LINDA L. FRYKMAN, Employee, v. ST. MARY'S MED. CTR., SELF-INSURED, Employer/Appellant, and COMPREHENSIVE CARE SERVS., INC., Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
FEBRUARY 23, 1999

No. [REDACTED SSN]

HEADNOTES

CAUSATION - GILLETTE INJURY. Substantial evidence, including the employee's testimony and medical and chiropractic treatment records, support the compensation judge's finding that the employee's work activities as critical care nurse for the employer aggravated her low back and left leg problems, and that the employee sustained a Gillette injury to her low back culminating in disability on November 6, 1996.

PERMANENT PARTIAL DISABILITY - BACK. Substantial evidence supports the compensation judge's award of a 7% permanent partial disability. The decision is modified, however, to reflect permanency due to a lumbar pain syndrome pursuant to Minn. R. 5223.0390, subp. 3.C.(1), rather than a radicular syndrome pursuant to Minn. R. 5223.0390, subp. 4.C.(1).

Affirmed as modified.

Determined by Johnson, J., Wilson, J. and Wheeler, C.J.
Compensation Judge: Donald C. Erickson

OPINION

THOMAS L. JOHNSON, Judge

The self-insured employer appeals from the compensation judge's finding that the employee sustained a Gillette[1] injury to her low back culminating in disability on November 6, 1996, and from the judge's award to the employee of a 7% permanent partial disability. We affirm as modified.

BACKGROUND

The employee, Linda L. Frykman, was 51 years old at the time of the hearing. She began working as a registered nurse (RN) for the self-insured employer, St. Mary's Medical Center, Duluth, Minnesota, on February 1, 1993. She initially worked in the post-coronary care unit; then in November 1995, transferred to the intensive care unit (ICU) float pool. The

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

employee normally worked the night shift.

The employee initially sought treatment for low back pain on July 20, 1994. She had worked a full shift on the post-coronary care unit the previous night. The employee testified that she left work between 7:30 and 8:00 a.m., then "puttered around" at home, bending and squatting to remove small pieces of dirt or sod from her back walkway. Afterward, she sat awhile, experiencing low back pain when she got up. (Finding 8; T. 45-47.) She was seen on July 20th by Dr. Christine Swensen, reporting lower lumbar pain without radiating symptoms. The doctor noted tenderness and spasm in the mid-lumbosacral area, limited range of motion, and a normal neurological examination. Dr. Swensen diagnosed musculoskeletal low back pain and prescribed Flexeril and Darvocet.

About a month later, on August 19, 1994, the employee developed sharp shooting pain down her left leg while at work. The employee was seen in the emergency room at St. Mary's after completing her night shift. The chart note relates "back pain radiates to left leg, started 8 pm 8/18." The employee was given medication and placed on bed rest for several days. She was off work for about two weeks, returning to full-duty work by September 6, 1994. The employee also received physical therapy, prescribed by Dr. Swensen, between August 23 and October 7, 1994, resulting in temporary improvement of her symptoms. An x-ray taken September 15, 1994, showed degenerative changes in the lumbar spine from L3 through S1.

In mid-October 1995, the employee began treating with Mary Cooley, D.C., reporting low back and intermittent left leg pain for the past six to nine months. The chiropractor's notes reflect "insidious" onset of left leg sciatica "one night at work, went to ER next am," as well as the incident "throwing small clumps of sod." (Ex. 7.) Dr. Cooley diagnosed acute lumbosacral strain/sprain with left leg sciatica. The employee continued to treat with Dr. Swensen and Dr. Cooley for periodic exacerbations of her low back and left leg pain.

On January 8, 1996, Dr. Swensen ordered an MRI scan, noting complaints of persistent and worsening low back pain and left leg sciatica. The MRI scan showed disc degeneration from L3-4 to L5-S1, including a small prolapsed disc at L3-4 to the left, possibly deviating the L4 nerve rootlet slightly, but "of equivocal significance," and a prolapsed disc on the right at L5-S1, without nerve root compression.

On August 7, 1996, the employee was seen by Dr. Michael J. DeBevec, an orthopedist, at the request of Dr. Swensen. The employee reported no specific injury, but stated her symptoms were exacerbated by the combination of lifting and bending, standing or walking for prolonged periods of time, sitting and shoveling. Dr. DeBevec diagnosed discogenic low back pain, and prescribed medications and additional physical therapy. The employee received therapy between August 14 and October 11, 1996, with little improvement. The therapist noted in the discharge summary that "the patient works at SMMC as an RN and has difficulty working an entire shift without flaring her back pain doing normal nursing tasks." (Ex. 5.) On October 30, 1996, the employee returned to Dr. Cooley reporting improved left sciatica but more low back pain. Dr. Cooley noted the employee was again off work due to her pain. The employee returned to

Dr. Cooley on November 5, 1996, who recorded "1st nite back to work [with increased] Sx's . . . sciatica bad." (Ex. 7.)

On November 6, 1996, the employee returned to Dr. DeBevec for follow-up, reporting the physical therapy had made her worse. Dr. DeBevec related that although "[w]ork she feels does not definitely exacerbate it," the employee was having increasing difficulty pursuing activities of daily living. He referred the employee for an epidural steroid block, and took the employee off work. The employee had three lumbar epidural steroid injections between November 6 and December 4, 1996. She experienced complete relief of her left leg pain, but continued to experience low back pain and symptoms. On December 17, 1996, Dr. DeBevec released the employee to return to work with permanent restrictions of no lifting over 40 pounds and no repetitive bending.

The employee was then seen by Dr. Jed Downs, on December 24, 1996, at the request of the self-insured employer. Dr. Downs noted the employee was an intensive care nurse and although the employer believed the 40 pound lifting restriction could be met, the restriction against repetitive bending and flexing probably could not be accommodated. Dr. Downs agreed with Dr. DeBevec's restrictions, and referred the employee for mobilization and pelvic stabilization therapy. The employee was unable to return to work with the self-insured employer, but in early January 1997, began working, full-time, as a nursing supervisor at Park Point Manor nursing home.

On February 6, 1997, facet block injections from L3 to S1 were administered. The employee did not respond to this treatment. Physical therapy was discontinued on February 21, 1997, due to recurring left leg pain, particularly after pelvic stabilization class. In a letter dated February 24, 1997, Dr. Downs, although recognizing "there is a substantial incidence of back pain among [RNs]," stated that it was "[m]y "feeling . . . that she has a chronic SI sprain from an acute event" and "I cannot state that her exposure at St. Mary's was a substantial causal relationship to her ongoing disability at this juncture." (Ex. 4.)

The employee returned to see Dr. DeBevec on April 22, 1997. He noted the employee reported minimal, intermittent left leg tingling, but continued to have pain and stiffness in the low back. He believed that further treatment, other than the use of pain and anti-inflammatory medications was contraindicated. In a letter dated April 24, 1997, Dr. DeBevec assigned a permanent partial disability rating of 7%, and responded "yes," to the employee's attorney's question: "In your opinion, was her work activity over time at St. Mary's <u>one of</u> the substantial causes <u>or one of</u> the substantial aggravating factors leading to [her] . . . permanent disability?" (Ex. 3.)

The employee was examined on April 29, 1997, by Dr. Edward Martinson, a physical medicine and rehabilitation specialist, at the request of Dr. Downs. Dr. Martinson concluded the employee's findings were consistent with facet and lumbar disc syndrome complicated by biomechanical dysfunctions. He concurred with the restrictions imposed by Drs. DeBevec and Downs, advised continuing medications as prescribed by Dr. Downs, and referred

the employee for instruction in a home stretching program. The employee continued to treat with Dr. DeBevec through the date of hearing for periodic exacerbations of her low back pain.

On May 26, 1997, the employee filed a claim petition, alleging a Gillette injury to her low back, culminating on November 5, 1996. She sought temporary partial disability benefits from and after mid-December 1996, a 7% permanent partial disability, and payment of medical expenses. The self-insured employer denied primary liability, asserting the employee's disability was personal in nature and was not causally related to her work duties at St. Mary's Medical Center. An independent medical examination was performed by Dr. Daniel Randa, a neurologist, on August 12, 1997. Dr. Randa diagnosed degenerative lumbar spondylosis with superimposed intermittent lumbar strains. He concluded there was no evidence in the medical records suggesting the employee's nursing activities caused any problems and, accordingly, opined that the employee's condition was due to gardening and other non-work activities. He noted no objective findings on examination, and opined the employee had 0 percent permanent partial disability as a result of her low back condition.

The case was heard by a compensation judge at the Office of Administrative Hearings, in Duluth, Minnesota, on June 2, 1998. In a findings and order, served and filed August 4, 1998, the compensation judge found the employee's low back and left leg symptoms were aggravated by her work activities, and the employee had sustained a work-related Gillette injury to her low back, culminating in disability on November 6, 1996. The judge further found the employee was entitled to permanent partial disability benefits of 7% to the body as a whole. The self-insured employer appeals.

STANDARD OF REVIEW

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). Where evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings must be affirmed. Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54, 60, 37 W.C.D. 235, 240 (Minn. 1984). Similarly, 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." Northern States Power Co. v. Lyon Food Prods., Inc., 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975).

DECISION

Gillette Injury

The self-insured employer argues that the employee failed, as a matter of law, to prove a Gillette injury on November 5, 1996, asserting the employee failed to introduce proper medical support for her claim as required by Steffen v. Target Stores, 517 N.W.2d 579, 50 W.C.D.

464 (Minn. 1994). Although couched in terms of legal argument, the self-insured employer essentially disputes the compensation judge's factual conclusions. As such, our role is solely to assess whether the judge's findings of fact are supported by substantial evidence. Minn. Stat. § 176.421, subd. 1.

In Steffen, the compensation judge denied benefits, concluding the medical evidence was insufficient to support the employee's Gillette claim. The employee relied on the opinion of the employer and insurer's independent medical examiner who opined the employee could have sustained a Gillette injury, *if* the employee's work activities did, in fact, include repetitive bending and lifting. The supreme court determined the lower courts had imposed an incorrect burden of proof, and reversed. Concluding, however, that Dr. Ahlberg's report was not sufficient, in and of itself, to support the claim, the supreme court remanded the matter for additional consideration.

Here, the compensation judge adopted the causation opinion of Dr. DeBevec, the employee's treating physician. Dr. DeBevec's one-word opinion responded to a March 20, 1997 letter from the employee's attorney, describing what is meant by a "Gillette injury" and briefly setting forth significant events in the employee's low back history and the basis for her claim of an injury resulting from her work as a nurse at St. Mary's. (Ex. A.) Dr. DeBevec had treated the employee's low back and left leg condition for nearly two years, was aware of the employee's work as an RN at St. Mary's Medical Center, and was familiar with her treatment history with other providers. While the causation opinion itself is barely adequate, there is clearly sufficient foundation for Dr. DeBevec's conclusion. Moreover, it is apparent that the compensation judge did not rely solely on Dr. DeBevec's opinion, but considered all the medical evidence before him, including the treatment records of Dr. Swensen, Dr. Cooley and Dr. DeBevec, the St. Mary's emergency room records, and the employee's physical therapy records. While recognizing the employee's non-work activities contributed to her low back problems, the compensation judge noted references in the employee's treatment records to aggravation of her symptoms during, or as a result of, her work at St. Mary's, and concluded the employee's work activities also substantially contributed to her low back and left leg problems.[2] (Mem. at 6-7.) The compensation judge's conclusions are borne out by the record.

The employee described her work activities in some detail, testifying that her job as an RN on the post-coronary care and intensive care units involved significant amounts of bending, flexing, pushing/pulling and lifting. She stated she was fatigued and had increased pain at the end of her work shifts. (T. 35-37, 39-44.) Dr. DeBevec and the physical therapist noted the employee's symptoms were exacerbated by bending and lifting, both of which were required by her normal nursing duties. (T. 56.) As noted by the compensation judge, although the

[2] It is not necessary for an employee to show that the work-related injury was the sole cause of her disability. It is only necessary to show the injury was an appreciable or substantial contributing cause. Salmon v Wheelabrator Frye, 409 N.W.2d 495, 497-98, 40 W.C.D. 117, 122 (Minn. 1987).

employee first reported low back pain after picking up small pieces of dirt at home, the employee had just completed a full shift at work prior to that incident. Shortly thereafter, the employee experienced left leg pain for the first time while at work on the post-coronary unit at St. Mary's. Although Dr. DeBevec's November 6, 1996 chart note suggests the employee did not feel that work exacerbated her symptoms, the employee disagreed with this statement. (T. 58.) The employee's testimony is consistent with the October 11, 1996 physical therapy discharge summary noting that "[t]he patient works at SMMC as an RN and has difficulty working an entire shift without flaring her back pain doing normal nursing tasks." (Ex. 5.) Similarly, on November 5, 1996, Dr. Cooley recorded the employee's symptoms had increased following her first night back at work. (Ex. 7.)

While a different conclusion could be reached, where more than one inference may reasonably be drawn from the evidence, the findings must be affirmed. Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54, 60, 37 W.C.D. 235, 240 (Minn. 1984). There is adequate support in the record as a whole for the compensation judge's determination that the employee's work activities substantially contributed to her low back and left leg problems, and that the employee sustained a Gillette injury, culminating in disability on November 6, 1996. We must, therefore, affirm.

Permanent Partial Disability

The self-insured employer further contends that the compensation judge's award of a 7% permanent partial disability is not supported by the evidence and is clearly erroneous, asserting the employee failed to prove persistent objective clinical findings as required by the applicable permanency schedule. We affirm as modified.

The compensation judge found the employee was entitled to a 7% permanent partial disability, adopting the opinion of Dr. DeBevec, who assigned a rating of 7% to the body as a whole pursuant to Minn. R. 5223.0390, subp. 4.C.(1).[3] We agree that the objective findings specifically required for a rating under subpart 4.C. are not present in this case. "Radicular pain" and "paresthesia" as defined in the permanency schedule, require evidence of pain or abnormal sensation radiating into an extremity in the distribution of a nerve root, along with consistent findings on provocation testing. Minn. R. 5223.0310, subps. 43, 44. While the treatment records

[3] Minn. R. 5223.0390, subp. 4.C.(1) provides, in pertinent part:

> **Subp. 4. Radicular syndromes.**
> C. Radicular pain or radicular paresthesia, . . . with persistent objective clinical findings confined to the region of the lumbar spine, that is, involuntary muscles tightness in the paralumbar muscles or decreased range of motion in the lumbar spine, and with any radiographic . . . or MRI scan abnormality not specifically addressed elsewhere in this part:
> (1) single vertebral level, seven percent; . . .

reflect persistent complaints of radiating left leg pain, the employee's neurological examinations were consistently normal.

We believe, however, that the employee's symptoms do meet the requirements for a 7% rating under Minn. R. 5223.0390, subp. 3.C.(1) for a lumbar pain syndrome.[4] The employee was diagnosed with essentially a lumbar sprain/strain secondary to underlying facet and disc degeneration. The employee clearly has symptoms of pain and stiffness in the lumbar spine, with x-ray and MRI scan abnormalities. The employer and insurer contend, however, that the employee failed to show persistent objective clinical findings in the lumbar spine region. We disagree. Muscle spasm or decreased range of motion need not be present at every examination to meet the requirements of the permanency schedule. Rather, it is sufficient where, as here, medical records show recurring findings on examination of involuntary muscle tightness or restricted range of motion over an extended period of time. See, Hanson v. Melvin Simon & Assocs., 55 W.C.D. 19 (W.C.C.A. 1996). A rating of permanent partial disability is one of ultimate fact, not solely a medical opinion, to be based on all relevant evidence in the record. See Hosking v. Metropolitan House Movers Corp., 272 Minn. 390, 138 N.W.2d 404, 409, 23 W.C.D. 673, 684-85 (1965). We believe the compensation judge's award of a 7% permanent partial disability is supported by the evidence and, accordingly, affirm as modified by this opinion.

---

[4] Minn. R. 5223.0390, subp. 3.C.(1) provides, in pertinent part:

> **Subp. 3. Lumbar pain syndrome.**
> C. Symptoms of pain or stiffness in the region of the lumbar spine, substantiated by persistent objective clinical findings, that is involuntary muscle tightness in the paralumbar muscles or decreased range of motion in the lumbar spine, and with any radiographic . . . or MRI scan abnormality not specifically addressed elsewhere in this part:
> (1) single vertebral level, seven percent; . . .