STATE OF VERMONT
DEPARTMENT OF LABOR

Debra Morrisseau

v.

Hannaford Brothers

Opinion No. 21-12WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Anne M. Noonan
Commissioner

State File No. BB-00676

OPINION AND ORDER

Hearing held in Montpelier on May 9, 2012
Record closed on June 25, 2012

APPEARANCES:

Christopher McVeigh, Esq., for Claimant
Robert Mabey, Esq., for Defendant

ISSUES PRESENTED:

1. Does Dr. Fenton's proposed treatment plan constitute reasonable medical treatment causally related to Claimant's August 20, 2009 compensable work injury?

2. Did Claimant reach an end medical result for her compensable work injury on or before April 30, 2011?

3. Is Claimant entitled to additional temporary total and/or temporary partial disability benefits?

EXHIBITS:

Joint Exhibit I:	Medical records
Claimant's Exhibit 1:	Temporary partial disability benefit calculation, with supporting pay stubs
Defendant's Exhibit A:	Medical records
Defendant's Exhibit B:	*Curriculum vitae,* Richard Levy, M.D.
Defendant's Exhibit C:	Dr. Levy report, October 2, 2011

CLAIM:

Temporary total disability benefits pursuant to 21 V.S.A. §642
Temporary partial disability benefits pursuant to 21 V.S.A. §646
Medical benefits pursuant to 21 V.S.A. §640(a)
Interest, costs and attorney fees pursuant to 21 V.S.A. §§664 and 675

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 began working as a part time associate in Defendant's bakery in 2002. Her duties included preparing baked goods for sale, decorating cakes and generally servicing the bakery department.

Claimant's August 2009 Work Injury and Subsequent Treatment Course

4. On August 20, 2009 Claimant was lifting a box of frozen cookie dough at work when she felt a pop in her right hand, followed by intense pain in her palm and triggering in her ring and small fingers. She reported the injury to her supervisor, and later in the day sought medical treatment.

5. Defendant accepted Claimant's injury as compensable and began paying workers' compensation benefits accordingly.

6. Initially Claimant was diagnosed with a right wrist sprain. Her pain predominated on the ulnar (outer) side of her palm and wrist, radiating out to her ring and small fingers and up into the ulnar area of her elbow. Intermittently she experienced sharp, severe pains, which she described as "zingers," as well, emanating from the wrist joint itself.

7. When her symptoms failed to improve with physical therapy, in September 2009 Claimant was referred to Dr. Frenzen, an orthopedic surgeon, for further evaluation. Diagnostic imaging studies revealed a TFCC (triangular fibrocartilage complex) tear in her wrist, as well as some evidence of ulnar impaction syndrome. The latter condition occurs when there is a variance in length between the ulna and the radius (the two forearm bones) at the wrist.

8. Imaging studies also documented degenerative changes in Claimant's wrist joint. These were most likely age-related and/or accelerated by a fracture she had sustained many years earlier on the distal (thumb) side of her wrist.

9. Dr. Frenzen attributed Claimant's ulnar-sided wrist pain to her TFCC tear. Without making a clear statement as to causal relationship, he acknowledged that "certainly the [August 2009 work injury] has set up a series of events by which her wrist has become painful."

10. After rest and a cortisone injection proved ineffective, in December 2009 Dr. Frenzen performed arthroscopic surgery to address both the TFCC tear and the ulnar variance at Claimant's wrist.

11. Post-surgery, Claimant continued to suffer aching pain and diminished range of motion in her wrist, intermittent but painful "zingers," and numbness and tingling in her ring and small fingers. Electrodiagnostic studies in May 2010 documented mild carpal tunnel and cubital tunnel syndromes, as well as mild swelling of the ulnar nerve at the wrist. Dr. Frenzen was unable to explain these findings in the context of his TFCC repair surgery.

12. At Defendant's request, in June 2010 Claimant underwent an independent medical evaluation with Dr. Davignon. Based both on his physical examination and on his review of the pertinent medical records, Dr. Davignon concluded as follows:

- That Claimant's right wrist symptoms were causally related to her work injury;
- That all treatment to date had been reasonable and necessary; and
- That the degenerative changes in Claimant's wrist were probably preexisting, but likely were aggravated by the work injury.

13. In June 2010 Dr. Frenzen referred Claimant to Dr. Johansson for further treatment. Dr. Johansson, an osteopath, is the medical director of the Vermont Center for Occupational Rehabilitation (VCOR). Among the services VCOR offers are physical therapy, myofascial therapy, biofeedback and pain management.

14. Claimant participated in the VCOR intensive rehabilitation program from June through November 2010. When her symptoms failed to respond to a cortisone injection midway through the program, Dr. Johansson referred her to Dr. Murphy, an orthopedic surgeon at Dartmouth Hitchcock Medical Center, for a second opinion.

15. Dr. Murphy evaluated Claimant in September 2010. He concluded that there was no good surgical solution to her ongoing symptoms. Instead, he recommended continued conservative management, including injections, splinting, anti-inflammatories and activity modification. From my review of the medical evidence, I find that Claimant already had undergone the therapies Dr. Murphy suggested, with no appreciable improvement in her symptoms.

16. As for the cause of Claimant's symptoms, Dr. Murphy concluded that the August 2009 work injury likely resulted in an aggravation of the preexisting, underlying arthritis and pathology in her wrist.[1]

17. Following Dr. Murphy's examination, Claimant returned to VCOR to complete her rehabilitation program. At his final evaluation on November 30, 2010 Dr. Johansson commented that Claimant still experienced pain, swelling and "zingers" in her wrist, but that she had developed coping strategies to allow her to better manage her pain. Dr. Johansson concluded that Claimant had reached an end medical result for her work injury, and rated her with a 5 percent permanent impairment referable to her wrist. He also released her to return to work on a full time basis, but with permanent light duty restrictions. These included limitations against lifting more than 10 pounds occasionally or performing repetitive tasks.

18. Dr. Johansson attributed the cause of Claimant's symptoms to a "flare up" of her preexisting osteoarthritic condition, which he asserted had been in a state "where it was more likely than not going to become a problem sooner rather than later" even had the August 2009 work injury not occurred. Notwithstanding this prediction, I find from the medical evidence that in fact Claimant's preexisting condition had been entirely asymptomatic for many years prior to her work injury, and particularly that it had not restricted her ability to function in any respect. Dr. Johansson's conclusion that despite ongoing pain and now permanent work restrictions Claimant had returned to her preexisting osteoarthritic baseline is plainly contradicted by this evidence.

19. At her attorney's recommendation, and because she was dissatisfied with the conclusions stated in Dr. Johansson's final report, in March 2011 Claimant returned to Dr. Murphy for an additional evaluation. Dr. Murphy found her condition to be essentially unchanged from his September 2010 exam, and reiterated his opinion that her symptoms would likely best be managed conservatively rather than surgically. Given the persistent numbness and tingling in her wrist, however, Dr. Murphy suggested that repeat electrodiagnostic studies would be helpful to determine whether her carpal tunnel syndrome had progressed.

20. With Dr. Johansson's November 2010 end medical result determination as support, the Department approved Defendant's discontinuance of temporary disability benefits effective April 30, 2011.

21. In June 2011 Claimant underwent repeat electrodiagnostic studies, as Dr. Murphy had suggested, with Dr. Zweber, the same neurologist who had performed her prior studies in May 2010. In his report, which documented no significant changes from the prior exam, Dr. Zweber noted that Claimant was considering a second opinion with Dr. Fenton, a specialist in interventional pain management. Dr. Zweber considered this to be an appropriate approach for Claimant to pursue.

Dr. Fenton's Proposed Treatment Plan

[1] Although Dr. Murphy did not specify the work injury as the cause of the aggravation in the report of his September 2010 evaluation, he did so later, in the context of his repeat evaluation in March 2011. *See* Finding of Fact No. 19, *infra.*

22. Claimant began treating with Dr. Fenton on September 1, 2011. Dr. Fenton, an osteopath, is board certified in physical medicine and rehabilitation. His clinical focus is on musculoskeletal and non-surgical orthopedic medicine. Fifty percent of his current practice involves upper extremity conditions.

23. Dr. Fenton diagnosed Claimant with osteoarthritis, joint inflammation and mild carpal tunnel syndrome at the wrist, and cubital tunnel syndrome and nerve irritation, or neuritis, at the elbow. In his analysis, which I find credible, all of these conditions were either caused or aggravated by the August 2009 work injury. According to Dr. Fenton, the abnormal motion and muscle guarding that resulted from both the injury and the subsequent surgery likely caused Claimant's ulnar neuritis to develop. Similarly, abnormal motion in the context of preexisting osteoarthritis in the wrist likely increased the pressure on her median nerve and thus led to the development of carpal tunnel syndrome.

24. The treatment approach that Dr. Fenton has suggested for these conditions is somewhat controversial. It is comprised of the following components:

- Diagnostic ultrasound of the median and ulnar nerves to better evaluate the extent of nerve compression and irritation;
- Ultrasound-guided hydro-dissection of the ulnar nerve at the elbow; and
- Ultrasound-guided corticosteroid injection in the wrist to identify the primary pain generator, followed by ultrasound-guided injections of platelet rich plasma.

25. Dr. Fenton has been using diagnostic ultrasound as a complement to electrodiagnostic testing for peripheral nerve entrapment disorders for more than eight years. Such testing is the standard of care among European orthopedists, and is also well accepted in the United States, though it is not prevalent in Vermont. Particularly with respect to diagnosing ulnar nerve compression, ultrasound has a very low false negative, meaning that it rarely misses abnormal findings. In contrast, although many U.S. doctors consider electrodiagnostic studies to be the gold standard for diagnosing both median and ulnar nerve compression syndromes, they yield a much higher rate of false negative findings and often do not correlate well with the severity of a patient's symptoms.

26. In Claimant's case, diagnostic ultrasound indicated fairly severe inflammation of the ulnar nerve at the elbow, which in Dr. Fenton's assessment required further intervention. Given the correlation between Dr. Fenton's findings and the severity of Claimant's ongoing symptoms, I find his analysis in this regard credible.

27. Dr. Fenton has recommended hydro-dissection as treatment for Claimant's ulnar nerve irritation. This procedure uses a series of fluid injections to open up the space between the nerve and the tissue surrounding it, in much the same manner that a scalpel would during surgery. Though not experimental, hydro-dissection is still an emerging treatment approach, and therefore the medical literature as to its effectiveness is limited. Nevertheless, it is, as Dr. Fenton described it, "quite hot in the international pain world," and is widely performed in that arena as a safer alternative to surgery.

28. Claimant already has undergone one hydro-dissection procedure in her elbow, in September 2011. Subsequently, her symptoms improved significantly for some time, with less discomfort and fewer "zingers" than previously. Dr. Fenton anticipates that Claimant will require one or two additional treatments, each spaced approximately twelve weeks apart, in order to realize lasting, restorative benefit. Given that Claimant derived substantial benefit from the first procedure, I find persuasive Dr. Fenton's prediction of additional success with further treatments.

29. As for the wrist, with the benefit of ultrasound guided cortisone injections Dr. Fenton recently has identified an area on the thumb side of Claimant's wrist as the most likely pain generator. As treatment, he has recommended that she undergo a series of platelet rich plasma (PRP) injections. Plasma that is highly concentrated in platelets is thought to release growth factors that attract stem cells and stimulate tissue regeneration. PRP injection therapy is widely accepted among sports medicine orthopedists, but due to the paucity of evidence-based studies is still considered experimental in cases involving joint injuries. In his own clinical experience, Dr. Fenton estimates he has obtained excellent results in approximately 75 percent of the wrist injuries he has treated with PRP injections.

30. Claimant has not yet undergone any PRP injections, as neither Defendant nor her group health insurer has agreed to cover them. As an alternative, Dr. Fenton has performed a series of local anesthetic injections. These have afforded Claimant some limited palliative relief of her wrist symptoms, but do not have any long-lasting, regenerative effect. Were she to undergo PRP injection therapy, Dr. Fenton anticipates a series of three injections, each four to six weeks apart.

31. Because both hydro-dissection and PRP injection therapies are restorative rather than palliative in nature, in Dr. Fenton's opinion Claimant should not be considered at end medical result until both series of treatments have been completed.

32. Dr. Fenton acknowledged that he did not review Claimant's medical records, was unfamiliar with the surgical technique Dr. Frenzen utilized to address the ulnar variance in her wrist and did not personally study the results of Dr. Zweber's electrodiagnostic testing. I find that these omissions were not critical to the formulation of his treatment plan, which was based instead on his specialized experience with the therapies he has proposed.

Dr. Levy

33. Defendant's expert, Dr. Levy, presented a different view of Dr. Fenton's proposed treatment plan. Dr. Levy is a board certified neurologist. He did not personally examine Claimant, but reviewed her medical records in October 2011.

34. Dr. Levy acknowledged that Claimant's August 2009 work injury likely caused her TFCC tear, and that Dr. Frenzen's surgery constituted reasonable treatment. He also concurred with Dr. Murphy's opinion that the work injury likely aggravated the underlying osteoarthritis in her right wrist, at least for a time. In Dr. Levy's opinion, however, at this point Claimant's ongoing symptoms are due solely to the natural progression of that preexisting condition, and are no longer related to her work injury in any respect.

35. Dr. Levy also concluded that there likely was no causal relationship between Claimant's work injury and her peripheral nerve entrapment disorders. In his opinion, an injury to the outer part of her wrist could not possibly have resulted in nerve compression at the elbow. As for her median nerve compression, Dr. Levy maintained that this likely was caused solely by preexisting osteoarthritis.

36. Dr. Levy acknowledged his unfamiliarity with the use of ultrasound as a tool for diagnosing peripheral nerve disorders, and emphasized instead that in Claimant's case, electrodiagnostic studies had revealed only mild entrapment. In his opinion, those results did not justify anything other than conservative treatment, such as splinting, stretching, physical therapy and possibly corticosteroid injections. However, I find from the medical evidence that Claimant already has undergone these therapies, without any appreciable improvement in her symptoms.

37. Dr. Levy was also unfamiliar with the efficacy of either hydro-dissection or PRP injections as treatment for Claimant's symptoms. He has no personal experience with either therapy, and gleaned only limited information about them from online research. In his opinion, neither treatment meets the recognized standard of care at this time.

Claimant's Post-Injury Wages and Temporary Disability Claim

38. Claimant's average weekly wage at the time of her August 2009 injury was $421.05. This yields a current weekly compensation rate for temporary total disability of $378.96.

39. As documented by her pay stubs, on August 14, 2011 Claimant began working as a home support aide for developmentally disabled adults. She also worked briefly as a substitute teacher, but stopped doing so when her home support aide hours increased. The work is non-physical and therefore is largely unaffected by the ongoing symptoms in her wrist. Claimant acknowledged in her formal hearing testimony that at least since February 2012 any differential between her current wages and her pre-injury wages is due primarily to client scheduling issues, not to any injury-related disability.

40. In support of her claim for temporary partial disability benefits, Claimant submitted a calculation sheet purporting to summarize the weekly differentials between the wages she has received since returning to work and her pre-injury wages. The calculation sheet lists September 9, 2011 as the first week during which Claimant earned wages; however, the accompanying pay stubs show wages paid beginning on August 14, 2011. Factoring in those wages (two weeks at $206.94 per week), I find that through February 3, 2012 the total differential between Claimant's pre-injury wages and her post-injury earnings was $4,418.64. Should she be deemed entitled to temporary partial disability benefits for this period, in accordance with 21 V.S.A. §646 the total amount owed would be $2,916.30.

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. 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).

3. The disputed issues here implicate both of these grounds for determining reasonableness. Claimant asserts that her ongoing symptoms are causally related to her work injury, that Dr. Fenton's proposed treatment plan is medically necessary, and that until she completes it she cannot be deemed to have reached an end medical result. Defendant argues that she has reached an end medical result for her work injury, that her ongoing symptoms are no longer causally related, and that even if they were Dr. Fenton's proposed treatments are unproven and therefore medically inappropriate.

4. The parties presented conflicting medical evidence as to the causal relationship question. 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).

5. Neither party's expert dominates when considering these factors. Dr. Fenton failed to review the pertinent medical records, but benefitted nonetheless from having personally examined Claimant on numerous occasions. Dr. Levy conducted a complete file review, but never discussed the severity of Claimant's symptoms directly with her. Both experts stated their causation opinions emphatically, but neither provided much in the way of detailed explanation. Both possess impressive qualifications, though their training and experience is in markedly different areas.

6. After closely considering the evidence, I conclude that Dr. Fenton's causation analysis is the most credible. I am persuaded that Claimant's current symptoms are attributable to the abnormal motion and muscle guarding that followed her August 2009 work injury and subsequent surgery, thus aggravating the preexisting pathology in her wrist.

7. Even Dr. Levy acknowledged that the work injury likely caused some aggravation of the underlying pathology in Claimant's wrist, at least for a time. Without explaining when or why the consequences of that aggravation ended, however, I cannot accept his conclusion that her symptoms are no longer related. It is true that a temporal relationship alone is often insufficient to establish causation, *Norse v. Melsur Corp.*, 143 Vt. 241, 244 (1983), but where symptoms that did not exist before are lit up by a work injury and then continue essentially unabated thereafter, breaking the causal link requires more than mere speculation. *See J.G. v. Eden Park Nursing Home*, Opinion No. 52-05WC (September 8, 2005), and cases cited therein.

8. Having concluded that Dr. Fenton's treatment plan is reasonable in the sense that it is related to Claimant's compensable injury, I next consider whether it is medically necessary. I conclude that it is.

9. The determination whether a treatment is medically necessary 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. *Cahill v. Benchmark Assisted Living*, Opinion No. 13-12WC (April 27, 2012); *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).

10. Weighing the expert testimony here, I conclude that Dr. Fenton's opinion as to the efficacy of ultrasound as a complement to electrodiagnostic testing in cases such as Claimant's is more credible than Dr. Levy's. Dr. Levy acknowledged his unfamiliarity with the use of this technique, which renders his opinion less persuasive. In contrast, Dr. Fenton's experience weighs heavily in his favor. The fact that ultrasound testing revealed findings consistent with the severity of Claimant's symptoms, whereas electrodiagnostic studies failed to do so, is also telling. I conclude that the ultrasound testing was medically necessary and therefore compensable.

11. I also conclude that Dr. Fenton's proposed treatment plan, including both hydro-dissection of the ulnar nerve at the elbow and PRP injections at the wrist, are medically necessary and therefore compensable as well. Again, I accept Dr. Fenton's opinion as more credible than Dr. Levy's on this issue. I am convinced both by his clinical experience with other patients and by Claimant's own positive response to the initial procedure that Dr. Fenton's plan offers a reasonable prospect of symptom relief and improved function.

12. Dr. Levy's principal argument against both hydro-dissection and PRP injections appears to be simply that they are new and unfamiliar to him. This is true. Dr. Levy did not cite to any specific studies establishing the treatments to be either unsafe or ineffective, however, and Dr. Fenton testified credibly that at least in his experience the opposite has so far proven true. Claimant already has tried the more conservative therapies Dr. Levy suggested without success, furthermore. Under the particular circumstances of this case, I conclude that it is appropriate to afford her the opportunity to attempt a different approach.

13. I conclude that Dr. Fenton's treatment plan is medically necessary and therefore compensable. Because the treatment is intended to be restorative rather than merely palliative, furthermore, I conclude that Claimant cannot be considered at end medical result until she completes it. 21 V.S.A. §642; *Coburn v. Frank Dodge & Sons,* 165 Vt. 529 (1996).

14. As Claimant had neither reached an end medical result nor successfully returned to work as of April 30, 2011 I conclude that Defendant was not justified in terminating her temporary total disability benefits on that date. 21 V.S.A. §643. To the contrary, I conclude that Claimant should have received ongoing temporary total disability benefits until August 14, 2011, the date upon which she began working at her current job. This period totals 15 weeks, payable at the temporary total disability rate of $378.96 per week, or $5,684.40.

15. I conclude that Claimant was entitled to temporary partial disability benefits beginning August 14, 2011, but only for so long as her reduced earning power was related to her work injury rather than to other factors, such as her clients' scheduling issues. 21 V.S.A. §646; *Orvis v. Hutchins,* 123 Vt. 18 (1962). Based on Claimant's own testimony, I conclude that any differential between pre- and post-injury wages after February 3, 2012 was no longer attributable to a work-related disability. For the period from August 14, 2011 through February 2, 2012 I conclude that Claimant is owed temporary partial disability benefits totaling $2,916.30.

16. As Claimant has substantially 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. Temporary total disability benefits totaling $5,684.40, in accordance with 21 V.S.A. §642, with interest calculated from April 30, 2011 in accordance with 21 V.S.A. §664;

2. Temporary partial disability benefits totaling $2,916.30, in accordance with 21 V.S.A. §646, with interest calculated from August 14, 2011 in accordance with 21 V.S.A. §664;

3. Medical benefits covering all reasonable medical services and supplies necessitated by Claimant's August 20, 2009 work injury, including but not limited to the treatments rendered to date and currently proposed by Dr. Fenton, in accordance with 21 V.S.A. §640; and

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

DATED at Montpelier, Vermont this 8th day of August 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.