Gloria Crowe v. The Fonda Group, Inc. (January 25, 2011)

STATE OF VERMONT
DEPARTMENT OF LABOR

Gloria Crowe

v.

The Fonda Group, Inc.

Opinion No. 02-11WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Anne M. Noonan
Commissioner

State File No. S-13358

OPINION AND ORDER

No hearing held; claim submitted on briefs
Record closed on December 2, 2010

APPEARANCES:

Christopher McVeigh, Esq., for Claimant
Marion Ferguson, Esq., for Defendant

ISSUES PRESENTED:

1. What is the appropriate permanent impairment rating referable to Claimant's cervical spine condition?

2. Is Defendant obligated to sign the treatment authorization form required by The Boston Spine Group?

EXHIBITS:

Claimant's Exhibit 1: Various correspondence
Claimant's Exhibit 2: *Crowe v. The Fonda Group, Inc.*, Opinion No. 37-07WC (January 8, 2008)
Claimant's Exhibit 3: Various medical records
Claimant's Exhibit 4: Various correspondence

Defendant's Exhibit A: *Crowe v. The Fonda Group, Inc.*, Opinion No. 37-07WC (January 8, 2008)
Defendant's Exhibit B: March 31, 2008 letter, with attached medical report
Defendant's Exhibit C: May 27, 2008 letter
Defendant's Exhibit D: Dr. Johansson Independent Medical Examination/Impairment Rating, February 23, 2004
Defendant's Exhibit E: February 10, 2010 correspondence
Defendant's Exhibit F: The Boston Spine Group treatment authorization form, unsigned
Defendant's Exhibit G: *AMA Guides to the Evaluation of Permanent Impairment*, p. 392
Defendant's Exhibit H: Dr. Backus medical record, December 29, 2009
Defendant's Exhibit I: Dr. Zweber medical record, July 19, 2002
Defendant's Exhibit J: Deposition transcript, John Johansson, D.O., February 21, 2007
Defendant's Exhibit K: Deposition transcript, Verne Backus, M.D., April 9, 2007
Defendant's Exhibit L: Johnson State College transcript, issued July 17, 2006

CLAIM:

Permanent partial disability benefits pursuant to 21 V.S.A. §648
Medical benefits pursuant to 21 V.S.A. §640
Costs and attorney fees pursuant to 21 V.S.A. §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 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*").

Claimant's Work Injury and Subsequent Medical Course

3. Claimant worked as a machine operator in Defendant's paper products manufacturing plant. On November 19, 2001 she was operating a large machine when she struck her head on an overhead ladder. As a result of this accident, Claimant suffered various injuries, including a right-sided cervical strain with radicular pain into her right shoulder, and also cervical spine-generated migraine headaches. Treatment for the latter condition was determined to be compensable following a formal hearing and decision by the Commissioner in 2008. *Crowe v. The Fonda Group, Inc.*, Opinion No. 37-07WC (January 8, 2008).

4. That there was a radicular component to Claimant's pain was corroborated by electrodiagnostic studies completed in July 2002, the results of which were suggestive of mild cervical radiculopathy at the C5 disc level. As Dr. Cody, a consulting physician who evaluated Claimant at the request of her treating orthopedic surgeon explained, this likely caused the muscles in Claimant's right shoulder to become weak, leading to secondary rotator cuff pathology. Claimant underwent shoulder surgery to repair this damage in January 2003.

5. As for her cervical symptoms, Claimant treated conservatively. Dr. Backus, an occupational medicine specialist, was her primary "gatekeeper" physician, both in the months immediately following her injury and again in 2005, when treatment focused more on alleviating her cervical-spine generated migraine headaches. After a course of prolotherapy injections, the compensability of which Defendant disputed in the context of the prior proceedings in this claim, the Commissioner determined that Claimant reached an end medical result for her work-related injuries on August 11, 2006. *Crowe v. The Fonda Group, Inc., supra.*

6. At Defendant's request, in February 2004 Claimant underwent an independent medical examination with Dr. Johansson, an osteopath. Dr. Johansson rated Claimant with an 8% whole person permanent impairment referable to her right shoulder. Neither party disputes this rating, and Defendant has since paid permanent partial disability benefits in accordance with it.[1]

Permanent Impairment Ratings Referable to Claimant's Cervical Condition

7. Both Defendant's medical expert, Dr. Johansson, and Claimant's treating physician, Dr. Backus, provided permanent impairment ratings referable to Claimant's cervical condition. To do so, both used the Diagnosis-Related Estimates (DRE) methodology suggested by the *AMA Guides*. Under this methodology, an individual is assigned to the correct impairment category based on symptoms, signs and appropriate diagnostic test results. *AMA Guides* §15.3 at p. 381. In Category I, the individual has only subjective complaints, but no significant clinical findings or documentable neurologic impairment. In Category II, he or she may have radicular complaints, such as pain or weakness in a nerve root distribution, but lacks objective verification by electrodiagnostic findings. In Category III, there are both significant signs of radiculopathy and objective electrodiagnostic verification. *Id.* §15.3 at p. 383 and Box 15-1, §15.6a at p. 392, Table 15-5. Each category carries with it a range of appropriate impairment ratings – 0% for Category I, 5-8% for Category II and 15-18% for Category III. *Id.* at Table 15-5.

8. In the context of his February 2004 independent medical examination, Dr. Johansson rated Claimant with a 5% permanent impairment referable to her cervical condition. In doing so, he concluded that Claimant was suffering from a chronic cervical strain, but with no active signs of radiculopathy. He thus placed her at the low end of the range provided for a DRE Cervical Category II impairment. *Id.* §15.6a at p. 392, Table 15-5.

[1] Defendant also has paid permanency benefits in accordance with Dr. Backus' 3% whole person impairment rating referable to Claimant's cervical-spine generated migraine headaches.

9. Dr. Backus first considered the extent of the permanent impairment referable to Claimant's neck injury in March 2008. At that time, however, he expressed uncertainty as to whether her cervical condition properly was ratable as a Category II impairment or as a Category III impairment. According to Dr. Backus' interpretation of the *AMA Guides*, the July 2002 electrodiagnostic studies had provided objective evidence of C5 radiculopathy, and if repeat studies verified that it still existed, then Claimant's cervical condition would be ratable as a Category III impairment. Alternatively, if repeat studies were now normal, indicating that the C5 radiculopathy had resolved, then only a Category II rating would be justified. With this uncertainty in mind, prior to assigning a definitive rating Dr. Backus recommended that Claimant first undergo repeat electrodiagnostic testing so that she could be rated according to whichever DRE category proved appropriate.

10. When requested to authorize the testing, however, Defendant refused. Initially it did so because it wanted to explore settlement possibilities first. Later, supported by Dr. Johansson's opinion, it opposed the testing on substantive grounds. From his review of Claimant's medical records, Dr. Johansson believed first, that there had never been any clinical evidence of radiculopathy, and second, that Claimant's current complaints were not at all radicular in nature. In his view, therefore, further electrodiagnostic testing was not medically necessary.

11. I find Dr. Johansson's opinion on this issue to be unpersuasive. In fact, there had been clinical evidence of radiculopathy in the past, *see* Finding of Fact No. 4 *supra*. The purpose of repeat testing, therefore, would be to determine if there still remained a radicular component to Claimant's pain, as this would have a direct bearing on her permanent impairment rating.

12. Lacking Defendant's authorization, Claimant declined to undergo the repeat testing.[2] In December 2009 Dr. Backus finalized his impairment rating, stating that because "[Defendant] has refused my recommendation to repeat the electrodiagnostic study to see if [the C5 radiculopathy] was resolved thus I must assume it is still present." Based both on that assumption and on Claimant's persistent complaints of radicular pain from her neck into her right shoulder, Dr. Backus concluded that she met the requirements for a DRE Cervical Category III impairment. Taking into account the impact that Claimant's chronic pain and headaches had had on her activities of daily living, Dr. Backus rated her with an 18% whole person impairment, the highest rating permissible within that category.

[2] Defendant asserts in its pleadings that at some point it did in fact authorize repeat electrodiagnostic testing, but that Claimant refused to undergo it. There is no evidence to that effect in the record, however.

13. In describing the basis for assigning an individual to DRE Category I, II or III, the *AMA Guides* state as follows:

> Since an individual is evaluated after having reached MMI [maximum medical improvement], a previous history of objective findings may not define the current, ratable condition but is important in determining the course and whether MMI has been reached. *The impairment rating is based on the condition once MMI is reached, not on prior symptoms or signs.*

AMA Guides §15.3 at p. 383 (emphasis in original).

The Boston Spine Group Treatment Authorization Form

14. At some point in 2009, Claimant was referred to Dr. Jenis, an orthopedic spine surgeon at The Boston Spine Group, for consideration of artificial cervical disc replacement surgery.

Defendant's medical expert, Dr. Johansson, felt that Claimant was not an appropriate candidate for this procedure and therefore that the referral was not medically necessary. Nevertheless, Defendant voluntarily agreed to authorize an initial evaluation on a without prejudice basis.

15. Prior to scheduling an evaluation, Dr. Jenis' office forwarded to Defendant's adjuster an authorization form, which provided as follows (emphasis in original):

> The above named patient was recently referred to Dr. Louis Jenis for evaluation and subsequent medical treatment for injuries sustained in an industrial accident. Prior to scheduling the patient for medical treatment at Dr. Jenis' office, **we must receive your signature** below authorizing treatment which is medically necessary and causally related to this injury, and **agreeing to full charges for physician fees as stated below.** ***Please note edits to this form will not be accepted.***
>
> Our fee schedule is as follows:
>
> **Initial Evaluation: $295.00**
> **Follow-Up Visits: $180.00**
>
> We will proceed with scheduling the patient as soon as your written authorization for payment at the above listed fee schedule is indicated in the space provided below.
>
> In addition, if surgery is indicated, we ***do not*** accept workers' compensation fee schedule. By signing this form, you agree to negotiate surgical fees in good faith.

16. Defendant's attorney executed the authorization on Defendant's behalf, but despite the admonition not to do so she edited it in two respects. First, Defendant's attorney circled the "**Initial Evaluation: $295.00**" line, and hand wrote the word "only" next to it, presumably to indicate that Defendant was only authorizing that visit, not any follow-up visits.

17. Second, Defendant's attorney altered the signature line. The blank form had read, "_____ agrees to pay full charges as listed on the physician fee schedule for initial evaluation and follow-up visits for the above named patient." Defendant's attorney modified it to read (deleted language struck, added language underlined), "[Defendant] agrees to pay full charges as listed on the physician fee schedule for initial evaluation ~~and follow-up visits~~ only for the above named patient." Again, presumably the purpose of this alteration was to indicate Defendant's authorization for treatment at the billing rates and upon the terms described in the form, but only as to the initial evaluation, not as to any subsequent visits.

18. Defendant tendered payment of the $295.00 charge for Dr. Jenis' initial evaluation, but without a signed, unedited authorization form the office has refused to schedule an appointment.

CONCLUSIONS OF LAW:

Permanent Impairment Referable to Claimant's Cervical Condition

1. The first issue raised by this claim concerns Claimant's entitlement to permanency benefits for her work-related cervical injury. Claimant seeks benefits in accordance with Dr. Backus' 18% whole person impairment rating. Defendant argues that benefits should be awarded in accordance with Dr. Johansson's 5% whole person rating instead. Claimant bears the burden of proof on this issue. *King v. Snide*, 144 Vt. 395, 399 (1984).

2. 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).

3. Consideration of these factors weighs in Dr. Backus' favor here. As the treating physician, Dr. Backus was more familiar with Claimant's symptoms, signs and medical course than Dr. Johansson was. In addition, his determination that Claimant required repeat electrodiagnostic testing in order to assign her to the appropriate DRE impairment rating category was supported objectively in at least two respects. First, there was previously documented electrodiagnostic evidence of radiculopathy in 2002. Second, there was prior clinical evidence of radiculopathy, namely the muscle weakness in Claimant's shoulder that Dr. Cody described as the origin of her rotator cuff pathology. Dr. Johansson's analysis ignored both of these facts.

4. I conclude that Dr. Backus applied the appropriate analysis to determining Claimant's permanent impairment in the context of his March 2008 evaluation – he declined to do so, pending the results of further testing. I cannot conclude, however, that he reached the right result when he reconsidered the issue in December 2009. At that point, faced with Defendant's refusal to authorize repeat electrodiagnostic testing, Dr. Backus made assumptions based on what he knew to be outdated test results, and thus derived an impairment rating that was grounded more in Claimant's prior condition than in her current one. The *AMA Guides* specifically admonish against such an approach, and I am bound by statute, 21 V.S.A. §648(b), to do likewise. For this reason, I cannot accept his 18% impairment rating as credible.

5. Vermont's Workers' Compensation rules require that the employer pay for at least one permanency examination and impairment rating from the claimant's treating physician, notwithstanding its decision to obtain a rating from its own medical expert as well. Workers' Compensation Rule 11.2400. Implicit in this mandate is the requirement that the employer pay for whatever diagnostic testing is necessary in order to calculate a rating in accordance with the *AMA Guides*. Otherwise an employer might be able to undermine a treating physician's impairment opinion simply by denying access to the tests required to support it. This is unfair, and not what the rules intend.

6. Rather than awarding permanency benefits based on Dr. Backus' unsubstantiated assumptions, the better path is to require that the electrodiagnostic testing he recommended be conducted so that Claimant's current impairment can be accurately assessed. Having found that Dr. Johansson's opinion discounting the need for such testing was unpersuasive, I conclude that it is medically necessary and that therefore Defendant is obligated to pay for it. 21 V.S.A. §640(a). Once the testing is concluded, presumably it will be possible to calculate an impairment rating that comports with the *AMA Guides'* requirements and is therefore more credible.

The Boston Spine Group Treatment Authorization Form

7. The second issue raised by this claim concerns whether Defendant can be ordered to execute The Boston Spine Group's treatment authorization form as presented. Claimant asserts that signing the form does not obligate Defendant to pay for any treatment beyond the initial evaluation and that therefore the edits Defendant seeks to interpose on it are unnecessary. I disagree.

8. It is true that even if it executes the form as presented Defendant will not waive its right to contest its responsibility for future treatments on the grounds that they are not reasonable and necessary, and thus not covered under §640(a). Should Defendant fight this battle as to future treatment and lose, however, by its clear terms the unedited form obligates it to pay the "full charges" imposed by The Boston Spine Group's fee schedule, even if Vermont's workers' compensation medical fee schedule might provide for a lesser charge. Defendant is well within its rights not to give any medical provider carte blanche in this manner.

9. Vermont's workers' compensation statute limits an employer's liability to pay for "medical, surgical, hospital and nursing services and supplies" to the maximum fee provided by the Workers' Compensation Medical Fee Schedule. 21 V.S.A. §640(d); Workers' Compensation Rule 40.000. The commissioner has discretion to authorize reimbursement at a higher rate, but only if the injured worker "demonstrates to the commissioner's satisfaction" that the treatment at issue is not available at the scheduled rate. 21 V.S.A. §640(d).

10. Whether Claimant can demonstrate that whatever future treatment Dr. Jenis might propose is unavailable at the Vermont fee schedule rate remains, of course, to be seen. If and when the question arises, however, Defendant is entitled to have it resolved by the commissioner, not by The Boston Spine Group. To the extent that the treatment authorization form bypasses the commissioner's authority to do so, Defendant's objection to signing it is entirely justified.

11. Were The Boston Spine Group to present Defendant with a treatment-specific authorization form rather than a global one, the current impasse might be overcome. In that way, Defendant could indicate its acquiescence to the fact that a particular treatment is not available at the Vermont fee schedule rate and thereby waive its right to have the commissioner decide that issue. Short of this solution, I cannot order Defendant to forego the protection that the statute specifically affords it.

12. I conclude, therefore, that Defendant was justified in refusing to execute the form as presented.

Costs and Attorney Fees

13. I conclude that Claimant has at least partially prevailed and therefore is entitled to an award of costs and attorney fees commensurate with the extent of her success. Claimant shall have 30 days from the date of this Opinion within which to submit her claim for reimbursement under 21 V.S.A. §678.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Claimant's request that Defendant be ordered to execute The Boston Spine Group's treatment authorization form is hereby **DENIED**. Defendant is hereby **ORDERED** to pay:

1. All medical costs associated with repeat electrodiagnostic testing as recommended by Dr. Backus in order that the permanent impairment referable to Claimant's cervical condition can be rated according to the *AMA Guides*; and

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

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.