STATE OF VERMONT
DEPARTMENT OF LABOR

Robert Bushey

v.

Adecco

Opinion No. 22-21WC

By: Beth A. DeBernardi
Administrative Law Judge

For: Michael A. Harrington
Commissioner

State File No. HH-57891

OPINION AND ORDER

Hearing held via Microsoft Teams on July 14, 2021 and August 11, 2021
Record closed on October 1, 2021

APPEARANCES:

Vanessa B. Kittell, Esq., for Claimant
Erin J. Gilmore, Esq., for Defendant

ISSUES PRESENTED:

1. When did Claimant reach an end medical result for his accepted January 2016 back injury?

2. What is the correct permanent impairment rating for Claimant's accepted January 2016 back injury?

3. Did Claimant sustain a psychological injury causally related to his accepted January 2016 back injury?

EXHIBITS:

Joint Exhibit I:	Joint Medical Exhibit ("JME")
Claimant's Exhibit 1:	*Curriculum Vitae* of Laurance Thompson, MS
Claimant's Exhibit 2:	Graph depicting progression of mental health concerns
Claimant's Exhibit 3:	Graph depicting mental health concerns in the context of Claimant's back injury
Claimant's Exhibit 4:	*Curriculum vitae* of Mark Bucksbaum, MD
Claimant's Exhibit 5:	Graph depicting medical treatment of the lumbar spine
Claimant's Exhibit 6:	*AMA Guides*, §§ 15.2 – 15.2a
Claimant's Exhibit 7:	Spinal regions diagram
Claimant's Exhibit 8:	Spinal levels diagrams
Claimant's Exhibit 9:	*Curriculum vitae* of Nathaniel Burns, PA-C
Claimant's Exhibit 10:	List of PA Burns' office visits and referrals

CLAIM:

Temporary disability benefits pursuant to 21 V.S.A. §§ 642 and 646
Permanent partial disability benefits pursuant to 21 V.S.A. § 648
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. Claimant was an employee and Defendant was his employer as those terms are defined in the Vermont Workers' Compensation Act.

2. I take judicial notice of all forms in the Department's file relating to this claim.

Claimant's Employment with Defendant

3. Claimant is a 54-year-old man who lives in East Berkshire, Vermont. He began working for Defendant around January of 2013. Defendant is a supplier of temporary staffing to various businesses.

4. Claimant worked several temporary job assignments during his employment with Defendant, including assignments with Revision Military and GenFoot. His last assignment was with Franklin Foods, a cream cheese producer based in Enosburg, Vermont.

5. Claimant worked at Franklin Foods as a palletizer. His position involved inspecting the product, bringing test supplies to quality control, placing the finished product on pallets, and bringing pallets to the warehouse.

Claimant's January 2016 Work Injury

6. On January 2, 2016,[1] Claimant loaded a pallet and then used an electric pallet jack to transport it towards a set of 12-foot-wide swinging doors. When he attempted to go through the doors with his pallet, he ran into another pallet situated inside the doorway. As Claimant reported when he first sought medical treatment on January 5, 2016, "the handle of the pallet jack ran into him hitting him in the left lower back pushing it up under his rib cage." (JME 2-1).

7. Claimant completed his work shift on January 2, 2016, despite pain in his lower back. He then went home, took a hot bath, and "tried to walk it off." On January 5, 2016, he first sought medical treatment for his injury at Northwestern Occupational Health. (JME 2-1 to 2-3).

[1] The First Report of Injury (Form 1) lists the injury date as January 2, 2016. The earliest medical records also list the injury date as January 2, 2016. *See, e.g.*, JME 2-1 (medical report of January 5, 2016 concerning a January 2, 2016 injury). Other documents in the Department's file list the injury date as January 5, 2016.

8. Defendant accepted Claimant's low back injury as compensable and paid some workers' compensation benefits accordingly.

Claimant's Subsequent Medical Treatment for his Back Injury

9. On January 5, 2016, Northwestern Occupational Health diagnosed Claimant with a lower back contusion and muscle spasm. (JME 2-1). He underwent some physical therapy and chiropractic adjustments. In September 2016, he received epidural steroid injections. (JME 3-27). Also in September, orthopedic surgeon Michael Barnum, MD, noted that Claimant would not benefit from surgery. (JME 3-21).

10. Claimant followed up with Dr. Barnum on February 14, 2017. (JME 3-54). Dr. Barnum diagnosed Claimant with mechanical low back pain. His medical record notes that Claimant got no lasting relief from the steroid injections. Dr. Barnum's recommendations for additional treatment at that time included aquatic therapy, land-based therapy and a work conditioning program. (JME 3-55).

11. Claimant saw Dr. Barnum again on May 17, 2017. (JME 3-57). Dr. Barnum recommended that he continue physical therapy and participate in a restoration program. (JME 3-61).

12. Claimant was discharged from physical therapy on July 17, 2017, when he declined to participate further. (JME 4-111 to 4-112). He did not engage in a functional restoration program in 2017 or 2018.

13. On May 31, 2018, Claimant saw physician assistant Timothy Balise in Dr. Barnum's office. (JME 3-58). Noting Claimant's continued left lower back pain, PA Balise wrote that Claimant had undergone numerous conservative treatments, including physical therapy and injection therapy, without significant improvement. Further, he noted that Claimant's 2016 MRI revealed minimal spondylosis with no significant neural compromise. (JME 3-58). PA Balise recommended continuation of Claimant's home exercise program, an updated MRI and, depending on the MRI findings, a possible referral to Dr. Shapiro for a diagnostic left SI joint injection. (JME 3-60). The medical records do not indicate that the MRI was performed, nor did Claimant follow up with Dr. Shapiro.

14. In November 2019, Claimant participated in a two-week functional restoration program at Dartmouth-Hitchcock Medical Center.[2] He had some physical therapy and chiropractic treatment in 2020.

Claimant's Subsequent Diagnosis and Medical Treatment for Depression

15. Claimant underwent an independent medical examination at Defendant's request with osteopath John Peterson, DO, on June 27, 2016. (JME 12-1 to 12-10). During the

[2] Claimant received temporary total disability benefits during his participation in the functional restoration program in November 2019.

examination, Dr. Peterson obtained data showing that Claimant's CES-D[3] score was 21, which indicates a depressed mood. (JME 12-8).

16. Dr. Peterson performed a second independent medical examination of Claimant on October 10, 2016. (JME 13-1 to 13-8). Again, Claimant's CES-D score indicated a depressed mood. (JME 13-6).

17. In August 2018, Claimant saw orthopedist Nicholas Antell, MD, at Copley Hospital. Dr. Antell noted Claimant's depressed mood at that time. (JME 9-10).

18. Claimant participated in a functional restoration program at Dartmouth-Hitchcock Medical Center from November 5 through November 22, 2019. His status was assessed via a "touch pad questionnaire" at the beginning and end of the program. A score of 19 or higher on the assessment indicates the presence of depression. Claimant's score at the beginning of the program was 22, and his score at the end was 20. Both scores indicate depression. (JME 7-29). On December 20, 2019, Dartmouth-Hitchcock staff indicated that Claimant might benefit from counseling focused on emotions and behaviors associated with chronic pain. Specifically, the provider mentioned cognitive behavioral therapy or biofeedback. (JME 7-65).

19. In January 2020, Claimant's son tragically committed suicide while they were talking on the telephone. On January 14, 2020, Claimant's vocational rehabilitation counselor called his primary care provider, PA Nathaniel Burns, to suggest a referral for counseling.

20. Claimant saw PA Burns on February 13, 2020, for several conditions, including depression. (JME 10-18 to 10-22). He reported "little interest or pleasure in doing things" and "feeling down, depressed or hopeless." (JME 10-18). More specifically, Claimant reported that his mood was down "from chronic pain, his son committing suicide, running out of money." (JME 10-19).[4] PA Burns assessed Claimant with adjustment disorder with depressed mood at this visit. (JME 10-21). PA Burns' office note states:

> He reports he has felt down since last fall, due to chronic pain and financial issues. This was exacerbated by his son committing suicide last month. He is interested trying a medication and seeing counsellor.

(JME 10-21).

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[3] The Center for Epidemiological Studies-Depression Scale (CES-D) is a 20-item measure that identifies and quantifies symptoms associated with depression. *See* American Psychological Association, Center for Epidemiological Studies-Depression, at www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/depression-scale, last accessed on October 20, 2021.

[4] The review of symptoms (ROS) section of the same medical record states that Claimant denies anxiety and depression. (JME 10-19). Given the affirmative statements about depression specifically related during this office visit, I find that the "ROS" section simply carried information forward from visit to visit without updating.

21. PA Burns' office had a licensed clinical social worker on staff at that time, Matthew Perrett. Claimant began counseling with Mr. Perrett on February 20, 2020. (JME 10-23). They had two counseling sessions before Mr. Perrett left his employment at the Richford Health Center. Claimant's discussions with Mr. Perrett included his feelings of depression related to his chronic pain, as well as his son's suicide. On February 27, 2020, Mr. Perrett noted that Claimant "continues to struggle with pain, which appears to be playing a large role in depressive symptoms." (JME 10-26).

22. Claimant returned to PA Burns on April 8, 2020 for a telehealth visit. (JME 10-29). PA Burns prescribed Cymbalta for Claimant's adjustment disorder with depressed mood. (JME 10-30). He also made a referral to a psychologist.

23. Claimant began treatment with master's level psychologist Laurance Thompson, MS, on April 22, 2020. (JME 17-1). Mr. Thompson listed Claimant's chief complaint as depression related to his work injury. In describing his work accident to Mr. Thompson, Claimant reported that he hit an electric skidder at work, was thrown ten feet, and lost consciousness. *Id.* Claimant reported increasing depression since his injury, including irritability, sadness, loss of interest, and pessimism. (JME 17-2). He attributed his depression to pain and physical limitations from his work injury and told Mr. Thompson that his depression was made worse by his son's suicide. *Id.*

24. Claimant saw Mr. Thompson again on April 29, 2020 (JME 17-5) and June 3, 2020 (JME 17-8). They discussed Claimant's worries about his physical and vocational future, and his feelings of low mood and hopelessness. (JME 17-9). Mr. Thompson expressed concern about Claimant's degree of depression and hopelessness and suggested an in-person visit for their next meeting. (JME 17-9).

25. Claimant met with Mr. Thompson one more time, in person, on June 9, 2020. (JME 17-12). This visit included a clinical interview, a Millon Behavioral Medicine Diagnostic (MBMD), a Pain Patient Profile, and a medical records review. They discussed Claimant's worries about his physical limitations, pain, financial future and loss of motivation. The MBMD testing found that Claimant responded to the questions in an open and honest manner and that he was substantially more depressed than the typical medical patient. (JME 17-14). Mr. Thompson's office note includes the following:

> I doubt the loss of his son has no lasting effect[;] however, most of his present depressive and anxious thoughts revolve around his work injury and fears of his future due to the injury. In addition, prior to his son's death, DHMC identified depression and pain related fears. His depression did seem to improve as his physical abilities improved. It is reasonable to conclude that his increased experience of pain and limitations along with uncertainty about his financial future and fears of losing his home is the primary driver of his present depression.

(JME 17-15).

Claimant's Prior Medical History and Current Status

26. Claimant previously asserted a claim for a work-related low back injury in 2011,[5] but he credibly testified that he had recovered from his prior injury before January 2016. Further, the prior injury did not prevent him from working full time and full duty for Defendant.

27. Claimant credibly described his current pain as a sudden "grab" or "grabbing" in his low back up under his ribcage. When the pain occurs, he displays a "flinching" reaction. He has difficulty sleeping and tires easily when performing physical chores. As of the hearing date, he had not returned to work, although he has been pursuing a vocational rehabilitation plan for small engine repair.

28. At the time of hearing, Claimant had a prescription for a depression medication but was not treating with a counselor.

Medical Opinions Concerning End Medical Result

29. The parties do not dispute that Claimant has reached an end medical result for his work-related back condition, but they disagree as to when he reached end medical result.

(a) Michael Barnum, MD

30. Michael Barnum, MD, is an orthopedic surgeon at Northwestern Orthopaedics in St. Albans, Vermont. He is one of Claimant's treating providers. On May 17, 2017, Dr. Barnum wrote that Claimant had reached an end medical result for his back injury. The relevant medical record provides as follows:

> At this point think patient is a point maximum medical improvement. He can work according to prescriptions of his functional capacity evaluation dated February 2017, had a sedentary job description. I would recommend he continue partial restoration program according to his FCE and I will see him back in 3-4 months check on his progress

(JME 3-61).

31. In its Requests to Find and Memorandum of Law, Defendant contends that Claimant reached an end medical result for his work-related back injury on May 17, 2017, based on Dr. Barnum's medical record. *Defendant's Requests to Find,* at 14-15.

32. The only basis that Dr. Barnum provided for his end medical result opinion was the functional capacity evaluator's statement that Claimant was able to work a sedentary job description. (JME 3-61). However, an individual's work capacity does not determine end medical result status. Rather, end medical result is the point at which a

[5] State File No. CC-01958.

person has reached a substantial plateau in the medical recovery process, such that significant improvement is not expected regardless of treatment. *See* Workers' Compensation Rule 2.2000. Dr. Barnum's opinion fails to address whether Claimant had reached a substantial plateau in his recovery process on May 17, 2017.

33. Further, on that date, Dr. Barnum recommended that Claimant participate in a "partial restoration program"[6] and then return for another visit in three to four months, so his progress could be checked. I find this recommendation, including the expectation of progress, to be at odds with the notion that Claimant had reached a substantial plateau in his recovery. For these reasons, I reject Dr. Barnum's conclusion that Claimant reached an end medical result on May 17, 2017.

(b) Mark Bucksbaum, MD

34. Mark Bucksbaum, MD, is a board-certified physical medicine and rehabilitation physician. He is also board-certified in pain management and as an independent medical examiner. Dr. Bucksbaum obtained his medical degree from St. George's University School of Medicine in Granada, West Indies, in 1984. He has a clinical physiatry practice in Rutland, where he focuses on pain management and addiction medicine.

35. At Claimant's request, Dr. Bucksbaum conducted an independent medical examination of him on January 30, 2019. (JME 15-1 through 15-40). The examination included a focused physical examination, an interview, and a medical records review. Claimant also completed questionnaires for Dr. Bucksbaum concerning his pain, function and abilities. Dr. Bucksbaum has never provided medical treatment to Claimant.

36. Dr. Bucksbaum diagnosed Claimant with chronic mechanical low back pain, L2-3 and L3-4 level spondylosis without radiculopathy or myelopathy, left-sided sacroiliac joint dysfunction, and chronic sprain of the left iliocostalis thoracis muscle. (JME 15-38).

37. In Dr. Bucksbaum's opinion, Claimant reached an end medical result for his work-related back condition on August 2, 2018. On that date, Claimant's treating provider at Copley Hospital offered no plan for additional treatment, but rather suggested Claimant follow up on an as needed basis. (JME 9-2). In Dr. Bucksbaum's opinion, as of that date, Claimant's condition was permanent and stationary, with no further recovery or restoration of function expected.

38. In Dr. Bucksbaum's opinion, Claimant was not at end medical result on May 31, 2018 because, on that date, PA Balise outlined a treatment plan that included an MRI and, depending on the MRI findings, possibly a left sacroiliac joint injection with Dr. Shapiro. (JME 3-58). Although Claimant did not undergo an MRI or a joint injection between May 31, 2018 and August 2, 2018, Dr. Bucksbaum testified that further recovery was expected on the earlier date but not on the later date.

[6] Dr. Barnum's medical records are compiled using voice recognition software. *See, e.g.*, JME 3-62. Accordingly, he may have dictated "*functional* restoration program," rather than "*partial* restoration program."

39. I find Dr. Bucksbaum's end medical result opinion to be credible, well supported by Claimant's medical records, and appropriately based on the requirements for end medical result set forth in the *American Medical Association Guides to the Evaluation of Permanent Impairment (5th ed.)* ("*AMA Guides*"). Accordingly, I find his opinion persuasive.

(c) George White, MD

40. George White, MD, is a board-certified occupational medicine physician. He obtained his medical degree from the University of Vermont Medical School in 1982 and currently works as an independent medical examiner and consultant. He has many years' experience treating patients with work injuries and evaluating such injuries.

41. At Defendant's request, Dr. White performed an independent medical examination of Claimant on April 20, 2018. (JME 14-1 through 14-8). Dr. White interviewed Claimant, performed a physical examination, and reviewed the medical records related to his back injury. He diagnosed Claimant with chronic low back pain. (JME 14-7).

42. In Dr. White's opinion, Claimant had reached an end medical result for his work-related back condition by the time of his April 20, 2018 independent medical examination. The basis for Dr. White's opinion was that Claimant's low back condition had been going on for about two years and appeared stable. Further, Claimant was not a surgical candidate, nor did he have a plan for any additional treatment. Finally, no substantial change in Claimant's condition was likely in the foreseeable future.

43. Although Dr. White's end medical result opinion is generally well supported, he did not take into consideration the treatment plan set forth in the May 31, 2018 medical record, as his examination took place before that date. As a result of this omission, Dr. White was not in as good a position to offer an end medical result opinion as was Dr. Bucksbaum. I thus find his opinion less persuasive than Dr. Bucksbaum's.

Medical Opinions Concerning Permanent Impairment

44. The parties also presented conflicting medical opinions concerning the permanent impairment referable to Claimant's back condition.

(a) Dr. Bucksbaum

45. Dr. Bucksbaum cited § 15.2 of the *AMA Guides* as setting forth two methods for assessing spinal impairment. The section provides as follows:

> Spinal impairment rating is performed using one of two methods: the diagnosis-related estimate (DRE) or range-of-motion (ROM) method.

> *The DRE method is the principal methodology used to evaluate an individual who has had a distinct injury.* When the cause of the impairment is not easily determined and if the impairment can be well characterized by the DRE method, the evaluator should use the DRE method.
>
> The ROM method is used in several situations:
>
> (1) When an impairment is not caused by an injury . . .
> **(2) When there is multilevel involvement in the same spinal region (eg, fractures at multiple levels, disk herniations, or stenosis with radiculopathy at multiple levels or bilaterally).**
> (3) Where there is alteration of motion segment integrity (eg, fusions) at multiple levels in the same spinal region . . .
> **(4) Where there is recurrent radiculopathy caused by a new (recurrent) disk herniation or a recurrent injury in the same spinal region.**
> (5) Where there are multiple episodes of other pathology producing alteration of motion segment integrity and/or radiculopathy.

AMA Guides, § 15.2 (*italics* in original; emphasis added in **bold**).

46. Dr. Bucksbaum selected the ROM method to assess Claimant's permanent impairment for two reasons. First, Claimant had a previous lumbar spine injury in February 2011. Under Dr. Bucksbaum's reading of the *AMA Guides*, § 15.2, ¶ 4, the ROM method is required because Claimant has a "recurrent injury in the same spinal region."

47. Second, in Dr. Bucksbaum's opinion, the ROM method is required because Claimant has "multilevel involvement in the same spinal region," as set forth in § 15.2, ¶ 2. Dr. Bucksbaum's opinion that Claimant has multilevel involvement relies on the following medical records:

- *Dr. Shapiro's September 2016 record of epidural steroid injections administered at more than one level of Claimant's lumbar spine (JME 3-27)*: Dr. Shapiro's record states that such injections would be "diagnostic and hopefully therapeutic." *Id.* Depending on Claimant's response to those injections, Dr. Shapiro's plan was to proceed with additional injections, possibly at other spinal levels. *Id.* When Dr. Shapiro saw Claimant two weeks after his steroid injections, he noted that Claimant had achieved some pain reduction; however, Dr. Shapiro did not attribute that result to any specific level of spinal treatment. (JME 3-34). Thus, to the extent that the injections were meant to be diagnostic, no diagnosis of a specific level or levels was made. Further, Dr. Shapiro's records do not document any additional injections at any levels of Claimant's spine.[7] Dr. Bucksbaum nevertheless

[7] In February 2017, Claimant reported to Dr. Barnum that he had no lasting relief from Dr. Shapiro's injections. (JME 3-54).

interpreted Dr. Shapiro's treatment as establishing multilevel involvement. Dr. Bucksbaum testified, "We don't put needles in people's backs for fun. It's done because we believe that you have a reasonable chance of having a benefit from those procedures." Although I do not doubt that treatment goal, Dr. Shapiro's treatment did not identify specific levels of Claimant's spine as the source of his pain; accordingly, his course of treatment does not establish multilevel involvement.

- *A February 2017 imaging study that identified mild disc space narrowing at L2/3 and L3/4 (JME 15-27)*: Although he relied on this study to support his opinion of multilevel involvement, Dr. Bucksbaum did not convincingly explain why these mild findings were likely the source of Claimant's back pain. Dr. Bucksbaum acknowledged that many people over age 40 have degenerative changes in their spines and that radiologic findings of abnormalities do not necessarily correlate with pain generators. He further acknowledged that imaging studies are typically not used to make a diagnosis. Accordingly, I find that this imaging study does not establish multilevel involvement.

- *Dr. Antell's August 2018 record assessing Claimant with SI joint dysfunction and facet arthropathy (JME 9-2)*: Although Dr. Antell made this assessment, he informed Claimant that he does not treat spine pathology and that the purpose of the visit was specifically just to evaluate his left hip. Having ruled out Claimant's hip as a source of his pain complaints, Dr. Antell referred Claimant back to his regular providers. *Id.* Given the limited and specific purpose of Dr. Antell's examination, I find that his work up of Claimant's hip does not establish that his back symptoms arise from multiple levels of his spine, either.

48. Having considered these medical records that form the basis for Dr. Bucksbaum's opinion that Claimant has multilevel involvement, I find that his opinion lacks objective support and is therefore unpersuasive.

49. Based on Dr. Bucksbaum's reading of the *AMA Guides*, the ROM method is required under the circumstances presented here. He therefore used the ROM method to assess Claimant with a 13 percent whole person impairment related to his lumbar spine. To ensure the validity of his assessment under the ROM method, he measured Claimant's range of motion with two inclinometers, and he repeated each measurement three times, as set forth in Figure 15-8 and § 15.9a of the *AMA Guides*. Based on Dr. Bucksbaum's credible testimony, I find that he properly computed the impairment rating under the ROM method.

50. However, this finding does not address whether the ROM method was the best method to use under these circumstances. With respect to Dr. Bucksbaum's first justification for using the ROM method, the parties do not dispute that Claimant had a prior low back injury. Whether that fact, standing alone, is sufficient to require the ROM

method, however, depends on one's interpretation of the *AMA Guides*, discussed at Conclusion of Law Nos. 11-13 *infra*.

51. As to his second justification for using the ROM method, multilevel spinal involvement, Dr. Bucksbaum's opinion that Claimant has multilevel involvement lacks objective support. *See* Finding of Fact No. 48 *supra*. Thus, his opinion that the ROM method is required under § 15.2, ¶ 2, is unpersuasive.

(b) <u>*Dr. White*</u>

52. Dr. White also cited the *AMA Guides* as providing two methods for evaluating permanent impairment of the spine, the DRE method and the ROM method. He credibly explained that the DRE method is the one to use in most cases, unless an individual meets the criteria for the ROM method. In his opinion, Claimant did not meet the ROM method criteria, so he used the DRE method in this case.

53. In determining that Claimant did not meet the criteria for the ROM method, Dr. White specifically addressed both his prior injury and whether his low back condition has multilevel involvement. First, under Dr. White's reading of the *AMA Guides*, § 15.2, ¶ 4, a prior injury by itself does not meet the criteria for using the ROM method. Rather, ¶ 4 provides that the ROM method should be used if the individual has a *recurrent radiculopathy* caused by *either* a new (recurrent) disk herniation *or* caused by a recurrent injury in the same spinal region. Thus, Dr. White interprets ¶ 4 as setting forth the conditions under which a recurrent radiculopathy requires the ROM method. He does not read "recurrent injury to the same spinal section" as a stand-alone criterion, but rather as part of the paragraph concerning radiculopathy. As Claimant did not have radiculopathy during Dr. White's independent medical examination, he did not meet the criteria of ¶ 4 for the ROM method.

54. Dr. White also considered whether to use the ROM method under the multilevel involvement provision set forth in § 15.2, ¶ 2. He decided against that methodology for two reasons. First, he was not convinced that Claimant has multilevel involvement. In his experience, abnormalities shown on radiologic imaging studies do not necessarily correlate with a patient's pain generators. Further, injection therapies administered to multiple levels of the spine do not establish which level or levels are the source of pain. Accordingly, in Dr. White's opinion, Claimant's medical records do not establish multilevel involvement. Second, even if Claimant had pain generators at multiple levels of his spine, he would not meet the criteria for the ROM method under ¶ 2 because he does not have fractures at multiple levels, or disk herniations or stenosis with radiculopathy at multiple levels, as required by his reading of ¶ 2. Accordingly, Dr. White used the DRE method to assess Claimant's impairment.

55. To determine Claimant's impairment under the DRE method, Dr. White reviewed the lumbar spine injury categories set forth in Table 15-3 of the *AMA Guides* and selected DRE lumbar spine category II as the applicable one. That category allows an impairment rating of from five to eight percent. Based on his clinical judgment, Dr. White determined that Claimant has a seven percent whole person impairment

referable to his lumbar spine. Dr. White explained that he selected seven percent in part because Claimant was in worse shape than the hypothetical man set forth in Example 15-2, who was assessed with a five percent impairment. Dr. White did not rate Claimant with eight percent, however, because he has encountered other individuals in DRE category II who have a more severe impairment than Claimant does, based on his experience. As he explained, assigning an impairment rating within the five to eight percent range is a clinical judgment call. I find Dr. White's explanation of his selection of DRE category II and his assessment of seven percent within that category to be well supported by his methodology, judgment and clinical experience.

56. Dr. White did not rate Claimant under the pain chapter of the *AMA Guides*, as the *AMA Guides* direct the examiner to use the more specific section for the body part or system at issue, except in limited circumstances that do not apply here. He explained that the five to eight percent range available under DRE category II allows the examiner to take an individual's pain into consideration and that he did so here. I find this testimony credible.

57. As both physicians correctly applied their chosen method for assessing permanent impairment under § 15.2 of the *AMA Guides*, the impairment rating for Claimant's back condition turns on whose interpretation of the *AMA Guides* is the more persuasive one. With insufficient evidence of multilevel involvement, the potential basis for the ROM method is Claimant's prior low back injury, as set forth in § 15.2, ¶ 4. The interpretation of this paragraph is discussed at Conclusion of Law Nos. 11-13 *infra*.

Medical Opinions Concerning Claimant's Psychological Condition

(a) Nathaniel Burns, PA-C

58. Nathaniel Burns is a certified physician assistant who has worked for the Richford Health Center for eight years. He obtained his MS degree from Northeastern University's physician assistant program in 2013 and participated in multiple clinical rotations, including one in psychiatry. (Claimant's Exhibit 9).

59. As a primary care provider, PA Burns has experience diagnosing and treating depression and other mental health conditions. When a patient presents a mental health complaint like depression, he takes the patient's history, evaluates any medical, biologic or other causes for the condition, and discusses condition management with the patient. Management may include counseling, coping mechanisms and prescription medications. Although PA Burns does not provide counseling, he has training in coping mechanisms and is licensed to prescribe medications.

60. PA Burns has been Claimant's primary care provider since 2016. He first saw Claimant for his back injury in May 2018 and has seen him for this condition multiple times since. Accordingly, PA Burns is familiar with Claimant's ongoing complaints of back pain.

61. On February 13, 2020, Claimant told PA Burns that he felt depressed from chronic pain, financial concerns, and his son's suicide. (JME 10-18 to 10-22). PA Burns diagnosed Claimant with an adjustment disorder with depressed mood. He referred Claimant for counseling with his office social worker, Matthew Perrett, and also prescribed an antidepressant called Cymbalta. PA Burns chose Cymbalta because that drug treats both pain and mood disorders. In April 2020, after Mr. Perrett's departure from the practice, PA Burns referred Claimant to psychologist Laurance Thompson for counseling.

62. PA Burns offered his opinion at the hearing that Claimant suffers from an adjustment disorder with depressed mood directly related to his back pain from his workers' compensation injury. He based his opinion on his established treating relationship with Claimant and on his knowledge, training and experience as a physician assistant, including diagnosis and treatment of patients with chronic pain and depression. In PA Burns' opinion, Claimant's depression is consistent with what he sees from other chronic pain patients.

63. Based on PA Burns' ongoing treating relationship with Claimant, and his knowledge, training and experience in diagnosing and treating patients with depression, I find his opinion to have a firm objective basis and to be credible.

(b) *Laurance Thompson, MS*

64. Laurance Thompson is a clinical psychologist who practices at the Central Vermont Medical Center's occupational medicine clinic. He obtained his master's degree in psychology from Millersville University in 1979 and has been treating patients continuously since 1985. Mr. Thompson specializes in behavioral medicine for chronic pain patients, including many patients who have work injuries. He is one of Claimant's treating providers. (JME 17-1 through 17-16).

65. Mr. Thompson has diagnosed Claimant with adjustment disorder with depressed mood and anxiety. In his opinion, to a reasonable degree of psychological certainty, Claimant's depression and anxiety are causally related to the chronic pain and functional limitations presented by his 2016 back injury.

66. In making these diagnoses, Mr. Thompson relied on his counseling sessions with Claimant, his clinical interview of Claimant, and two diagnostic tests that he administered: the Millon Behavioral Medicine Diagnostic (MBMD) and the Pain Patient Profile. In his opinion, the MBMD indicated that Claimant was experiencing substantially more depressive symptoms than the typical medical patient and that he was significantly more distressed than was usual for him. The MBMD includes validity indicators embedded in the diagnostic; those indicators suggested that the test data were valid. Similarly, the Pain Patient Profile indicated that Claimant was suffering from increased depression, anxiety, and concern about his physical symptoms.

67. As these diagnostic tests do not themselves establish the cause of Claimant's depression and anxiety, Mr. Thompson relied on Claimant's presentation of his thoughts and beliefs during treatment. Those thoughts and beliefs related primarily to his chronic pain, his loss of avocational activities, and concern for his financial future. Although Mr. Thompson thought that Claimant's son's suicide also had an effect on his psychological condition, the content of his depressive and anxious thoughts revolved around his work injury, chronic pain, and future fears. Mr. Thompson also relied on the records from the Dartmouth-Hitchcock functional restoration program providers, who identified depression in November 2019, prior to the loss of Claimant's son, in concluding that the primary driver of his psychological condition was chronic pain.

68. Mr. Thompson did not think that Claimant was feigning psychological symptoms in order to reap any secondary gains.

69. Based on Mr. Thompson's treating relationship with Claimant, which provided him with a first-hand opportunity to assess his complaints and credibility, and based on his knowledge and experience as a psychologist who specializes in chronic pain, I find Mr. Thompson's opinion to be well grounded, clearly expressed and persuasive.

(c) *William Nash, Ph.D.*

70. William Nash, Ph.D., is a licensed psychologist. His current practice focuses on forensic psychological evaluations in workers' compensation and criminal matters. Dr. Nash obtained a master's degree in counseling psychology from the University of Vermont and a doctorate in psychology from Walden University in Minneapolis in 1992.

71. In July 2020, Dr. Nash reviewed Claimant's medical records and provided a written report to Defendant concerning whether Claimant's psychological treatment was reasonable treatment for his work injury. (JME 18-1 through 18-12). He was not a treating provider in this case, nor did he ever meet Claimant or perform a psychological evaluation of him.

72. Dr. Nash testified that he identified some anomalies or "red flags" in his review of Claimant's medical records, including Claimant's variable reports about how his injury occurred, one reference to a low effort in physical therapy, and the fact that Claimant's mental health treatment did not commence until shortly after his son's suicide. According to Dr. Nash, these "red flags" tell him that Claimant might be "gaming the system."

73. Further, Dr. Nash expressed concern that Claimant was dishonest in his presentation to Mr. Thompson, for example, by exaggerating his work accident to include hitting his head and losing consciousness, details for which there is no contemporaneous evidence. Dr. Nash also noted that Claimant told Mr. Thompson he was diagnosed with depression at Dartmouth-Hitchcock, but Dr. Nash found no mention of depression in the Dartmouth-Hitchcock medical records. Similarly, Dr. Nash noted

that Claimant did not mention depressive symptoms in his independent medical examinations with Dr. White or Dr. Bucksbaum. Based on these concerns, Dr. Nash concluded that Claimant could be feigning depression for secondary gain.

74. I find most of Dr. Nash's concerns to be unfounded. Claimant's depression is in fact mentioned in the Dartmouth-Hitchcock medical records (JME 7-29 and 7-65) and in both of Dr. Peterson's 2016 independent medical examinations. (JME 12-8 and 13-6). Further, although Claimant reported a loss of consciousness to Mr. Thompson without having reported that to any provider previously, there is no evidence that Mr. Thompson based his opinions specifically on whether Claimant lost consciousness on January 2, 2016, nor are there other indications that Claimant was untruthful with Mr. Thompson. For these reasons, I find Dr. Nash's testimony generally unpersuasive.

75. Finally, Dr. Nash did not offer his own opinion as to the causal relationship between Claimant's psychological condition and his work injury. Rather, he recommended that Defendant arrange for an independent assessment of Claimant's psychological condition before approving or disapproving any treatment for depression. (JME 18-11). No such assessment has been performed.

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, *see, e.g., Burton v. Holden & Martin Lumber Co*., 112 Vt. 17 (1941), 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, supra* at 19; *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. Where the causal connection between employment and injury is obscure, and a layperson could have no well-grounded opinion as to causation, expert medical testimony is necessary. *Lapan v. Berno's Inc.*, 137 Vt. 393, 395-96 (1979).

End Medical Result

3. End medical result is the point at which an individual has reached a substantial plateau in the medical recovery process, such that significant improvement is not expected regardless of treatment. Workers' Compensation Rule 2.2000.

4. Claimant contends that he reached end medical result for his accepted January 2016 back injury on August 2, 2018, based on Dr. Bucksbaum's opinion. Defendant contends that Claimant reached end medical result by April 20, 2018, as Dr. White testified.

5. 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).

6. In this case, the second *Geiger* factor is the determining one. Although Dr. White offered a thorough and well-supported opinion, he did not have the benefit of PA Balise's May 31, 2018 medical record outlining a treatment plan from which improvement in Claimant's condition could be expected. *See* Finding of Fact No. 43 *supra*. As Claimant did not pursue that treatment plan, Dr. Antell advised him on August 2, 2018 to just follow up as needed. In Dr. Bucksbaum's opinion, based on these additional medical records, Claimant reached an end medical result on August 2, 2018.

7. Dr. Bucksbaum's opinion is clear, thorough and well-supported by the additional medical records that were not available to Dr. White. I therefore find his opinion the most persuasive and conclude that Claimant reached an end medical result for his accepted January 2016 back condition on August 2, 2018.

Permanent Impairment

8. Vermont's workers' compensation statute provides that the determination of the degree of permanent partial impairment shall be made as set out in the Fifth Edition of the *AMA Guides*. 21 V.S.A. § 648(b).

9. Claimant contends that he has a 13 percent whole person impairment based on Dr. Bucksbaum's application of the ROM method set forth in the *AMA Guides*. Defendant contends that Claimant has a seven percent whole person impairment based on Dr. White's application of the DRE method. Both physicians correctly applied their respective methods. *See* Finding of Fact Nos. 49, 55-56 *supra*. Thus, the assessment of Claimant's permanent impairment turns on which method was the best one to use in the circumstances presented here.

10. As both physicians credibly testified, the *AMA Guides* provide that the DRE method is the principal methodology for assessing spinal impairment and that the evaluator should use the DRE method unless one of five situations is present. *See AMA Guides*, § 15.2.

11. Dr. Bucksbaum first contends that the ROM method is indicated because Claimant has "a recurrent injury in the same spinal region." *AMA Guides*, § 15.2, ¶ 4. He reads ¶ 4 as requiring the ROM method if the individual has a recurrent radiculopathy caused by a new (recurrent) disk herniation or if the individual has a recurrent injury in the same spinal region without reference to radiculopathy. Thus, under his reading, having a

recurrent injury in the same spinal region, by itself, is sufficient to require the ROM method.

12. Dr. White disagrees. According to Dr. White, the entirety of ¶ 4 pertains to recurrent radiculopathy. If the recurrent radiculopathy is caused by either a new disk herniation or by a recurrent spine injury in the same spinal region, then (and only then) does ¶ 4 apply. *See* Finding of Fact No. 53 *supra*.

13. Paragraph 4 of the *AMA Guides*, § 15.2, is not a model of clarity, and either interpretation is possible. However, I find Dr. White's interpretation more persuasive in this case. If simply having a recurrent injury in the same spinal region were enough to require the ROM method, then there would be no need to include the language about recurrent radiculopathy or a new disk herniation in ¶ 4. Similarly, there would be no need to include ¶ 5, which addresses multiple episodes of other pathology that produces alteration of motion segment integrity. For these reasons, I find Dr. White's opinion that Claimant's prior low back injury does not dictate the use of the ROM method to be well supported, not just by Dr. White's knowledge, training and experience, but also by the overall text and structure of § 15.2.

14. Second, Dr. Bucksbaum offered his opinion that the ROM method is applicable because Claimant has "multilevel involvement in the same spinal region." *AMA Guides,* § 15.2, ¶ 2. Again, Dr. White's reading of the *AMA Guides* differs from Dr. Bucksbaum's. According to Dr. White, multilevel involvement, by itself, is not enough to require the ROM method under ¶ 2. He testified that, if multilevel involvement alone were enough, then there would be no need for ¶ 2 to include three examples of multilevel involvement, set forth in ¶ 2 as "(e.g., fractures at multiple levels, disk herniations, or stenosis with radiculopathy at multiple levels or bilaterally)."

15. In this case, there is insufficient evidence to establish multilevel involvement in the same spinal region. *See* Finding of Fact No. 48 *supra*. Thus, under either interpretation of § 15.2, ¶ 2, Claimant does not meet the criteria for the ROM method.

16. As neither paragraph of § 15.2 supports Dr. Bucksbaum's use of the ROM method, I conclude that the DRE method was the appropriate method under the *AMA Guides* to assess Claimant's spinal impairment here.

17. I therefore conclude that Claimant has a seven percent whole person impairment, in accordance with Dr. White's opinion.

Psychological Condition

18. A claimant is entitled to workers' compensation benefits if he or she received an injury arising out of and in the course of employment. 21 V.S.A. § 618. Claimant here contends that he sustained a psychological injury causally related to his accepted January 2016 back injury.

19. Claimant offered well-founded opinions from two treating providers, PA Burns and psychologist Laurance Thompson, as to the causal relationship between his work injury and his psychological condition. Defendant offered testimony from Dr. Nash concerning the factual basis of Mr. Thompson's opinion, but Dr. Nash did not offer his own opinion on whether Claimant's psychological condition was work-related. Although Dr. Nash testified that Claimant's statements to Mr. Thompson raised some "red flags," I have found that those concerns do not substantially affect the basis for Mr. Thompson's causation opinion.

20. Therefore, based on the clear, thorough and well-supported opinions of PA Burns and Mr. Thompson, I conclude that Claimant's psychological condition is causally related to his accepted January 2016 workplace injury.

ORDER:

Based on the foregoing Findings of Fact and Conclusions of Law, Defendant is **ORDERED** to pay:

1. Temporary total and/or temporary partial disability benefits through August 2, 2018 for Claimant's compensable January 2016 back injury, to the extent not already paid, with interest thereon;

2. Permanent partial disability benefits based on Dr. White's assessment of a seven percent impairment for Claimant's compensable January 2016 back injury, to the extent not already paid, with interest thereon;

3. All workers' compensation benefits to which Claimant proves his entitlement as causally related to his compensable psychological condition; and

4. Costs and attorney fees commensurate with Claimant's success. As Claimant submitted his petition for costs and attorney fees with his proposed findings, Defendant shall have 30 days from the mailing of this Opinion and Order in which to file any response to Claimant's petition.

DATED at Montpelier, Vermont this 13th day of December 2021.

_____
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.