STATE OF VERMONT
DEPARTMENT OF LABOR

Katie Dye	Opinion No. 10-20WC
v.	By: Stephen W. Brown Administrative Law Judge
Pine Heights at Brattleboro Center for Nursing and Rehabilitation	For: Michael A. Harrington Commissioner
	State File No. KK-63488

OPINION AND ORDER

Hearing held in Montpelier on January 22, 2020
Record closed on April 6, 2020

APPEARANCES:

Robert D. Mabey, Esq., for Claimant
Keith J. Kasper, Esq., for Defendant

ISSUE PRESENTED:

What is the extent, if any, of Claimant's permanent partial disability?

EXHIBITS:

Joint Exhibit 1:	Joint Medical Exhibit ("JME")
Joint Exhibit 2:	Stipulation
Claimant's Exhibit 1:	*Curriculum Vitae* of Douglas P. Kirkpatrick, MD
Claimant's Exhibit 2:	Deposition of Douglas P. Kirkpatrick, MD
Defendant's Exhibit A:	*Curriculum Vitae* of William F. Boucher, MD

FINDINGS OF FACT:

1. I take judicial notice of all relevant forms and correspondence in the Department's file for this claim. I also take judicial notice of the AMA Guides to the Evaluation of Permanent Impairment, 5th ed. (the "AMA Guides").

2. Claimant is a 27-year-old woman who presently resides in Grand Isle, Vermont. As of April 2018, she resided in Newfane, Vermont, and was employed as a licensed practical nurse and charge nurse at Defendant's long-term care facility in Brattleboro, Vermont. In that role, she managed the care of 29 residents and oversaw the work of other floor staff. Her average weekly wage for the period relevant to this case was $1,105.00. (*See* Joint Exhibit 2).

3. On April 29, 2018, Claimant was performing a safety check at the beginning of her shift when she noticed that a male resident was attempting to "self-transfer." Knowing that this resident was not capable of self-transfer, Claimant entered his room to assist. The resident lost his balance while Claimant was standing in front of him, and she reached her right arm out to prevent him from hitting his head on the bed-side table.

4. Claimant weighed approximately 110 pounds at the time of the incident and credibly estimated that the resident weighed approximately 200 pounds.

5. Claimant temporarily bore the resident's full weight with her right arm but stabilized herself on the resident's bed with her left arm. She was eventually able to move the resident back onto his bed.

6. She immediately felt pain down through her back underneath her scapula and numbness and tingling down her arm into all the fingers of her right hand. She experienced muscle spasms in her right shoulder and stabbing pains in her back and the inside of her right forearm. After the incident, she also experienced a significant decrease in right-hand grip strength and had trouble holding on to items in that hand.

7. On May 2, 2018, she presented to ClearChoiceMD Urgent Care in Brattleboro, where her nurse practitioner suspected a rotator cuff injury and prescribed muscle relaxants and nonsteroidal anti-inflammatory drugs. She was released to light-duty work at that time. (JME 1-2).

8. After one day of light-duty work, her symptoms worsened. She returned to the urgent care center on May 7, 2018, with complaints of pain and shoulder tenderness and scapular winging. At that time, she started taking prednisone and began physical therapy. (JME 3-10).

9. For the rest of that month, Claimant treated with injections, gabapentin, and other conservative modalities. (JME 13-46). In June 2018, her pain became so severe that she visited the Brattleboro Memorial Hospital's emergency department (JME 47-56), where she was taken out of work entirely until further notice. (JME 56, 60).

10. Later that month, she followed up with orthopedic specialists and also underwent electrodiagnostic and MRI studies, neither of which revealed any specific abnormalities. (*See* JME 71-78). However, her providers still kept her out of work. (JME 79). She continued to experience significant pain and complained to her providers of numbness in her fingers, weakness in her hand and arm, and of problems continually dropping things. She began treating with trigger point dry needling (*e.g.*, JME 84-89, 96-99), and by August 2018, her physician recommended a more active physical therapy regime as well as trigger point injections. (JME 112-114).

11. In September 2018, Claimant began receiving psychological counseling for anxiety and depression related to her pain and functional limitations. (*E.g.*, JME 160-163). That same month, she also began a work hardening program that consisted of seven two-hour sessions over approximately two weeks and involved exercises designed to

increase her work capacity. Although she had difficulty tolerating these sessions and often had to end early due to worsened shoulder symptoms, she made functional gains during that program. Nonetheless, she continued to experience increased right arm pain afterward. (JME 183). In November 2018, she was released back to work with restrictions. (JME 200).

12. When Claimant returned to work for Defendant, she initially attempted to perform administrative work such as typing and charting with her left arm only. However, Defendant was ultimately unable to accommodate her work restrictions, and her employment with Defendant eventually ended.

13. Claimant now works as an overnight charge nurse at an independent living facility in Saint Albans, Vermont, where a significant portion of her job duties consists of paperwork. She can generally perform her job functions in that role within her physical limitations, but she still occasionally experiences pain that interferes with her daily activities.

14. Her current symptoms include persistent numbness and tingling, primarily in her right fourth and fifth fingers, but occasionally numbness near her right thumb when writing; episodic pain in her forearm with activity; and pain and spasms in her right shoulder. Her functional limitations include restricted abduction of her right shoulder, a 35-pound lifting restriction, and a recommendation against repetitive motions with her right shoulder. She did not have any of these symptoms or limitations before her April 2018 injury.

15. The parties disagree as to the extent of Claimant's permanent impairment under the AMA Guides, and each side presented expert testimony in support of its position. Defendant presented William F. Boucher, MD, who performed an independent medical examination ("IME") of Claimant on November 29, 2018 and found no permanent impairment. Claimant presented Douglas P. Kirkpatrick, MD, who performed a permanent impairment evaluation of Claimant on May 14, 2019; he assessed Claimant with injuries to her ulnar and long thoracic nerves and rated her whole person impairment under the AMA Guides as 16 percent.[1] Their respective opinions are discussed below.

Dr. Boucher's IME and Testimony

16. Dr. Boucher is a board-certified preventative medicine physician and independent medical examiner who resides in Biddeford, Maine. His clinical work in Maine comprises approximately ten percent of his practice, with the remaining ninety percent of his practice consisting primarily of forensic work such as IMEs, almost all of which he performs at the request of insurers.

[1] Initially, Dr. Kirkpatrick found that Claimant's whole person impairment rating was 17%, but he revised that figure to 16% in an addendum to correct a computation error. (JME 256-257).

17. Dr. Boucher travels to Vermont approximately four days per month to conduct IMEs. While in Vermont, he usually conducts four or five IMEs per day, although sometimes he performs as many as seven in a day.

18. Dr. Boucher's IME of Claimant lasted approximately one hour, roughly three-quarters of which consisted of him reading Claimant's medical file[2] aloud into a recording device while Claimant sat in the room. He spent approximately ten minutes physically examining her.

19. During his physical examination, Dr. Boucher tested Claimant's shoulder range of motion for extension and flexion, but he did not test her shoulder's adduction or abduction ranges of motion. He also asked her to turn her head from side to side and measured her cervical spine's range of motion.

20. He testified that the range of motion measurements he took were normal, but acknowledged that he performed only one measurement of each range of motion parameter, rather than the three measurements required by the AMA Guides.[3] When asked on cross-examination about his choice to take only a single measurement for each movement instead of the three required by the AMA Guides, Dr. Boucher testified that Claimant's counsel was "missing the point" and that "that's the way everyone operates" when the initial reading is normal.[4]

21. Dr. Boucher also briefly placed his hand on Claimant's scapula and asked her to move it to check for scapular winging, which he testified that he did not find. He acknowledged that some of her medical notes referred to slight scapular winging but stated later notes did not.

22. He testified that scapular winging can indicate an injury to the long thoracic nerve, but that winging can also result from other sources such as muscular problems. However, he testified that because injuries to the long thoracic nerve are permanent and do not disappear and reappear, he believes that if Claimant has any winging, it must be due either to a new injury or muscular deconditioning. He does not believe that she has a long thoracic nerve injury.

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[2] There is some uncertainty as to the completeness of Dr. Boucher's medical records review, specifically as it relates to records from Claimant's work hardening program, which are not referenced in his IME report. However, his report reflects a review of most of Claimant's other key medical records and he demonstrated a familiarity with the essential chronology of Claimant's treatment.

[3] *See* AMA Guides at 403 ("Perform at least three measurements of each motion. Determine which measurements meet reproducibility criteria described under general measurement principles…").

[4] Defendant contends that Dr. Boucher's failure to perform three range of motion measurements as required by the AMA Guides is not relevant because Dr. Kirkpatrick did not specifically base Claimant's permanent impairment on her range of motion. I disagree and find Dr. Boucher's noncompliance with the Guide's mandatory guidelines in this respect relevant to the overall thoroughness of his examination. Although Dr. Kirkpatrick did not assess permanency specifically for a range of motion deficit, his observations during his range of motion testing led him to conduct the portions of his examination that ultimately resulted in his conclusion that Claimant had suffered long thoracic and ulnar nerve injuries. *See generally* Findings of Fact Nos. 32-34, *infra.*

23. He also testified that Claimant did not have an ulnar nerve injury. He appears to have based this opinion primarily on his review of Claimant's medical records. In particular, he cited the lack of evidence before Dr. Kirkpatrick's 2019 permanency evaluation of strength or sensory deficits that could be attributable to Claimant's ulnar nerve.

24. For instance, Dr. Boucher did not test Claimant's grip strength but instead relied on an absence of any recorded grip strength deficit in her medical records in determining that she did not have an ulnar nerve injury, although he also characterized grip strength as "highly subjective." He also relied on Claimant's normal EMG nerve conduction studies in forming his opinion concerning her ulnar nerve, although he credibly acknowledged that patients with ulnar nerve injuries can nonetheless have normal EMG studies.

25. Claimant told Dr. Boucher during the IME that her symptoms included numbness, tingling, and diminished hand strength. Dr. Boucher described her pain as diffuse and testified that in his opinion, Claimant's symptoms in her hand were inconsistent with the pattern of nerves that go to the hand.

26. Dr. Boucher diagnosed Claimant with a right shoulder girdle strain, psychogenic pain, and depression. (JME 216). He found that there was a "possible causal relationship" between her present complaints and her April 2018 workplace injury, but that her shoulder girdle pain had resolved and that her current complaints were "psychogenic in nature." (*Id.*). Specifically, he stated in his report that her

> … psychologist seemed to attribute her psychological difficulties to her injury. However, given the lack of objective evidence of injury, it is far more likely that the opposite is true. She does have a significant degree of psychogenic pain, which has not been adequately addressed.

(*Id.*)

27. Dr. Boucher acknowledged at the formal hearing that he is not a psychologist or psychiatrist. I do not find that he has offered any compelling explanation or support for his opinion concerning the psychogenesis of Claimant's current complaints, particularly given the cursory nature of his physical examination and the lack of support for this causal theory from Claimant's own psychologist. (*Cf.* JME 160-163). Instead, it appears that Dr. Boucher did not look very hard for a physiological explanation of Claimant's complaints and relied on the existence of mental health care records to explain Claimant's symptoms as psychogenic. I do not find his analysis convincing in this regard.

28. In December 2019, over a year after he performed his IME, Dr. Boucher prepared an addendum to his report, in which he stated that in his opinion, Claimant had become more deconditioned and that her ongoing work restrictions were "due to her stature and not any specific injury." (JME 260). I find this unpersuasive, particularly given

that Dr. Boucher did not speak with or re-examine Claimant before rendering this supplemental opinion.

29. In Dr. Boucher's opinion, Claimant has no objective physiological impairment. He therefore assessed her with a zero percent permanent impairment rating under the AMA Guides.

Dr. Kirkpatrick's Evaluation and Testimony

30. Dr. Kirkpatrick is a board-certified orthopedic surgeon and certified independent medical examiner residing in Glens Falls, New York. Approximately ninety percent of his practice in New York consists of clinical practice, and the remaining ten percent consists of primarily of performing IMEs.

31. Dr. Kirkpatrick reviewed all of Claimant's medical records before performing his permanency evaluation in May 2019. His evaluation lasted approximately two hours, most of which consisted of a physical examination.

32. During his physical examination of Claimant, Dr. Kirkpatrick tested her range of motion multiple times and observed her move freely. After observing that her right shoulder blade would not hold its position, he checked for scapular winging, which he found to be present. In his report, Dr. Kirkpatrick noted that Claimant's scapular winging was "not seen as clearly in forward flexion but with abduction clearly the claimant is unable to hold her shoulder blade in appropriate position during abduction." (JME 247).

33. Because there are multiple types of winging, he performed additional shoulder tests, including the strength in Claimant's serratus anterior, the main muscle that controls the shoulder blade. He found that muscle was diminished by 50 percent, which is typically associated with a long thoracic nerve injury and/or a brachial plexus injury. He also found that manual manipulation of Claimant's shoulder blade improved her symptoms, which suggested denervation of the serratus anterior. Based on his observations and clinical findings, he concluded that Claimant had suffered a long thoracic nerve injury, which he credibly explained was consistent with the mechanism of her injury.[5]

34. Dr. Kirkpatrick also assessed Claimant for sensory loss along her ulnar nerve distribution, including two-point discrimination, and found a 50 percent loss of sensation in the fourth and fifth fingers, which are in that nerve's distribution. He found intrinsic weakness with abduction and adduction, and performed static grip strength tests, which showed that Claimant had roughly half as much strength on her right side as on her left, even though she is right-handed. (JME 248). Based on his

[5] Although Dr. Kirkpatrick believes that Claimant likely also suffered a broader brachial plexus injury, and that such an injury would provide a causal explanation for Claimant's observed ulnar nerve deficits, he credibly testified that his examination did not yield enough objective support or consistency for him to render a permanent impairment rating specifically attributable to her brachial plexus.

findings of sensory and motor loss, he determined that Claimant had suffered an ulnar nerve injury.

35. Although Dr. Kirkpatrick did not conduct EMG testing on Claimant,[6] he was aware that her prior EMG was normal, and he credibly characterized that result as an outlier in her total clinical picture. He noted that her EMG did not specifically test the serratus anterior or the long thoracic nerve, (JME 256), and he credibly cited studies showing that ulnar nerve injuries in particular are difficult to diagnose via EMG.[7] Additionally, in his experience as a surgeon, he has operated on many patients for ulnar nerve issues who had normal EMGs, which he credibly testified is consistent with the surgical standard of care when other clinical findings include clear numbness and weakness in the relevant distribution.

36. Based on his clinical findings, Dr. Kirkpatrick assessed a 50 percent impairment attributable to Claimant's long thoracic nerve injury and a 50 percent impairment attributable to her ulnar nerve injury. Following the guidelines and tables in the AMA Guides, he combined his ratings to form a 26 percent upper extremity impairment, which translated to a 16 percent whole person impairment rating. (JME 256-257). I find Dr. Kirkpatrick's analysis clear, credible, and persuasive.

CONCLUSIONS OF LAW:

1. Claimant has the burden of proof to establish all facts essential to the rights she presently asserts. *Goodwin v. Fairbanks Morse & Co.*, 123 Vt. 161, 166 (1962); *King v. Snide*, 144 Vt. 395, 399 (1984). She must establish by sufficient credible evidence the character and extent of the injury, *see Burton v. Holden & Martin Lumber Co.*, 112 Vt. 17, 20 (1941), as well as the causal connection between the injury and the employment. *Egbert v. The Book Press*, 144 Vt. 367, 369 (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, supra*, 112 Vt. at 20; *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. 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;

[6] The AMA Guides recommend but do not require that compression neuropathies like those that Dr. Kirkpatrick assessed in Claimant be confirmed with EMG studies. *See* AMA Guides at 493 (providing that diagnosis "*should* be documented by electromyography [EMG] as well as sensory and motor nerve conduction studies.") (emphasis added).

[7] Dr. Boucher expressed a general familiarity with the studies concerning the limitations of EMG for ulnar nerve diagnostics, but he but broadly characterized those studies as "flawed."

and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (Sept. 17, 2003).

3. In this case, Drs. Boucher and Kirkpatrick both demonstrated impressive qualifications and credentials, reviewed at least most of the pertinent medical records, and were retained as forensic examiners rather than as treating providers. Thus, the first, second, and fifth factors weigh substantially equally as to the two experts.

4. However, I find that the third and fourth factors favor Dr. Kirkpatrick's analysis. He performed a significantly more detailed and intensive physical examination than Dr. Boucher and provided a convincing account of how deficits in Claimant's long thoracic and ulnar nerves contributed to her present symptoms and limitations. *See* Findings of Fact Nos. 30-36. By contrast, Dr. Boucher's physical examination was so brief as to raise significant questions about how much information he could meaningfully gain about Claimant's condition through his own observations. He relied heavily on the absence of findings in other providers' medical records rather than thoroughly examining Claimant himself. He also did not adequately rule out physiological mechanisms before concluding Claimant's pain to be primarily psychogenic in origin. *See* Findings of Fact Nos. 16-29. Based on the entirety of the evidence presented, I find Dr. Kirkpatrick's testimony more persuasive.

5. Claimant is therefore entitled to permanent partial disability benefits consistent with a 16 percent whole person disability rating. 21 V.S.A. § 648.

ORDER:

Based on the foregoing findings of fact and conclusions of law, Defendant is ORDERED to pay permanent partial disability benefits consistent with a 16 percent whole person impairment referable to Claimant's physical injuries.

DATED at Montpelier, Vermont this 16th day of June 2020.

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Michael A. Harrington
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.