggressive. I do not find that Dr. Mann was in a position to reliably discredit Claimant's assertion that she feared for her life.

62. Dr. Mann also argued that the October 2015 workplace incident could not satisfy Criterion A because being attacked by an agitated dementia patient is simply "a common and unfortunate reality" of working in Claimant's profession. (JME 668). I find this reasoning particularly troubling. While it may be true that LNAs endure physical assaults more often than the general population, it does not follow that such assaults cannot constitute an exposure to actual or threatened death or serious injury.

63. While Dr. Mann believed that Claimant's 1995 wartime injuries would satisfy Criterion A of a PTSD diagnosis, he said that Claimant denied any relationship between those events and her current psychological symptoms. From that, he concluded that Claimant could not have PTSD. I find this reasoning overly simplistic and unpersuasive.

64. Dr. Mann also disbelieved Claimant because of her scores on psychometric testing. He claimed that her test scores indicated that she was likely to be exaggerating, and that she was, among other things, "manipulative," "needy," and using her symptoms to obtain preferential treatment at work. (JME 640). While the names of those psychometric tests and some interpretive notes from the tests' publishers are in his report, there is insufficient evidence of the scientific basis justifying the specific inferences Dr. Mann has made about Claimant's motivations and truthfulness from

[3] "Criterion A" for a PTSD diagnosis in adults is in material part as follows:

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
    1. Directly experiencing the traumatic event(s).
    2. Witnessing, in person, the event(s) as it occurred to others.
    3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
    4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (*e.g.*, first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

See American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th ed., Arlington, VA, 2013 ("DSM-V").

Claimant's test results. While psychometric tests may certainly play an important role in a rigorous analysis, Dr. Mann has not persuasively provided a path for me to draw the same inferences as he has drawn in this case.

65. Dr. Mann also questioned Claimant's credibility based on some of her past medical providers' reports of nonorganic findings and lack of structural explanations for her subjective pain reports. However, he did not convincingly explain why that undermines her assertion that she has suffered a psychological injury. Indeed, Claimant's prior primary care provider, Dr. Willingham, noted in July 2015 that some of Claimant's then-current physical symptoms were related to her PTSD. *See* Finding of Fact 12, *supra*. I do not find that Dr. Mann adequately accounted for the possibility that Claimant's psychological conditions may have contributed to her otherwise unexplained physical complaints.

66. Finally, Dr. Mann stated that nothing in Claimant's medical records reflected a worsening of her preexisting psychological conditions after her October 2015 workplace incident. I find this assertion generally unsupported by Claimant's psychological treatment records. *Cf.* Findings of Fact Nos. 8, 11-13, 24, 30-34, 40-47.

C. Dr. Borrello's Testimony Concerning Injections

67. Claimant presented Dr. Borrello, a board-certified physician in pain management and anesthesia, as an expert witness in support of her contention that the facet injections he administered in 2018 were medically reasonable and necessary treatment that was causally related to her October 2015 incident.

68. Although the injections ultimately did not provide Claimant with any lasting relief, Dr. Borrello credibly testified that they were medically appropriate and that he followed this course of treatment to its logical conclusion.

69. He also testified that he found it likely that Claimant's 2015 workplace injury injured her facet joint. He based this opinion largely on his factually incorrect belief that Claimant did not have any neck pain prior to that incident. *Cf.* Findings of Fact Nos. 7-8, 13. He had reviewed only a small portion of Claimant's records and was unaware of her extensive pre-2015 history of chronic neck, back, and shoulder pain. I do not find Dr. Borrello's causation analysis persuasive.

D. Dr. Nancy Binter's Opinions Concerning Physical Therapy and Injections

70. Defendant presented Nancy Binter, M.D. as an expert witness. Dr. Binter is a board-certified neurosurgeon whom Defendant hired to perform an independent medical examination and medical records review of Claimant.

71. Based on her review and examination, Dr. Binter testified that Claimant's October 2015 workplace incident most likely caused a soft tissue neck injury that resolved after several months. She testified that while that recovery period is somewhat longer than usual, it was within the normal range.

72. In forming this opinion, Dr. Binter relied not only on her examination of Claimant but also upon Dr. Peterson's medical records. Specifically, Dr. Peterson's records from March 2016 show that Claimant's gait and posture were normal, that she was able to lift fifty pounds, and that she had no spinal or cervical complaints. Dr. Peterson also released Claimant back to full-time, full-duty work at that time; she initially tolerated her return to work well. (JME 366-367). Although Claimant certainly expressed pain complaints after this time, Dr. Binter accurately noted that her treating providers had generally been unable to identify anatomical explanations for her continuing pain. I find Dr. Binter's analysis in this regard credible, persuasive, and well-supported.[4]

73. Dr. Binter testified that there was nothing objectively unreasonable about Dr. Borrello's 2018 course of injections. However, she did not believe that those injections had anything to do with Claimant's 2015 workplace injury because by 2018, she had returned to her baseline condition of chronic neck pain. I find this analysis credible and persuasive.

74. Dr. Binter acknowledged that Claimant's physical therapy may potentially be beneficial for her longstanding chronic pain. However, for the same reasons discussed above, she testified that any need Claimant has for that physical therapy is no longer causally related to her October 2015 workplace incident. I find this analysis credible and persuasive.

75. Dr. Binter also extensively questioned Claimant's credibility. She noted multiple nonorganic findings in her treatment records, apparent inconsistencies in her symptom reporting, and Claimant's lack of effort during her physical examination. I find these concerns relevant and have taken them into account in my factual findings. However, they do not justify disbelieving Claimant's testimony in wholesale fashion.

76. Dr. Binter also remarked that Claimant appeared to lack guilt or remorse that her injury adversely affected her daughter's college plans. I find this oddly moralistic and wholly unpersuasive as evidence of Claimant's credibility.

CONCLUSIONS OF LAW

1. Claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). 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 her injury and her 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

[4] While Claimant was subsequently taken out of work or given restricted work duties several times after March 2016, the weight of the evidence suggests that the primary impediment to Claimant's full return to work was her worsening psychological condition rather than any physiological problem. Additionally, while there is no reason to doubt the genuineness of Claimant's pain complaints, the evidence causally tying her ongoing pain to her October 2015 workplace incident is at best tenuous, particularly given her long prior history of chronic pain in the same parts of her body.

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).

Claimant's 2015 Incident Aggravated Her Preexisting Psychological Condition

2. Claimant alleges that the dementia patient's attack in October 2015 aggravated her preexisting anxiety, depression, and PTSD. To prevail on this claim, she must show that her work-related physical injury aggravated or accelerated her preexisting psychological conditions. *Lydy v. Trustaff, Inc.*, Opinion No. 05-12WC (February 8, 2012) (holding that nurse's depression and anxiety following a patient's physical attack were compensable where they triggered long-repressed emotions stemming from a sexual assault she had suffered as a teenager), *aff'd on other grounds*, 194 Vt. 165 (2013); *Marsigli's Estate v. Granite City Auto Sales, Inc.*, 124 Vt. 95, 103–04 (1964).

3. The parties presented conflicting expert testimony from Ms. Solomon and Dr. Mann about whether the October 2015 attack aggravated Claimant's pre-existing psychological conditions. The Commissioner traditionally considers five factors in assessing competing experts' comparative persuasiveness: (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).

4. The first and fourth *Geiger* factors favor Ms. Solomon, due to her continuous and frequent provision of primary care to Claimant over four years, compared to Dr. Mann's two days of interaction with her. *Cf.* Findings of Fact Nos. 12, 22, 30-31, 44, 51-56, 58, *supra*. The second and fifth factors favor Dr. Mann, given his more comprehensive records review and superior professional credentials. *See* Findings of Fact Nos. 55, 58, *supra*.

5. The third factor, which I find to be the most important in this case, strongly favors Ms. Solomon. Her opinion that Claimant's pre-existing psychological conditions were stable and well-managed before the October 2015 attack but became more severe afterward is clear, credible, and corroborated by the overwhelming weight of Claimant's psychological treatment records from Ms. Morse, Ms. Fisher, Mr. Brewer, and Dr. Greenlee.[5] *See* Findings of Fact Nos. 40-47, *supra.* There is no persuasive

[5] While Dr. Greenlee opined that Claimant did not have PTSD before the October 2015 workplace incident, he did not testify at the hearing and therefore was not able to explain his rationale for that opinion. His opinion in this regard is an outlier in Claimant's medical records and is insufficient standing alone to overcome the voluminous and compelling evidence of Claimant's pre-2015 diagnoses of anxiety, depression, and PTSD. Nevertheless, I find that his opinion broadly corroborates Ms. Solomon's conclusion that the incident made Claimant's psychological condition worse than it was before.

evidence that this worsening resulted from anything other than the October 2015 attack.

6. By contrast, Dr. Mann's opinion that the October 2015 attack could not satisfy Criterion A of the PTSD diagnostic criteria because it did not expose Claimant to actual or threatened death or serious injury is entirely unpersuasive. At the very least, the evidence is clear that the attack exposed Claimant to a *threatened* serious injury, which is sufficient to satisfy Criterion A of the DSM-V upon which he relied. *See* Findings of Fact Nos. 14-20, 59. Indeed, Claimant's physical injuries were severe enough for her treating provider to take her out of work almost immediately after the attack because of her "severe and worsening condition." *See* Finding of Fact No. 21, *supra.*

7. Moreover, Dr. Mann's assertion that Claimant's preexisting psychological conditions did not worsen after the October 2015 incident is broadly inconsistent with Claimant's medical records. Taken at face value, her records lead to exactly the opposite conclusion. *See* Findings of Fact Nos. 13, 22, 24, 30-34, 40-47.

8. It is a rare case where a physician's assistant's opinion is credited over a doctoral-level professional testifying within his field. This is such a case. Dr. Mann's analysis is deeply problematic for a host of reasons, and I therefore accord his opinions little weight in this case. Ms. Solomon was competent to render the opinions she expressed. She expressed them credibly and persuasively, and her opinions have convincing corroboration from multiple other providers' records.

9. Claimant has satisfied her burden to establish that her preexisting depression, anxiety, and PTSD were aggravated by the October 14, 2015 attack. As such, these conditions are compensable. *See Lydy*, *supra*, Opinion No. 05-12WC; *Marsigli's Estate*, *supra*, 124 Vt. at 103–04.

Defendant is Not Liable for Claimant's Cervical Spinal Injections or Physical Therapy

10. The Workers' Compensation Act requires an employer to provide injured workers with all "reasonable" medical treatment for compensable conditions. *See* 21 V.S.A. § 640(a). A treatment is reasonable when it is "both medically necessary and offered for a condition that is causally related to the compensable work injury." Workers' Compensation Rule 2.3800. Thus, a treatment may be unreasonable "either because it is not medically necessary or because it is not causally related to the compensable injury." *Lahaye v. Kathy's Caregivers*, Opinion No. 05-18WC (March 26, 2018).

11. Where the employer has previously accepted responsibility for a treatment, it has the burden to show that it is no longer reasonable under that definition. *J.D. v. Employer R.*, Opinion No. 22-07WC (August 2, 2007) (citing *Merrill v. University of Vermont*, 133 Vt. 101 (1974)). Otherwise, the claimant retains the burden of proving that a proposed medical treatment is reasonable. *See Heller v. Bast & Rood Architects*, Opinion No. 32-10WC (October 5, 2010).

A. *Cervical Spinal Injections*

12. Defendant did not accept liability for Claimant's series of spinal injections in 2018. *See* Finding of Fact Nos. 35-36, *supra*. As such, Claimant bears the burden to prove that treatment's reasonableness under Section 640(a). *See Heller*, *supra*, Opinion No. 32-10WC. In establishing reasonableness under that Section, Claimant must specifically prove the causal relationship between the disputed injections and her work-related injury. *See* Workers' Compensation Rule 2.3800. The parties presented conflicting expert testimony on that issue from Dr. Borrello and Dr. Binter.

13. Dr. Borrello credibly testified that the injections he administered were appropriate treatment for Claimant's pain complaints; Dr. Binter did not contradict him on that point. *See* Findings of Fact Nos. 68-69, 73, *supra*. However, Dr. Borrello failed to establish any causal link between her pain in 2018 and the October 2015 attack. This failure of proof largely stems from his lack of knowledge of Claimant's extensive and well-documented history of chronic pain before 2015, placing him in a poor position to assess the extent to which her pain in 2018 related to preexisting problems as opposed to the dementia patient's assault. *See* Finding of Fact No. 69, *supra*.

14. By contrast, Dr. Binter's opinion that by March 2016 Claimant's musculoskeletal injuries had resolved and returned to their previous baseline condition of chronic pain is credible and well-supported for the reasons explained *supra* at Findings of Fact Nos. 70-76. Her opinion in this regard undermines the asserted causal relationship between Claimant's workplace injury and her ongoing pain complaints that led to Dr. Borrello's 2018 injections.

15. Because Dr. Borrello has failed to establish the necessary causal link between Claimant's 2015 workplace incident and the injections he administered, I find it unnecessary to weigh his testimony and Dr. Binter's under each of the *Geiger* factors discussed above. Claimant has not sustained her burden to prove the necessary element of causation relating to the disputed injections. Defendant is therefore not responsible for this treatment.

B. *Physical Therapy*

16. Defendant initially accepted physical therapy as a compensable treatment for Claimant's workplace injuries until November 2017, when it sought to discontinue liability for that treatment. *See* Findings of Fact Nos. 28-29. It therefore has the burden to demonstrate that this treatment is no longer reasonable treatment for Claimant's accepted injury. *See J.D.*, *supra*, Opinion No. 22-07WC.

17. Defendant offered Dr. Binter as an expert witness in support of its contention that Claimant's physical therapy is no longer causally related to her 2015 workplace injury. As with the injection therapy discussed above, she credibly acknowledged that physical therapy may well be beneficial treatment for Claimant's longstanding chronic pain issues. However, in her opinion, all of Claimant's musculoskeletal injuries stemming from the October 2015 workplace incident most likely resolved by March

2016, which would be within the outer bounds of a normal recovery time for the kinds of soft tissue injuries she sustained. After that time, in Dr. Binter's opinion, Claimant returned to her previous baseline marked by longstanding chronic neck and shoulder pain. As such, Dr. Binter finds no basis to causally link Claimant's October 2015 workplace incident with any current need for physical therapy. Her analysis in this regard is credible, well-supported, and within her scope of expertise. *See* Findings of Fact Nos. 70-76.

18. Claimant put forth no expert witness in support of her claim for physical therapy. Nor did she cite any other persuasive evidence to contradict Dr. Binter's analysis in this regard. Therefore, it is unnecessary to consider the *Geiger* factors on this issue.[6]

19. Defendant has satisfied its burden to prove that physical therapy is no longer reasonable medical treatment for Claimant's October 2015 workplace incident because it is not causally related. *See* Workers' Compensation Rule 2.3800. It is not liable for any ongoing physical therapy.

ORDER:

For the reasons set forth above, Defendant must pay all medical and indemnity benefits related to Claimant's psychological conditions including anxiety, depression, and PTSD. However, it need not pay for the disputed physical therapy or cervical spinal injections.

Claimant may recover reasonable attorneys' fees and costs in an amount to be proved, commensurate with her level of success.

DATED at Montpelier, Vermont this 15 day of October 2019.

_____
Michael A. Harrington
Interim 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] To the extent that Dr. Borrello's testimony concerning causation is relevant to any issue concerning the causal relationship between Claimant's October 2015 workplace incident and her presently-asserted need for physical therapy, his causation analysis is unpersuasive for the same reasons discussed above. *See* Conclusions of Law Nos. 13-15, *supra*.