HEATHER CRAIN, Employee/Appellant v. RIVERVIEW HEALTHCARE ASS'N and SELF-INSURED/SEDGWICK JAMES OF MINN., Employer-Insurer and NORTHERN PLAINS HEALTH PLAN and MAYO FOUND.

WORKERS' COMPENSATION COURT OF APPEALS
JANUARY 6, 1998

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

HEADNOTES

CAUSATION - NATURE OF THE INJURY; EVIDENCE - EXPERT MEDICAL OPINION. Substantial evidence, including expert medical opinion, supports the compensation judge's finding the employee's disability is due to chronic pain syndrome rather than reflex sympathetic dystrophy.

PERMANENT PARTIAL DISABILITY - NON-SCHEDULED INJURY. Remand for additional findings where compensation judge did not make findings regarding the closest compensable category in the disability schedules to compensate the employee for her functional loss and basis for rating non-scheduled injury cannot be determined.

Affirmed in part and remanded.

Determined by Johnson, J., Hefte, J., and Wheeler, C.J.
Compensation Judge: Peggy A. Brenden

OPINION

THOMAS L. JOHNSON, Judge

The employee appeals from the compensation judge's finding that she failed to establish that she suffers from reflex sympathetic dystrophy. The employee further appeals the award of a 5% permanent partial disability to the body as a whole as a result of chronic pain syndrome. We affirm the findings regarding the reflex sympathetic dystrophy but remand the permanency issue for further findings.

BACKGROUND

On October 25, 1991, Heather Crain, the employee, sustained an injury to her right foot and ankle while working for Riverview Healthcare Association, then self-insured for workers' compensation liability. The self-insured employer admitted liability and paid certain workers'

compensation benefits to the employee including payment for a 10% permanent partial disability of the right foot.[1]

The employee treated with Dr. R. C. Hanson at the Northwestern Clinic in Crookston, Minnesota. The initial diagnosis was ankle sprain with possible ligamentous damage. On November 5, 1991, Dr. Hanson applied a cast. By December 9, Dr. Hanson questioned whether the employee may have a fracture at the base of the fourth metatarsal. A bone scan on February 11, 1992, was normal. An arthrogram in May 1992 was also normal, although the employee continued to be symptomatic. The employee was referred to Dr. Thomas D. Nagle, an orthopedic surgeon at the Fargo Clinic, whom she saw on May 1, 1992. He diagnosed instability of the calcaneocuboid joint of the right foot. On May 22, 1992, Dr. Nagle performed a right calcaneal cuboid fusion. The employee continued to have problems with her right foot. An x-ray on October 22, 1992, noted the joint space was apparent at the calcaneocuboid articulation and the doctor could not state that there was a bony fusion. Dr. Nagle questioned whether the employee was developing a reflex sympathetic dystrophy. (Pet. Ex. C-4). In November 1993, the employee saw Dr. Paul Lindquist also at the Fargo Clinic. He diagnosed reflex sympathetic dystrophy, right leg, state II, with osteoporosis. (Pet. Ex. C-4).

The employee saw Dr. Robert H. Clayburgh, an orthopedic surgeon, on January 4, 1993. His impression was possible nonunion calcaneal cuboid arthrodesis of the right foot. The doctor ordered a bone scan and a CT scan, both of which were normal and showed no evident nonunion. (Pet. Ex. C-4). Dr. Clayburgh referred the employee to Dr. Scott R. McGarvey, an orthopedic surgeon on April 19, 1993. Dr. McGarvey's impression was post-traumatic lateral column pain status post attempted calcaneal cuboid arthrodesis. In July 1993, the doctor performed a subtalar fusion with an iliac crest bone graft and an exploration of the calcaneal cuboid fusion. The employee then followed with Dr. McGarvey. In October 1993, the doctor allowed the employee to return to work with restrictions. The employee returned to see Dr. McGarvey in January 1994. He diagnosed tibiotolar synovitis and prescribed physical therapy. In February 1994, Dr. McGarvey noted the employee remained a diagnostic enigma. (Pet. Ex. C-7).

The employee next saw Dr. Thomas J. Valente, who performed sympathetic nerve blocks. In May 1994, Dr. Valente recommended a surgical ablation of the sympathetic nerve fibers. (Pet. Ex. C-7). The employee was referred to Dr. Gaylen Rockswold who performed a right lumbar sympathectomy[2] on October 18, 1994. The employee was pain free after this procedure for only six weeks and then her symptoms returned. In March 1995, the employee attended the North Pain Institute, a chronic pain program. On December 10, 1995, the employee fell at a hockey arena and suffered a fractured toe on her right foot.

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[1] Apparently this payment was based on a rating by Dr. McGarvey under Minn. R. 5223.0170, subp. 8A(2)(c). See Pet. Ex. C-7.

[2] The transection, resection or other interruption of some portion of the sympathetic nervous pathways. Dorland's Illustrated Medical Dictionary 1284 (26th Ed. 1985).

The employee was seen by Dr. Thomas R. Jacques, a neurologist, on December 9, 1996, at the request of the insurer. On examination, the doctor found the employee's lower extremity neurologic function was intact. The doctor noted the Mayo Clinic evaluation showing a difference in the sympathetic function between the right and the left leg which Dr. Jacques stated was to be expected after the sympathectomy surgery. The doctor diagnosed chronic pain syndrome and stated I do not see sufficient evidence of reflex sympathetic dystrophy to make this diagnosis. (Resp. Ex. 1).

The employee filed a claim petition asserting the fall and the broken toe were a consequence of the admitted 1991 injury and contending that she now suffers from reflex sympathetic dystrophy (RSD) of the right leg. The employee sought wage loss benefits and an additional 26% whole body disability for RSD. The matter came on for hearing before a compensation judge at the Office of Administrative Hearings. In Findings and Order served and filed July 10, 1997, the compensation judge found the work injury of October 25, 1991, was a substantial contributing cause of the employee's fall and broken right toe on December 10, 1995. (Finding 3.) The compensation judge then found the employee was temporarily partially disabled during specific periods of time. (Finding 6.) These findings are unappealed. The compensation judge further found the employee failed to establish that she suffers from RSD and concluded the employee has a 5% permanent partial disability to the body as a whole as a result of chronic pain syndrome. The employee appeals these findings.

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 (1992). 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

Reflex Sympathetic Dystrophy

A number of physicians who examined the employee referred to or diagnosed reflex sympathetic dystrophy (RSD). Dr. Nagle stated on October 22, 1992: I am wondering if she is developing a reflex sympathetic dystrophy. (Pet. Ex. C-4). Dr. Nagle referred the employee to Dr. Lindquist, a rehabilitation medicine specialist who diagnosed reflex sympathetic dystrophy, right leg, Stage II with osteoporosis. (Pet. Ex. C-4). Dr. Thomas J. Valente also diagnosed RSD (Resp. Ex. 8). Dr. Rockswold and Dr. Pilling also diagnosed RSD. (Resp. Ex. 7, Pet. Ex. C-9). Dr. Seth Rosenbaum diagnosed RSD and rated permanent disability. (Pet. Ex. C-11). The employee was seen by Dr. Catherine Willner at the Mayo Clinic in May 1996. Dr. Willner reviewed the employee's medical records, examined the employee and obtained various laboratory tests. The final diagnoses were: 1) chronic right lower extremity pain status post multiple arthrodesis procedures (calcaneocuboid and subtalar); 2) no evidence of active complex regional pain syndrome; 3) chronic pain syndrome; 4) post sympathectomy changes right lower extremity (Pet. Ex. C-10). The compensation judge specifically adopted the Mayo Clinic diagnosis.

The employee argues the Mayo Clinic physicians did not rule out RSD and that a diagnosis of chronic pain syndrome does not necessarily exclude a diagnosis of RSD. Further, the employee points out that Dr. Willner in her letter of July 25, 1996, states she found evidence for active features that would suggest an ongoing diagnosis of complex regional pain syndrome. (Pet. Ex. C-10). Complex regional pain syndrome, the employee contends, is RSD. Accordingly, the employee asserts the compensation judge erroneously relied on the Mayo Clinic reports in denying her claim that she has RSD. We are not persuaded.

On June 3, 1996, Dr. Willner reported the results of a three-phase bone scan of the lower legs, an EMG, autonomic screening studies and a thermoregulatory sweating study. The doctor noted there was no significant evidence suggesting any variant of reflex sympathetic dystrophy. In her handwritten notes, Dr. Willner stated: Imp; chronic pain syndrome RLE. (Resp. Ex. 10). Dr. Hanson reviewed these reports from the Mayo Clinic. In his November 1996 report, the doctor stated: The Mayo Clinic physicians do not feel that currently she has reflex sympathetic dystrophy. (Pet. Ex. C-1). Dr. Jacques also concluded the employee did not have RSD. The compensation judge concluded from the Mayo Clinic reports that Dr. Willner determined the employee did not have RSD. This is a reasonable conclusion given all the medical evidence in the case. Further, we find no support for the employee's assertion that complex regional pain syndrome is the same diagnosis as RSD. In any event, Dr. Willner specifically stated there was no evidence of active complex regional pain syndrome. (Pet. Ex. C-10).

The compensation judge noted the evaluation at the Mayo Clinic was the most comprehensive and impartial evaluation of the employee's condition. It is the opinion of the Mayo physician that the employee's difficulties are a consequence of chronic pain syndrome rather than RSD, and I find that opinion persuasive. (Memo at 6). It is the compensation judge's

responsibility, as trier of fact, to resolve conflicts in expert testimony. Nord v. City of Cook, 360 N.W.2d 337, 342, 37 W.C.D. 364, 372 (Minn. 1985).

The employee also contends that the evidence establishes that she has at least five of the conditions defined in Minn. R. 5223.0400, subp. 6, which states:

> For purposes of rating under this part, reflex sympathetic dystrophy, causalgia, and cognate conditions are deemed to occur in a member if at least five of the following conditions persist concurrently in that member: edema, local skin color change of red or purple, osteoporosis in underlying bony structures demonstrated by radiograph, local dyshidrosis, local abnormality of skin temperature regulation, reduced passive range of motion in contiguous or contained joints, local alteration of skin texture of smooth or shiny, or typical findings of reflex sympathetic dystrophy on bone scan.

Accordingly, the employee argues, the compensation judge was required to find the employee has RSD as a matter of law. Again, we are not persuaded.

The date of injury in this case is October 25, 1991. The disability schedules in effect for this date of injury are set forth at Minn. R. 5223.0010 et seq. Those schedules contain no rating for RSD. Permanent disability for the lower extremity under the schedules then in effect is based on amputation (Minn. R. 5223.0150) or nerve injury or motor and sensory loss (Minn. R. 5223.0160). The rule relied upon by the employee, Minn. R. 5223.0400, subp. 6, did not become effective until July 1, 1993. See Minn. R. 5223.0300, subp. 2. A basic tentative workers' compensation law is that the parties' rights are fixed by the date of the controlling event. Joyce v. Lewis Nut & Bolt Co., 412 N.W.2d 304, 40 W.C.D. 209 (Minn. 1987). As a general principle, most often the occurrence of a compensable personal injury is the controlling event. Id. at 307, 40 W.C.D. at 213. The permanent partial disability schedules in effect on the date of injury govern. Reirson v. Michael Motors, Inc., 40 W.C.D. 382 (W.C.C.A. 1987). Since Minn. R. 5223.0400, subp. 6 was not in effect in 1991, the compensation judge need not consider the rule. In any event, both Dr. Willner and Dr. Jacques concluded the employee did not have RSD. The compensation judge was entitled to rely on those opinions. See Nord, 360 N.W.2d at 342, 37 W.C.D. at 372. The compensation judge's conclusion that the employee failed to prove she suffers from RSD is supported by substantial evidence and is affirmed.

Permanent Partial Disability

The employer and insurer previously paid the employee for a 10% permanent partial disability (PPD) of the right foot. In this proceeding, the employee claimed an additional 26% permanent disability for RSD. The employee relied on the report of Dr. Seth Rosenbaum dated February 26, 1997, rating a 26% whole body disability for RSD pursuant to Weber v. City

of Inver Grove Heights, 461 N.W.2d 918, W.C.D. 471 (Minn 1990).[3] The compensation judge awarded the employee a 5% whole body disability (Finding 8), noting this was a reasonable approximation of the additional impairment the employee suffers as a result of her chronic pain syndrome. (Memorandum at 6.)

The employee appeals the compensation judge's denial of her claim for permanent partial disability benefits. She argues that even if she does not have RSD, she's eligible for a Weber rating. In Weber, the supreme court held that compensation judges have discretion to assign the nonscheduled injury to its closest compensable category in the schedule. Id. at 922, 43 W.C.D. at 478. Minn. Stat. § 176.105, subd. 18 was enacted in 1992 and appears to codify the principle of the Weber decision, requiring that an unrated injury must be assigned and compensated for at the rating for the most similar condition that is rated. This condition, the employee contends, is RSD. Accordingly, the employee argues the compensation judge erred in failing to use Minn. R. 5223.0400, subp. 6 as a basis for the Weber rating. We disagree.

As we noted, Minn. R. 5223.0400, subp. 6 (rating RSD) was not effect in 1991 so the compensation judge certainly is not legally bound to utilize that rule.[4] Under the disability schedules in effect in 1991 both chronic pain syndrome and RSD are nonscheduled injuries. The employee argues, however, the compensation judge erred because she failed to base the permanency rating on the most similar condition in the applicable disability schedules. We are compelled to agree. While the 5% rating assigned by the compensation judge may be appropriate, we cannot determine the basis for the rating. The compensation judge did not identify the closest compensable category in the schedule to compensate the employee for her functional loss due to the chronic pain syndrome. Accordingly, the case is hereby remanded to the compensation judge for additional findings consistent with this opinion. The compensation judge may, in her discretion, make such findings on the existing record, may solicit supplemental briefs from the parties or may reopen the record for additional evidence.

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[3] Dr. Rosenbaum diagnosed RSD. Since RSD was not a rateable category under the disability schedules in effect at the time of injury, the doctor concluded it must be rated pursuant to Weber. Dr. Rosenbaum relied upon the AMA Guides to the Evaluation of Permanent Impairment and rated the RSD at a 26% whole body disability. (Pet. Ex. C-11). Combined with the prior 10% PPD and reduced by the A + B formula (see Minn. Stat. § 176.105, subd. 4(c)), the doctor assigned a total PPD rating of 33.4%.

[4] The 1993 disability schedules may, however, be used to provide guidance for a Weber rating even though the date of injury predates the effective date of the 1993 schedules. Carlson v. Montgomery Ward, File No. *[redacted to remove social security number]* (W.C.C.A. April 1, 1996).