M. A. v. Ben & Jerry's (November 5, 2008)

STATE OF VERMONT
DEPARTMENT OF LABOR

M. A.

v.

Ben & Jerry's/Broadspire
Ben & Jerry's/NovaPro Risk

Opinion No. 44-08WC

By: Jane Dimotsis, Esq.
Hearing Officer

For: Patricia Moulton Powden,
Commissioner

State File Nos. X-52456 & M-17136

OPINION AND ORDER

Hearing held in Montpelier on April 28th and 29th, 2008
Record closed on May 16, 2008

APPEARANCES:

Steven Cusick, Esq., for Claimant
David McLean, Esq., for Defendant Broadspire
David Berman, Esq., for Defendant NovaPro Risk

ISSUES PRESENTED:

1. Was Claimant's meralgia paresthetica aggravated by his 2005 injury, and if so, is it compensable?

2. Was Claimant's post-hernia pain syndrome aggravated by his 2005 injury, and if so, what benefits are due?

3. Is Claimant's genital pain and erectile dysfunction causally related to injuries sustained at work and thus compensable?

4. Has Claimant reached an end medical result for his compensable injuries?

5. If not, what reasonably necessary medical procedures are compensable?

6. Which insurer is responsible for payment of whatever benefits are determined to be due?

EXHIBITS:

Joint Medical Exhibit
NovaPro Risk Exhibit A: Form 22, March 25, 2002

Broadspire Exhibit 1: Selected Medical Records
Broadspire Exhibit 2: Dr. White 3/21/08 IME report and addendum
Broadspire Exhibit 3: FCE report from IHMS
Broadspire Exhibit 4: Surveillance videos
Broadspire Exhibit 5: Marriage certificate
Broadspire Exhibit 6: Imago web pages
Broadspire Exhibit 7: Selections from *AMA Guides*, 5th ed.

CLAIM:

Temporary disability benefits pursuant to 21 V.S.A. §642
Permanent partial disability benefits pursuant to 21 V.S.A. §648
Medical benefits pursuant to 21 V.S.A. §640
Attorney's fees and costs pursuant to 21 V.S.A. §678

FINDINGS OF FACT:

1. Judicial notice is taken of all forms and correspondence contained in the Department's files relating to this claim.

2. At all times relevant to these proceedings, Claimant was an employee and Defendant was an employer as defined in Vermont's Workers' Compensation Act.

3. Claimant is a 52 year old male who worked for Defendant for approximately 18 years until he was terminated in December 2006.

<u>The 1999 Injury</u>

4. The first injury related to this case occurred on February 13, 1999. Claimant was performing maintenance work when he suffered pain in his lower back, groin and right lateral leg. The insurance carrier on the risk at that time, NovaPro Risk, accepted that the injuries to Claimant's lower back, groin and right lateral leg were compensable and paid benefits accordingly.

5. As a result of the work injury, Claimant suffered bilateral inguinal hernias, which were repaired surgically in May 1999.

6. Claimant's treating physician at the time of his 1999 injuries was Dr. Verne Backus. Dr. Backus prescribed physical therapy for Claimant's lower back injury and narcotics for his pain. In addition, following his hernia repair surgery Claimant suffered post-hernia repair pain for which he underwent nerve blocks in February 2000.

7. The medical records indicate that Claimant first mentioned having pain prior to an erection to his surgeon in December 1999.

8. Claimant also mentioned scrotal pain in 2000 to Dr. Elke Pinn, who was treating him with bilateral trigger point injections in his groin. The purpose of the injections was to relieve pain associated with his post hernia condition. However, the relief was only temporary.

9. On January 1, 2001 Claimant had a release of the right lateral femoral cutaneous nerve at the inguinal ligament performed by Dr. Bruce Tranmer for pain relief. However, again there was no success in relieving Claimant's pain.

10. In 2001 Dr. Backus determined that Claimant's back injury was at end medical result, and rated him with an 8% whole person impairment. In October 2001 Dr. Backus determined that Claimant had reached end medical result as to his other injuries as well. Dr. Backus rated 2% permanent impairment for the pain and numbness in Claimant's right thigh, the medical term for which is meralgia paresthetica, and 5% for his hernias.

11. Claimant returned to work full-time for Defendant.

The 2005 Injury

12. In September 2005 Claimant suffered a second work injury while lifting a box. As had occurred following the 1999 injury, Claimant experienced immediate pain in his back, groin area and right leg. In addition, Claimant asserted that this time he experienced immediate pain in his genitals as well.

13. Broadspire was the insurer on the risk at the time of this second injury. It accepted Claimant's claim for what it deemed to be a low back strain and began paying benefits accordingly.

14. Genital pain was not reported to a medical professional until two weeks after the injury. On September 29, 2005 Claimant told Dr. Mercia that he felt like his penis "broke" when he was injured at work. Dr. Mercia reported that Claimant had acute and chronic low back pain with an overall change in pain pattern in both the right lower extremity and the back. A physical therapy report on September 20, 2005 stated that both hernias were aggravated by the new injury.

15. In October 2005 Claimant underwent a lumbar spine MRI, which documented a tiny broad based protrusion and annulus tear at L5-S1, unchanged since a prior MRI performed on July 17, 2001.

16. Dr. Backus had been treating Claimant since 1999 for his low back pain, post bilateral hernia repair pain and right thigh meralgia paresthetica. On November 21, 2005 Dr. Backus stated that in his opinion Claimant had suffered an aggravation to his back, right leg and hernia repairs as a result of the September 2005 lifting incident, as well as new pain in his genitals. As a result of these injuries, Dr. Backus determined that Claimant was limited to working a maximum of four hours per day.

17. Dr. Backus has continued to treat Claimant for pain in his low back, right leg, hernia repair area, and genitals until the present date. Broadspire has covered the costs of these treatments.

18. In late 2005 and early 2006, Claimant attended a functional restoration program at the Vermont Center for Occupational Rehabilitation (VCOR) under the care of Dr. John Johansson. In January 2006 Dr. Johansson noted that Claimant had increased pain particularly in his testicles. Dr. Johansson stated that Claimant's greatest pain complaint at that time was in his groin and that his back pain was secondary.

19. In general, the VCOR program offered Claimant only limited relief. Upon Claimant's completion of the program in February of 2006 Dr. Johansson determined that Claimant had a 5% whole person permanent impairment referable to the spine. Dr. Johansson did not know at this time that Dr. Backus previously had rated Claimant with an 8% impairment referable to the spine as a result of Claimant's 1999 injury.

20. After completing the VCOR program Claimant returned to work full-time light duty. However, he soon became incapable of full time work due to the level of pain he suffered. Dr. Backus again reduced Claimant's work capacity to four hours per day. On December 31, 2006 Claimant's employer terminated him because it was no longer able to accommodate his work restriction. Dr. Backus subsequently determined that Claimant's condition had deteriorated to the point where he had no meaningful work capacity.

21. On January 19, 2007 Dr. Backus stated that he did not have a good anatomical basis to fully understand all of Claimant's pain symptoms. However, he made a referral for pain treatment at a comprehensive inpatient facility at the Spaulding Clinic in Boston for pain rehabilitation. Broadspire denied payment for the referral.

22. The Department issued an Interim Order approving the Spaulding Clinic for payment by Broadspire and awarded Claimant temporary disability payments until April 2007, when he would have completed the program. Unfortunately, by the time the interim order issued, the Spaulding program had been discontinued.

23. With the Spaulding program no longer available, in the summer of 2007 Dr. Backus referred Claimant to a urologist and a neurosurgeon in order to determine whether there might be any other medical conditions that possibly could be causing Claimant's pain. Claimant still consistently complained of lower back pain, groin pain and leg pain.

24. In May and October of 2007 Claimant was videotaped by surveillance persons hired by Broadspire. He appears on two videotapes walking either to or from buildings. In one tape he is seen to have his hands on his lower back as he walks slowly toward the building and in the other tape he seems to walk better and does not exhibit pain symptoms.

25. No further diagnostic information was gleaned by the referral physicians except that Claimant's condition was neither neurological nor urological. In particular, Dr. Tranmer, the neurosurgeon, noted that Claimant's MRI showed no cause for his genital pain.

26. In January 2008 Claimant saw Dr. Ralph Beasley and Dr. Amy Gjerde at Dartmouth-Hitchcock Hospital Pain Clinic for his back, groin and testicle pain.

27. Dr. Beasley requested prior authorization for a spinal cord stimulator to treat Claimant's chronic pain. In Dr. Beasley's opinion, Claimant's genital pain is neuropathic, secondary to ilioinguinal neuralgia. Dr. Beasley believed that Claimant was an excellent candidate for spinal cord stimulator therapy to address his low back pain. As for Claimant's groin pain, both Dr. Beasley and Dr. Gjerde thought that it would be difficult to alleviate this pain with the stimulator.

28. At Broadspire's request, Dr. George White conducted independent medical evaluations of Claimant on March 29, 2005 and March 21, 2008. Dr. White concluded that the September 13, 2005 lifting incident caused an aggravation of Claimant's pre-existing low back injury. Even though Claimant's groin pain had increased, Dr. White did not find a new inguinal hernia or damage to either the abdominal muscles or the fascia. Dr. White opined that the increase in groin pain Claimant experienced related back to the 1999 work injury.

29. Dr. White also suggested that Claimant's use of opioid analgesics since the 1999 injury might have had the paradoxical effect of increasing his overall pain sensitivity. Alternatively, Dr. White conjectured that Claimant could have a somatization disorder.

30. Dr. Penar, a pain management specialist, examined Claimant on December 7, 2007. Dr. Penar has a special interest in ilioinguinal and genitofemoral nerves. In reference to Claimant's left groin pain, Dr Penar noted that "one could consider that some of this pain would be referred to the groin from any level of lumbar disc disease."

31. At NovaPro Risk's request, Dr. William Boucher conducted an independent medical examination of Claimant on April 10, 2008. Dr. Boucher was unable to offer any explanation for Claimant's genital pain. In his opinion, such isolated genital pain could not be caused by spinal pathology except in extreme cases involving cauda equina syndrome. Dr. Boucher observed signs of symptom magnification in Claimant's examination, and opined that Claimant's motivation for such exaggerated pain complaints could be narcotic dependence.

32. Aside from Dr. Boucher, no other medical expert found signs of symptom magnification while evaluating Claimant. Notably, Dr. Backus never observed any evidence of symptom magnification during the nine years he has been treating Claimant.

33. Claimant has asked different providers, including local emergency room physicians, for narcotic pain medications on a fairly consistent basis for many years. He has taken narcotic medications for many years. After the 1999 injury he was on Valium, Percocet and Ultram. Claimant has a history of migraine headaches dating back to his late teens. He has been taking Fiorinal, a barbiturate, for migraine control at least since 1974. Presently he takes three Fiorinal daily. In 2000 Claimant sought treatment from Dr. Ciongoli for his headaches. Dr. Ciongoli opined that Claimant was drug seeking and wanted Demerol and Phenergan. A March 4, 2002 record from Claimant's primary care provider contains the notation "[u]sed 60 Fiorinal in <2 mos!!!"

34. Claimant continued to work while on these medications until 2006. The narcotic medication Oxycontin prescribed by Dr. Backus later was changed to a Duragesic patch, which contains fentanyl.

Impairment Rating for Meralgia Paresthetica

35. In October 2007 the Department approved Broadspire's discontinuance of temporary disability benefits on the grounds that Claimant had reached an end medical result. Even though he disagreed with the Department's determination, Dr. Backus then completed another permanency evaluation. He assigned an additional 1% whole person permanent impairment for Claimant's meralgia paresthetica. Drs. Boucher and White both agree that this rating was appropriate, although they do not agree that it was causally related to either of Claimant's work injuries.

Impairment Rating for Post-Hernia Pain

36. Dr. Backus also assigned Claimant an additional 4% whole person impairment referable to Claimant's post-hernia pain. Dr. Backus' conclusion was based both on his interpretation of the relevant section of the *AMA Guides* and on his understanding of prior Department decisions. *See Estabrook v. New England Precision*, Opinion No.10-00WC (May 16, 2000); *Knapp-Bowen v. Equinox Terrace*, Opinion No. 4-98WC (January 19, 1998).

37. The relevant section of the *AMA Guides*, Table 6-9, lists the criteria for rating a Class 1 permanent impairment due to herniation, for which the rating range is 0-9% whole person, as follows:

> Palpable defect in supporting structures of abdominal wall
> **and**
> slight protrusion at site of defect with increased abdominal pressure; readily reducible
> **or**
> occasional mild discomfort at site of defect but not precluding most activities of daily living. (Emphasis in original).

38. Dr. Backus found Claimant to be at the high end of Class 1. In his opinion, a surgically repaired hernia is still a defect even if it is neither palpable nor protruding. Thus, Claimant's surgically repaired hernia, combined not only with occasional discomfort but also with intermittent pain "so strong that it takes him to his knees," qualified him for a Class 1 impairment under the third phrase quoted above. As Dr. Backus already had rated Claimant with a 5% impairment following the original 1999 injury, he added an additional 4% for Claimant's post-hernia pain to bring the final rating up to the maximum of 9%.

39. Dr. Boucher and Dr. White both interpret the AMA Guides differently, and therefore both disagree with Dr. Backus' rating. They interpret Table 6-9 to require *both* a palpable defect (the first phrase noted above) *and either* a protrusion (the second phrase) *or* discomfort at the site (the third phrase) in order to qualify for a rating greater than 0%. According to this interpretation, as Claimant's hernia was neither palpable nor protruding once it had been surgically repaired, there was no additional permanency to be rated for Claimant's post-hernia pain beyond the 5% he had received initially.

Expert Opinions as to Sexual Dysfunction

40. The medical experts disagree as to whether Claimant's sexual dysfunction is causally related to either of his work injuries and, for that matter, if it even exists. Although most of the experts accept the possibility that either low back or hernia pain can affect the nerves that wrap around the groin area, with the exception of Dr. Backus they do not believe these nerves affect the penis directly or create erectile dysfunction. In contrast, Dr. Backus believes that Claimant's genital pain stems from his low back injury and therefore is causally related to the aggravation that occurred as a result of the September 2005 lifting incident.

41. Dr. White's position was that Claimant's sexual dysfunction was not causally related to either of his work injuries. He noted that Claimant had experienced testicular pain as early as 2000 (as indicated in the February 22, 2000 visit with Dr. Elke Penn), indicating problems many years prior to the 2005 injury. Dr. White conceded that testicular pain can interfere with sexual function but still did not relate this to Claimant's work injuries.

42. Dr. Backus testified that Claimant's genital pain was radiating from his lumbosacral region. He explained that spinal nerves S2, S3 and S4 enervate the penis and that an injury to that area of the back can cause penile pain.

43. Dr. Boucher disagreed with Dr. Backus and stated that only a fracture in the sacral region could cause pain radiating to the penis. Claimant does not have a fracture in this region, and therefore Dr. Boucher would not attribute his genital pain to his low back pain.

44. Dr. Backus rated Claimant with a 9% whole person impairment referable to his sexual dysfunction. According to the AMA Guides, a permanency rating of 1% to 9% is proper if "sexual functioning is possible, but difficulty of erection or ejaculation in men or lack of awareness, excitement, or lubrication in either sex" is present. The Guides require that the patient's previous level of sexual functioning be considered, and note in this regard that age is only one criterion for doing so.

45. Claimant testified about his sexual life after the work injury in 2005 and his short re-marriage. His testimony was inconsistent and not completely credible. It is unclear whether he simply was uncomfortable discussing sexual issues or whether he was deliberately inaccurate.

Expert Opinions as to Spinal Cord Stimulator

46. Dr. Backus advocates that Claimant undergo a trial of treatment with a spinal cord stimulator and/or spinal injections, both to address his pain issues and hopefully, to restore function as well. Dr. White testified that such a trial would not be "unreasonable," but that it was not likely that he would direct Claimant in this fashion.

47. Despite giving permanency ratings when asked to do so, Dr. Backus strongly believes that claimant is not at end medical result. In his opinion, Claimant could achieve restored function if he attends a comprehensive pain rehabilitation and restoration program, undergoes a spinal cord stimulator trial and receives spine injections. Dr. Backus believes this treatment program also would reduce Claimant's reliance on narcotic pain control medications.

48. It is somewhat unclear whether Claimant is committed to undergoing Dr. Backus' proposed treatment program. No other medical provider has offered any alternative plan, however.

Claimant's Work Capacity

49. At Defendant's request, on March 14, 2008 Claimant underwent a functional capacities evaluation with Erica M. Galipeau, PT, CSCE, CEES. After administering a battery of tests, Ms. Galipeau determined that Claimant could work in a sedentary to light capacity for a 4-hour work day that allowed for him to change positions every twenty minutes. Ms. Galipeau found that Claimant may have given less than full effort in testing, but concluded that this may not have been intentional. Ms. Galipeau admitted that it was questionable whether it was feasible for Claimant to return to work in a position that allows for the frequent change of position he requires.

50. Dr. Backus disagreed with Ms. Gailipeau's conclusions. In his opinion, Claimant's work capacity is limited to a maximum of two hours per day, if at all. As noted above, Dr. Backus believes that Claimant's level of function probably will improve with further treatment.

Attorney's Fees and Costs

51. Claimant has submitted a claim for attorney's fees under 21 V.S.A. §678 totaling $25,854.00 and costs totaling $2,433.46. Defendant has challenged various aspects of the fees sought, particularly charges for conferences with other staff attorneys in Claimant's attorney's firm.

CONCLUSIONS OF LAW:

1. In workers' compensation cases, the claimant has the burden of establishing all facts essential to the rights asserted. *King v. Snide*, 144 Vt. 395, 399 (1984). He or she must establish by sufficient credible evidence the character and extent of the injury as well as the causal connection between the injury and the employment. *Egbert v. The Book Press*, 144 Vt. 367 (1984). There must be created in the mind of the trier of fact something more than a possibility, suspicion or surmise that the incidents complained of were the cause of the injury and the resulting disability, and the inference from the facts proved must be the more probable hypothesis. *Burton v. Holden Lumber Co.*, 112 Vt. 17 (1941); *Morse v. John E. Russell Corp.*, Opinion No. 40-92WC (May 7, 1993).

2. This claim presents several complex issues, all of which depend on the credibility of competing medical opinions. 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; and (5) the qualifications of the experts, including training and experience. *Geiger v. Hawk Mountain Inn*, Opinion No. 37-03WC (Sept. 17, 2003). With these factors in mind, the key question is which expert medical opinion is the most credible? *Bonenfant v. Price Chopper*, Opinion No. 13-07WC (May 8, 2007).

Is Claimant entitled to additional permanency benefits for meralgia paresthetica causally related to the September 2005 lifting incident?

3. Dr. Backus determined that Claimant's meralgia paresthetica was aggravated by the September 2005 injury, and assigned an additional 1% for the increased pain attributable to this condition. Dr. Backus' opinion was credible, and neither Dr. White nor Dr. Boucher disagreed with his rating. There is no dispute as to this issue, therefore.

Is Claimant entitled to additional permanency benefits for post-hernia repair pain?

4. The dispute here centers on the proper interpretation of Table 6-9 of the *AMA Guides*. The Commissioner previously has determined that a hernia constitutes a defect even after it has been repaired surgically. *Estabrook v. New England Precision*, Opinion No. 10-00WC (May 16, 2000); *Knapp-Bowen v. Equinox Terrace*, Opinion No. 4-98WC (January 19, 1998). Given that precedent, Dr. Backus' interpretation of Table 6-9 was appropriate. Based on the degree of discomfort and limitation in Claimant's activities following the 2005 injury, Dr. Backus properly increased the impairment rating by 4% beyond what had been rated following the original 1999 injury.

Is Claimant's genital pain and erectile dysfunction compensable?

5. Neither NovaPro Risk nor Broadspire ever accepted responsibility for Claimant's genital pain or erectile dysfunction. The burden is on Claimant, therefore, to establish that these conditions were causally related to his work injuries. Dr. Backus believes that they are; Drs. White and Boucher maintain that they are not.

6. Although Dr. Backus has been Claimant's treating physician for many years, I find that his opinion is not the most credible in this regard. Dr. Backus is not a specialist in this area, and admitted that he sought out other physicians' opinions as to these conditions because he could not find objective support for Claimant's ongoing complaints. In fact, no such objective support was produced, and Claimant's subjective testimony was not sufficiently credible to overcome the deficiency thus created. *See Bowen v. E.F. Wall*, Opinion No. 17-04WC (April 20, 2004). Under these circumstances, I find that Claimant has not sustained his burden of proof, and that neither his genital pain nor his erectile dysfunction are compensable conditions.

Has Claimant reached an end medical result for his compensable injuries and if not, what reasonably necessary medical procedures are compensable?

7. Vermont's Workers' Compensation Rules define end medical result as "the point when a person has reached a substantial plateau in the medical recovery process, such that significant further improvement is not expected, regardless of treatment." *Workers' Compensation Rule 2.1200.*

8. I find that the most credible evidence establishes that Claimant has not yet reached an end medical result as to his low back injury and that the further treatment proposed by Dr. Backus, specifically a spinal cord stimulator trial and/or spinal injections, as well as participation in a comprehensive functional restoration program, reasonably might result in significant further improvement. Notably, Dr. Backus strongly believes that Claimant's work capacity will increase as well if he pursues this treatment plan.

9. Broadspire has asserted that Claimant's true motivation for seeking additional treatment and/or benefits is a desire for narcotics. This claim is without merit. There is no dispute that Claimant suffered very painful injuries. He has tried a variety of medications and treatments to manage his pain. The fact that narcotic pain medications have proven more successful in this regard than any of the other treatments neither negates the extent of Claimant's compensable injuries nor the degree of pain from which he suffers. Indeed, it only serves to validate Claimant's need for further treatment designed both to improve his condition and to decrease his reliance on narcotics for effective pain control.

10. Having failed yet to reach an end medical result for his low back condition, Claimant is entitled to a resumption of temporary disability benefits retroactive to their discontinuance. It is only fair, however, that Claimant demonstrate a firm commitment to pursue the treatment Dr. Backus has proposed. Thus, should Claimant fail to take the steps necessary to begin undergoing the recommended treatment within the next thirty days, he shall be deemed to be at end medical result.

11. I do find that Claimant has reached an end medical result as to his meralgia paresthetica and post-hernia repair pain conditions. None of the treatments proposed by Dr. Backus is likely to result in significant further improvement in these conditions.

Which insurer is responsible for the benefits now determined to be due?

12. Answering this question requires a determination whether Claimant suffered an aggravation of his pre-existing injuries as a result of the September 2005 lifting incident. The Department historically has used a five-part test to determine if such an aggravation has occurred: (1) whether a subsequent incident or work condition destabilized a previously stable condition; (2) whether the claimant had stopped treating medically; (3) whether the claimant had successfully returned to work; (4) whether the claimant had reached an end medical result; and (5) whether the subsequent work contributed independently to the final disability. *Trask v. Richburg Buliders,* Opinion No. 51-98WC (August 25, 1998). The critical question is whether the September 2005 lifting incident combined with Claimant's pre-existing impairment to produce a disability greater than what otherwise would have occurred. *Farris v. Bryant Grinder*, 177 Vt. 456, 458 (2005), citing *Pacher v. Fairdale Farms*, 166 Vt. 626, 627 (1997).

13. With the *Trask* factors in mind, I find it significant that prior to the 2005 injury Claimant had been able to return to work without restrictions; following it he was limited at best to four hours per day. Equally telling is the fact that following the 2005 injury, Dr. Backus felt it necessary to rate additional permanency, both for Claimant's meralgia paresthetica and for his post-hernia repair pain. I find Dr. Backus' testimony both persuasive and credible. I conclude, therefore, that the September 2005 injury resulted in an aggravation of Claimant's compensable low back, meralgia paresthetica and hernia conditions, for which Broadspire is the responsible carrier.

Attorney's fees and costs

14. Aside from his claim that his genital pain and erectile dysfunction are compensable conditions, Claimant has substantially prevailed. He is entitled to an award of those costs relating to the claims he successfully prosecuted. *Hatin v. Our Lady of Providence*, Opinion No. 21S-03WC (October 22, 2003). As issues of end medical result, further medical treatment, work capacity and temporary disability related to all of Claimant's claims, however, it is difficult to separate out specific costs as referring to successful versus unsuccessful claims. Under these circumstances, I find it appropriate to award Claimant 75% of his costs, or $1,825.10.

15. The same analysis applies to an award of attorney's fees. Thus, I find it appropriate to award Claimant 75% of his attorney's fees, or $19,390.50. This deduction from the amount requested also takes into account Broadspire's argument that Claimant's attorney inappropriately billed for consultations with other staff attorneys in his firm.

ORDER:

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

1. Permanent partial disability benefits for a 1% impairment referable to Claimant's meralgia paresthetica;

2. Permanent partial disability benefits for a 4% impairment referable to Claimant's post-hernia repair pain;

3. Medical benefits covering all reasonably necessary medical services and supplies causally related to treatment of Claimant's low back pain, including a spinal cord stimulator and/or spinal injections;

4. Temporary disability benefits retroactive to their discontinuance and ongoing until properly discontinued in accordance with the workers' compensation statute and rules, with due regard to the time frame noted in Conclusion of Law Number 10 above;

5. Interest on the above amounts in accordance with 21 V.S.A. §664; and

6. Costs of $1,825.10 and attorney's fees totaling $19,390.50.

7. Claimant's claim for workers' compensation benefits related to genital pain and/or erectile dysfunction is hereby **DENIED**.

DATED at Montpelier, Vermont this 5th day of November 2008.

_____
Patricia Moulton Powden
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.