STATE OF VERMONT
DEPARTMENT OF LABOR

Lorrie Cahill

v.

Benchmark Assisted Living

Opinion No. 13-12WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Anne M. Noonan
Commissioner

State File No. BB-53987

OPINION AND ORDER

Hearing held in Montpelier on January 27, 2012
Record closed on March 12, 2012

APPEARANCES:

William Skiff, Esq., for Claimant
Craig Matanle, Esq., for Defendant

ISSUE PRESENTED:

Is proposed lumbar fusion surgery a medically reasonable and necessary treatment for Claimant's work-related chronic low back pain?

EXHIBITS:

Joint Exhibit I:	Medical records
Claimant's Exhibit 1:	*Curriculum vitae*, Robert Monsey, M.D.
Defendant's Exhibit A:	*Curriculum vitae*, Verne Backus, M.D., M.P.H.
Defendant's Exhibit B:	ACOEM Occupational Medicine Practice Guidelines
Defendant's Exhibit C:	Brox, JI *et al., Randomized Clinical Trial of Lumbar Instrumented Fusion and Cognitive Intervention and Exercises in Patients with Chronic Low Back Pain and Disc Degeneration*, SPINE, 2003; 28(17):1913-1921; Brox, JI *et al, Lumbar instrumented fusion compared with cognitive intervention and exercises in patients with chronic back pain after previous surgery for disc herniation: A prospective randomized controlled study,* Pain, 2006; 122:145-155

Defendant's Exhibit D: Fairbank, J *et al., Randomised controlled trial to compare surgical stabilization of the lumbar spine with an intensive rehabilitation programme for patients with chronic low back pain: the MRC spine stabilization trial,* BMJ, doi:10.1136/bmj.38441.620417BF (23 May 2005)

Defendant's Exhibit E: Fritzell, P *et al., 2001 Volvo Award Winner in Clinical Studies: Lumbar Fusion Versus Nonsurgical Treatment for Chronic Low Back Pain,* SPINE, 2001; 26(23):2521-2534

CLAIM:

Medical benefits pursuant to 21 V.S.A. §640(a)
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 contained in the Department's file relating to this claim.

3. Claimant has worked as a licensed practical nurse at The Arbors, a dementia care community owned by Defendant, since 2007. Her duties have included performing assessments on new residents, training new staff, completing patient charts and often, lifting residents and assisting with bed, bathroom and chair transfers. The latter function in particular is physically strenuous.

Claimant's Work Injury and Subsequent Medical Treatment

4. On October 9, 2009 Claimant was assisting a wheelchair-bound resident with a bathroom transfer. Midway through the transfer, the resident, who weighed approximately 200 pounds, began to fall. Claimant supported his weight and guided him back into the wheelchair. As she did so, she felt a pull in the right side of her lower back.

5. Claimant promptly reported her injury and then sought medical care in accordance with Defendant's established procedures. To date, her treatment has been conservative in nature, as overseen by Dr. Bjornson, the provider to whom Defendant initially referred her. Claimant has undergone courses of physical therapy, osteopathic manipulation, epidural steroid injections, medial branch blocks and radiofrequency ablation. She has fully complied with all treatment recommendations, and has maintained a home exercise program that includes walking and daily exercise. Despite these efforts, none of the conservative therapies she has undergone have provided effective long-term relief of her symptoms.

6. Since her injury Claimant has continued to suffer from low back pain, sometimes accompanied by a pinching sensation in her lumbosacral spine. The pain interferes with her sleep. It is relieved somewhat by sitting, and aggravated by standing or walking. It precludes her ability to engage in many of the recreational activities she used to enjoy, such as hiking with her family, playing with her grandchildren, snow shoeing, sledding and camping. At the formal hearing, Claimant became visibly and credibly upset when discussing these limitations.

7. After a relatively brief period of temporary total and/or partial disability, Claimant returned to work full time in January 2010. She was restricted, however, from lifting, pushing or pulling more than ten pounds. This restriction, which remains in effect today, precludes her from performing her full duties as a floor nurse. Claimant can no longer assist with patient transfers. She has difficulty getting down to floor level to assess a patient who has fallen. She frequently requires help from co-employees to complete tasks that she used to be able to undertake on her own. Having to do so, she stated, "makes me feel like I'm one of my patients instead of a whole person." Again, Claimant became visibly and credibly upset when discussing the impact that the injury has had on her work.

8. To its credit, Defendant has fully accommodated Claimant's work restrictions, and as a result she has continued to be employed there on a full time basis. As she did prior to her injury, Claimant works two days per week in the office, performing patient assessments and other administrative tasks. Clearly, however, her inability to do the type of direct patient care she enjoyed previously weighs heavily on her. Claimant testified credibly that she devotes her entire work day to dealing with her pain, to the point where at the end of every day she is exhausted. If her pain continues at its current level, she is concerned that she may not be able to maintain full time work at a job she loves. I find this concern to be justified.

Dr. Monsey's Surgical Recommendation

9. Claimant has undergone numerous MRI scans since her injury. These have revealed mild degenerative changes from L4-5 to L5-S1, including a small central disc herniation at the latter level, but with no evidence of nerve root impingement.

10. At Dr. Bjornson's referral, in October 2010 Claimant underwent an evaluation with Dr. Monsey, a board certified orthopedic surgeon. Dr. Monsey diagnosed mechanical low back pain, with no evidence of myelopathy, radiculopathy or spinal instability.

11. To assist in determining the source of her pain, at Dr. Monsey's referral Claimant underwent further diagnostic testing, known as discography. Proponents of discography theorize that the test provides a means of identifying whether a particular disc is the source of a patient's mechanical low back pain. During testing, needles are inserted in the middle of various discs, and the patient's pain response is noted accordingly. If the patient experiences "concordant pain," that is, pain identical in location and character to his or her chronic pain, then the disc injected is presumed to be the pain generator. If the patient fails to experience concordant pain, then the injected disc is presumed not to be the pain generator.

12. Noting the correlation between Claimant's reported symptoms, her diagnostic imaging studies and her response to discography, Dr. Monsey identified her L4-5 and L5-S1 discs as the source of her low back pain. As treatment, he has recommended fusion surgery. The procedure he proposes is complicated. It involves both anterior and posterior incisions, with placement of a cage to support the spine from the front and pedicle screws to support it from the back.

13. In Dr. Monsey's estimation, there is a 70 percent chance that the fusion surgery he has proposed will provide Claimant with good relief of symptoms, a 30 percent chance that it will not result in any appreciable change, and a 1 to 2 percent chance that it will cause her symptoms to worsen.

14. Dr. Monsey has characterized the proposed fusion surgery as one involving a quality of life decision for Claimant. It is based solely on her assessment of how severe her pain is and how much it impacts the quality of her life, balanced against the risk that surgical intervention will not work and might even cause her pain to increase.

15. Claimant's primary treating physician, Dr. Bjornson, has expressed support for Dr. Monsey's proposed surgery as a reasonable treatment option given Claimant's failure to respond adequately to conservative treatment measures.

16. Claimant testified credibly that she understands the potential risks of surgery as Dr. Monsey explained them to her, including the risk that she might suffer serious surgical complications, that she might require repeat surgery and/or that the surgery might prove ineffective. In her estimation, the risks of undergoing the procedure are more than outweighed by the possibility that it will increase the quality of her life and restore her ability to function.

Dr. Backus' Opinion; the ACOEM Practice Guidelines

17. At Defendant's referral, Claimant has undergone two independent medical examinations with Dr. Backus, the first in April 2010 and more recently in January 2012. Dr. Backus is a board certified specialist in occupational and environmental medicine. He also holds a master's degree in public health. Dr. Backus' educational background includes a focus on epidemiology and statistics. With this training, he strives to analyze and incorporate the results of so-called "evidence-based" medical research studies into his treatment recommendations.

18. Based both on his review of Claimant's medical records and on his own physical examination, Dr. Backus has concluded, to a reasonable degree of medical certainty, that her current complaints are causally related to her compensable work injury. He disagrees, however, with Dr. Monsey's surgical treatment recommendation. In Dr. Backus' opinion, fusion surgery does not constitute reasonable and necessary medical treatment for the type of mechanical low back pain from which Claimant suffers.

19. In formulating his opinion as to the reasonableness of Dr. Monsey's proposed surgery, Dr. Backus relied heavily on the practice guidelines published by the American College of Occupational and Environmental Medicine (ACOEM). In developing these practice standards, which encompass a wide range of occupational injury treatment strategies, the ACOEM uses panels of specialists to identify and review original research studies and then grade them for design, execution and analysis of results. Based on these reviews, the panels evaluate the strength of evidence showing that a particular treatment, test or intervention improves important health and functional outcomes. Balancing the potential benefit against both the potential harm and the anticipated cost, the ACOEM decides whether to issue a recommendation either for or against each treatment's use.

20. In matters germane to this claim, the ACOEM has studied both the use of discography as a diagnostic tool and spinal fusion as a treatment option for patients with non-specific, mechanical low back pain. It has designated both interventions as "moderately not recommended," meaning that at least "moderate evidence[1]" exists that they are either ineffective and/or that the harms or costs outweigh their benefits.

21. As to discography, the ACOEM practice guideline cites "quality studies" finding that the test's positive predictive value is at or below 50 percent, meaning that it does not reliably indicate what particular disc is the source of a patient's pain. The lack of standardized technique, the invasive nature of the test and potential adverse side effects also mandate against its use as a surgical planning tool, according to the ACOEM.

22. In explaining the rationale behind its spinal fusion practice guideline, the ACOEM discussed four "high quality" studies at some length. All four studies, copies of which were introduced into evidence, compared the efficacy of treating patients suffering from mechanical low back pain with surgical intervention (lumbar fusion) as opposed to non-operative therapies (either ongoing physical therapy or a combination of cognitive behavioral therapy and exercise). The earliest study, conducted in 2001, showed significantly better outcomes in the surgical group, in terms of both diminished pain and decreased disability, but was criticized by subsequent researchers for its faulty design. No clear evidence emerged from the later studies, conducted in 2003, 2005 and 2006, that spinal fusion surgery produced significantly better outcomes than non-operative therapies. With no definitive evidence of the surgery's efficacy, and factoring in what it terms a "significant rate of serious complications" and a "substantial cost," the ACOEM currently recommends against "routinely providing" lumbar fusion as treatment for chronic non-specific low back pain.

[1] The ACOEM defines "moderate evidence" as involving at least one "high quality" study or multiple "moderate quality" studies relevant to the topic and the working population.

23. It is important to note that none of the four studies specifically discussed in the ACOEM practice guideline concluded that lumbar fusion was *ineffective* at treating mechanical low back pain. Indeed, the reported results included a 33 percent reduction in back pain among the surgical patients in the 2001 study, a 70 percent surgical success rate in the 2003 study, and a 50 percent surgical success rate in the 2006 study. Rather, with the exception of the 2001 study the primary finding of the more recent studies was simply to establish the efficacy of non-operative interventions, particularly those with both a cognitive behavioral and an exercise component, as an effective *alternative* to surgery, one that carries fewer potential risks and comes at a lower cost than fusion.[2]

24. In formulating his opinion as to the efficacy of Dr. Monsey's proposed fusion surgery as treatment for Claimant's low back pain, Dr. Backus relied not only on the ACOEM practice guidelines but also on his own clinical experience. He has treated many patients for whom fusion surgery has failed to provide effective long-term relief. Dr. Backus acknowledged, however, that as a surgeon Dr. Monsey likely has followed more fusion patients. He agreed, furthermore, that were Dr. Monsey to perform the surgery he has proposed, this would not constitute malpractice or qualify in any way as outside the accepted medical standard of care.

25. Neither Dr. Monsey nor Dr. Bjornson has ever recommended that Claimant undergo a combination of cognitive behavioral therapy and intensive exercise such as that offered to the non-operative groups in the 2003, 2005 and 2006 research studies. Given that Claimant has continued to work full time, Dr. Backus acknowledged that she likely has already incorporated at least some of the components of such a program into her life.

CONCLUSIONS OF LAW:

1. Vermont's workers' compensation statute obligates an employer to pay only for those medical treatments that are determined to be both "reasonable" and causally related to the compensable injury. 21 V.S.A. §640(a); *MacAskill v. Kelly Services,* Opinion No. 04-09WC (January 30, 2009). The Commissioner has discretion to determine what constitutes "reasonable" medical treatment given the particular circumstances of each case. *Id.* A treatment can be unreasonable either because it is not medically necessary or because it is not related to the compensable injury. *Baraw v. F.R. Lafayette, Inc.*, Opinion No. 01-10WC (January 20, 2010).

2. The treatment issue here revolves solely around the medical necessity question. Both parties' experts agree that Claimant's current condition is causally related to her compensable injury. Where they disagree is as to whether fusion surgery is a medically appropriate treatment option for her mechanical low back pain.

[2] To compare, the non-operative success rate in the 2003 study was 76 percent; in the 2006 study it was 48 percent.

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. I conclude here that Dr. Monsey's opinion is the most persuasive. His status as Claimant's treating physician merits serious consideration. He is a well qualified surgeon, whose treatment recommendation is based on his own experience with similar patients. I have no reason not to believe his prediction that the fusion surgery he has proposed likely will be successful.

5. Neither the ACOEM practice guidelines nor the research studies upon which Dr. Backus relied are sufficient to convince me otherwise. None of those sources went so far as to advocate against the use of fusion surgery in every circumstance, or even to posit that it is an ineffective treatment. Even notwithstanding such evidence-based research, therefore, the door remains open for an experienced treating surgeon to recommend the procedure for a particular patient, as Dr. Monsey has done here.

6. The determination whether a treatment is reasonable must be based primarily on evidence establishing the likelihood that it will improve the patient's condition, either by relieving symptoms and/or by maintaining or increasing functional abilities. *Quinn v. Emery Worldwide*, Opinion No. 29-00WC (September 11, 2000). An injured worker's subjective preferences cannot render a medically unreasonable treatment reasonable. *See, Britton v. Laidlaw Transit,* Opinion No. 47-03WC (December 3, 2003). As is the case with many aspects of medical decision-making, however, there can be more than one right answer, and thus more than one reasonable treatment option for any given condition. *Lackey v. Brattleboro Retreat*, Opinion No. 15-10WC (April 21, 2010). I conclude that this is the case here.

7. I acknowledge what the available research appears to show, namely that in appropriate circumstances a combination of cognitive behavioral therapy and intensive exercise may be as effective as fusion surgery at treating mechanical low back pain. To the extent that this non-surgical option comes with fewer risks and lower costs, in some cases it may well be the more attractive alternative. This does not mean, however, that the surgical option is automatically rendered unreasonable as a result. *Lackey, supra.* The test remains one of balancing the relative risks and benefits to a particular patient in a particular case. *See, e.g., Estate of George v. Vermont League of Cities and Towns*, 2010 VT 1 (cautioning against use of epidemiological studies to establish specific work-related causation in a workers' compensation claim).

8. Although the workers' compensation statute mandates that employers pay only for "reasonable" medical treatment, it does not in any way require that injured workers thereby forfeit the right to direct their own medical care. *Lackey, supra.* I am convinced by the evidence here that Dr. Monsey has proposed a reasonable treatment option, one that likely will relieve Claimant's symptoms and improve her ability to function, and that Claimant has chosen it after thoughtfully weighing the inherent risks against the potential benefits. This is her prerogative.

9. I conclude that the fusion surgery Dr. Monsey has proposed constitutes medically necessary treatment for Claimant's work injury, and is thus reasonable under the circumstances. Defendant is therefore obligated to pay for the medical and indemnity costs associated with it.

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

ORDER:

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

1. Medical benefits associated with Dr. Monsey's proposed fusion surgery, in accordance with 21 V.S.A. §640(a); and

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

DATED at Montpelier, Vermont this 27th day of April 2012.

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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.