Jeffrey Marshall v. State of Vermont, Vermont State Hospital (January 25, 2011)

STATE OF VERMONT
DEPARTMENT OF LABOR

Jeffrey Marshall	Opinion No. 01-11WC
v.	By: Phyllis Phillips, Esq. Hearing Officer
State of Vermont, Vermont State Hospital	For: Anne M. Noonan Commissioner
	State File No. S-22038

OPINION AND ORDER

Hearing held in Montpelier, Vermont on October 6, 2010
Record closed on November 12, 2010

APPEARANCES:

Patricia Turley, Esq., for Claimant
William Blake, Esq., for Defendant

ISSUES PRESENTED:

1. Is Claimant entitled to additional permanent partial disability and/or medical benefits referable to his June 2002 compensable work injury?

2. Did Defendant fail to give Claimant proper notice of its denial of various medical bills, and if yes, is Defendant thereby obligated to pay?

3. Is Defendant entitled to apportionment of any permanent partial impairment on account of Claimant's 1989 and/or 1997 injuries?

4. Is Claimant barred by the statute of limitations from seeking additional permanent partial disability benefits referable to his 2002 injury?

EXHIBITS:

Joint Exhibit I: Medical records

Claimant's Exhibit 1: Letter from Tim Vincent, August 7, 2003
Claimant's Exhibit 2: Vocational Rehabilitation Progress Report, March 31, 2004
Claimant's Exhibit 3: Letter from Susan Drapp, RN, March 28, 2005
Claimant's Exhibit 4: Letter from Bruce Chenail (with attachments), August 1, 2005
Claimant's Exhibit 5: Letter to Department (with attachments), September 6, 2005
Claimant's Exhibit 6: *Curriculum vitae*, Sikhar Banerjee, M.D.

Defendant's Exhibit A: Form 22 approved February 3, 2004
Defendant's Exhibit B: Form 22 approved December 28, 1993
Defendant's Exhibit C: Deposition of Dr. William Boucher, September 29, 2010

CLAIM:

Medical benefits pursuant to 21 V.S.A. §640
Permanent partial disability benefits pursuant to 21 V.S.A. §648
Interest, costs and attorney fees pursuant to 21 V.S.A. §§664 and 678

FINDINGS OF FACT:

1. At all times relevant to these proceedings, Claimant was an employee and Defendant was his employer as those terms are defined in Vermont's Workers' Compensation Act.

2. Judicial notice is taken of all relevant forms and correspondence contained in the Department's file relating to this claim. Judicial notice also is taken of relevant portions of the *AMA Guides to the Evaluation of Permanent Impairment (5th ed.)* (hereinafter the "*AMA Guides*").

3. Claimant was employed by Defendant as a ward aide. On June 6, 2002 he was assisting a co-employee to restrain a self-abusive patient. At one point the patient lifted both legs off the floor, requiring Claimant and the co-employee to support his entire weight. Claimant felt the immediate onset of low back pain, with sciatic pain radiating down both legs.

Claimant's Prior Low Back Injuries

4. At the time of this injury Claimant already had suffered three previous work-related low back injuries. The first one occurred in 1987. While working for a prior employer, Claimant experienced low back pain and radicular symptoms down his left leg as a result of a forklift accident. He was diagnosed with a significant left-sided L5-S1 disc herniation, for which he underwent surgery in 1989. The surgery went well, and aside from some minor residual numbness in his left foot Claimant's symptoms completely resolved. He resumed his regular activities without restriction, both at work and recreationally. The latter included hunting, fishing, working on his land and other outdoor pursuits.

5. Claimant was not rated for his permanent impairment following the 1987 injury and subsequent surgery. He did not seek, and was not paid, any permanent partial disability benefits as a result.

6. The second injury occurred in 1992, when Claimant lifted a heavy patient while at work for Defendant. He experienced the same symptoms he had suffered as a result of the 1987 injury – low back pain and radicular symptoms down his left leg – and was diagnosed with a recurrent disc herniation at L5-S1, the same disc that had ruptured previously. Again Claimant underwent disc surgery, and again his symptoms almost completely resolved, allowing him to resume both recreational and work activities without restriction.

7. Having reached an end medical result for his 1992 injury, in November 1993 Claimant's treating surgeon rated him with a 10% permanent impairment of the spine. Defendant accepted this rating and paid permanent partial disability benefits accordingly. In doing so it made no attempt to determine whether some portion of Claimant's permanent impairment should have been allocated back to his 1987 injury.

8. Claimant injured his back for the third time in June 1997, again while working with a patient in the course of his employment for Defendant. As before, his symptoms included low back pain and radicular symptoms down his left leg. Once again, Claimant was diagnosed with a recurrent disc herniation at L5-S1, for which he underwent surgery and then successfully recovered.

9. Claimant was not rated for his permanent impairment after the 1997 injury, and was not paid any permanent partial disability benefits referable to it.

Claimant's Medical Course Following the June 2002 Low Back Injury

10. Claimant's symptoms following the June 2002 injury were different from those he had experienced after any of his three previous injuries. Whereas the predominant symptoms after his prior injuries were radicular pain, numbness and tingling down his left lower extremity, this time Claimant's low back pain was predominant, and his radicular symptoms were both left- and right-sided.

11. Claimant treated with Dr. Cyr, a chiropractor, following his 2002 injury. Diagnostic x-rays taken shortly after the event showed mild degenerative changes at L4, L5 and S1. A July 2002 MRI study revealed a small recurrent left-sided disc herniation at L5-S1, but did not note abnormalities at any other level. Specifically, the study did not mention any findings whatsoever at the L4-5 level.

12. Claimant opted not to treat surgically for his 2002 injury. Dr. Tranmer, a spine surgeon with whom he consulted in August 2002, remarked that as he was managing "reasonably well" with exercises and chiropractic care, surgery to remove the recurrent disc herniation likely was not necessary. Dr. Krag, the surgeon who had treated Claimant following his 1997 injury, concurred with this assessment. In his opinion, it was unlikely that Claimant's symptoms were associated with the July 2002 MRI findings. It was more likely that the June 2002 incident caused a muscle strain or ligament injury, and that Claimant's current symptoms were attributable to resulting back spasms, perhaps also with a component of disc degeneration. Rather than surgery, therefore, as treatment Dr. Krag recommended physical therapy and home exercises aimed at strengthening Claimant's back.

13. Given Claimant's extensive history of low back injuries and surgeries, Dr. Tranmer, Dr. Krag and Dr. Cyr all recommended as well that Claimant not return to his prior job and that instead he seek less physically demanding work. The results of a January 2003 functional capacities evaluation indicated likewise.

14. Claimant treated regularly with Dr. Cyr throughout the fall and winter of 2002, and also underwent a course of physical therapy. On February 24, 2003 Dr. Cyr determined that Claimant had reached the point of maximum medical improvement, or end medical result. As discussed further *infra*, using the fifth edition of the *AMA Guides* Dr. Cyr rated Claimant with an 8% whole person impairment referable to the spine.

15. Unlike his course following his previous injuries, after reaching an end medical result for his 2002 injury Claimant still experienced lingering low back pain and radiculopathy. Having been advised not to return to his prior job, he was frustrated in his efforts to find suitable alternative work. He also was frustrated by his inability to resume the recreational activities he had enjoyed in the past.

16. Claimant voiced his frustration to Dr. Curchin, his primary care physician, at various times in 2004. At Dr. Curchin's referral, he underwent an MRI study in November 2004 and then consulted with Dr. Grzyb, a spine specialist, in March 2005. The MRI revealed chronic changes at L5-S1, the site of Claimant's previous disc injuries and surgeries. It also showed a disc protrusion at L4-5, possibly affecting the right L5 nerve root. This was a new finding, one that had not been evident at the time of Claimant's July 2002 MRI. Notably, the possibility of right L5 nerve root irritation is consistent with Claimant's right-sided radicular symptoms.

17. At Dr. Grzyb's referral, in April 2005 Claimant underwent an evaluation with Dr. Borrello, a pain management specialist. Dr. Borrello suggested injection therapy, but Claimant was not interested, such treatments having proved ineffective in conjunction with one of his prior low back injuries. Instead he opted for medication as his primary pain management tool.

18. Claimant continues to use prescribed medications for pain relief. Other than that, the medical records do not reflect that he has treated actively for his ongoing symptoms since 2005. His pain significantly limits his activities, and has continued to worsen in the years since Dr. Cyr declared him at end medical result. Claimant still has not returned to work.

The February 2004 Permanency Agreement

19. As noted above, Finding of Fact No. 14 *supra*, after determining that Claimant had reached an end medical result for his June 2002 injury, in February 2003 his treating physician, Dr. Cyr, rated him with an 8% whole person impairment referable to the spine. Both Claimant and Defendant accepted this permanency rating and entered into an Agreement for Permanent Partial Disability Compensation (Form 22) in accordance with it. As part of the agreement, the parties acknowledged that Claimant previously had been compensated for a 10% impairment of the spine in conjunction with his 1992 injury, *see* Finding of Fact No. 7 *supra*. That impairment having been calculated according to an earlier version of the *AMA Guides*, it was converted under the current version to a 6% whole person impairment. As mandated by statute, 21 V.S.A. §648(d), the parties then agreed to subtract that amount from the 8% that Dr. Cyr had rated, leaving 2% still owed as attributable to the June 2002 injury.

20. The Department approved the parties' Form 22, and thus awarded Claimant permanency benefits equating to a 2% whole person impairment on February 3, 2004. Defendant timely paid these benefits.

21. At no time during the process of rating or paying the permanency due Claimant on account of his 2002 injury did Defendant raise the issue whether it was entitled to further apportionment of Dr. Cyr's 8% rating on account of any permanency that might have been attributable to Claimant's 1987 and/or 1997 injuries. Nor did Claimant investigate whether in fact he might have been owed additional permanency as a consequence of those injuries.

Defendant's Denial of Payment for Drs. Grzyb and Borrello Evaluations

22. As noted above, Findings of Fact Nos. 16 and 17 *supra*, in March and April 2005 Claimant underwent evaluations with Dr. Grzyb, a spine specialist, and Dr. Borrello, a pain management specialist. The reason for these evaluations was to determine what, if any, additional treatments might prove effective at managing Claimant's back pain and associated symptoms. Defendant denied payment of both bills on the grounds that the evaluations were not causally related to the June 2002 injury, but rather were for the purpose of supporting Claimant's application for social security disability benefits. I find that although this issue may have been discussed, it was not the primary purpose of either doctor's evaluation.

23. Defendant's denials, which were dated in August and September 2005 respectively, were issued well outside the 30-day time limit for either accepting or denying workers' compensation-related medical bills under Workers' Compensation Rule 40.021(C). In addition, Defendant mistakenly addressed both denials. As a result, Claimant did not receive either of them and therefore was not seasonably apprised of Defendant's action. I find that Defendant had Claimant's correct mailing address in its possession, and particularly when one of the denials was returned stamped "unable to forward," it should have realized its mistake and acted to correct it. By its failure to do so, I find that Claimant was prejudiced in his ability to appeal Defendant's determination.

24. It is unclear from the record whether these bills were paid by other insurance, whether Claimant himself paid them, or whether they remain unpaid to date.

Expert Opinions as to Claimant's Permanent Impairment

25. Claimant has undergone three evaluations directed at assessing the extent of his permanent impairment following the June 2002 injury. As noted above, Finding of Fact No. 14 *supra*, Dr. Cyr rated Claimant's permanent impairment in February 2003, after determining that he had reached an end medical result for the 2002 injury. At his attorney's referral in July 2008, and as revised in August 2010, Dr. Banerjee rendered a second impairment rating. Last, at Defendant's referral Dr. Boucher issued a third permanency rating in March 2010. In deriving their ratings, each doctor reviewed Claimant's medical history, conducted his own evaluation and applied his findings in accordance with his particular interpretation of the *AMA Guides*.

(a) General Rating Principles under the AMA Guides

26. The *AMA Guides* provide two alternative methods for calculating permanent impairment referable to the lumbar spine. Under the "Diagnosis-Related Estimates" (DRE) method, the permanency rating is derived by assigning an individual to one of five categories of impairment based on his or her symptoms, signs and diagnostic test results. *AMA Guides* §15.3 at p. 381 and §15.4 at p. 384. Under the "Range of Motion" (ROM) method, in addition to considering the individual's diagnosis, both range of motion deficits and nerve root impairment are factored in as well. *Id.* at §15.8 *et seq.* Particularly with respect to quantifying an individual's range of motion, the *Guides* give specific instructions so as to ensure that all of the measurements used are valid and reproducible. This includes allowing the patient adequate opportunity to warm up prior to taking any measurements, requiring that measurements be discarded if they change substantially with repeated efforts, and taking care that the measurement device is properly positioned on the spine. *Id.* at §§15.8a and 15.8b.

27. The *AMA Guides* direct evaluators to use the DRE method as the "principal methodology" for rating impairment due to a distinct injury. *Id.* at §15.2, p. 379. In some situations, however, the ROM method is preferable. For example, where there is multilevel involvement in the same spinal region (such as multiple lumbar disc herniations), or where there is recurrent radiculopathy caused by a recurrent disc herniation or injury, the *Guides* direct that the ROM method be used. *Id.* at p. 380. Last, recognizing that there exist some instances in which either method might be appropriate, the *Guides* direct the evaluator to use whichever one will yield the higher rating. *Id.*

28. As for apportioning impairment between a current and a prior injury, the *Guides* first acknowledge that "most states have their own customized methods for calculating apportionment." *Id.* at §1.6b, p. 12. An examiner must therefore defer to the "jurisdiction practices" that will apply given the particular context in which an impairment rating is to be considered. *Id.* at §15.2a, p. 381. Within that framework, the *Guides* instruct as follows:

> If requested, apportion findings to the current or prior condition, following jurisdiction practices and assuming adequate information is available on the prior condition. In some instances, to apportion ratings, the percent impairment due to previous findings can simply be subtracted from the percent based on the current findings. Ideally, use the same method to compare the individual's prior and present conditions. If the ROM method has been used previously, it must be used again. If the previous evaluation was based on the DRE method and the individual now is evaluated with the ROM method, and prior ROM measurements do not exist to calculate a ROM impairment rating, the previous DRE percent can be subtracted from the ROM ratings. Because there are two methods and complete data may not exist on an earlier assessment, the apportionment calculation may be a less than ideal estimate.

Id.

(b) *Dr. Cyr's Impairment Rating*

29. Dr. Cyr specifically referenced the DRE method as the basis for the 8% impairment rating he calculated in February 2003. Notably, at the time of Dr. Cyr's rating there was not yet any indication that Claimant's L4-5 disc was in any way contributing to his symptoms, and therefore presumably no basis yet existed for discarding the DRE method due to multilevel disc involvement. *AMA Guides* at p. 380, *see* Finding of Fact No. 27 *supra*. Similarly, although Dr. Cyr was well aware at the time that Claimant previously had suffered recurrent disc herniations at the L5-S1 level, there was no mention in his report of recurrent radiculopathy. *Id.* With this in mind, it is by no means clear from the evidence presented that Dr. Cyr was wrong to have used the DRE method given Claimant's symptoms, signs and diagnostic test results as of February 2003.

30. Dr. Cyr did not also calculate Claimant's impairment using the ROM method, and therefore there is no way to know whether that method would have yielded a higher or lower rating than the 8% he calculated according to the DRE method.

(c) Dr. Banerjee's Impairment Rating

31. Dr. Banerjee first evaluated Claimant in July 2008, more than six years after his injury. Dr. Banerjee is board certified in physical and rehabilitation medicine. He reviewed Claimant's medical records and conducted his own physical examination. From that, he concluded that Claimant's current symptoms were related to a right L4-5 disc herniation resulting from the June 2002 work injury. In reaching this conclusion, Dr. Banerjee relied primarily on the fact that Claimant's current complaints had begun with the June 2002 injury and had remained consistent thereafter.

32. In formulating his opinion, Dr. Banerjee failed to explain why, if the June 2002 injury had caused an L4-5 disc herniation, this would not have been apparent on the July 2002 MRI study. As he did not personally review the study, he could only speculate that perhaps the finding had been missed. Dr. Banerjee also did not explain why in his opinion the L4-5 disc herniation was more likely due to injury-associated trauma as opposed to either age-related degeneration or some other cause. Disc herniations are very common in people of Claimant's age, and although certainly they can be triggered by injury-related trauma, they often occur for no apparent reason at all.

33. Because he believed that Claimant's current symptoms were entirely attributable to a different disc level (L4-5) from the one involved in his earlier injuries (L5-S1), initially Dr. Banerjee interpreted the *AMA Guides* as allowing a DRE-based impairment rating. Using this method, he calculated a 13% whole person impairment referable to the June 2002 injury. The difference between this rating and Dr. Cyr's earlier 8% rating lies at least partially in the extent of the radicular signs that each doctor observed. Whereas Dr. Cyr did not mention radicular complaints at all as a basis for his DRE rating, Dr. Banerjee's rating depended in part on them. I find from this evidence that Claimant's radicular symptoms likely worsened in the years between Dr. Cyr's evaluation and Dr. Banerjee's.

34. Dr. Banerjee later determined that his interpretation of the *AMA Guides* had been incorrect, and that because Claimant had suffered lumbar disc herniations at multiple levels, it was more appropriate to rate impairment using the ROM method rather than the DRE method. Using the ROM method, Dr. Banerjee calculated Claimant's current impairment at 25% whole person. He then apportioned away the 8% previously rated and paid in accordance with Dr. Cyr's 2003 DRE-based evaluation, leaving 17% additional whole person impairment attributable to the June 2002 injury.

(d) Dr. Boucher's Impairment Rating

35. Dr. Boucher evaluated Claimant in March 2010, at Defendant's request. Dr. Boucher is board certified in occupational medicine. He is experienced at rating permanency under the *AMA Guides*, and was a contributor to the most recent edition.

36. Based both on his review of Claimant's medical records and on his physical examination findings, Dr. Boucher concluded that the June 2002 work injury consisted of a lumbosacral strain, which aggravated some pre-existing degenerative changes in his lumbar spine but did not in any way cause the L4-5 disc herniation. In Dr. Boucher's opinion, more likely than not the June 2002 injury is no longer contributing significantly to Claimant's ongoing complaints.

37. As Dr. Banerjee had, Dr. Boucher used the ROM method to calculate the extent of Claimant's current impairment, which he rated at 20% whole person. The difference between this rating and Dr. Banerjee's 25% rating is attributable to two factors. First, Claimant exhibited less severe range of motion deficits on Dr. Boucher's examination than he had at the time of Dr. Banerjee's evaluation. Second, having determined that the L4-5 disc herniation was not contributing in any way to Claimant's current complaints, Dr. Boucher did not factor it into his rating, while Dr. Banerjee did.

38. Where Dr. Boucher's opinion diverged most sharply from Dr. Banerjee's was as to how best to apportion Claimant's permanency between the current impairment and whatever impairment was – or should have been – rated previously. As noted above, Finding of Fact No. 34 *supra*, Dr. Banerjee did so simply by subtracting from his own 25% rating the 8% previously rated and paid in accordance with Dr. Cyr's 2003 evaluation. As Dr. Banerjee's rating was based on the ROM method, and Dr. Cyr's on the DRE method, apportioning in this way may have led to what the *AMA Guides* acknowledge is "a less than ideal estimate." *AMA Guides* §15.2a at p. 381; *see* Finding of Fact No. 28 *supra*. Nonetheless, it is what the *Guides* recommend where, as here, prior ROM measurements are not available. *Id.*

39. Dr. Boucher approached the problem differently. In his opinion, given Claimant's multiple injuries and surgeries it would be inappropriate to use a DRE-based impairment rating for any part of the apportionment calculation. Instead, Dr. Boucher made a number of assumptions as to the range of motion deficits that he thought Claimant would have suffered after his 1997 surgery, and from those he attempted to recreate what he estimated Claimant's ROM-based impairment would have been just prior to the June 2002 injury.

40. Using this methodology, Dr. Boucher determined that Claimant's prior impairment would have been 18% whole person. Subtracting that amount from the 20% impairment Dr. Boucher rated at the time of his evaluation left an impairment of only 2% referable to the June 2002 injury. This is exactly the amount that was paid in accordance with the parties' February 2004 permanency agreement. According to Dr. Boucher's calculations, therefore, Claimant is not due any additional permanency relative to his June 2002 injury.

41. Given the care with which the *AMA Guides* instruct practitioners to measure range of motion deficits, *see* Finding of Fact No. 26 *supra*, the methodology Dr. Boucher employed seems particularly imprecise. For that reason, I find that Dr. Banerjee's apportionment methodology comports more closely with the *Guides'* directives.

CONCLUSIONS OF LAW:

1. At issue in this case is Claimant's claim to additional medical and permanency benefits causally related to his June 2002 work injury. Claimant alleges that his current low back pain and radicular symptoms are directly attributable to that injury. He bears the burden of proof, *Egbert v. The Book Press*, 144 Vt. 367 (1984), and as the issues presented are beyond a layperson's expertise, he must establish his claim by way of credible expert testimony. *Marsigli's Estate v. Granite City Auto Sales, Inc.*, 124 Vt. 95 (1964).

2. Here, Claimant offered Dr. Banerjee's testimony in support of his claims, while Defendant countered with that of Dr. Boucher. Where expert medical opinions are conflicting, the Commissioner traditionally uses a five-part test to determine which expert's opinion is the most persuasive: (1) the nature of treatment and the length of time there has been a patient-provider relationship; (2) whether the expert examined all pertinent records; (3) the clarity, thoroughness and objective support underlying the opinion; (4) the comprehensiveness of the evaluation; and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (September 17, 2003).

Claimant's Entitlement to Additional Permanency Benefits

3. Claimant has presented two alternative grounds in support of his claim for additional permanency benefits. On the one hand, he asserts that his condition has worsened appreciably since his original permanency award in February 2004. On those grounds, he argues, the award should be modified and additional benefits paid in accordance with Dr. Banerjee's 2008 evaluation and subsequent ROM-based impairment rating. *See* 21 V.S.A. §668.

4. Alternatively, Claimant asserts that because the parties were mutually mistaken as to the extent of Claimant's permanent impairment as rated by Dr. Cyr in 2003, their prior Form 22 permanency agreement should be invalidated and Dr. Banerjee's rating substituted instead. The basis for this assertion is that Dr. Cyr improperly interpreted the *AMA Guides* by deriving Claimant's impairment using DRE-based rather than ROM methodology.

(a) Modification of Award on Grounds of Change in Condition

5. I cannot accept Claimant's first argument. It is true that Claimant's condition has worsened since Dr. Cyr first rated his impairment in 2003. This much is clear simply by comparing his 8% rating to Dr. Banerjee's 13% DRE-based rating in 2008. Dr. Banerjee's rating was based on his opinion that Claimant's ongoing symptoms were attributable to an L4-5 disc herniation, which he believed occurred as a result of the June 2002 work injury even though it was not diagnosed until 2004.

6. Dr. Banerjee's opinion is deficient in two important respects, however. First, he failed adequately to explain why, if the June 2002 injury in fact caused the L4-5 disc herniation, this finding would not have been noted at the time of the July 2002 MRI. Second, he failed adequately to explain the basis for his conclusion that the herniation resulted from injury-related trauma as opposed to some other cause, such as, for example, age-related degeneration. Given these omissions, I find that Dr. Banerjee's opinion lacks clarity, thoroughness and objective support.

7. In contrast, Dr. Boucher's causation opinion – that the June 2002 work injury did not cause Claimant's L4-5 disc herniation and is not responsible for his current condition – adequately accounts for the differences between the 2002 and 2004 MRI findings.

8. Considering the weaknesses in Dr. Banerjee's analysis, I cannot accept his opinion as more credible than Dr. Boucher's. As Claimant bears the burden of proof on this issue, I cannot conclude, therefore, that the June 2002 injury was responsible either for his worsened condition or for his increased permanent impairment in 2008.

(b) *Material Mistake of Fact as Basis for Re-Opening Prior Permanency Award*

9. As an alternative argument in support of his claim for additional permanency, Claimant asserts that the parties' prior Form 22 permanency agreement is subject to reopening on the grounds that it was based on a material mistake of fact. I disagree.

10. It is generally accepted that once the parties to a workers' compensation claim execute a Form 22 or other form agreement, and the Commissioner (or her designee) approves it, it becomes a binding and enforceable contract. Workers' Compensation Rule 17.0000; *Lushima v. Cathedral Square Corporation,* Opinion No. 38-09WC (September 29, 2009). Absent evidence of fraud or material mistake of fact, the parties will be deemed to have waived their right to contest the material portions of the form, and the Department will consider it to represent a final determination of any dispute as to its contents. *Id.*

11. It is important to note, first of all, that the "material portion" of the Form 22 at issue here concerns only the impairment rating to which the parties agreed – 8% whole person – not the methodology used to derive it. No evidence was introduced as to what that impairment rating would have been had Dr. Cyr calculated it according to the ROM method, as Claimant alleges he should have, rather than according to the DRE method. It is impossible to know, therefore, whether the 8% permanency to which the parties ultimately agreed would have been higher, or lower, or perhaps just the same.

12. Even if Dr. Cyr's interpretation of the *AMA Guides* was mistaken, furthermore, I still cannot categorize the outcome as a mistake of fact. As the *Guides* acknowledge, rating impairment is both an "art" and a "science." *AMA Guides* §1.5 at p. 11. The process combines objective, scientifically based data with a physician's clinical judgment to produce an estimate that reflects the severity of an individual's medical condition. *Id.* §1.2a at p. 4 and §1.5. The result is an opinion, not a fact.

13. I conclude that there is no basis for awarding Claimant additional permanency benefits on the grounds that his prior award was based on a mutual mistake of fact.[1]

Defendant's Responsibility for Medical Charges Denied in 2005

14. As a final issue, Claimant asserts that Defendant should be deemed responsible for the medical charges it denied in 2005, on the grounds that it failed to notify Claimant seasonably of its denial. I agree.

15. The workers' compensation rules require prompt written notification to a claimant whenever an employer seeks to deny benefits. Workers' Compensation Rule 3.0900. Where the employer fails to comply, the Commissioner has discretion to order that benefits be paid. Workers' Compensation Rule 3.1300.

16. It is appropriate to exercise that discretion here. Defendant's mistake was avoidable, and Claimant was prejudiced as a result. I conclude that Defendant is obligated to pay the medical charges associated with Dr. Grzyb's and Dr. Borrello's March and April 2005 evaluations, with interest from the date payment should have been made under Workers' Compensation Rule 40.021(C). If either of these bills has already been paid, Defendant shall reimburse the payor, with interest.

17. Having already concluded that Claimant has failed to sustain his burden of proving that his current condition is causally related to his June 2002 work injury, his claim for ongoing medical benefits (aside from those denied in 2005) must fail as well.

Costs and Attorney Fees

18. Claimant having failed to substantially prevail on his claim, he is not entitled to an award of costs or attorney fees.

[1] Having determined that Claimant is not entitled to additional permanency on either of the grounds he asserted, I need not decide the merits of Defendant's statute of limitations defense. Nor is it necessary to consider Defendant's claim that it is entitled to apportionment as a consequence of Claimant's 1987 and/or 1997 injuries.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Claimant's claim for additional permanent partial disability and/or ongoing medical benefits causally related to his June 6, 2002 work-related injury is hereby **DENIED**. Defendant is hereby **ORDERED** to pay:

1. Medical benefits in accordance with Conclusion of Law No. 16 above, with interest as required by 21 V.S.A. §664.

DATED at Montpelier, Vermont this 25th day of January 2011.

_____
Anne M. Noonan
Commissioner

Appeal:

Within 30 days after copies of this opinion have been mailed, either party may appeal questions of fact or mixed questions of law and fact to a superior court or questions of law to the Vermont Supreme Court. 21 V.S.A. §§670, 672.