Gilles Boutin v. United Parcel Service (August 5, 2011)

STATE OF VERMONT
DEPARTMENT OF LABOR

Gilles Boutin

v.

United Parcel Service

Opinion No. 21-11WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Anne M. Noonan
Commissioner

State File No. W-52535

OPINION AND ORDER

Hearing held in Montpelier, Vermont on April 6, 2011
Record closed on May 9, 2011

APPEARANCES:

Michael Green, Esq., for Claimant
Jason Ferreira, Esq., for Defendant

ISSUES PRESENTED:

1. Was Claimant's cervical spondylotic myelopathy causally related to his September 14, 2004 work injury?

2. If yes, to what workers' compensation benefits is Claimant entitled?

EXHIBITS:

Joint Exhibit I: Medical records

Defendant's Exhibit A: *Curriculum vitae*, Leon Ensalada, M.D., M.P.H.
Defendant's Exhibit B: Cervical spondylosis diagram
Defendant's Exhibit C: Cervical MRI diagram

CLAIM:

Temporary total disability benefits pursuant to 21 V.S.A. §642
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.

3. Claimant is 57 years old, and has worked for Defendant since 1978. For the first ten years he was a delivery package driver. For the past 22 years he has been a feeder driver, driving 18-wheel tractor-trailer trucks through the night from hub to hub within Defendant's system. Claimant's assigned route takes him from Barre to Burlington, Vermont, then to Chelmsford, Mass., and then back to Barre by way of White River Junction. He typically works ten to eleven hours nightly.

Claimant's September 2004 Work Injury

4. On September 14, 2004 Claimant was backing his tractor up to connect it to a trailer. He was traveling at approximately five miles per hour, with his head turned to the right so that he could see behind him. The coupling did not go smoothly, and the truck jarred as it came together with the trailer. Claimant's head snapped back and he immediately felt pain in his neck and numbness and tingling in his elbows and hands bilaterally.

5. Claimant reported the injury to his supervisor and sought treatment the next day from Geoffrey Robinson, a physician's assistant. By that time, the numbness and tingling in Claimant's elbows and hands had improved, and was limited primarily to his middle and ring fingers bilaterally. Mr. Robinson diagnosed a mild cervical strain with nerve root irritation.

6. Defendant accepted Claimant's injury as compensable and began paying medical benefits accordingly. As Claimant did not miss any time from work, no indemnity benefits were paid.

7. At subsequent visits in October and November, Mr. Robinson reported that Claimant's neck pain still persisted, as did the paresthesias in his third and fourth fingers, more so on the right than on the left. At Mr. Robinson's referral, Claimant underwent a course of physical therapy. He also treated with Dr. Peterson, an osteopath. By January 2005 Dr. Peterson reported that Claimant's cervical range of motion was improved and his discomfort had decreased. He advised Claimant as to a home exercise program and anticipated that he would be at end medical result within three or four months.

8. Claimant did not treat for any cervical spine-related symptoms between January 2005 and August 2008. He continued to experience neck pain during this period, but self-treated with stretching, ice and heat. His wife often rubbed the "knot" in the back of his neck. Claimant also continued to experience paresthesias in his right middle and ring fingers. He was constantly dropping his keys and had difficulty picking up small objects, such as coins or a cup of coffee.

9. At some point in 2008 both Claimant and his wife noticed that he was experiencing balance issues while walking. His legs felt weak and he was clumsy on his feet, often tripping over sidewalks or stubbing his toes. Claimant thought he was just becoming more uncoordinated as he aged. His wife suspected an inner ear infection.

10. As his balance problem gradually worsened, in April 2009 Claimant sought treatment with Dr. Stafford, his primary care provider. Based both on Claimant's complaints, which included sharp, shooting pains when turning his neck, and on his physical exam, which revealed overly responsive reflexes, Dr. Stafford immediately suspected a spinal source for his symptoms. These suspicions were confirmed by MRI testing, which documented both impingement and swelling in Claimant's spinal cord at multiple cervical levels. The MRI showed nerve root impingement at various cervical levels as well.

11. The MRI testing thus revealed that Claimant suffered from two separate conditions in his cervical spine. The first one, called cervical spondylotic myelopathy, involves compression on the spinal cord itself. The second one, called cervical radiculopathy, involves pressure on the nerve roots that exit the spinal canal at each disc level.

12. Cervical spondylotic myelopathy is the most common spinal cord disorder in persons 55 years of age and older. Spondylosis refers to the degenerative changes that occur in the spine. With aging, intervertebral discs dry out. Osteophytic spurs, or bony growths, develop, and depending on the direction in which these grow they can cause compression either on the spinal cord (myelopathy) or on one or more nerve roots (radiculopathy).

13. Trauma also can contribute to the development of either myelopathy or radiculopathy. When the spine is insulted by injury, it is part of the body's natural healing process to lay down calcium. This then is another source of bony buildup around the spine.

14. It typically takes years for cervical spondylotic myelopathy to develop. Symptoms in the early stages include both neck stiffness and numbness or tingling in the hands or fingers. Other characteristic signs and symptoms include weakness or clumsiness in the legs or hands, unsteadiness of gait, and overly responsive reflexes. By 2008 Claimant was exhibiting almost all of these.

15. As treatment for his cervical spondylotic myelopathy, on November 9, 2009 Claimant underwent a three-level cervical discectomy and fusion. Since then he has recovered well with almost complete resolution of his symptoms, including his neck pain, the numbness and tingling in his fingers and the weakness and unsteadiness in his legs. He was cleared to return to work on March 15, 2010.

Claimant's Prior Medical History

16. Claimant's prior medical history includes the following:

- An evaluation by his primary care provider in August 2000 for a chronic cervical strain of two months' duration, with an additional complaint that his hands tended to stiffen up and sometimes fall asleep while truck driving;

- Evaluations by his primary care providers in July and October 2002 for right arm and/or elbow pain, diagnosed as tendinitis secondary to overuse;

- Treatment for a work-related low back injury that occurred in April 2003, following which Claimant was disabled from working until January 2004.

17. Claimant testified that the neck, right arm and hand symptoms he experienced in 2000 and 2002 were qualitatively different from what he felt after the February 2004 injury. He characterized his earlier symptoms as being sharper, and as not involving the same type of numbness, tingling or weakness that he later experienced. The contemporaneous medical records corroborate this testimony, and I find it credible.

Expert Medical Opinions

18. Each party presented its own expert medical testimony as to the causal relationship, if any, between Claimant's February 2004 work injury and his cervical spondylotic myelopathy. Testifying on Claimant's behalf, Dr. Bucksbaum concluded that such a relationship existed. Testifying for Defendant, Dr. Ensalada came to the opposite conclusion. Both witnesses are well known to this Department as experts with training in occupational medicine, and I find that both are equally qualified to render opinions as to causation. Both doctors rendered their opinions after physically examining Claimant and reviewing his relevant medical records. Both stated their opinions to the required reasonable degree of medical certainty.

(a) Dr. Bucksbaum

19. In formulating his opinion as to causation, Dr. Bucksbaum first considered the mechanism of Claimant's February 2004 injury. He found significant the fact that Claimant had his head turned to look behind him at the moment of impact. This combination of events – force being applied to a mechanically rotated spine – would have resulted in an unusual amount of stress, and thus provided an adequate explanation as to why he might later develop cervical myelopathy. I find this analysis to be persuasive.

20. Dr. Bucksbaum credibly discounted Claimant's pre-2004 symptoms as in any way indicative of cervical spondylotic myelopathy. Claimant complained of stiffness in his neck and hands in 2000, but these symptoms did not progress and likely were due to completely separate anatomical issues. And although he demonstrated decreased grasp strength in conjunction with his right arm and elbow complaints in 2002, this was noted to be secondary to pain; it was not due to any loss of power to the muscle itself.

21. In contrast, Claimant's complaints after his February 2004 injury were entirely consistent with a shock to the spinal cord. Claimant complained immediately of numbness and tingling from his elbows down to his fingers. Over time these symptoms progressed to include the classic signs of cervical spondylotic myelopathy, most notably clumsiness in his legs, gait unsteadiness and overly responsive reflexes.

22. Having (1) eliminated Claimant's prior medical history as causative, and (2) identified the mechanism of his February 2004 injury as consistent, Dr. Bucksbaum concluded that Claimant's cervical spondylotic myelopathy most likely was causally related to the latter event.

23. Dr. Bucksbaum supported fusion surgery as both reasonable and necessary treatment for Claimant's cervical spondylotic myelopathy.

24. Dr. Bucksbaum determined that Claimant had reached an end medical result as of the date of his examination, September 22, 2010.

25. As for permanency, initially Dr. Bucksbaum rated Claimant with a 25% whole person permanent impairment using the Diagnosis-Related Estimates (DRE) method provided for in the *AMA Guides to the Evaluation of Permanent Impairment, 5th ed.* (the *"AMA Guides"*). However, on cross-examination he acknowledged that because Claimant had undergone a multi-level fusion, it was more appropriate to use the range of motion methodology instead. Using that method, Dr. Bucksbaum recalculated Claimant's whole person permanent impairment at 24%.

(b) *Dr. Ensalada*

26. Dr. Ensalada disagreed with Dr. Bucksbaum's analysis, both as to the relevance of Claimant's prior medical history and as to the impact of his February 2004 injury. According to Dr. Ensalada, the constellation of symptoms that Claimant exhibited in 2000 – a stiff neck accompanied by symptoms in his hands as well – were indicative of cervical degenerative disc disease. In his opinion, the natural progression of that disease was strictly age-related, and was neither caused nor accelerated by trauma. That the condition ultimately developed into cervical spondylotic myelopathy was a result that would have occurred even without the February 2004 incident, therefore.

27. In reaching this conclusion Dr. Ensalada relied heavily on the fact that Claimant did not seek treatment for any symptoms indicative of cervical spondylotic myelopathy until April 2009, more than four years after he stopped treating for his February 2004 injury. In Dr. Ensalada's view, this time frame did not allow for a causal relationship back to that injury.

28. Dr. Ensalada did not credit Claimant's testimony that neither his neck pain nor the paresthesias in his right fingers – both symptoms indicative of cervical spondylotic myelopathy – ever abated during the period when he was not treating. Claimant's wife corroborated this testimony, and I find it to be credible. Dr. Ensalada's opinion is somewhat undermined as a result.

29. Dr. Ensalada acknowledged that no matter what the cause of Claimant's cervical spondylotic myelopathy, the fusion surgery he underwent in November 2009 clearly was a reasonable and necessary treatment. In this respect, his opinion is consistent with Dr. Bucksbaum's.

30. Having found no causal relationship between Claimant's condition and his February 2004 work injury, Dr. Ensalada did not calculate a permanency rating. He concurred that Dr. Bucksbaum should have used the range of motion rather than the DRE method for doing so. Beyond that, however, he offered no comment as to the accuracy of Dr. Bucksbaum's 24% rating.

CONCLUSIONS OF LAW:

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). He or she must establish by sufficient credible evidence the character and extent of the injury as well as the causal connection between the injury and the employment. *Egbert v. The Book Press*, 144 Vt. 367 (1984). There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the resulting disability, and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden Lumber Co.*, 112 Vt. 17 (1941); *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. The question here is whether Claimant's February 2004 work injury caused, aggravated or accelerated the cervical spondylotic myelopathy with which he was diagnosed in April 2009. Each party offered its own medical evidence on this issue.

3. 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).

4. Neither of the experts here was a treating physician. Both examined the pertinent records and conducted a comprehensive evaluation. Both were well qualified to render an opinion.

5. One area where the two experts diverged was as to the credit each gave to Claimant's own testimony. Consistent with this testimony, Dr. Bucksbaum determined that Claimant's prior medical history was essentially non-contributory. Instead, he accepted as valid Claimant's assertion that both his neck pain and the paresthesias in his fingers – symptoms indicative of the early stages of cervical spondylotic myelopathy – began with his February 2004 injury and never abated thereafter. Dr. Ensalada chose to disregard this testimony. Having myself concluded that Claimant's account was credible, I favor Dr. Bucksbaum's analysis.

6. I also find persuasive Dr. Bucksbaum's explanation as to how the mechanism of Claimant's February 2004 injury caused traumatic force to be applied to his cervical spine in such a way as was likely to precipitate bone spurs as part of the body's healing process.

7. I conclude that Dr. Bucksbaum's opinion was better supported than Dr. Ensalada's, and therefore is the most credible. I thus conclude that Claimant has established a causal connection between his February 2004 work injury and his cervical spondylotic myelopathy sufficient to render the latter condition compensable.

8. I also accept as credible Dr. Bucksbaum's determination that Claimant has suffered a 24% whole person permanent impairment as a result of his condition. Although Defendant argues that Dr. Bucksbaum applied the range of motion method erroneously and therefore reached the wrong result, it produced no expert testimony in support of its assertion. Navigating the *AMA Guides* is a complex process. As between Claimant's medical expert and Defendant's attorney, in this case I defer to the doctor. *See Marsigli's Estate v. Granite City Auto Sales, Inc.*, 124 Vt. 95 (1964).

9. Claimant has submitted a request under 21 V.S.A. §678 for costs totaling $3,542.47 and attorney fees totaling $9,557.00. An award of costs to a prevailing claimant is mandatory under the statute, and therefore these costs are awarded. As for attorney fees, these lie within the Commissioner's discretion. I find they are appropriate here, and therefore these are awarded as well.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Defendant is hereby **ORDERED** to pay:

1. Temporary total disability benefits from November 9, 2009 through March 14, 2010, in accordance with 21 V.S.A. §642;

2. Permanent partial disability benefits as compensation for a 24% permanent impairment referable to the spine, in accordance with 21 V.S.A. §648;

3. Interest on the above amounts calculated in accordance with 21 V.S.A. §664;

4. Medical benefits covering all reasonable and necessary medical services and supplies causally related to treatment of Claimant's cervical spondylotic myelopathy, in accordance with 21 V.S.A. 640;

5. Costs totaling $3,542.47 and attorney fees totaling $9,557.00, in accordance with 21 V.S.A. §678.

DATED at Montpelier, Vermont this 5th day of August 2011.

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Anne M. Noonan
Commissioner

Appeal:

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