RORY L. CLAYSON, Employee/Appellant, v. PLASTIC PRODUCTS and LIBERTY MUT. INS. CO., Employer-Insurer, and MN DEP'T OF ECONOMIC SECURITY, Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
JULY 23, 1998

No. *[redacted to remove social security number]*

HEADNOTES

CAUSATION - AGGRAVATION. Where it was based on adequately founded expert medical opinion and a reasonable assessment of the witnesses' credibility, the compensation judge's conclusion that the employee failed to prove that his work injury was a permanent aggravation of his preexisting cervical disc herniation was not clearly erroneous and unsupported by substantial evidence.

Affirmed.

Determined by Johnson, J., Wheeler, J., and Wilson, J.
Compensation Judge: Bernard Dinner

OPINION

THOMAS L. JOHNSON, Judge

The employee appeals from the compensation judge's conclusion that the employee's work injury was only a temporary sprain/strain and not a permanent aggravation of his preexisting cervical disc herniation. We affirm.

BACKGROUND

In September of 1989, the employee underwent an MRI scan in treatment for longstanding back problems. The scan was read to reveal intervertebral disc herniations at C5-6 and C6-7. The herniation at C5-6 was read to be compressing the spinal cord and the C6 nerve root. The herniation at C6-7 was read to be smaller and without significant spinal cord or nerve root compression. About a year later, in September of 1990, the employee injured his neck in an automobile accident. X-rays on September 14, 1990, revealed slight narrowing of the C6-7 level suggesting some degenerative disc disease. The x-rays also revealed some minimal compromise of the neural foramina at that same level. The x-ray report contains no reference to the C5-6 level. About two years later, in June of 1992, the employee saw rehabilitation specialist Dr. Alan Bensman for neck pain. Dr. Bensman ordered an MRI scan, which was conducted on June 23, 1992. The scan was read to reveal a [c]entral and left, mild to moderate, contained disc herniation at C6-7, resulting in mild indentation of the left side of the spinal cord. This finding was unchanged since 1989. Also unchanged was a [c]entral and right, moderate to large, contained disc

herniation at C5-6 that resulted in moderate compression of the right side of the spinal cord. Dr. Bensman referred the employee to neurosurgeon Dr. Edward Seljeskog. On July 23, 1992, Dr. Seljeskog performed a discectomy and fusion at C5-6. Following the employee's completion of a functional capacity evaluation in early December 1992, Dr. Bensman concluded the employee had made a full recovery from his surgery and could return to work full time with restrictions. On March 19, 1993, Dr. Bensman issued restrictions specifically against lifting over twenty pounds and against climbing, crawling, and repetitive bending and stooping. There is no evidence that these restrictions were ever lifted.

Except for two or three complaints of chronic low back and neck pain in the spring of 1994, the employee was essentially free of spinal symptoms for about two years. In January 1995, the employee took a job as a press operator for Plastic Products [the employer]. A job description signed by the employee on January 13, 1995, acknowledged the job routinely required lifting of up to twenty-five pounds, repetitive bending from a sitting position, and repetitive stooping. On February 1, 1995, on his second day on the job, the employee experienced pain in his upper back after attempting to remove a jammed part from a molding machine. The following day he saw Dr. Michael Zurek for his symptoms. Dr. Zurek diagnosed thoracic back strain and took the employee off work for four days. X-rays subsequently revealed mild degenerative changes but no destructive lesions. Dr. Zurek prescribed physical therapy and released the employee to work half time at light duty. The employer acknowledged liability and paid medical benefits and four days of temporary total disability benefits.

Symptoms persisted, and Dr. Zurek eventually referred the employee to physiatrist Dr. Paul Biewen. Dr. Biewen saw the employee on March 16, 1995, for evaluation of persistent mid-back pain. On that date, Dr. Biewen reported the following:

> Current symptoms consist of a . . . very localized pain [in] his thoracic spine at the level of the inferior border of the scapula. He describes a burning and aching pain which is localized and does not radiate laterally. There is no radicular symptoms into the rib or abdominal region. He denies that his neck or low back has been exacerbated by this.

On examination, Dr. Biewen found no evidence of radicular involvement and concluded that the employee's symptoms were most likely due to ligamentous strain. He denied the employee's request for further radiologic studies, concluding that [a]ny type of findings such as disc herniation in my opinion would be incidental and certainly not a result of the activity [the employee] describes. Concluding also that the employee's current work activity [was] ideally suited to his situation, Dr. Biewen released the employee to full time work with restrictions against lifting over twenty-five pounds. He indicated that this restriction was more to protect the employee's low back than his mid back.

Pursuant to the employee's continuing complaints, and notwithstanding Dr. Biewen's recommendation, on March 23, 1995, Dr. Zurek restricted the employee's daily work

hours to six and his lifting to twenty pounds, fifteen pounds repetitively. About a week later, Dr. Zurek referred the employee to see occupational medical expert Dr. John Jacoby, who examined the employee on April 13, 1995. Dr. Jacoby noted that the employee's pain was located at a T5 level pretty much in the midline. On examination he noted also that the employee had near normal range of motion in the neck, without significant pain. The employee had indicated to Dr. Jacoby that he thought a further reduction in work hours was necessary, but Dr. Jacoby declined to support such a reduction. By the end of April 1995, the employee began complaining of neck pain as well as of back pain. Dr. Zurek increased the employee's restriction on working hours to four a day and ordered an MRI scan. The scan was conducted on April 27, 1995, and revealed in part a broad disc herniation with associated stenosis at C6-7. The employee was referred to neurosurgeon Dr. Daniel Ahlberg, whom he saw on June 23, 1995. Dr. Ahlberg, diagnosed only subacute cervical strain and recommended that the employee continue with range of motion and strengthening exercises and continue working full time.

On July 25, 1995, the employee saw Dr. Zurek's colleague Dr. Daniel Fordahl. Dr. Fordahl noted that the employee was complaining of a recent exacerbation of his cervical strain, which had appeared approximately 4-5 days ago. At an examination two days later, Dr. Jacoby noted that the employee's primary complaints were now of cervical rather than of thoracic pain. He indicated that [t]his is an entirely different problem than I saw [the employee] for back in April. In light of these new symptoms, Dr. Jacoby recommended continuation of restrictions against working more than four hours a day and against more than limited lifting and bending. Dr. Jacoby referred the employee back to Dr. Biewen, who on August 10, 1995, recommended that the employee continue in conservative care and be more consistent with attending work. Dr. Zurek noted on August 28, 1995, that the employee had been missing two or three days of work a week because of back pain. He indicated that, since the employee's condition had been stable and perhaps even improving for some time, he would no longer provide the employee with regular medical excuses for absences from work. On August 31, 1995, Dr. Biewen concluded that the employee's initial thoracic problems had resolved and recommended continued conservative care for his cervical problems. Two weeks later, on September 14, 1995, the employee was terminated by the employer for excessive unexcused absences from work.

On September 29, 1995, the employee saw Dr. Robert Wengler with complaints of left shoulder and arm pain, persistent neck pain into the upper part of the back, and radiating pain and numbness into the seventh cervical nerve root distribution of the left arm and hand. Noting that the protrusion of the employee's C6-7 disc appeared larger on the employee's April 1995 MRI scan than it had on the 1992 scan, Dr. Wengler recommended that the employee seriously consider having C6-7 fused. In a report on that same date, Dr. Wengler expressed an opinion that [t]he effect of work activities of January 31, 1995 appear[s] to have been that of a material aggravation of an underlying pathology. He reported also that the employee was feeling somewhat better in the two weeks since he's been off work and had declined to undergo the recommended fusion.

Subsequent to his termination, the employee received unemployment compensation and then began working at various intermittent and part time jobs. On January 21, 1997, he filed

a claim petition, alleging entitlement to wage replacement benefits continuing from September 14, 1995, and to undetermined permanent partial disability benefits.

On April 17, 1997, the employee was examined for the employer and insurer by Dr. Gary Wyard. After review of the entire record, it was Dr. Wyard's opinion that the employee did not sustain a significant new injury to his neck as a result of his work for the employer on February 1, 1995, although [h]e may have had a temporary aggravation of his preexisting condition. Dr. Wyard found that the employee did have a permanent disability to the neck which required permanent restrictions. He concluded, however, that that disability and the restrictions it now necessitated were entirely the result of a condition preexisting the employee's work injury. Dr. Wyard concluded that any injury sustained by the employee in February 1995 was no more than a thoracic sprain/strain. Finally, Dr. Wyard concluded that the employee would have reached maximum medical improvement from such a sprain/strain about three months after the injury. On May 9, 1997, the employee was served with Dr. Wyard's report.

On August 21, 1997, radiologist Dr. William Ford reviewed the employee's June 1992 and April 1995 MRI scans. Dr. Ford noted in part a central spur at C6-7 extending to but not appreciably deforming the cervical cord. He concluded that the condition of the employee's spine at this level appeared essentially unchanged in April 1995 from what it had been in June 1992.

The matter came on for hearing on October 30, 1997. At the hearing, the employee was cross-examined extensively, sometimes over objection, about certain old car collecting and metal scrapping activities that he had engaged in since his youth.[1] He testified that he was in a routine of working at these activities almost daily at the time of his work injury and up through the date of his termination. He testified that he would work at them from shortly after getting off work from the employer at 7:00 a.m. until close to the time he went to bed at mid afternoon. He characterized the activity as a hobby, but he did acknowledge that he earned about $50.00 a ton for the scrap metal he collected and sold. The employee's partner, Richard Moos, also testified regarding these activities. Following the hearing, the compensation judge concluded the employee had not proven his February 1995 work injury permanently aggravated either his C5-6 or his C6-7 preexisting disc herniation. In so finding, the judge expressly relied on the opinion of Dr. Wyard, that the employee's ongoing cervical symptoms were a result of the employee's preexisting cervical degenerative disc disease and cervical fusion and not a result of his work-related sprain/strain. Dr. Wyard also concluded the employee's outside activities scrapping cars [c]ertainly . . . contributed to or caused his neck symptoms. Apparently in light of that opinion, and finding expressly that Mr. Moos's testimony about the activities had been credible, the judge also concluded that the employee's outside activities, scrapping cars, including lifting

[1] The employee's objection was based on a contention that the employee was not claiming benefits for any time prior to his termination and that questioning about his outside activities during that pre-claim period was irrelevant. The employee asks this court to strike this testimony. We conclude the testimony was relevant, in that the testimony bears on the issue of the nature and extent of the February 1995 injury.

transmissions, engine blocks, and differentials contributed to or caused his neck problems. The judge found also, finally, that the employee had never told Dr. Zurek, Dr. Biewen, Dr. Jacoby, or Dr. Bensman about these daily scrapping activities and that Dr. Wengler's report does not set forth any history as to those activities. The employee appeals.

STANDARD OF REVIEW

In reviewing cases on appeal, the Workers' Compensation Court of Appeals must determine whether the findings of fact and order [are] clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted. Minn. Stat. § 176.421, subd. 1 (1996). Substantial evidence supports the findings if, in the context of the entire record, they are supported by evidence that a reasonable mind might accept as adequate. Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54, 59, 37 W.C.D. 235, 239 (Minn. 1984). Where evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings are to be affirmed. Id. at 60, 37 W.C.D. at 240. Similarly, [f]actfindings are clearly erroneous only if the reviewing court on the entire evidence is left with a definite and firm conviction that a mistake has been committed. Northern States Power Co. v. Lyon Food Prods., Inc., 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975). Findings of fact should not be disturbed, even though the reviewing court might disagree with them, unless they are clearly erroneous in the sense that they are manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole. Id.

DECISION

The employee contends that substantial evidence does not support the compensation judge's conclusion that the employee did not prove that his work injury was more than a temporary aggravation. He argues that all symptoms stemming from his herniation at C6-7, including his radicular symptoms, appeared subsequent to his work injury and therefore establish that the work injury was a permanent aggravation of his preexisting herniation. He suggests that the judge's decision to the contrary over emphasized the employee's car collecting and metal scrapping activities. He argues finally that, at the time he was terminated, he was subject to work injury-related restrictions that have never been lifted and so continue to affect his earning capacity. We are not persuaded.

The mere fact that the employee's radicular symptoms appeared following his admitted strain/sprain injury at work does not prove that they were caused by the same incident that caused the strain/sprain. The employee was examined by at least nine different doctors, eight of them treating doctors. Only Dr. Wengler opined that current radicular symptoms consequent to the employee's herniation at C6-7 were causally related to the employee's work activities on February 1, 1995. Dr. Wyard rendered an opinion expressly to the contrary A trier of fact's choice between experts whose opinions conflict is usually upheld unless the facts assumed by the chosen expert in rendering his opinion are not supported by the evidence. Nord v. City of Cook, 360 N.W.2d 337, 342-43, 37 W.C.D. 364, 372-73 (Minn. 1985). In this case there is no evidence that Dr. Wyard's opinion was based on any false premises. Moreover, neck problems, as opposed

to mid back problems, were not documented in the medical record until about three months after the work injury, and the radicular symptoms more critically at issue here were not clearly documented until September 29, 1995, fully eight months after the work injury on February 1, 1995.

With regard to his scrapping activities, the employee emphasizes that both he and Mr. Moos testified that he suffered no specific injury in the course of those activities. The employee emphasizes in this regard that he had both personal and machine help in doing any heavy lifting required by the scrapping work. He asserts that he never exceeded his restrictions in performing the activities and that, at any rate, he was not performing the activities very much during the summer of 1995. These assertions, however, are at least somewhat in conflict with the testimony of Mr. Moos, which the judge expressly found credible, notwithstanding the employee's position that Mr. Moos had had a falling out with the employee and was biased against him.. Assessment of a witness's credibility is the unique function of the trier of fact. Brennan v. Joseph G. Brennan, M.D., 425 N.W.2d 837, 839-40, 41 W.C.D. 79, 82 (Minn. 1988), citing Spillman v. Morey Fish Co., 270 N.W.2d 781, 31 W.C.D. 187 (Minn. 1978).

Finally, with regard to the employee's argument that he remains subject to work injury-related restrictions, we note Dr. Biewen's conclusion on August 31, 1995, that the employee's [m]id back pain which was his initial presentation post injury is not problematic and that as of that date the doctor did not expect that [the employee] would need to be restricted for this. The radicular symptoms apparently referable to the employee's pre-existing disc herniation are a separate issue from the work injury-related pain and restrictions that Dr. Biewen asserts to be ended.

The compensation judge's decision was reasonably based on adequately founded expert medical opinion, his assessment of the witnesses' credibility was within his sound discretion, and his decision was not otherwise unreasonable. For these reasons, we affirm the judge's conclusion that the employee failed to prove that his work injury was a permanent aggravation of his preexisting cervical disc herniation. Hengemuhle, 358 N.W.2d at 59, 37 W.C.D. at 239.