George Fifield v. Heatech Inc (February 25, 2015)

STATE OF VERMONT
DEPARTMENT OF LABOR

George Fifield

v.

Heatech, Inc.

Opinion No. 04-15WC

By: Phyllis Phillips, Esq.
Hearing Officer

For: Anne M. Noonan
Commissioner

State File No. CC-57213

OPINION AND ORDER

Hearing held in Montpelier on December 4, 2014
Record closed on January 21, 2015

APPEARANCES:

Mark Kolter, Esq., for Claimant
Erin Gilmore, Esq., for Defendant

ISSUE PRESENTED:

Does the sacroiliac joint injection recommended by Claimant's treating provider constitute reasonable medical treatment causally related to his compensable October 29, 2010 work injury?

EXHIBITS:

Joint Exhibit I:	Medical records
Claimant's Exhibit 1:	Melynda Wallace, CRNA, office note, February 13, 2014
Claimant's Exhibit 2:	Letter from Maureen Boardman, FNP, May 12, 2014
Claimant's Exhibit 3:	Letter from Melynda Wallace, CRNA, April 6, 2014
Claimant's Exhibit 4:	Letter from Leonard Rudolf, MD, November 10, 2014
Claimant's Exhibit 5:	*Curriculum vitae*, Leonard Rudolf, MD
Defendant's Exhibit A:	*Curriculum vitae*, Douglas Kirkpatrick, MD

CLAIM:

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 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.

Claimant's October 2010 Work Injury and Subsequent Medical Course

3. Claimant worked for Defendant as a woodstove installer. On October 29, 2010 he suffered a work-related injury while lifting a 400-pound cast iron woodstove with a coworker. Claimant felt a "pop" in his lower back, followed by severe pain, dizziness and blurred vision. After a brief rest, he took "a handful of pills" and continued working.

4. Claimant did not seek medical treatment for his injury until almost two months later. On December 20, 2010 he presented to Dr. Reynolds with complaints of lingering tightness, spasm and pain at the base of his spine, all causally related to the October 2010 lifting incident. Defendant accepted the injury, initially diagnosed as chronic low back pain, as compensable and paid workers' compensation medical benefits accordingly.

5. Claimant embarked thereafter on a course of conservative treatment supervised by Maureen Boardman, a family nurse practitioner who practices with Dr. Reynolds, and who has been Claimant's primary care provider since 2001. At first his symptoms were described as involving only his lower back, but over time he developed left-sided buttock, hip, thigh and leg pain as well. Imaging studies done in February 2011 (x-ray), June 2012 (MRI) and February 2013 (MRI) revealed only some early lumbosacral degenerative disc and facet disease. However, there was no nerve root impingement, and therefore no explanation for these left-sided symptoms.

6. At Ms. Boardman's referral, between 2011 and 2013 Claimant underwent three courses of physical therapy, as well as extensive acupuncture treatments, with no sustained relief of his low back pain. Concerned over his worsening left leg pain, in January 2013 Ms. Boardman referred Claimant to Dr. Magnadottir, a neurosurgeon, for further evaluation. Again, however, with no evidence of nerve root compromise or spinal canal narrowing visible on MRI, Dr. Magnadottir concluded that his condition was not surgically correctable.

Sacroiliac Joint Dysfunction as Possible Pain Generator

7. In June 2013 Ms. Boardman referred Claimant to Melynda Wallace, a pain specialist, for consideration of alternative treatment modalities. Ms. Wallace is a certified registered nurse anesthetist and nurse practitioner, and also a certified fellow with the American Academy of Pain Management. She has been specializing in chronic pain management since 2004, and has extensive training and experience in treating sacroiliac joint disorders.

8. The sacroiliac (SI) joint forms the anatomic junction between the sacrum, which is the pelvic bone located at the very base of the spine, and the ilium, which is the large, upper bone comprising either half of the pelvis. The SI joint attaches at the iliac crest, which is located below and approximately three inches to the side of the spinal column. At hearing, Claimant credibly identified this area as the location of his pain. His medical records substantiate these complaints, dating back at least to June 2011.

9. Ms. Wallace first evaluated Claimant in February 2014. Based both on the history he reported and on her focused clinical examination, she suspected that his pain originated not from his lumbar spine, as other medical providers had assumed, but rather from his SI joint. Among the specific clues she noted:

- The mechanism of Claimant's injury, though admittedly consistent with many pain generators, was certainly not inconsistent with an SI joint injury;

- The timing and quality of Claimant's reported symptoms, which initially involved the sensation of a "pop" in his lower back with "knifelike" left buttock and leg pain developing more gradually, are more suggestive of sciatic irritation due to a loosening SI joint than it is of an injury to the muscles around the spinal column itself;

- The absence of any identified pain generator on lumbar spine MRI studies that could account for Claimant's symptoms, combined with his failure to improve despite extensive physical therapy targeting his lumbosacral spine, suggested an alternative cause; and

- Claimant's positive response to various clinical tests indicative of SI joint dysfunction (for example, compression, Patrick's, Gaenslen, ASIS distraction and Fortin finger tests) and negative response to tests indicative of lumbosacral dysfunction (for example, straight leg raise, sensory, strength, reflex, motor and facet loading tests) tended to rule out the latter diagnosis, and made the former one more likely.

10. While the factors listed above are sufficient to establish SI joint dysfunction as a possible cause of Claimant's pain, the "gold standard" for definitively diagnosing the condition is by way of an SI joint injection, and this is Ms. Wallace's recommended next step. Using radiologic imaging to ensure that the needle is correctly positioned, a small amount of local anesthetic is injected directly into the SI joint capsule. The patient then tests the joint while it is numb, by standing, sitting and moving about. If he or she experiences significant pain relief, then the diagnosis can be made with assurance. If not, then the search for another pain generator must resume.

11. Ms. Wallace has done hundreds of SI joint injections over the course of her career. She credibly described the procedure as a relatively inexpensive means of obtaining essential diagnostic information.

12. Asked why no other medical provider had yet recognized the possibility that Claimant's symptoms might be attributable to SI joint dysfunction rather than chronic low back pain, Ms. Wallace credibly testified that the diagnosis is often overlooked. Concurrent with the advent of MRI studies in the 1970's, the general medical community has for some time focused primarily on the vertebral discs in the spinal column as the most common cause of low back pain. Despite its large size, only recently has the focus begun to shift to the SI joint as a possible pain generator. Yet SI joint dysfunction accounts for approximately twenty percent of all low back pain etiologies.

13. From the medical records she reviewed, Ms. Wallace also inferred that the other providers who evaluated Claimant likely did not perform the same type of focused clinical exam that she undertook in order to justify including SI joint dysfunction in her differential diagnosis. The provocative tests she performed, during which as she described, "you pretty much have to turn people into a pretzel," are designed to isolate the joint from its surrounding structures. Merely palpating the area, as Dr. Magnadottir appears to have done, for example, is inadequate.[1] Based on my own review of the medical records, I find this analysis completely credible.

14. Ms. Wallace credibly dismissed the few reports of contrary diagnostic indications from other providers as well. When questioned about a physical therapist's finding in January 2011 that a Faber's test was negative for sacroiliac provocation, she noted that that maneuver by itself only tests for hip pain; to isolate the pain specifically to the SI joint further provocative testing is also necessary. And when asked about Ms. Boardman's report of a positive straight leg raise test in May 2012, she explained that the details necessary to identify the pain as radicular in origin were lacking. I find these explanations credible.

15. In fact, Ms. Boardman herself corroborated Ms. Wallace's testimony. She acknowledged that by focusing first on Claimant's low back as the primary pain generator, she and other providers had overlooked the possibility that his symptoms might instead have originated from his SI joint. When she repeated Ms. Wallace's provocative testing in April 2014, she too concluded that the results justified further evaluation and treatment for possible SI joint dysfunction causally related to his October 2010 work injury. She thus believes that an SI joint injection is now clearly indicated. I find this analysis credible.

16. Assuming the recommended injection confirms her diagnosis, in Ms. Wallace's opinion Claimant's SI joint dysfunction is likely causally related to his October 2010 work injury. Though the provocative testing she performed did not occur until some three and a half years later, she believes the temporal relationship between the lifting event and the onset of his pain is sufficient to establish the connection. I find this analysis credible.

[1] Dr. Boucher as well noted no "sciatic notch or sacroiliac tenderness" in the course of his June 2011 independent medical examination. As with Dr. Magnadottir, there is no evidence that he did anything other than merely palpate the area, however.

17. According to Ms. Wallace, if the diagnosis of SI joint dysfunction is confirmed the appropriate next step would be a course of physical therapy aimed specifically at isolating the SI joint. If that proves unsuccessful, then she likely would refer Claimant to Dr. Rudolf for consideration of possible SI joint fusion surgery. As discussed *infra*, Finding of Fact No. 26, Dr. Rudolf is an orthopedic surgeon who has developed specialized expertise in this area.

18. SI joint fusion surgery is a relatively new, minimally invasive operative procedure. The rationale upon which it is based is that pain occurs when the ligaments supporting the SI joint become stretched or dislodged, thus allowing excess motion. Fusing the joint restricts it from wiggling around.

19. Preliminary research studies have so far established SI joint fusion surgery as both safe and effective. Ms. Wallace testified to her knowledge of four such studies published since 2012 – two conducted by Dr. Rudolf and two by another researcher. Patients in all four studies reported markedly diminished pain scores with minimal if any surgical complications. Perhaps more striking, follow-ups in each of the studies documented ongoing pain relief at one, two, three and in one study even five years post-surgery.

20. Ms. Wallace's clinical experience has been similarly positive. At least twelve of her patients have undergone SI joint fusion surgery with Dr. Rudolf; all have experienced either marked or complete relief of symptoms, with no complications.

Claimant's Current Status

21. Claimant has never lost any time from work as a consequence of his injury. He left Defendant's employ in mid-December 2010, and has continued to work since then as a self-employed carpenter and general contractor. He still experiences pain in his left hip, left buttock and down his left leg, all worsened with extended driving or sitting. He remains able to hunt, fish and hike, though to a somewhat more limited extent than he was previously.

Expert Medical Opinions

(a) Dr. Kirkpatrick

22. At Defendant's request, in March 2014 Dr. Kirkpatrick, a board certified orthopedic surgeon, reviewed Claimant's medical records and rendered an opinion whether an SI joint injection constitutes reasonable medical treatment for his October 2010 work injury. Dr. Kirkpatrick is a board certified orthopedic surgeon. Although he has experience treating SI joint injuries, in all his years of practice he has never referred a patient for an SI joint injection.

23. From his review of the medical records, Dr. Kirkpatrick concluded that for Claimant to undergo treatment, including diagnostic injection, for SI joint dysfunction is neither medically necessary nor causally related to his work injury. Among the salient points underlying his opinion regarding causation:

- An SI joint injury typically occurs as a result of significant trauma to the pelvis itself, such as might occur in a motor vehicle accident or with a fall from a substantial height. Because the joint is a fairly solid structure, merely bending and lifting, as was the case here, would be an unlikely mechanism of injury;

- Prior to Ms. Wallace's involvement, Claimant's medical records document numerous evaluations of his SI joint by a variety of medical providers, none of whom found any evidence to support a diagnosis of SI joint dysfunction;

- Coming more than three years after the fact and from a provider whose training as a nurse anesthetist presumably was "not as rigorous" as some of the other evaluators, Ms. Wallace's diagnosis of SI joint dysfunction causally related to Claimant's work injury is suspect.

24. I can find no evidence whatsoever to support this last presumption. In fact, viewed in light of her extensive training and experience treating SI joint dysfunction patients, Ms. Wallace's credible testimony establishes just the opposite.

25. As for the medical necessity of an SI joint injection to confirm the diagnosis, Dr. Kirkpatrick asserted:

- As with any injection into a joint, an SI joint injection is not an entirely benign procedure, but rather carries with it the risk of infection, cartilage breakdown and damage to the joint itself;

- If palpating the joint and performing a Faber's test produce negative results, as various evaluators prior to Ms. Wallace reported, then neither additional provocative testing nor a joint injection are necessary to rule out a diagnosis of SI joint dysfunction.

(b) Dr. Rudolf

26. At Claimant's request, in November 2014 Dr. Rudolf reviewed Claimant's medical records and stated his opinion whether an SI joint injection constitutes medically necessary treatment for Claimant's October 2010 work injury. Dr. Rudolf is a board certified orthopedic surgeon. He has extensive experience treating patients who suffer from SI joint dysfunction, and with the advent of minimally invasive techniques, since 2007 he has developed a special interest in SI joint fusion surgery as a treatment option. He has performed more than 160 such surgeries, and as Ms. Wallace referenced in her testimony, Finding of Fact No. 19 *supra*, he has published two patient outcome studies reporting positive results. Dr. Rudolf acknowledged that he owns a small stock interest in the company that manufactures the surgical hardware he uses, and also has entered into a consulting agreement for the purpose of training other surgeons in the procedure. I find that these business interests have not affected his ability to render a credible opinion as to the disputed issues specifically before me now.

27. Based on his review of the medical records, Dr. Rudolf concluded that Claimant likely suffered a lumbar strain/sprain as a consequence of his October 2010 lifting injury, and subject to diagnostic confirmation, probably SI joint dysfunction as well. It is very common for an injury to result in more than one anatomical pain generator, and also for treatment to be more oriented in one direction rather than another, at least initially. In Claimant's case, it was reasonable at the start to treat the injury as if it consisted solely of a lumbar strain. However, when his symptoms first persisted and then worsened, it became appropriate to consider other anatomical structures. According to Dr. Rudolf, Ms. Wallace's focus on the SI joint as a diagnostic entity meriting further evaluation was thus entirely justified. I find this analysis persuasive.

28. As with all joints, anatomically the SI joint is composed of bones, supporting ligaments and surface cartilage. In the context of an injury to the area, the ligaments may become stretched, which causes the joint to become lax. Increased motion causes stress, which either alone or in combination with a loss of surface cartilage integrity causes the joint to become painful.

29. Dr. Rudolf is well acquainted with Ms. Wallace. He described her as both astute and thorough, and for that reason he has considerable respect for her abilities as a pain management provider. He fully supported the methodology she employed to evaluate the possibility that Claimant's SI joint was a likely pain generator. In Dr. Rudolf's words, it was a "textbook workup," beginning with a review of the patient's medical history, including both mechanism of injury and reported symptoms, and then progressing to a detailed and meticulous physical examination with provocative testing.

30. As for why earlier evaluators failed to appreciate the possibility of SI joint involvement as a pain generator, Dr. Rudolf concluded simply that they had not oriented their thinking in the direction of differential diagnoses. In fact, he found elements indicative of SI joint dysfunction in their medical records; for example, the acupuncturist with whom Claimant treated throughout 2011 and 2012 reported symptoms of SI joint pain on more than one occasion, and Dr. Boucher's June 2012 independent medical examination included a pain drawing in which Claimant depicted the site of his pain at the approximate location of his left SI joint. Neither provider documented the type of focused exam that Ms. Wallace undertook, however, which explains why they may have missed these clues. "You're not going to find what you're not looking for," Dr. Rudolf admonished. I find this analysis credible.

31. Provocative testing having created an index of suspicion for SI joint dysfunction, Dr. Rudolf concurred "100 percent" with Ms. Wallace's recommendation that Claimant undergo an SI joint injection to confirm the diagnosis. He described the procedure as very low risk, with no real contraindications. None of his patients have reported any complications. I find this testimony credible.

32. Should Claimant respond positively to an SI joint injection, according to Dr. Rudolf the reasonable next steps treatment-wise likely would include targeted physical therapy, non-steroidal anti-inflammatories, and possibly radiofrequency ablation and/or prolotherapy. Dr. Rudolf was not asked and did not render an opinion whether Claimant was a likely candidate for SI joint fusion surgery.

33. As to the cause of Claimant's SI joint dysfunction, in Dr. Rudolf's opinion, to a reasonable degree of medical certainty the October 2010 lifting injury was likely a significant factor. The medical history did not indicate a preexisting condition, the temporal relationship between the injury and the onset of his symptoms was strong, and there is no evidence of a more likely causative event. I find this analysis credible.

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 issue in this case is whether Ms. Wallace's proposed SI joint injection constitutes reasonable medical treatment for Claimant's October 2010 work injury. The parties offered conflicting expert testimony on the question. 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. With particular focus on the fourth and fifth factors, I conclude that Ms. Wallace's and Dr. Rudolf's opinions are the most credible. Both practitioners have extensive training, experience and expertise in diagnosing patients who suffer from SI joint dysfunction. Both cogently described the importance of conducting the type of detailed and focused exam that Ms. Wallace undertook as a means of establishing the differential diagnosis. Both relied on the experience of their own patients in asserting that a joint injection is a safe, effective and inexpensive means of confirming the diagnosis. And though not directly relevant to the specific issue before me now, in the event the joint injection yields positive results, both are familiar with recent treatment innovations, up to and including SI joint fusion surgery.

5. In contrast, Dr. Kirkpatrick's opinion was based primarily on the fact that until Ms. Wallace, prior evaluators had failed to appreciate the possibility that Claimant's pain might be originating from his SI joint. Had there been documentation that these earlier providers conducted the same sort of focused examination that Ms. Wallace undertook to support her diagnosis, perhaps I would have found Dr. Kirkpatrick's reliance on their reports more justified. Without such evidence, I remain unpersuaded. As in so many areas of medical decision-making, the analysis required to make an accurate diagnosis is most often a question of quality, not quantity.

6. Should the diagnosis of SI joint dysfunction be confirmed, I further conclude that Ms. Wallace's and Dr. Rudolf's opinions regarding causation are more persuasive than Dr. Kirkpatrick's. Again, their extensive experience treating SI joint dysfunction patients lends greater credibility to their analyses.

7. I conclude that Claimant has sustained his burden of proving that an SI joint injection is medically necessary to confirm a diagnosis of SI joint dysfunction causally related to his

October 2010 work injury. It therefore constitutes reasonable medical treatment under 21 V.S.A. §640.

8. As Claimant has prevailed on his claim for benefits, he 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 his itemized claim.

ORDER:

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

1. Medical benefits covering all reasonable medical services and supplies associated with SI joint injection as proposed by Ms. Wallace, in accordance with 21 V.S.A. §640; 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 February 2015.

_____
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.