STATE OF VERMONT
DEPARTMENT OF LABOR

Brent Betit	Opinion No. 12-22WC
v.	By: Stephen W. Brown Administrative Law Judge
Landmark College	For: Michael A. Harrington Commissioner
	State File No. FF-61054

OPINION AND ORDER

Hearing held via Microsoft Teams on December 9, 2021
Record closed March 23, 2022

APPEARANCES:

Christopher McVeigh, Esq., for Claimant
Jennifer K. Moore, Esq., for Defendant

ISSUES PRESENTED:

1. Are Claimant's ongoing cervical spinal complaints causally related to his March 7, 2014 accepted workplace injury?

2. Are Modafinil and/or Armodafinil[1] reasonable medical treatments for Claimant's accepted workplace injury?

EXHIBITS:

Joint Medical Exhibit (JME)

Defendant's Exhibit A: Preauthorization Request to Defendant for Modafinil

Defendant's Exhibit B: Prior Authorization Request and Billing Records Relating to Claimant's Health Insurer's Coverage for Modafinil

Defendant's Exhibit C: Healthline Article, "Nuvigil and Provigil: How are They Similar and Different?" by University of Illinois, updated on February 2, 2019

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[1] Modafinil and Armodafinil are members of the same drug class. Modafinil is sold under the name Provigil, and Armodafinil is sold under the name Nuvigil. Each of these names appears repeatedly in the medical records in this case and the parties treat these drug names substantially interchangeably. For the sake of terminological consistency, I refer to all drugs in this category as "modafinil," even where a witness or medical record uses a different name.

Defendant's Exhibit D: SingleCare Article, "Armodafinil vs. Modafinil: Differences, Similarities, and Which is Better for You" by Gerardo Sison, Pharm.D., February 20, 2020

Defendant's Exhibit E: WebMD Article, "Nuvigil—Uses, Side Effects, and More"

Defendant's Exhibit F: FDA Label for Modafinil

FINDINGS OF FACT

1. Defendant operates a post-secondary school in Putney, Vermont specializing in educating students with disabilities.

2. Claimant was an employee of Defendant for nearly thirty years, beginning in 1985 and continuing until 2014. He first worked for Defendant as a maintenance supervisor and eventually worked in roles such as vice president for planning and dean of admissions, among other roles. He also served as a consultant with the King Salman Center for Disability Research in Saudi Arabia while working for Defendant, which required periodic travel to Saudi Arabia.

3. This claim arises out of a traumatic head injury that Claimant sustained on Defendant's premises on March 7, 2014. Before that date, Claimant and Defendant had already decided not to renew Claimant's contract for the following academic year. The last day of his then-current employment contract was June 30, 2014.

Claimant's Pre-Injury Medical Status and Activity Level

4. Claimant had multiple medical conditions that predate the injury giving rise to this claim. He underwent lumbar fusion surgery in 2009 to relieve lower back pain and muscle spasms. That surgery increased his functionality and stopped his muscle spasms, but he continued to experience significant pain afterwards.

5. After his 2009 lumbar surgery, Claimant treated that pain with physical therapy and an increasingly high dosage of opioid medications. Among the side effects of opioid medications are fatigue and impacts on cognitive functioning. Claimant had attempted to taper his opioid usage several times before the injury giving rise to this case, but those efforts were largely unsuccessful.

6. Claimant had also been diagnosed with low testosterone, depression, migraine headaches, prediabetes, and sleep apnea[2] before his March 2014 workplace injury.

7. Between 2007 and 2013, his medical records reflect complaints of fatigue, sleep difficulties, and difficulties with work. However, he never lost time from work because of fatigue before his 2014 injury, and he always successfully met the demands of high-responsibility professional roles and received positive work evaluations.

[2] Claimant underwent sleep apnea treatment prior to the injury giving rise to this case and credibly testified that it significantly increased the quality of his sleep.

8. Despite his complex medical situation, Claimant maintained a high activity level in the years preceding his March 2014 workplace injury. Between 2012 and early 2014, for instance, he served in a senior vice president role for Defendant with multiple direct reports and several divisions reporting to him. During this period, he also traveled internationally, served on a public school board, and provided end-of-life care to his aging father.

9. Though Claimant had many medical conditions prior to the injury giving rise to this case, he did not have any significant history of neck injuries or pain before March 2014.

Claimant's March 7, 2014 Workplace Injury and Immediate Medical Treatment

10. On March 7, 2014, while working at Defendant's campus, Claimant was walking up a concrete handicapped ramp when he tripped, fell forward, and struck the right side of his head against a brick wall.

11. A security officer observed Claimant's fall and ran over to see if he was okay. Claimant eventually oriented himself enough to go to his office. Sometime later, his assistant stopped hearing sounds coming from Claimant's office and entered his office, where she found Claimant lying on the floor unconscious.

12. Defendant accepted liability for this injury and has paid some benefits accordingly.

13. Claimant was transported from Defendant's premises to the Brattleboro Memorial Hospital's emergency room, where he presented as confused and disoriented. His providers diagnosed him with a concussion. (JME 33.35).

14. Following his discharge from the emergency room, Claimant continued to experience post-concussive symptoms including dizziness, headache, nausea, fatigue, difficulty concentrating, and difficulty looking at computer screens.[3]

15. Claimant missed several weeks of work before attempting to return on a part-time basis, but these symptoms persisted after his return to the workplace and made it difficult for him to keep up with his work duties. As a result, he voluntarily resigned in April 2014, approximately two months earlier than he had originally planned to leave Defendant's employment.

16. In mid-April 2014, Claimant began seeing Matthew Gammons, MD, a physiatrist with the Rutland Regional Medical Center with expertise in traumatic brain injuries (TBIs).

17. In addition to post-concussive symptoms, Dr. Gammons's intake notes reflect tenderness in Claimant's paraspinal muscles but found that his range of motion was good. He referred Claimant to physical therapy and released him to work with a

[3] Claimant credibly testified that looking at computer screens would cause him to experience vertigo and dizziness that would eventually cause him to vomit.

recommendation for accommodation in the form of breaks during the workday should Claimant's post-concussive symptoms worsen. (JME 52, 60). Claimant also continued to treat with his primary care physician, Peter Park, MD.

New Employment; Involuntary Opioid Withdrawal

18. Claimant's condition improved through May and June 2014, although he continued to experience fatigue. (*See generally* JME 66-146). He was discharged from physical therapy in July 2014, and his physical therapist noted that Claimant had had an "excellent result" from his therapy. (JME 146). During this period of symptom improvement, Claimant began searching for new employment.

19. By the middle of 2014, he had secured a new position as executive director of the King Salmon Center for Disability Research in Saudi Arabia, which he began performing that fall. Because of the limitations of medical care available to expatriates in Saudi Arabia, he arranged for his medical treatment to continue virtually with his American providers via telephone and email, with medications to be shipped to him from the United States.

20. In November 2014, during a brief return to the United States, Claimant expressed concerns about fatigue and the need for sleep but noted that it was not interfering with his ability to work or concentrate (JME 164-171; 175-178).

21. After he returned to Saudi Arabia, Claimant underwent an abrupt and involuntary withdrawal from opioid medications because of delays in international shipments. He became extremely ill in early 2015 as a result. He experienced light-headedness, blurry vision, weakness, hot flashes, difficulty balancing, and vertigo. He slept during nearly all non-working hours, developed word retrieval difficulties, and became easily distracted. He also experienced blackouts, frequent nightmares, and at least one fainting episode. He vomited nearly every day at work and lost significant amounts of bodyweight. He maintained contact with Drs. Gammons and Park during this period via email and telephone. (*See generally* JME 193-204).

22. Claimant also had two minor motor vehicle accidents while living in Saudi Arabia, but neither resulted in any significant injury or medical care. There is no credible evidence that either accident contributed to any worsening of the symptoms he was already experiencing.

Claimant's Return to the United States; Variable Improvement; Multiple Medical Evaluations

23. In July 2015, after Claimant had returned to Vermont, he underwent several medical examinations, including with endocrinologist Filip Lapp, MD to investigate the possibility of pituitary dysfunction secondary to his head trauma. Dr. Lapp characterized Claimant's fatigue as non-specific and possibly without a neuroendocrine source. He also noted that Claimant's narcotic use and sleep apnea were both risk factors. (JME 240).

24. By the fall of 2015, Claimant's fatigue and other post-concussive symptoms were again improving, and by late October of that year, he had begun working part-time as a consultant and was helping his son build a barn. (*E.g.*, JME 297-310). His symptoms were not completely resolved, however, as Dr. Gammons noted in January 2016 that Claimant was still having some issues with fatigue but that his condition should continue improving. (JME 325).

25. Later in January 2016, Claimant saw Dr. Park, who found that Claimant's functionality was improving but that he suffered from ongoing malaise and fatigue with "no obvious etiology." (JME 329). Dr. Park recommended that Claimant reduce his pain medications to the lowest amount possible and follow up by telephone after four weeks. Dr. Park noted that if Claimant did not respond to that reduction, then he would consider prescribing modafinil and/or a sleep study. (JME 332).

26. In February 2016, Claimant underwent neuropsychological testing with Nicole Miller, PsyD. (JME 335 *et seq.*). Claimant performed mostly within normal limits with some weaknesses in copying large figures and fine motor speed and coordination. Dr. Miller pointed to Claimant's pain medication as a potential cause of any cognitive weaknesses but noted that his results "should help to alleviate concerns regarding the magnitude and extent of his perceived cognitive difficulties." (JME 342).

27. In April 2016, Claimant saw Dr. Gammons and reported improvement in his cognitive function and fatigue. Dr. Gammons noted that although more than two years had elapsed since Claimant's workplace injury, his time overseas likely set his recovery timeline back. Dr. Gammons released Claimant to work full time but did not find that he was at end medical result at that time. (JME 348).

Opioid Taper; Beginning of Modafinil Usage to Treat Fatigue in 2016

28. Later in April 2016, Claimant requested that Defendant preauthorize modafinil, relying on Dr. Park's treatment records. (Defendant's Exhibit A). The treatment records filed in support of that preauthorization request redacted references to Claimant's history of sleep apnea as well as Dr. Park's statement that Claimant's fatigue had "no obvious etiology." (*Cf.* Defendant's Exhibit A; JME 329). Dr. Park also wrote a letter in support of Claimant's preauthorization request stating that Claimant "suffered a traumatic brain injury, after which he has had difficulty with fatigue, and malaise. This was not an issue prior to his injury. This is why we are prescribing Provigil [modafinil]." (Defendant's Exhibit A).

29. Defendant covered modafinil from approximately October 2016 through September 2018.

30. In May 2016, Dr. Park noted that Claimant was continuing to taper his opioid medications and was experiencing withdrawal symptoms and increased pain with that taper, but that he expressed a desire to continue tapering nonetheless. (JME 353).

31. Later that month, at Claimant's request, occupational and environmental medicine physician Karen Huyck, MD performed a permanent impairment rating on Claimant's neck. She noted tenderness to palpation in his neck and right trapezius and found this range of motion was mostly normal but with tightness. She assessed axial neck pain and assigned him a five percent permanent impairment rating. She also recommended a sleep medicine evaluation but declined to opine on Claimant's use of modafinil or to assign a permanent impairment rating attributable to his sleep disorder, noting potential non-occupational factors contributing to his fatigue. (JME 359-66).

32. By October 2016, Claimant was living in North Carolina, where he was working as the headmaster of a private school for children with special needs. He reported to Dr. Park that he still had issues with attention and concentration but stated that modafinil was helpful. Dr. Park increased his dosage of that medication. (JME 377).

33. Thereafter, Claimant's reported response to modafinil was somewhat variable. In December 2016, he saw Dr. Park for severe fatigue, and Dr. Park assessed sleep apnea and again increased Claimant's dosage. (JME 391). Claimant told Dr. Gammons in February 2017 that modafinil was a "life saver." (JME 395). However, in June 2017, Claimant told Dr. Park that he was so exhausted that on weekdays he would come home and fall asleep and that he slept all day on Saturdays. (JME 412). He also began taking Ambien to help him sleep. (JME 428-34).

34. Dr. Gammons noted in an April 2017 letter to Claimant's counsel that although there is a known association between head injuries and fatigue, the mechanism is not well understood; thus, treatment is symptomatic. Dr. Gammons believed that modafinil would be beneficial for Claimant, although he did not expect significant improvement or worsening of his fatigue in the future. (JME 408-09).

35. In December 2017, at his own request, Claimant underwent two independent medical evaluations (IMEs): one with preventative medicine physician Philip Davignon, MD relating to his hearing (JME 448 *et seq.*), and one with psychologist William Nash, Ph.D. relating to his cognitive and psychological impairment (JME 453 *et seq.*).

36. Significantly, Dr. Nash noted that Claimant was "highly preoccupied with various cognitive complaints such as memory and concentration, vague neurological concerns, general malaise, and may respond to stress and normal fatigue with somatic complaints." (JME 462). Although Claimant relayed excessive fatigue and the inability to accomplish much, Dr. Nash found that he demonstrated a "rather average" level of energy, sufficient to run a school but feel tired at the end of the day. (JME 465). He also noted that Claimant's low testosterone and opioid medications may have been contributing factors in his relative fatigue and that Claimant may have been misattributing some normal memory lapses to his concussion.

Claimant's Renewed Complaints of Neck Pain in 2018

37. Between the summer of 2014 and December 2018, Claimant's medical records contain almost no explicit reference to ongoing neck pain, although some records do reflect

general "pain" complaints in connection with his controlled opioid taper in 2016. (*E.g.*, JME 353). Claimant credibly testified that he was experiencing neck pain throughout this time but that the pain was manageable because he was still on opioid medications from his earlier back surgery, and that his primary concerns during this period related to his post-concussive symptoms and fatigue.

38. While this explanation might ostensibly fail to account for Claimant's involuntary withdrawal from opioid medication in Saudi Arabia in early 2015, the severity of his withdrawal symptoms combined with the lack of immediate in-person medical care in Saudi Arabia plausibly explain the absence of neck complaints in Claimant's medical records during this period. I find that Claimant continued to experience some level of neck pain between 2014 and 2018 despite his medical records' relative silence as to those complaints.

39. In December 2018, Claimant complained to Dr. Park of neck issues, and Dr. Park planned for x-rays, a physiatry appointment, and an MRI upon Claimant's return to Vermont from North Carolina (JME 522-29). Defendant denied subsequent preauthorization requests for those services.

40. At a July 2019 spine evaluation, Claimant relayed both his March 2014 workplace injury and that he had experienced a significant flare after shearing hedges at his home in North Carolina. He was diagnosed with spondyloses without myelopathy or radiculopathy and prescribed physical therapy and a muscle relaxant. (JME 571).

41. Claimant underwent two neurosurgical consultations in early 2020. In January of that year, he stated that he had been experiencing persistent neck pain that had waxed and waned since his March 2014 workplace injury. He was assessed with neck pain and hyperflexia, likely related to degenerative disc disease. (JME 622.20-622.24).

42. In March of that year, he also expressed radicular symptoms including numbness and tingling in his fourth and fifth fingers and stated that he had experienced these symptoms since his workplace injury. His provider noted that a CT myelogram showed right-sided foraminal stenosis and disc herniations in his cervical spine. Claimant's provider discussed the possibility of surgery with him but noted that he did not have an urgent surgical indication. Claimant declined surgery at that time, preferring to continue with pain management. His provider found this election reasonable. (JME 645.13).

Expert Medical Testimony

43. Claimant, at his own request, underwent an IME with physical medicine and rehabilitation physician Mark Bucksbaum, MD in January 2019. At Defendant's request, retired neurosurgeon Nancy Binter, MD performed a medical records review of Claimant's file in February 2020.

44. Drs. Bucksbaum and Binter both testified as to their opinions concerning the reasonableness and necessity of modafinil and as to the causal relation between

Claimant's workplace injury and his neck complaints. Dr. Park also testified via preservation deposition as to his treatment and care of Claimant.

Dr. Park

45. Dr. Park has practiced as a family medicine physician in southwestern Vermont since approximately 1998, and he has been Claimant's primary care physician since approximately June 2005.

46. He does not claim any specialized experience or training relating to either cervical spinal injuries or TBIs and could not say to a reasonable degree of medical certainty whether Claimant's neck pain complaints in 2018 related to his 2014 workplace injury

47. With respect to Claimant's fatigue complaints, Dr. Park was uncertain of the extent to which Claimant had reported fatigue complaints prior to his workplace injury, but he described his post-injury fatigue as "profound," noting that Claimant had difficulty making it through the workday and spent much of his non-working time asleep.

48. Dr. Park prescribed modafinil for Claimant's fatigue and credibly testified to his belief that Claimant's use of modafinil had been beneficial for that condition. He eventually changed Claimant's prescription from Provigil (modafinil) to Nuvigil (armodafinil) for administrative reasons in hopes of increasing the likelihood of securing insurance coverage, as armodafinil was less expensive than modafinil.

Dr. Bucksbaum

49. Dr. Bucksbaum is a physician board-certified in physical medicine practicing in Rutland, Vermont. He has extensive experience treating traumatic brain injuries (TBIs) and dedicates approximately fifteen percent of his practice to forensic work including IMEs.

50. Dr. Bucksbaum reviewed Claimant's medical records and physically examined him. Although he did not initially have all of Claimant's pre-injury medical records, he eventually reviewed Claimant's records dating back to 2006.

Opinions Concerning Claimant's Neck Complaints

51. Dr. Bucksbaum observed one-sided degenerative patterns in Claimant's cervical spine and credibly explained that this pattern generally suggests a traumatic origin, since natural age-related degeneration tends to present symmetrically and bilaterally.

52. Dr. Bucksbaum found Claimant's one-sided degenerative pattern on the same side of his neck as his 2014 workplace injury to be consistent with that mechanism of injury in this case. He credibly explained this by noting that the spine's network of vertebrae, muscles, tendons, and ligaments ordinarily enjoys freedom of movement in a pendulum-like pattern, but when some of the soft tissues are damaged, the body's response is to tighten the muscles, which in turn limits the range of motion and affects

the transfer of forces in the neck with movement. Normally, the spine diffuses forces in diagonal patterns, but when muscles are tightened, more forces transfer directly into the neck and head. This, in turn, causes the body to send calcium to the areas where those forces accumulate, which can lead to spondylosis and other related degenerative changes.

53. Dr. Bucksbaum accurately noted that shortly after his 2014 workplace injury, Claimant frequently complained of neck pain, but that there was a long period during which his medical records are relatively silent as to neck concerns. However, he noted that Dr. Huyck found in her 2016 IME that Claimant had an asymmetrical loss of cervical range of motion.

54. Dr. Bucksbaum attributed the lapse in reported neck pain in part to his continued use of opioids to manage unrelated post-surgical lumbar pain. He also noted that Claimant's renewed complaints of neck pain temporally corresponded with a controlled tapering of opioid medications.

55. In Dr. Bucksbaum's opinion, Claimant's current cervical spinal complaints are, to a reasonable degree of medical probability, causally related to his March 2014 workplace injury.

<u>Opinions Concerning Modafinil</u>

56. Dr. Bucksbaum credibly testified that he has been very familiar with modafinil since the early days of his practice, and that this drug is often used to treat fatigue because it has significantly fewer side effects and less risk of addiction compared to other available drugs. Although modafinil is approved by the Federal Drug Administration (FDA) for narcolepsy and related sleep disorders, it is commonly used off-label to treat fatigue secondary to multiple diagnoses. Dr. Bucksbaum credibly testified that many physicians commonly prescribe medications off-label, that the FDA expressly contemplates such prescriptions, and that there is nothing medically unethical about this practice.

57. With respect to the causal relationship between Claimant's workplace injury and his fatigue complaint, Dr. Bucksbaum testified that TBIs can cause fatigue, both because of hormonal changes from the injury itself and from cognitive changes secondary to the injury that can gradually wear patients down. Additionally, medications used to treat TBI patients can contribute to fatigue.

58. Dr. Bucksbaum acknowledged that opioid medications can contribute to fatigue, but in his opinion, Claimant's ongoing neck pain from his workplace injury contributed to his continued need for opioid medications.

59. Dr. Bucksbaum acknowledged that Claimant had some preexisting fatigue at the time of his workplace injury but was not requiring medical treatment for that fatigue. He noted that Claimant had a positive response to taking modafinil for his fatigue and that he had a negative response when it was discontinued. In Dr. Bucksbaum's opinion,

modafinil is a reasonable and necessary treatment for Claimant's fatigue stemming from his March 2014 workplace injury.

60. I find Dr. Bucksbaum's opinions concerning Claimant's neck complaints to be persuasive and well-supported in all respects. I also find his testimony that modafinil is a reasonable medication to treat fatigue, and that TBIs *can* lead to increased fatigue to be persuasive.

61. However, I do not find that Dr. Bucksbaum has convincingly established a causal relationship beyond a mere possibility between Claimant's workplace injury and the fatigue complaints that ultimately led Dr. Park to prescribe modafinil, especially considering the complexity of Claimant's pre-injury medical situation including persistent fatigue complaints and multiple documented risk factors for fatigue unrelated to his workplace injury.

Dr. Binter

62. Dr. Binter is a board-certified neurosurgeon who has retired from active practice. She reviewed Claimant's medical records and his deposition, but she has never examined him.

Opinions Concerning Claimant's Neck Complaints

63. In Dr. Binter's opinion, Claimant likely suffered a mild neck strain following his March 2014 workplace injury that resolved approximately two months later. She testified that this recovery time would be typical for a minor neck strain. She accurately notes that Claimant's medical records reflect symptomatic improvement after that timeframe, followed by a lengthy treatment gap.

64. Dr. Binter does not consider it plausible that Claimant experienced neck pain during his treatment gap without complaining about it to his providers. She rejected the hypothesis that Claimant's ongoing opioid use mitigated the severity of his neck pain during the gap in his treatment records because, in her opinion, narcotic pain medications have not been shown to be effective for chronic pain. She also noted that Claimant began tapering his opioid usage in 2016, but his neck pain complaints do not appear in medical records until early 2018. While this is accurate, his records do reflect some complaints of "pain" without further specifying the location of that pain after he began tapering in 2016.

65. Dr. Binter also rejected Dr. Bucksbaum's theory that Claimant's traumatic cervical injury in 2014 contributed to degenerative changes. In her opinion, there is no mechanism for a mild strain to cause progressive degenerative changes four years later. I do not find that this conclusory rejection weakens the persuasive strength of Dr. Bucksbaum's causal analysis. I also find the persuasive force of Dr. Binter's testimony concerning Claimant's neck pain hampered by the fact that she never physically examined him and based her opinion entirely upon a medical records review.

Opinions Concerning Modafinil

66. Dr. Binter was not familiar with modafinil before she was retained as an expert witness in this case. She did, however, review several articles from sources such as Healthline and WebMD relating to modafinil and related drugs (Defendant's Exhibits C through E), as well as the FDA label for that drug (Defendant's Exhibit F).

67. In Dr. Binter's opinion, it was inappropriate for Dr. Park to prescribe modafinil off-label for Claimant's fatigue complaints, analogizing to her own practice in the field of neurosurgery, wherein she would expect serious adverse consequences if she implanted a medical device off label. I do not find this to be a persuasive analogy.

68. I also find it troubling that a board-certified physician would express an expert opinion about the appropriateness of a drug that is so clearly outside of her area of expertise that she would need to rely upon consumer-oriented informational websites to educate herself about the drug.

69. With respect to the causal relation between Claimant's workplace injury and his fatigue, Dr. Binter accurately noted that Claimant had complained of fatigue before his March 2014 workplace injury and had multiple known risk factors for fatigue that existed both before and after that 2014 injury, including sleep apnea, insomnia, medications (including Ambien, opioids, and Cymbalta), depression, low testosterone, low thyroid, hypertension, migraines, and irregular heart rate. These risk factors are well-documented in Claimant's medical records.

70. While I find Dr. Binter's identification of Claimant's fatigue risk factors relevant, her lack of familiarity with modafinil significantly lessens the persuasive force of her opinions concerning the reasonableness and necessity of that drug.

CONCLUSIONS OF LAW

1. Claimant has the burden of proof to establish all facts essential to the rights he presently asserts. *Goodwin v. Fairbanks Morse & Co.*, 123 Vt. 161, 166 (1962); *King v. Snide*, 144 Vt. 395, 399 (1984). He 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. The parties have presented conflicting expert medical opinions on the disputed issues in this case. In such instances, 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 (Sept. 17, 2003). However, because Claimant bears the burden of proof, the persuasiveness of his expert witness ultimately matters most. *See Meau v. The Howard Center, Inc.*, Opinion No. 01-14WC, Conclusion of Law No. 5 (January 24, 2014).

Claimant's Neck Complaints

3. As to Claimant's neck complaints, the first, second, and fifth factors weigh roughly evenly as between Drs. Binter and Bucksbaum: both are board-certified experts in fields relevant to this injury who reviewed all pertinent medical records and testified as forensic experts rather than treatment providers. The fourth factor weighs in Dr. Bucksbaum's favor as he physically examined Claimant while Dr. Binter only performed a medical records review.

4. The third factor, which I find most important here, weighs in Dr. Bucksbaum's favor. I find that his causal analysis of Claimant's one-sided cervical spinal degeneration on the same side as his injury is clear, convincing, and well-supported.

5. While Dr. Binter is well-qualified to testify about the cervical spine and I find the lengthy gap in the medical record relevant to the causation analysis, Dr. Bucksbaum more convincingly accounted for that concern by explaining the role of opioid medications that Claimant was using for an unrelated condition. I find that this explanation has support from Claimant's treatment chronology, which shows an increase in pain complaints after Claimant began his 2016 opioid taper, even if those records do not specify the location of his pain.

6. I conclude that Claimant suffered a cervical spinal injury as a result of his 2014 workplace injury and that his complaints of neck pain beginning in 2018 and continuing through the present are causally related to that injury.

Modafinil

7. With respect to Claimant's prescription for modafinil, however, I cannot conclude that Dr. Bucksbaum, or any other physician, has established a causal link beyond a mere possibility between Claimant's fatigue complaints and his March 2014 workplace injury. *See* Findings of Fact Nos. 55-60, *supra*.

8. Claimant's medical records reflect a long history of fatigue complaints before his March 2014 workplace injury, as well as numerous well-documented preexisting risk factors for fatigue. It is true that he had never missed work because of his fatigue complaints before his injury and yet compelled to resign after his injury in part because of his fatigue. However, he was only out of work for a relatively brief period; only a few months after his injury, he accepted a senior leadership position with a research institute in a foreign country. *See* Finding of Fact No. 19, *supra*.

9. While there is evidence that Claimant's injury may have worsened his fatigue for some period immediately following it, I find the results of his medical evaluations between 2015 and 2017 informative. In 2015, Dr. Lapp could not identify any neuroendocrine explanation for his fatigue that would be secondary to his workplace injury. Neuropsychologist Dr. Miller found in 2016 that Claimant's cognition and attention were within normal limits. Clinical psychologist Dr. Nash found in 2017 that Claimant displayed a "rather average" level of energy given the high level of responsibility associated with his job at that time. *See* Findings of Fact Nos. 23, 26, 31, 35-36, *supra*. All three of these evaluators pointed to non-occupational factors that may have contributed to Claimant's fatigue complaints. *See generally id.* While nothing in these evaluations rules out the possibility that Claimant's workplace injury contributed to his fatigue complaints, they do little to support any positive inference in Claimant's favor on the question of causation.

10. Also telling are Dr. Park's 2016 note indicating that there was "no obvious etiology" of Claimant's fatigue and his admitted uncertainty as to the extent of Claimant's pre-injury fatigue. *See* Findings of Fact Nos. 25, 47, *supra*.

11. Against the backdrop of Claimant's medical history and his evaluators' findings, I cannot conclude that his March 2014 workplace injury created his need for modafinil.

12. To be clear, Dr. Bucksbaum's testimony as to the appropriateness of modafinil for fatigue is far more convincing than Dr. Binter's given her prior lack of familiarity with the drug, and I find no reason to conclude that Dr. Park acted unreasonably in prescribing that medication for Claimant's complaints. However, Claimant is only entitled to receive medical workers' compensation benefits for treatments for conditions that are casually related to his workplace injury. 21 V.S.A. § 640; Workers' Compensation Rule 2.3800 ("'Reasonable medical treatment' means treatment that is both medically necessary and offered for a condition that is causally related to the compensable work injury."). Because the evidence does not support a conclusion that Claimant's need for modafinil resulted from his workplace injury, I need not consider each of the *Geiger* factors with respect to Drs. Bucksbaum's and Binter's testimony concerning that drug.

13. For these reasons, Defendant shall have no further liability for modafinil or armodafinil.

ORDER:

Based on the foregoing Findings of Fact and Conclusions of Law, Defendant shall pay all medical and indemnity benefits related to Claimant's cervical spinal condition, but it shall have no further liability for Claimant's use of modafinil or armodafinil.

DATED at Montpelier, Vermont this 31st day of May 2022.

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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.