

STATE OF MINNESOTA
IN SUPREME COURT
A07-1267

Kathy L. Maricle,

Relator,

vs.

Farmstead Foods/Self-Insured and
Special Compensation Fund,

Respondents,

EMPI, Inc., Minnesota Department of
Human Services, Mayo Foundation,
Blue Cross/Blue Shield of GA/Healthcare
Recoveries, Inc., Ucare Minnesota,

Intervenors.

BRIEF AND APPENDIX OF EMPLOYEE-RELATOR

BAUDLER, BAUDLER, MAUS
& BLAHNIK
Robert M. Maus
Attorney for Employee-Relator
108 North Main Street
Austin, Minnesota 55912
(507) 433-2393

RORY H. FOLEY
Office of the Attorney General
Attorney for Respondents
Suite 900
445 Minnesota Street
St. Paul, Minnesota 55101-2127
(651) 297-2972

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STATEMENT OF LEGAL ISSUES

- I. Did Employee's employment cause Gillette injuries which led to severe permanent injuries to her neck, right shoulder and fibromyalgia?

WCCA affirmed compensation judge's determination of lack of causation. Nord v. City of Cook, 360 N.W.2d 337, 37 W.C.D. 364 (Minn. 1985).

I.

STATEMENT OF THE CASE

The above entitled matter came on for hearing, pursuant to notice, before The Honorable Danny P. Kelly, Compensation Judge of the Office of Administrative Hearings on August 18, 2006, in Austin, Minnesota. Employee's claim for benefits is listed in Employee's Exhibit 57. By Findings and Order served and filed on November 14, 2006, Judge Kelly denied all claims made by Employee finding that the disabilities and medical care claim by Employee were not causally related to her work activities based on opinions of Dr. Friedland, who did an independent medical exam (IME) for Respondents.

Employee then appealed this matter to the Minnesota Workers' Compensation Court of Appeals (WCCA). WCCA affirmed the compensation judge's decision and Employee appealed to the Supreme Court.

II.

STATEMENT OF FACTS

Employee's treating doctors determine that the following disabilities were causally related to her employment:

DOCTORS	SPECIALTY	DISABILITIES	TREATMENT	EXHIBITS
1. Dr. David W. Beck, Neurological Surgery, Mason City, Iowa	Board Certified Neurosurgeon	Herniated discs at C5-6 and C6- 7 levels	C6-7 anterior discectomy and fusion at C5-6, C6-7 level June 18, 2004	29, 33, 35, and 36

2. Dr. Matthew J. Kirsch, Austin Medical Center, Austin, Minnesota	Orthopedic Surgeon	Right shoulder partial thickness under surface supraspinatus tear, subacromial impingement Right de Quervain's tenosynovitis Right carpal tunnel	Right shoulder arthroscopic subacromial decompression, right shoulder limited glenohumeral debridement November 12, 2004 Surgical release of the first dorsal extensor compartment January 19, 2006 Right carpal tunnel release March 2, 2006	37, 38, 42, and 43
3. Dr. Barry J. Larson, Austin Medical Center, Austin, Minnesota	Family Medicine	Fibromyalgia	Amitriptyline April 5, 2005 Clonazepam April 18, 2005	16 and 20
4. Dr. M.P. Christian, Albert Lea, Minnesota	Chiropractor	Fibromyalgia	Chiropractic manipulation and ultrasound 1996-2001	45 and 46
5. Dr. Keith A. Bengtson, Spine Center, Mayo Clinic, Rochester, Minnesota	Board Certified in Physical Medicine and Rehabilitation	Neck and lower thoracic pain	A wheeled walker February 22, 2006	21, 25, and 26

Dr. Mark E. Friedland performed two independent medical examinations for Respondents and based on his exams and review of the records gave the following opinions on causation:

1. Neck - Employee's new disc herniations at C5-6 and C6-7 levels found in 2002 and Employee's degenerative disc disease were not the consequence of the alleged injury of September 29, 1989 but rather were part and parcel of the normal aging process of the cervical spine over the course of the ensuing 13 years. In his review of Employee's medical records he noted the following "salient" point: "the patient did not seek any further or ongoing care or treatment for her cervical ... symptomatology by physicians until 2002." (SF Ex. 6 p. 6). In his report dated July 5, 2006, Friedland notes that "Ms. Maricle was not found to have any evidence of objective disc injury at the time of the incident in 1989" and therefore, was not made more susceptible to subsequent disc herniations. (SF Ex. 13 p. 1). His "salient" points did not include the fact that Employee's moderately successful surgery for her 1990 work-related impingement syndrome was redone during the November 12, 2004 surgery.
2. Right shoulder - Employee's right shoulder injury was permanent in nature and resulted in a 3% permanent partial disability but ongoing medical care or treatment subsequent to December 20, 1990 was not causally related to the injury of 1989. The osteophyte formation of the subacromial space of the right shoulder and resultant minimum partial thickness tear was a consequence of the normal aging process. In review of the Employee's medical records he noted the following: "salient" point: "The patient did not seek any further or ongoing care or treatment for her ... upper right extremity symptomatology by physician until 2002." (SF Ex. 6 p. 6).
3. Right hand and wrist - Employee's right hand and wrist symptomatology was not a substantial result of her work activities and/or alleged injury of September 29, 1989. Her right De Quervain's and right carpal tunnel release surgical procedures were not reasonable and necessary.
4. Low thoracic spine - Employee's low thoracic symptomatology was not a substantial result of her work injuries as his diagnosis was mild appropriate multilevel thoracic degenerative disc disease with subjective symptomatology in excess of objective findings on physical exam.
5. Fibromylgia - Employee did not have findings that would be diagnostic of true fibromylgia. She had global tenderness that was not localized to specific trigger points that would be required for the diagnosis of fibromylgia. In his report dated October 18, 2005, Dr. Friedland noted that Employee's medical records were extremely voluminous in nature and could not be totally summarized in his report and then he noted "salient" points. (SF Ex. 6 p. 5). His "salient" notes did not

include the fact that five treating doctors found specific trigger points in Employee's right scapular area. His two exams of Employee's right shoulder do not indicate that he palpated her right shoulder blade.

Employee was born on September 20, 1962 and is only 44 years of age.

The Employee started working for Employer, Farmstead Foods, in 1985. She initially worked as a floater performing various jobs in the Albert Lea, Minnesota, plant. In 1987, she was given a permanent job assignment as a full-time puller in the casing department, a job that involved pulling hog intestines with both of her hands away from the ruffle fat. Over time changes were made to the production line which resulted in an increased work pace for the Employee's job.

Employee's work injuries occurred gradually. (T. 57). Her symptoms started in the early part of 1988 (T. 56).

She continued to have problems with her neck and right upper extremity until September, 1989 when she could barely lift her right arm anymore. (T. 57). Her first report of injury was filed with an injury date of September 25, 1989 and describing her injuries as neck/shoulder-strain-extended neck position. (Ex. 1). She went to see Dr. M.P. Christian, a chiropractor, who initially diagnosed her with thoracic sprain or strain, and she received a series of chiropractic adjustments which failed to provide her with permanent relief. (Ex. 46, p. 1).

On November 30, 1989, she had a neurological consultation with Dr. Allen at the Albert Lea Medical Center, and she reported to Dr. Allen that she had pain in her right neck, shoulder, down the right arm into the hand and that Farmstead had recently doubled the speed of the line which required very rapid, repetitive movements of the hands and shoulders and required her to stand for long periods of time with her neck sharply flexed forward, watching what she was doing. Dr. Allen's exam revealed pain in the right shoulder and arm with forward flexion of her neck, hyper-

extension, and with left lateral flexion. Dr. Allen's diagnosis included tendinitis of multiple levels in the right upper extremity secondary to her occupation. (Ex. 2, p. 3).

On December 29, 1989, Employee was seen at the Austin Medical Center by Dr. Barry J. Larson. On palpation of the superior aspect of the right scapula, Dr. Larson found what appeared to be a definite fibrocytic nodule. Employee was point tender in a classic trigger point area. His diagnosis was probable fibrositis. (Ex. 20, p. 1).

Dr. Allen referred Employee to Dr. Douglas A. Lilly, an orthopaedic surgeon. On January 29, 1990, Dr. Lilly performed an exploration and debridement of Employee's right shoulder, involving the removal of the coracoacromial ligament and subdeltoid bursa. (Ex. 7, p. 1). The operative diagnosis was impingement with chronic tenosynovitis of the right shoulder. He opined that Employee did have a permanent disability of 3% to her right shoulder. With respect to her neck injury, he thought she had not reached maximum medical improvement and left it to the neurologist for interpretation. (Ex. 5, p. 2).

A neurologist, Dr. Zarling, issued a report dated September 10, 1990, noting that the Employee's symptoms had been subjective in nature without evidence of restriction of motion or other objective findings. His diagnosis was occipital neuralgia which was secondary to a healed sprain, strain, or contusion of the cervical spine. On page 2 of his report, he stated that the Employee had suffered a permanent partial disability to her neck as a result of the work injury of 3.5% and she did have chronic muscle spasm, tightness, and rigidity which had been persistent with some sensory changes without demonstrable degenerative changes. (Ex. 3, p. 2).

Employee was seen by neurologist, Dr. Lawrence A. Farber of Noran Neurological Clinic, on November 15, 1990, and upon examination Dr. Farber found moderately limited range of motion

of her neck with extension, flexion caused some pain in the right posterolateral neck and shoulders, turning to the left side caused the most pain in the right posterolateral neck and shoulder and to the right side very little pain, but some pain. She had decreased C7 dermatomal sensation on the right side. (Ex. 8, p. 2).

A CT scan was performed on November 15, 1990, which showed a minimal disc bulge at the C5-6 level.

By report dated December 30, 1990, Dr. Farber stated that Employee had a permanent partial disability rating of 7% to her neck based upon objective criteria of findings indicated on the November 15, 1990, exam plus the changes on the CT scan. (Ex. 12, p. 2).

Employee submitted to an independent medical examination performed by Dr. Engasser for the Respondents on May 2, 1991. He noted that Employee felt that her shoulder condition did improve with surgery, but "it now is becoming worse over time." Physical examination indicated the Employee had full range of motion of the right shoulder and full range of motion of the cervical spine. He noted Employee also had "pain with abduction" of the right shoulder against resistance and abduction and external rotation on extreme caused discomfort. It was Dr. Engasser's opinion that Employee did suffer a local injury to the right shoulder as a result of her repetitive work at Farmstead Foods, and he felt Employee had an impingement type syndrome and had underwent "moderately successful surgery." He thought she would be able to use her right upper extremity at or above shoulder level only occasionally, she should have a 40 pound lifting restriction due to her residual shoulder problems on the right, found her to be at MMI, and rated her right shoulder at 3% permanent partial disability. (SF Ex. 8, p. 3). He also opined that Employee suffered only a

temporary strain to her cervical spine as a result of her work activity and stated her CT scan on the cervical spine did not show significant pathology.

In December, 1996, Employee received a series of treatments from her chiropractor, Dr. Christian, for upper back and neck pain and she reported intermittent tingling in her arm, hand and involving her index and middle finger. (Ex. 46, p. 4). Dr. Christian on exam found the Employee had right scapular inflamed nodules.

On December 23, 1996, she then went to the Albert Lea Clinic and saw Dr. Waldron and asked for anti-inflammatory medication per her chiropractor's request. On exam, Dr. Waldron found Employee's right shoulder to have "point tenderness throughout the shoulder" like tendinitis, his diagnosis was shoulder tendinitis and he prescribed Relafen to Employee for pain. (Ex. 14, p. 9).

She went back to Dr. Waldron on January 22, 1997, with symptoms of neck discomfort. The history taken by Dr. Waldron was as follows:

"She has been asymptomatic, other than the aches and pains she has had in her neck and back. These are **chronic**. Usually gets relief with chiropractic treatment and manipulation." (Ex. 14, p. 7).

On exam, Dr. Waldron found her bilateral sternocleidomastoids were tender, range of motion provoked her pain somewhat, and her paraspinal muscles were somewhat tender grossly and throughout the cervical region.

Employee continued to see the chiropractor for treatment for upper back and neck pain on occasion from 1997 to 2001 (Ex. 46, p. 5-6 and Ex. 55). She was also treated by the chiropractor in March, 1997, for a non-work related low back injury, and on occasion for the same thereafter.

On January 25, 2002, Employee visited Dr. Heather Winkels for right shoulder pain which she said she had for years. She reported a lot of pain in the shoulder at night and also in the morning,

along with numbness in her right hand, mainly in the second through the fourth fingers. Dr. Winkels found that Employee was extremely tender to palpation over the entire shoulder and had “trigger points” along the trapezius muscles. Dr. Winkels then ordered an MRI to evaluate Employee’s shoulder. (Ex. 14, p. 13).

An MRI of the right shoulder was done on February 1, 2002, which showed:

1. Impingement
2. Rotator cuff tear supraspinatus tendon with no retraction (Ex. 14, p. 15)

On March 29, 2002, Employee had an MRI of the cervical spine which showed a posterior disc herniation at the C5-6 level essentially to the left of midline and causing pressure on the thecal sac and some pressure on the foramina. A similar, less prominent appearance was seen at the C6-C7 level and also a subtle protrusion posteriorly centrally to the left of midline and also causing some flattening of the thecal sac. (Ex. 14, p. 27).

On February 15, 2005, Employee saw Dr. Kirsch and upon examination, Dr. Kirsch found she had “trigger points” in her posterior scapula and levator scapular origin which were tender. He diagnosed Employee with a right shoulder pain status post-right shoulder decompression and right scapular trigger points, fibromyalgia. (Ex. 44, p. 20).

From April 5, 2005, to June 28, 2005, Employee treated upon referral from Dr. Kirsch with Dr. Barry J. Larson for “reactive shoulder girdle fibromyalgia.” Dr. Larson found marked “trigger point tenderness” and pain behavior at the medial trapezius and the suprascapular levels. Dr. Larson’s diagnosis was fibromyalgia syndrome involving primarily the right shoulder. (Ex. 20, p. 4-12). Dr. Larson stated in his note on May 23, 2005, that “I do not see her having any measure of work ability at this time.” (Ex. 20, p. 9).

III.

ARGUMENT

A. STANDARD OF REVIEW

In reviewing decisions of the WCCA, the Supreme Court should view the facts in the light most favorable the findings of the WCCA and those findings should not be disturbed unless they are manifestly contrary to the evidence or unless the evidence clearly requires reasonable minds to adopt a contrary conclusion. Egeland v. City of Minneapolis, 344 N.W.2d 597, 601 (Minn. 1984).

B. EMPLOYEE'S EMPLOYMENT CAUSED GILLETTE INJURIES WHICH LED TO PERMANENT INJURIES TO HER NECK, RIGHT SHOULDER AND FIBROMYALGIA.

A Gillette injury is a result of minute injuries from repeated trauma which results in a compensable injury when the cumulative effect cumulates in disability. See Gillette v. Harold, Inc., 257 Minn. 313, 101 N.W.2d 200, 21 W.C.D. 105 (1960). An employee's work activities during an insured's period of coverage must have substantially contributed to the employee's disability in order for liability to be imposed on that insurer. See Tannahill v. Mid-American Lines, Inc., 40 W.C.D. 726, 728 (WCCA 1987), summarily aff'd (Minn. Feb. 1, 1988); See also Gray v. Sears Roebuck & Co., 60 W.C.D. 273, 282 (WCCA 2000); Crimmins v. NACM No. Central Corp., 45 W.C.D. 445, 439 (WCCA 1991); summarily aff'd (Minn. Nov. 26, 1991) While evidence of a specific work activity may be helpful as a practical matter, the question of a Gillette injury primarily depends on medical evidence. Steffen v. Target Stores, 517 N.W.2d 579 (Minn. 1994). Whether given by testimony or written report, an opinion by a medical expert as to the casual link between the claimant's disability and the job must be based on adequate foundation. Grunst v. Immanuel-St.

Joseph Hosp., 424 N.W.2d 66, 68 (Minn. 1988); Gendro v. Brown Boveri Turbo Machinery Co., 355 N.W.2d 716, 719 (Minn. 1984).

Primary liability in workers' compensation cases addresses the work connectedness of the claimed personal injury. In cases involving disputed primary liability, the question is whether the injury "arose out of and in the course of employment." M.S. §176.011, subd. 16. The Supreme Court articulated the distinction between the two causation tests in Jackson v. Red Owl Stores, Inc., 375 N.W.2d 13, 17-18, 38 W.C.D. 170, 177 (Minn. 1985) The court observed that medical causation is a "distinct legal concept that concerns the connection between the primary injury and a later condition . . . 'how far the range of compensable consequences is carried, once the primary injury is causally connected with the employment'."

Questions of medical causation fall within the province of the compensation judge. Felton v. Anton Chevrolet, 513 N.W.2d 457, 50 W.C.D. 181 (Minn. 1994). It is the compensation judge's responsibility as trier of fact to resolve conflicts in expert testimony and a judge's choice between expert opinions is generally upheld unless the facts assumed by the expert in rendering his opinion are not supported by the evidence. Nord v. City of Cook, 360 N.W.2d 337, 342, 37 W.C.D. 364, 372 (Minn. 1985).

Compensation judge's findings on causation are clearly erroneous for the following reasons:

1. **Neck–Employee's Chronic Work-Related Neck Injury Led to Employee's Neck Fusion on June 18, 2004**

Dr. Beck, Employee's treating neurosurgeon, by report dated August 23, 2004, found Employee's work at Farmstead Foods to be a substantial contributing factor to her disc herniations. In June, 2006, he rated her at 16.5%, and after reviewing Dr. Friedland's report, Dr. Beck in his

report dated March 30, 2006, confirmed that the work injury was a substantial contributing factor because it made Employee's cervical spine more susceptible to degenerative arthritis and resulting disc herniations.

Dr. Bengtson of the Mayo Clinic Spine Center in his report dated April 7, 2006 confirms that Employee's work injury on September 25, 1989 led to her neck fusion.

The compensation judge found at Finding of Fact No. 21 that Employee sustained only a work-related temporary sprain to her cervical spine based upon the IME doctor's opinions. IME doctor noted in his report on October 18, 2005, Employee did not seek any further care by a physician for her neck symptoms from October 27, 1992, until 2002, and that in his opinion Employee's herniated discs resulted from the normal aging process of the cervical spine. He also noted that Dr. Zarling on September 10, 1990, stated that the patient did not have any objective findings to substantiate her subjective symptomatology. In his report dated July 5, 2006, Friedland opined because Employee was not found to have any evidence of an objective disc injury at the time of the incident in 1989 that her neck was not made more susceptible to disc herniations as a result of the work injuries.

Dr. Friedland's opinions are based upon inadequate foundation because:

- (a) On January 22, 1997, Employee did visit a physician, Dr. Waldron, with complaints of "chronic" neck pain, even though Friedland stated Employee did not seek further care from a physician until 2002.
- (b) Employee had objective findings of disc injuries as Dr. Zarling found chronic muscle spasm, tightness and rigidity with some sensory changes on September 10, 1990; Dr. Farber found limited range of motion on November 15, 1990; and a CT scan taken November 15, 1990, showed a bulging disc at the C5-6 level, even though Friedland claimed no evidence of an objective disc injury at time of injury.

Employee's report of chronic neck pain and objective findings of disc injuries in 1990 nullify IME doctor's opinion that the herniated discs resulted solely from the normal aging process, especially when considering the fact that Employee is only 44 years old.

The WCCA found that Friedland's opinion regarding the Employee's cervical disc herniations was based on the absence of herniation findings in the Employee's 1990 cervical CT scan and on the progression of Employee's degenerative disc disease as a normal aging process, not Friedland's mistake concerning Employee's gap in treatment. WCCA misinterprets the basis of Friedland's opinion. In his report dated October 18, 2005, Friedland stated that it was a "salient" point that Employee was not seen by a physician until 2002 for treatment of neck pain. In his report dated July 5, 2006, Friedland stated that Employee was not found to have "any evidence" of objective disc injury and as a result, was not made more susceptible to disc herniations. Based on Friedland's own statements, the misinformation was crucial part of the foundation for his opinion of lack of causation.

The Court should vacate compensation judge's Finding No. 21 concerning Employee's neck injury as it is manifestly contrary to the weight of the evidence as a whole as IME doctor failed to consider as a basis for his opinion on causation of Employee's "chronic" work-related neck injury substantiated by objective medical evidence in the record at the time of the work injury.

2. **Right Shoulder—Employee's Right Shoulder Surgery Performed on January 29, 1990, Was Only "Moderately Successful" and Was Redone on November 12, 2004 as a Result of her Admitted Work-Related Right Impingement Syndrome.**

Dr. Engasser's IME report dated May 2, 1991, stated that the Employee felt that her shoulder condition was now becoming worse over time. On exam, Employee had pain with abduction of the right shoulder against resistance. Dr. Engasser concluded Employee had undergone "a moderately

successful” surgery on January 29, 1990 for her admitted work-related right shoulder impingement syndrome. She was rated with a 3% permanent partial disability to her right shoulder.

Dr. Kirsch in his extensive report dated March 16, 2006, opined that patient’s Gillette-type work injury, as discussed in Dr. Farber’s 1990 reports was a substantial contributing factor toward Employee’s right shoulder problems in 2004 because although there were changes present attributed to the normal aging process (example: formation of a large right shoulder acromial spur identified in his work-up but not present during a previous shoulder surgery), her shoulder symptoms had been persistent since her date of injury, only to a small portion modified by treatment modalities.

Compensation judge at Finding of Fact No. 45 found Employee failed to prove her right shoulder injury was a substantial contributing factor to her claimed medical expenses and wage loss subsequent to December 30, 1990, based on IME doctor’s opinions. In his report dated October 18, 2005, Friedland’s opinion was that Employee’s sustained an injury of the right shoulder in the form of impingement syndrome without rotator cuff tear and that the second right shoulder surgery on November 12, 2004, was the product of the Employee’s right shoulder lateral osteophyte formation which was the consequence of the normal aging process. He also noted as a “salient” point that Employee did not seek any further treatment by a physician for her right shoulder symptoms from October 27, 1992, until 2002.

Dr. Friedland failed to recognize in stating his opinion on causation these salient facts:

- (a) The second surgery performed on November 12, 2004, included the removal of the bursa and CA ligament and a diagnosis of subacromial impingement syndrome which was same operative diagnosis for the moderately successful surgery in 1990 for her admitted work-related impingement syndrome..
- (b) Employee saw Dr. Waldron for right shoulder pain in December of 1996 and received a prescription for an anti-inflammatory, even though Friedland in his

report claimed she had no medical treatment for her shoulder symptoms from October 27, 1992, until 2002.

Employee's treatment for right shoulder tenosynovitis in 1996 and her second surgery in 2004 for her work-related impingement syndrome void Friedland's opinion that Employee's second shoulder surgery was solely the result of the aging process, especially when considering the fact that Employee is only 44 years of age.

The WCCA determine that there was no foundational defect concerning Friedland's opinion of lack of causation for the right shoulder without any further comment. The WCCA overlooked the two defects referred to above. IME doctor stated the gap in treatment was a "salient" point in the Employee's medical history. By IME doctor's own admission, the misinformation was a crucial fact used in forming his opinion. IME doctor also failed to reconcile the fact that the moderately successful 1990 surgery for Employee's work-related right shoulder impingement was redone in 2004. His failure to explain this critical similarity in disability and treatment makes the foundation for his opinion defective.

The Court should vacate compensation judge's Finding No. 45 concerning the right shoulder as the evidence on the whole clearly establishes that the IME doctor failed to consider that Employee's right shoulder subacromial impingement syndrome diagnosed after the surgery in 2004 was similar to and connected by chronic pain to the subacromial impingement syndrome in her right shoulder diagnosed after surgery in 1990.

3. Fibromyalgia—Employee has Reactive Shoulder Girdle Fibromyalgia as a Direct Result of her Work-Related Fibrositis and Multiple Surgeries.

On June 28, 2005, Dr. Larson stated "I certainly believe that she does have some reactive fibromyalgia. She had tender points in a fairly classic fibromyalgia distribution." Dr. Larson issued

a Health Care Provider Report on May 23, 2005, indicating the fibromyalgia was related to the work injury dated September 25, 1989, and was “building over months to years after multiple surgeries.” She was also diagnosed with Fibromylgia by Dr. Kirsch and Dr. Christian.

At Finding of Fact No. 24, compensation judge found Employee failed to prove she suffered from fibromyalgia as a result of the work injuries. He relied upon the opinion of the IME doctor that Employee did not have findings that would be diagnostic of true fibromyalgia. According to Dr. Friedland, Employee had global tenderness that was not localized to specific trigger points that would be required for the diagnosis of fibromyalgia.

In his report dated October 18, 2005, the IME doctor noted that Employee was diagnosed with fibromyalgia at Austin Medical Center in 2005 without stating that both Dr. Kirsch and Dr. Larson found trigger points in Employee’s right scapular area on examination of Employee. IME doctor did not mention that doctors found trigger points in Employee’s right scapular area on examinations of Employee in 1989, 1996, and 2002.

Despite five doctors finding specific trigger points on exam in Employee’s right scapular area, the IME doctor claimed Employee’s tenderness was not localized to specific trigger points on exam. On review of Friedland’s reports he makes no mention during exams of the Employee’s right shoulder that he palpated Employee’s right shoulder blade for trigger points. Five treating doctors finding trigger points in Employee’s right scapular area consistently over the years from the date of Employee’s injury convincingly trumps Friedland’s claim of global tenderness with no specific trigger points on examine.

WCCA assumed Friedland was aware that five other doctors found specific trigger points in Employee’s right shoulder blade and that Friedland did not mention it in his report because the

voluminous medical records could not be fully summarized. The WCCA assumes too much. Dr. Friedland indicates he summarizes the “salient” points from the medical records and what could be more salient on the issue than five treating doctors finding specific trigger points in Employee’s right shoulder blade.

The WCCA determined that the compensation judge was entitled to conclude that Friedland’s opinion was based on a difference in medical view point rather than an absence of critical information. WCCA failed to grasp that five treating doctors over the years found specific trigger points in Employee’s right scapular area and this is extremely critical information that could not be ignored by Dr. Friedland in summarizing the “salient” points of the foundation for his opinion.

The Court should determine that compensation judge’s Finding No. 24 concerning fibromyalgia is erroneous as manifestly contrary to the weight of the evidence because five treating doctors found trigger points in Employee’s right shoulder scapular area on exam over the years commencing December 29, 1989, which established Employee’s reactive shoulder girdle fibromyalgia was the natural consequence of Employee’s work-related fibrositis and multiple surgeries and this was not addressed by the IME doctor in his foundation for his opinion on causation.

IV.

CONCLUSION

For several years Kathy Maricle pulled ruffle fat from small hog intestines at Farmstead Foods. She is only 44 years of age and claims her employment caused Gillette injuries to her neck and right shoulder which led to a two level neck fusion, two arthroscopic surgeries of her right shoulder and fibromylgia. The compensation judge denied Employee’s claim for benefits, adopting

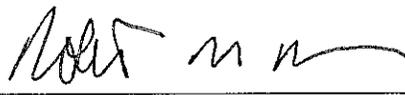
IME doctor's opinions that Employee's herniated cervical discs and second shoulder surgery in 2004 were solely related to the aging process and that she lacked specific trigger points that would be required for a diagnosis of fibromylgia. IME doctor's opinions were based on inadequate foundation, as IME doctor did not adequately consider:

1. Chronic nature from date of injury of Employee's neck and shoulder disabilities;
2. Objective findings of a neck injury at the time of the work injury;
3. Moderately successful first surgery on the right shoulder for admitted work-related impingement syndrome was redone in 2004; and
4. Five treating doctors found on exam specific trigger points in Employee's right scapular area, evidencing fibromylgia.

The Supreme Court should reverse the WCCA's decision affirming compensation judge's findings of lack of causation as manifestly contrary to the weight of the evidence as a whole and remand the case to the compensation judge for findings necessary to grant benefits consistent with Employee's claim as stated in Exhibit 57 and the Court's decision.

Respectfully submitted,

BAUDLER, BAUDLER, MAUS & BLAHNIK, LLP
Attorneys for Relator
108 North Main Street
Austin, MN 55912
(507) 433-2393

By:  _____

Robert M. Maus, #68950

The appendix to this brief is not available for online viewing as specified in the *Minnesota Rules of Public Access to the Records of the Judicial Branch*, Rule 8, Subd. 2(e)(2) (with amendments effective July 1, 2007).