STATE OF VERMONT
DEPARTMENT OF LABOR

Paula Perry

v.

State of Vermont,
Office of Attorney General

Opinion No. 13-13WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Anne M. Noonan
Commissioner

State File No. J-22042

OPINION AND ORDER

Hearing held in Montpelier on January 2, 2013
Record closed on February 19, 2013

APPEARANCES:

Heidi Groff, Esq., for Claimant
Keith Kasper, Esq., for Defendant

ISSUE PRESENTED:

Do various medications either previously or currently prescribed as treatment for Claimant's May 1, 1996 compensable work injury constitute reasonable medical treatment under 21 V.S.A. §640(a)?

EXHIBITS:

Joint Exhibit I:	Medical records, October 26, 2011 – November 5, 2012
Joint Exhibit II:	Prior medical records (on disc)
Claimant's Exhibit 1:	*Curriculum vitae*, John Matthew, M.D.
Claimant's Exhibit 2:	Dr. Matthew deposition, November 6, 2012
Claimant's Exhibit 3:	Medication list, 4/19/12-10/30/12
Claimant's Exhibit 4:	Prescription payment spreadsheet
Claimant's Exhibit 5:	Pharmacy prescription payment records
Claimant's Exhibit 6:	Trial memo/summary of arguments
Claimant's Exhibit 7:	Formal hearing decision, *Perry v. State of Vermont, Office of Attorney General*, Opinion No. 01-08WC (February 1, 2008)
Defendant's Exhibit A:	*Curriculum vitae*, Jonathan Sobel, M.D.

CLAIM:

Medical benefits pursuant to 21 V.S.A. §640(a)
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 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 the commissioner's prior decision in *Perry v. State of Vermont, Office of Attorney General*, Opinion No. 01-08WC (February 1, 2008).

3. Claimant worked for Defendant as an administrative assistant. On May 1, 1996 she injured her lower back while lifting some files at work. As a consequence of that injury, and despite two subsequent lumbar spine surgeries, she continues to suffer from chronic low back pain, radicular (nerve root) pain into her legs and at times, depression. She has never returned to work.

4. On January 18, 2000 the Department approved the parties' proposed Form 14 (Medical Benefits Open) Settlement Agreement. By the terms of that agreement, Claimant received $275,000.00 in full and final settlement of her claim for workers' compensation indemnity benefits. Defendant remained obligated to pay for whatever ongoing medical treatments, including prescription medications, were established to be reasonable under 21 V.S.A. §640(a).

5. In addition to the chronic pain referable to her work-related injury, Claimant suffers from a number of unrelated medical conditions as well, including diabetes, anemia, hypertension, obesity, hypothyroidism and gastroesophageal reflux disease, or GERD. Over the course of many years, Claimant's primary care physician, Dr. Matthew, has prescribed numerous medications as treatment for these conditions. Dr. Matthew is board certified in both internal and family medicine. As such, I find that he is well qualified to determine an appropriate medication regimen for patients who suffer from multiple, inter-related chronic medical conditions. Furthermore, while he holds no specific certification in pain management, I find that in his role as a primary care provider he has developed credible expertise in the effective use of pharmacology to treat chronic pain patients.

6. Defendant first questioned its responsibility for some of the medications Dr. Matthew had prescribed as treatment for Claimant's injury-related chronic pain in April 2003. Following a formal hearing in 2008, the commissioner determined that the following medications were both medically necessary and causally related, and therefore that Defendant was obligated to pay for them:

    - Amantadine, which Dr. Matthew had prescribed for chronic pain;
    - Trileptal and Keppra, prescribed for neuropathic pain;
    - Ritalin (methylphenidate), a stimulant prescribed as an adjunctive medication for depression;
    - Clonazepam and Lorazepam, prescribed as sleep aids; and
    - Lasix (furosemide), a diuretic prescribed to reduce the swelling in Claimant's ankles caused by weight gain and inactivity, and Klor-con, a supplement prescribed to counteract Lasix' potassium-wasting side effect.[1]

7. In accordance with the commissioner's 2008 opinion and order, for the next four years Defendant paid for the above prescription medications and others as well, including oxycodone and Cymbalta.

8. At Dr. Matthew's referral, in October 2011 Claimant underwent an evaluation with Dr. Fama, a rheumatologist, for complaints of joint pain involving her spine, shoulders, hips, knees, ankles, wrists and fingers. Dr. Fama noted Claimant's extensive prior medical history, including not only the conditions listed above, *see* Finding of Fact No. 5 *supra*, but also depression, chronic lumbar radiculopathy, osteoarthritis in her knees and degenerative joint disease in her hips.

9. Dr. Fama diagnosed Claimant with two conditions relevant to her rheumatic evaluation: (1) osteoarthritis involving her spine, hips, knees, feet and probably shoulders; and (2) diffuse idiopathic skeletal hyperostosis, or DISH. The latter condition is a degenerative process in which bony growths and calcifications occur not only in the spine but also in peripheral joints such as the hands and ankles. DISH can cause severe, disabling pain and stiffness in the tendons and ligaments of multiple joints. The specific cause of the condition is not yet known; it has been associated with metabolic syndromes, such as diabetes, or it might be genetically derived. Its diagnosis in Claimant's case is likely not related in any way to her May 1996 work injury.

[1] The commissioner's 2008 formal hearing decision absolved Defendant of responsibility for two medications – Plaquenil (hydroxychloroquine), used to treat inflammatory arthritis, and Prilosec (omeprazole), used to treat GERD – on the grounds that they were not causally related to Claimant's compensable work injury. Neither of these medications is at issue in the current dispute.

10. As treatment for the two conditions she diagnosed, Dr. Fama recommended that Claimant stop taking methotrexate, a drug Dr. Matthew previously had prescribed for pain and inflammation in her shoulders and hip girdle, because of its unclear benefit and deleterious side effects. Aside from endorsing her continued use of narcotic medications for pain control, Dr. Fama did not otherwise comment on Claimant's medication regimen.

11. I find that Dr. Fama's comments, as to both diagnosis and treatment, were intentionally limited to conditions within her expertise as a rheumatologist. Thus, the fact that she did not discuss in her office note the causal relationship between Claimant's 1996 work injury and her chronic low back and radicular pain does not mean that she rejected the possibility that such a relationship existed. Nor do I take Dr. Fama's failure to comment on those aspects of Dr. Matthew's medication regimen that were directed at Claimant's injury-related symptoms as an indication that she disagreed with his treatment approach.

Expert Medical Opinions as to Claimant's Current Medication Regimen

12. At Defendant's request, in January 2012 Dr. Sobel reviewed Claimant's medical records for the purpose of determining whether her current medication regimen was medically necessary and causally related to her 1996 work injury. Later, he reviewed Claimant's more recent medical records, as well as Dr. Matthew's deposition testimony. Dr. Sobel is a board certified orthopedic surgeon. In the course of his practice, he frequently has treated patients with chronic pain complaints arising from spinal injuries and dysfunction.

13. Citing Claimant's numerous medical problems, and what he characterized as "increasingly painful whole body symptoms" over the course of the past several years, to a reasonable degree of medical certainty Dr. Sobel concluded that her chronic pain syndrome is likely no longer related in any way to her 1996 work injury. To the contrary, in his opinion Dr. Fama's diagnosis of both DISH and generalized osteoarthritis fully account for Claimant's ongoing symptoms. According to Dr. Sobel, those and other non-work-related systemic conditions have driven Claimant's need for the various medications Dr. Matthew has prescribed, not her work injury.

14. With Dr. Sobel's expert opinion as support, effective February 20, 2012 the Department approved Defendant's discontinuance of the following prescription medications on the grounds that they were not causally related to Claimant's 1996 work injury:

- Amantadine
- Trileptal
- Keppra
- Ritalin
- Clonazepam
- Lorazepam
- Lasix
- Klor-con
- Oxycodone

15. Beyond concluding that Claimant's work injury was no longer driving her need for any of the above medications, in his formal hearing testimony Dr. Sobel also questioned whether some of the drugs were being used in an off-label context, and therefore might not be medically appropriate in her case. Specifically:

- Amantadine. According to Dr. Sobel, this drug is primarily used to treat movement disorders such as Parkinson's disease; in his experience it would not typically be prescribed for the type of low back and radicular pain from which Claimant suffers.

- Trileptal and Keppra. These are anti-seizure medications; Dr. Sobel speculated that they might have been prescribed off-label for pain control and depression.

- Ritalin. Ritalin's primary use is in patients with adult attention deficit disorder; Dr. Sobel assumed it was prescribed in Claimant's case for an off-label use, though he did not specify in what context or for what purpose.

16. Dr. Sobel admitted that he had no specific knowledge as to when, by whom or for what purpose the medications listed above were prescribed, or even whether Claimant was still taking them as of the date of his medical records review. I find his conclusion that these medications were inappropriately prescribed and therefore not medically necessary to be somewhat weakened as a result.

17. As for the other medications covered by Defendant's discontinuance:

- Clonazapam and Lorazepam. Dr. Sobel characterized Clonazapam as an anti-anxiety drug, and Lorazepam as a tranquilizing medication. Again, he was unaware whether Claimant was still using these drugs as of the date of his records review.

- Lasix and Klor-con. Dr. Sobel asserted that Claimant's use of these medications could not be related in any way to her 1996 work injury. From his review of the medical records, he surmised that the fluid retention and edema these drugs were designed to treat were causally related to other medical conditions from which she suffered, such as congestive heart failure and high blood pressure. To the extent the commissioner determined otherwise in the context of her 2008 formal hearing decision, Dr. Sobel declared that this was a mistake.

- Oxycodone. Dr. Sobel did not state an opinion as to whether Claimant's continued use of this narcotic was medically appropriate.

18. Claimant's current medication regimen still includes Amantadine, Lasix, Klor-con and oxycodone. She also takes Cymbalta, a pain control and antidepressant medication, and more recently added Marinol as well, another pain control medication.[2] She no longer takes Trileptal, Keppra, Ritalin, Clonazepam or Lorazepam. As Dr. Matthew credibly testified, finding the most effective combination of drugs and dosages is often a matter of trial and error, particularly when a new medication is introduced. As a result, alterations such as this to a chronic pain patient's pharmaceutical treatment plan are not unusual.

19. In his deposition testimony, Dr. Matthew emphatically defended his medication choices. Although some of the drugs he has prescribed are being used in a manner not specifically endorsed by the *Physician's Desk Reference (PDR)*, all comport with the protocols and guidelines developed in his practice group for treating chronic pain patients. Specifically:

- Amantadine. Though identified in the *PDR* for use in treating both Parkinson's disease and influenza, according to Dr. Matthew Amantadine is also of "enormous help" in treating chronic pain. Patients who use narcotic pain medications chronically often develop a hypersensitivity to pain. Once that occurs, they require ever-increasing dosages to combat a steadily decreasing pain threshold. Amantadine reverses the sensitization process, and thus allows the patient to realize more effective pain control at a lower narcotics dosage.

- Trileptal and Keppra. As Dr. Sobel correctly surmised, Dr. Matthew prescribed these anti-seizure medications off-label, because they have proven helpful in managing radicular pain.

- Ritalin. Dr. Matthew prescribed this drug to combat the sleepiness that accompanied Claimant's use of narcotic pain medications.

20. As for the other medications Dr. Matthew is now prescribing:

- Lasix and Klor-con. As he did in the context of the 2008 formal hearing, Dr. Matthew defended Claimant's need for these drugs as causally related to her 1996 work injury. The fluid retention and edema they are designed to treat have resulted in part from inactivity and weight gain caused by her work injury. In addition, the narcotic medications necessitated by her injury-related pain are also a contributing factor. These drugs aggravate Claimant's alveolar hypoventilation, a condition that restricts her breathing and causes further fluid retention and edema.

[2] Although these medications were not listed in Defendant's February 2012 discontinuance notice, both parties introduced expert evidence as to whether Claimant's need for them was causally related to her work injury. I therefore consider them to be at issue here.

- Cymbalta and Marinol. Claimant has long taken Cymbalta for management of her chronic low back and radicular pain. With the recent addition of Marinol, a drug derived from tetrahydrocannabinol, the active ingredient in marijuana, she has been able to cut her use of Cymbalta in half.

- Oxycodone. Claimant continues to require this narcotic medication for pain control, but at a significantly diminished dosage level given her greater reliance on non-narcotics such as Cymbalta and Marinol instead.[3] As a result, she no longer requires Clonazepam, Lorazepam or Ritalin.

21. Dr. Matthew strongly asserted that he is better positioned to evaluate the causal relationship between Claimant's work injury and her chronic pain than either Dr. Sobel or Dr. Fama. He respects Dr. Fama's expertise as a rheumatologist, and does not disagree with her diagnosis of DISH as a likely cause of Claimant's diffuse joint pain. However, having treated Claimant for many years, he is confident that the chronic pain from which she suffers, focused as it is primarily in her lower back and legs, derives not from that condition but rather from her 1996 work injury. I find Dr. Matthew's assertions in this regard both credible and convincing.

22. Claimant submitted pharmacy records documenting a total of $17,231.68 in third-party insurance payments and $605.39 in patient co-payments, all for medications prescribed by Dr. Matthew as treatment for her 1996 work injury. Defendant did not introduce any contrary evidence, and therefore I find that the records submitted accurately reflect the amounts so paid.

CONCLUSIONS OF LAW:

1. The disputed issue in this claim is whether Defendant is obligated to pay for Claimant's chronic pain medication regimen as reasonable treatment for her compensable May 1996 work-related low back injury. Defendant asserts that it is not, both because her current complaints are unrelated to her work injury and/or because at least some of the medications at issue are not medically necessary.

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] Contrary to Defendant's assertion, the medical records do substantiate Dr. Matthew's claim that Claimant's oxycodone dosage level has decreased with greater reliance on Cymbalta and Marinol. She still takes two 20-milligram tablets per dose, but now only three times daily rather than four. In addition, whereas in prior years she required both fast-acting and controlled release oxycodone, currently she takes only the controlled-release formulation.

3. The parties presented conflicting expert testimony on both of these factors. In such cases, 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. Considering all of these factors, I conclude here that Dr. Matthew's opinions, as to both causal relationship and medical necessity, are more credible than Dr. Sobel's. Dr. Matthew has been Claimant's treating physician for many years. Given the nature and extent of that relationship, his ability to differentiate between Claimant's injury-related chronic low back and leg pain and the diffuse joint pain that led to Dr. Fama's more recent DISH diagnosis was credible and convincing. Similarly, his pharmacological treatment plan reflects years of trial, error and revision. With constant attention, he has managed to achieve what in Claimant's case must be deemed a successful outcome – maintaining effective pain control with fewer drugs and lower narcotic dosages.

5. In contrast, Dr. Sobel's causation opinion was based entirely on an assumption – that Dr. Fama's diagnosis necessarily excluded all other possible causes for Claimant's ongoing pain – which I have specifically rejected. That he was personally unfamiliar with the specific nature of her injury-related symptoms was evident not only in this regard but also as to the various drugs comprising her medication regimen. For Dr. Sobel to conclude that certain medications were not medically necessary without knowing who prescribed them or for what purpose indicates an unacceptable lack of clarity, thoroughness and objective support. For these reasons, I reject his opinions as unpersuasive.

6. I conclude that Claimant has sustained her burden of proving that her current medication regimen, as prescribed and managed by Dr. Matthew, is both medically necessary and causally related to her 1996 compensable work injury. It therefore constitutes reasonable medical treatment under 21 V.S.A. §640(a).

7. Specifically, I conclude that the following prescription medications have been, and/or continue to be, compensable under 21 V.S.A. §640(a):

- Amantadine
- Trileptal
- Keppra
- Ritalin
- Clonazepam
- Lorazepam
- Lasix
- Klor-con
- Oxycodone
- Cymbalta
- Marinol

8. Having found the above medications compensable, I conclude that Defendant is obligated to reimburse Claimant for prescription co-payments totaling $605.39. In addition, should any third-party payor assert a lien or claim repayment for prescriptions, Defendant is obligated to reimburse them accordingly.[4]

9. As Claimant has prevailed on her claim for benefits, she is entitled to an award of costs and attorney fees. She has submitted a request for costs totaling $227.64, and these are awarded. As for 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.

[4] I decline to grant Claimant's request that reimbursement due to third-party payors be paid to her first. This is a matter for resolution directly between Defendant and the payors. *See, Avdibegovic v. University of Vermont,* Opinion No. 06-09WC (February 23, 2009).

ORDER:

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

1. Medical benefits covering reasonable treatment for Claimant's compensable 1996 work-related injury, including but not limited to the prescription medications listed in Conclusion of Law No. 7 above, in accordance with 21 V.S.A. §640(a);

2. Reimbursement to Claimant for prescription co-payments totaling $605.39, with interest as calculated in accordance with 21 V.S.A. §664;

3. Reimbursement to any third-party payor who asserts a lien and/or claims repayment for any of the prescriptions listed in Conclusion of Law No. 7 above, with interest as calculated in accordance with 21 V.S.A. §664 if so demanded by the payor;

4. Litigation costs totaling $227.64 and attorney fees in an amount to be determined, in accordance with 21 V.S.A. §678(a).

DATED at Montpelier, Vermont this 25th day of April 2013.

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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.