

JAMES C. DREKE, Employee/Appellant, v. ROBERTS AUTOMATIC PRODS. and FEDERATED MUT. INS. CO., Employer-Insurer.

WORKERS' COMPENSATION COURT OF APPEALS
APRIL 28, 1999

No. [REDACTED SSN]

HEADNOTES

PERMANENT PARTIAL DISABILITY - SUBSTANTIAL EVIDENCE. Where the IME rated the employee's cervical condition at 9.5% and there was no objective evidence of upper extremity nerve root specific muscle weakness, the compensation judge's decision was supported by substantial evidence and not clearly erroneous in not accepting the employee's doctor's rating of 14.5% under Minn. R. 5223.0370, subp. 4D.

Affirmed.

Determined by Wheeler, C.J., Johnson, J., and Pederson, J.
Compensation Judge: Bonnie A. Peterson.

OPINION

STEVEN D. WHEELER, Judge

The employee appeals from the compensation judge's award of a 9.5% permanent partial disability rating of the whole body as a result of his condition at spinal level C4-5.

BACKGROUND

The employee, James Dreke, worked as a machinist for the employer, Roberts Automatic Products. On July 20, 1987, the employee sustained an admitted injury to his cervical spine. At the time the employee was 45 years of age. The employee underwent an anterior discectomy and fusion at spinal level C5-6 on December 29, 1987.

Following a period of recuperation from the surgery the employee returned to work for the employer. The employee's treating physician, Dr. Harry M. Rogers, a neurosurgeon, issued a maximum medical improvement report on August 10, 1988. Dr. Rogers rated the employee's permanent partial disability at 11.5% of the whole body under Minn. R. 5223.0070, subp. 2D, "fusion of a single vertebral level with or without laminectomy." (Resp. Ex. 1, tab 3, MMI report of 8/10/88.) The employer and insurer paid this benefit.

The employee returned to see Dr. Rogers in January 1993, complaining of pain in his neck and left arm and some tingling in his thumb and index finger. An MRI scan taken on

May 12, 1993 indicated “a central bulging or herniated disc at C4-5,” but Dr. Rogers did not “see a good explanation for his symptoms down his left arm.” (Resp. Ex. 1, tab 3, office note of 5/24/93.) An EMG of the left arm was then performed on June 28, 1993, but proved to be normal. (Resp. Ex. 1, tab 5.) The employee was given a cervical traction unit for home use. The employee returned to see Dr. Rogers in May of 1994, continuing to complain of pain in his neck and left shoulder. On May 27, 1994 a cervical myelogram and contrast-enhanced CT scan was performed. Dr. Rogers interpreted these tests to show “progression of his disc disease at C4-5” with a “moderate-sized central disc herniation effacing the thecal sac and flattening the ventral aspect of the spinal cord.” At the time of a June 9, 1994 examination the employee indicated that he “continues to have more and more trouble with neck and left shoulder pain.” Dr. Rogers’ examination showed no neurological deficit but did find a “limitation of motion of his neck and tenderness in the left trapezius area.” (Resp. Ex. 1, tab 3, office notes of 6/9/94.)

On August 24, 1994, the employee was examined at the request of the insurer by Dr. Joseph H. Perra, M.D. At the time of the examination, Dr. Perra noted the following history given by the employee:

Approximately two years ago, Mr. Dreke indicates he had return of neck pain. This went to the left side, into his shoulder but never really down the arm, to the hand as his previous symptoms had. He subsequently returned to see Dr. Rogers who had an MRI and EMG performed and this suggested to Dr. Rogers there was central bulging at C4-5, which he thought may be slightly more significant than years ago. There was also some central bulging at C3-4. He did not see any clear signs for why he was having left arm symptoms. An EMG was obtained which was normal. Throughout this, Mr. Dreke was continuing to work but not able to do all the jobs of his usual occupation by report. He returned to see Dr. Rogers and then a myelogram was performed in May of 1994. This showed what was felt to be increased size of disc at C4-5. In June, they discussed surgical intervention for this problem.

The neurological examination performed by Dr. Perra was essentially normal, with the exception of some effects on the right side which were attributable to the problems at levels C5 and C6. Dr. Perra’s interpretation of the May 1993 MRI and May 1994 CT and myelogram is as follows:

The MRI shows evidence of disc annular tears at C2-3 and C3-4 and C4-5 with central, very small protrusion of the disc at C3-4, more significant protrusion at the C4-5 level. C4-5 level does contact the spinal cord in the midline. Only mild foraminal narrowing is present. At C5-6, there is no cord or root compression of significance. Signal changes are suggestive of a solid fusion. Myelogram dated 5/27/94 shows narrowing of the dye column around spinal cord, at the C2-3, C3-4 and C4-5 level. CT scan is

most helpful here, showing moderate to large size, central disc protrusion at C4-5 with deformation of the cord at this level.

At the C4 vertebral level, there is evidence of spotty ossification of posteroligamentous ligament without cord compression. At the C3-4 level, mild central protrusion of the disc is present, causing thecal sac impingement without cord compromise.

Dr. Perra's impression was "Primarily persistent mechanical type neck symptoms of two years' duration with attempted nonoperative treatment. Central disc protrusion C4-5." Dr. Perra, when describing the outcome of possible surgery, indicated that because the employee's problems were "primarily mechanical pain," as contrasted with "radicular pain," surgery would be less likely to be successful. (Resp. Ex. 1, tab 3.)

As a result of the employee's continued difficulties during the latter part of 1994 and early 1995 Dr. Rogers performed an anterior discectomy and fusion at spinal level C4-5 on January 31, 1995. The employee was seen in follow-up by Dr. Rogers and other physicians at his clinic, Neurosurgical Associates, through at least November 7, 1995. (Resp. Ex. 1, tab 3.) The employee underwent 12 physical therapy treatments from June 8 through August 1, 1995. (Resp. Ex. 1, tab 6.) In November 1995 and early 1996, the employee was examined by Dr. Joseph Wegner at the request of the employer and insurer. Dr. Wegner opined that the employee had an additional permanent partial disability rating of at least 5% for a fusion at an adjacent level under Minn. R. 5223.0070, subp. 2B(4). (Resp. Ex. 1, tab 10.) The employer and insurer related this injury to the employee's original 1987 work-related injury and only agreed to pay the employee an additional 5% permanent partial disability for a herniated disc at an adjacent level. The employee's treating physician subsequently opined that the second surgery was the result of a separate Gillette injury.¹ As of the date of hearing below all parties stipulated that the employee had suffered a separate Gillette injury which culminated on January 31, 1995.

Dr. Robert Wengler, who examined the employee on a consultation basis at the request of the employee's attorney on November 14, 1997, opined that the employee's injury at the C4-5 level should be rated as a 14.5% permanent partial disability of the body, relying on Minn. R. 5223.0380, subps. 4D (9%) and 4D(1) (3%) and subpart 5 (2.5%, fusion modifier). (Pet. Ex. B, report of 11/14/97.) Dr. Steven Lebow, the examiner retained by the employer and insurer, examined the employee on May 4, 1998 and opined that the employee's permanent partial disability rating at spinal level C4-5 should be limited to 9.5%, pursuant to Minn. R. 5223.0380, subp. 4C (7%) and subp. 5 (2.5%). (Resp. Ex. 1, tab 11.)

Pursuant to a claim petition filed by the employee on December 15, 1997, the dispute concerning the appropriate level of permanent partial disability came before a compensation judge at the Office of Administrative Hearings on September 23, 1998. In Findings

¹ Gillette v. Harold, Inc., 257 Minn. 313, 101 N.W.2d 200, 21 W.C.D. 105 (1960).

and Order filed October 27, 1998, the compensation judge found that the appropriate rating should be 9.5%. 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 (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

A compensation judge's finding regarding the rating of permanent partial disability is one of ultimate fact and must be affirmed if it is supported by substantial evidence. Jacobowitch v. Bell & Howell, 404 N.W.2d 270, 274, 39 W.C.D. 771, 778 (Minn. 1987). In order to receive a permanent partial disability rating, the employee must prove each element of the scheduled disability. Knudson v. Twin City Hide, Inc., 40 W.C.D. 336, 338 (W.C.C.A. 1987).

On appeal the employee contends that the compensation judge's decision was not supported by substantial evidence and was clearly erroneous when she refused to award a permanency rating of 14.5% of the whole body pursuant to Minn. R. 5223.0370, subps. 4D and 4D(1) and subp. 5A, as determined by Dr. Wengler. The employee contends that all of the prerequisites required in subpart 4D had been satisfied.

The compensation judge, in her memorandum made the following statement with respect to the permanency rating determination:

The employee relies on Dr. Wengler, the employer relies on Dr. Lebow. The main dispute seems to be the difference between the employee's complaints of radicular pain into his arm. Minn. R. 5223.0370, subp. 4C deals with radicular pain confined to the cervical spine and is supported by objective findings. It is clear the employee had a fusion and did have findings on a CT scan. It was a single level which would result in the 7%. All parties agree that

the employee should receive a 2.5% additional permanency rating under subp. 5 for fusion. The dispute seems to be whether or not subp. C or subp. D should be used. Subp. D includes a 9% permanency and allows for additional ratings to be used. Dr. Wengler used the 9% rating and also D1 to add an additional 3%. Subd. D, seems to require some type of an additional objective finding in the upper extremity. There seems to be no indication of nerve root impingement and also an EMG was performed which was normal. The employee does not seem to have the requisite objective findings to fall into subd. 4D.

In reaching her determination, the compensation judge made the following relevant findings:

Finding 7. The employee has radicular pain.

Finding 8. The employee has persistent and objective clinical findings confined to the region of the cervical spine. The employee has voluntary muscle tightness and additionally has radiographic findings.

Finding 9. The findings are at a single vertebral level or 7% permanent partial disability.

Finding 11. Although the employee has complaints of radicular pain, it is not supported by objective findings and specifically an EMG shows no abnormality in the shoulder or arm area.

The provisions of the permanency schedules cited by the parties and the compensation judge are set forth in Minn. R. 5223.0370 as follows:

Subp. 4. Radicular syndromes.

* * *

C. Radicular pain or paresthesia, with or without cervical pain syndrome, with persistent objective clinical findings confined to the region of the cervical spine, that is, involuntary muscle tightness in the paracervical muscle or decreased passive range of motion in the cervical spine, and with any radiographic, myelographic, CT scan, or MRI scan abnormality not specifically addressed elsewhere in this part:

(1) single vertebral level, seven percent;

* * *

D. Radicular pain or paresthesia, with or without cervical pain syndrome, and with objective radicular findings, that is,

hyporeflexia or EMG abnormality or nerve root specific muscle weakness in the upper extremity, on examination and myelographic, CT scan, or MRI scan evidence of intervertebral disc bulging, protrusion, or herniation that impinges on a cervical nerve root, and the medical imaging findings correlate anatomically with the findings on neurologic examination, nine percent with the addition of as many of subitems (1) to (4) as apply, but each may be used only once:

(1) if chronic radicular pain or paresthesia persist despite treatment, add three percent;

* * *

(3) for additional surgery, other than fusion, regardless of the number of additional surgeries, add two percent, if the additional surgery included a fusion, the rating is as provided in subpart 5;

* * *

Subp. 5. Fusion.

A. Fusion, as defined in part 5223.0310, subpart 29, at one level performed as part or all of the surgical treatment of a cervical pain or radicular syndrome, add 2.5 percent to the otherwise appropriate category in subpart 3 or 4.

(Emphasis added.)

The parties have focused their arguments on the highlighted phrase in subpart 4D. The employee does not argue that there is evidence of hyporeflexia or EMG abnormality. He contends that the medical records show that the employee has “nerve root specific muscle weakness in the upper extremity, on examination.” He states “his treating physician clearly identified the muscle weakness in the trapezius as related to the herniated disc that was impinging the spinal cord and nerve root as evidenced by the myelogram.” (EE reply brief at p. 2.) In addition, the employee argues that the condition described in Minn. R. 5223.0370, subp. 4C, under which the compensation judge awarded permanency benefits, by its terms, does not apply to the condition evidenced in the medical records. The employee contends that subpart 4C is “a hybrid” which contemplates an individual’s clinical symptoms solely confined to the neck with some sort of abnormal finding on a diagnostic scan that is not a herniated disc. The employee argues that since he had a herniated disc with radicular symptoms that subpart 4D is the appropriate subdivision under which to rate his condition.

The employer and insurer argue that there is no evidence to support the existence of any of the three conditions required by the nerve root specific muscle weakness portion of subpart 4D. The employer and insurer point out that the presurgery MRI and myelogram, while showing some nerve root impingement, did not establish the required nerve root specific muscle weakness in the upper extremity. The employer and insurer also point out that the MRI scan and myelogram were performed long before the 1995 surgery in which the herniated and impinging

disc was removed from the employee's spine. The employer and insurer note that the June 28, 1993 EMG was negative for any radiculopathy into the employee's left upper extremity.

The question of whether there were any objective radicular findings in the nature of nerve root specific muscle weakness in the upper extremity on examination is a question of fact for the compensation judge. In this case the compensation judge's determination that no such objective radicular findings were present is supported by the report, examination and opinions of Dr. Lebow and Dr. Perra. These physicians indicated that most of the employee's difficulties are localized in and about the cervical spine and have not caused any particular muscle weakness in either of the employee's upper extremities. While we note that the employee cites to Dr. Rogers' findings in 1995 that he had some difficulties with his trapezius muscle, the compensation judge was not clearly erroneous in not being persuaded that this represented evidence which satisfied the requirement of objective findings of nerve root specific muscle weakness in the upper extremity in subpart 4D. As a result, we cannot say that the compensation judge's determination with respect to the permanent partial disability suffered by the employee is clearly erroneous and we affirm.