GILBERT NELSON, Employee, v. ENTERTAINMENT PARTNERS and TIG INS. CO., Employer-Insurer/Appellants, and MEDICARE, Intervenor, and SPECIAL COMP. FUND.

WORKERS' COMPENSATION COURT OF APPEALS
AUGUST 31, 1999

No.[REDACTED SSN]

HEADNOTES

CAUSATION - SUBSTANTIAL EVIDENCE. Substantial evidence, including the employee's testimony, medical records, and expert medical opinion, supported the compensation judge's finding that the employee's 1993 work injury was a substantial contributing factor in aggravating or accelerating the employee's preexisting hip condition.

Affirmed.

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

OPINION

STEVEN D. WHEELER, Judge

The employer and insurer appeal from the compensation judge's finding that the employee's admitted work injury on March 24, 1993 was a substantial contributing cause of a permanent aggravation or acceleration of the employee's pre-existing hip condition. We affirm.

BACKGROUND

The employee, Gilbert Nelson, sustained an admitted work injury on March 24, 1993 while working for the employer, Entertainment Partners, a movie production company. On that date, he fell from the bed of his truck, landing on rocks next to the truck. At the time of the accident the employee was 56 years old and had a weekly wage of $1,356.46. (T. 23-25.)

The employee testified that shortly after the fall he was black and blue on his back and hip, felt pain and had no feeling in his right foot. The next day, after reporting the fall to the employer's transportation coordinator, he was put on lighter duty work driving automobiles as a chauffeur. The employee testified that he had intended to seek medical attention for his injury within the next few days but that, as the employer's union steward, he was responsible for locating a driver with the proper license to take a semi-trailer carrying the employer's movie cameras to New York, then Boston, then Maine, and finally to Burbank, California. He waited to seek medical attention for the injury until after he had made these arrangements. (T. 26-28.)

The employee went to the emergency room at St. Luke's Hospital in Duluth on March 29, 1993. He testified that by that time he was "really hurting," that he was having difficulty with standing or sitting for extended periods of time, that he had pain in both legs to the knees and occasionally to the ankles, and that when he would lie down he had pain in the groin and buttocks unless he lay on his left side. The history recorded at St. Luke's was that "while lifting a 5th wheel trailer, [the employee] noted the sudden onset of lumbar back pain . . . today the patient lifted an object and twisted at which time he noted sudden increased pain in the low back and pain radiating down his left buttock and thigh. No other symptoms were reported." The employee was diagnosed with an acute low back strain, restricted from heavy lifting, straining or uncomfortable positions until improved, and told to follow up with a physician in seven to ten days if not improved. (T. 28-29; Exh. 9: 3/29/93.)

The employee was next seen at the Duluth Clinic on April 5, 1993 by Dr. K. M. Thompson. Dr. Thompson recorded that the employee described straining his lower back while working with a trailer. The employee reported very little improvement with rest and ibuprofen. He was noted to complain of pain across the lower back with sciatica. Dr. Thompson prescribed physical therapy and advised the employee to return in two weeks. (Exh. 4: 9/18/93.)

The employee underwent physical therapy from April 8, 1993 through April 16, 1993, but did not improve. He returned to the Duluth clinic in follow-up on April 19, 1993, and an MRI scan was ordered. The MRI scan, performed the same day, showed spinal stenosis at L3-L4 secondary to symmetric disc protrusion, ligamentous hypertrophy, and hypertrophy in the facet joints. At L3-L4 these were accompanied by a "fairly striking" narrowing of the neural foramina. On May 13, 1993, Dr. Thompson noted that the employee had experienced progressive low back pain since the injury, with transverse lumbosacral sulcus pain, down the buttocks and posterior thighs. He found there was hypertrophic ligamentum flavum. The employee reported that he could not walk for any significant distance. Surgery was recommended. On May 20, 1993 the employee underwent a decompressive laminectomy at L2, L3 and L4, with partial facetectomy, performed by Dr. R. F. Donley. (Exh. 1; Exh. 3: 4/19/93, 5/13/93; Exh. 10: 5/20/93.)

On July 19, 1993 Dr. Donley saw the employee in follow-up and recorded that the employee's claudication symptoms in the lower extremities had completely cleared. However, the employee complained of clumsiness with his right lower extremity and difficulty with sitting and was thought to continue to have a right facet pain syndrome. On January 10, 1994 Dr. Donley examined the employee and noted that the employee reported that his pre-operative radicular pain down the buttocks and thighs was completely gone, although the employee continued to experience mechanical low back pain as well as an inability to sit for any length of time. The employee also reported to his physician that he was only able to lie on one side because lying on the other irritated him. He testified that he could not lie on his right side. (Exh. 3: 7/19/93, 1/10/94; T. 28.)

On April 8, 1994 the employee went to the Duluth Clinic reporting that he had been suffering from low back discomfort but that over the past several days he had developed excruciating pain in the left neck, shoulder and arm. Medical, chiropractic and physical therapy

treatment from that date through May 2, 1994 focused primarily on these symptoms. The employee continued to treat with a chiropractor, Dr. Gary D. Johnson, periodically through May 20, 1995 for low back as well as neck, upper back and arm symptoms. (Exh. 3: 4/8/94-5/2/94; Exhs. 6, 8.)

The employee saw Dr. Donley on June 29, 1995. His symptoms on that date were "transverse low back pain, right buttocks pain, pain radiating around anteriorly into the right groin and down the inside of right thigh into the knee . . . ." Dr. Donley ordered a series of caudal epidural steroid injections. On July 13, 1995, the injections were administered, and during the procedure the employee reported pain in the right groin. (Exh. A.)

On October 4, 1995, the employee was seen for a recheck of his back problems by his family practitioner, Dr. Martin C. Hinz. The employee was started on a weight management program. On October 11, 1995, the employee returned to Dr. Hinz for a recheck and reported that he had been experiencing some significant pain radiating down the anterior right thigh and had fallen several times during the past week due to leg weakness. Dr. Hinz diagnosed a herniated lumbar disc with peripheral nerve root involvement. (Exh. 7: 10/4/95 - 10/11/95.)

The employee was seen for a medical evaluation by Dr. Michael W. Davis on behalf of the employer and insurer on October 16, 1995. Dr. Davis recorded that the employee had been injured when he fell over the side of a truck to the ground and experienced pain in the low back, discomfort in both legs, but worse in the right leg, and numbness in the right foot. The doctor noted that about three months after the employee's 1993 low back surgery, the employee began to have increasing pain in his low back with pain radiating into the right leg. The employee's current symptoms were pain in the low back radiating into the right leg, and occasionally radiating into the right groin. (Exh 2: 10/16/95.)

When Dr. Hinz saw the employee for a recheck of his weight management program on October 25, 1995, he recorded that the employee was still having considerable pain radiating to the right hip and right thigh region, and that the employee had been experiencing problems with his
leg giving out causing him to fall. (Exh. 7: 10/25/95.)

The employee returned to the Duluth Clinic on December 3, 1995 and on December 11, 1995 was evaluated in the clinic's neurology department by Dr. Wolcott S. Holt. The employee reported that he had done well for two to three months following his May 1993 surgery but that his symptoms thereafter had gradually worsened. He now had difficulty walking and standing. On examination, the employee was observed to be unable to stand on a stool with his right leg though he could do so with the left. There was obvious atrophy to the right leg and loss of reflexes was greater in that limb than on the left. Dr. Holt was uncertain whether the employee's radicular symptoms were due to a compressive neuropathy which had not been detected on MRI studies or whether there was a significant vascular component. He ordered an EMG of the right leg and a vascular study of the lower extremities with emphasis on whether the employee had claudication. (Exh. 3: 12/3/95, 12/11/95.)

The EMG was suggestive of a right S1 radiculopathy. Since the employee's 1991 MRI scan had not shown evidence of an L4-5 or L5-S1 disc impingement, a lumbar myelogram and CT scan was done on December 22, 1995. The employee returned to Dr. Holt on December 26, 1995. Dr. Holt recorded that the employee complained of right sciatica coming down into the right groin down the anterior and lateral thigh and occasionally into the heel. He noted that the CT scan showed what appeared to be a free fragment along the right side of the canal near the L2-3 disc, but observed that it was questionable whether this free fragment was consistent with the pain described by the employee. He referred the employee back to Dr. Donley, who had performed the 1993 back surgery. (Exh. 3: 12/19/95; Exh. 10: 12/22/95.)

Dr. Donley saw the employee on January 2, 1996. The employee was noted to have much difficulty getting out of his wheelchair and getting onto and off of the examining table. Straight leg raising was positive and the employee could not externally rotate either his right or left hip. He reported that although his left sided pain had resolved, he still had pain in the tailbone and into the right buttocks and right hip and anterior into the groin and down the anterior thigh. Occasionally this pain radiated into the right lower leg, right foot and right great toe. Dr. Donley reviewed the employee's December 1995 CT scan and concluded that "an extruded epidural mass at the L2-3 level . . . is consistent with a fairly large herniated disc that obliterates the right L3 nerve roots." He recommended that the employee undergo a right L2-3 and L3-4 laminectomy and removal of the extruded disc fragment. (Exh. 3: 1/2/96.)

The employee underwent the surgery on January 4, 1996. On February 29, 1996 he returned to Dr. Donley, who recorded that the employee's pain into the distal leg had completely cleared but that the employee continued to experience aching in his right anterior thigh into the right groin. The employee continued to treat with Dr. Hinz and with various doctors at the Duluth Clinic over the next several months, and repeatedly reported pain in the right hip, thigh and groin. (Exh. 3: 2/29/96 - 5/15/96; Exh. 7: 2/21/96 - 3/25/96.)

On May 23, 1996 the employee, employer and insurer entered into a stipulation for settlement in which the parties agreed that the employee was permanently and totally disabled since April 19, 1993 as the result of a March 24, 1993 work injury to his back. (Judgment Roll.)

On May 31, 1996 the was reevaluated by Dr. Holt for failed laminectomy syndrome or recurrent disc. The employee reported increasing pain radiating down from the right buttock into the right groin, such that he was unable to walk or sleep. The employee indicated the increased pain was accentuated in January 1996 but had been there since the last surgery and he had not been able to lie on his right side since the first back surgery in 1993. The employee's right leg also gave out at the knee on occasion. The employee related all of these symptoms to his April 23, 1993 work injury. On examination, Dr. Holt noted that the employee had "a very positive internal and fabere maneuver in his knee with some mild tenderness over the greater trochanter." Radicular pain radiated more like an L5 radiculopathy than one originating at L2 through L4. Dr. Holt found it unclear whether the employee had a compressive polyradiculoneuropathy related to recurrent scar, herniation, lateral recess stenosis, or facet syndrome, or whether, in light of the fabere maneuver, the employee's pain radiated from the right

hip. (Exh. 3: 5/31/96.)

X-ray and MRI studies of the employee's hips subsequently revealed avascular necrosis, a degenerative condition, in both hips, with degeneration being worse on the left. The right femoral head had a focal area of impaction or osteonecrosis. (Exh. 3: 5/31/96, 6/11/96; Exh. 4: 6/14/96.) Dr. Henry indicated that the left hip did not have an impaction fracture and was symptom free. (Henry Depo., p. 14.)

On June 24, 1996 the employee was seen in the orthopedics section of the Duluth Clinic for an evaluation of the right hip by Dr. Joseph E. Henry. Dr. Henry recorded that the employee had experienced pain diffusely in the low back and bilaterally in the lower extremities after falling off a truck on April 23, 1993. The employee denied prior lower extremity complaints. After laminectomy in May 1993 and repeat laminectomy in January 1996 the pain in the left lower extremity resolved but he continued to have difficulties with pain in the right lower extremity. As of the date of examination, the employee was reporting current symptoms of diffuse pain in the lumbosacral area, somewhat more on the right, radiating to the anterior hip, thigh and knee. The employee's discomfort was aggravated by arising, attempts at weightbearing, pivoting, or rotational maneuvers of the hip. Dr. Henry reviewed the x-ray studies and noted that the right hip showed sclerotic and cystic changes involving the femoral head with limited collapse consistent with avascular necrosis. The superior weightbearing joint space was largely absent. The femoral head appeared incompletely covered by the acetabulum. Dr. Henry noted that it was impossible to say whether these changes were present prior to the employee's1993 work injury, but he opined that the injury had been an aggravating factor because of the onset of symptoms at that point. Dr. Henry explained that a total right hip arthroplasty was indicated and scheduled the employee for intra-articular right hip injections with Sensorcaine and Celestone for diagnostic purposes. (Exh. 3: 6/24/96.)

The employee returned to Dr. Henry on August 9, 1996. He reported that the hip injection July 3, 1996 gave significant temporary relief of the groin and thigh pain, though the pain had since returned. Dr. Henry recommended that the employee undergo porous coat total right hip arthroplasty. The employee underwent the procedure on September 11, 1996. The expenses of the treatment were paid by the intervenor, Medicare. (Exh. 3: 8/9/96; Exh. 10; Finding 10.)

On November 1, 1996 the employee was seen by Dr. Henry in follow up of his hip surgery. The employee reported that he was amazed at the pain relief he had experienced since the surgery with virtually complete relief of the right thigh and knee pain with weightbearing. On September 3, 1997 the employee was seen by Dr. Henry in one-year follow up of his hip surgery and reported that he had experienced no pain in the right hip and thigh with weightbearing. He continued to have intermittent low back discomfort. The employee was seen by Dr. Alan M. Johns at the Duluth Clinic for his yearly physical examination on December 22, 1997. He no longer had any radicular pain in his legs. He told Dr. Johns that the hip replacement had made a big difference in his overall lifestyle and that he had again been able to walk and to get out to fish on Lake Superior. He continued to have chronic low back pain which he treated with ibuprofen. (Exh. 3: 11/1/96, 9/3/97, 12/22/97.)

In several letters and deposition testimony, Dr. Henry offered the opinion that the employee certainly had a preexisting hip problem prior to the 1993 injury, based on the extent of the degenerative changes. He also stated that in light of the absence of complaints of pain in the hip area prior to that time the superimposed trauma from the 1993 injury precipitated the onset of pain and, in his view, the 1993 injury was a significant aggravating factor in the development of the employee's symptoms and of the need for the arthroplastic surgery. (Exh 3: 12/4/96, 4/7/98 and 4/8/98 letters; Exh. J at 13.)

The employee was re-examined on behalf of the employer and insurer by Dr. Michael Davis, an orthopedic surgeon, on April 13, 1998. Dr. Davis agreed that the employee had a longstanding osteoarthritic hip condition which predated the 1993 work injury. He opined, however, that the 1993 work injury was not a substantial contributing factor to aggravating the employee's hip condition or to the eventual need for hip replacement surgery. He based his opinion in part on the absence of complaints of groin pain from the medical records for several years following the 1993 injury. (Exh. 13 at 10-12.)

The employee filed a claim petition on July 24, 1997 seeking permanent partial disability compensation for the right hip and medical expense reimbursement. The employer and insurer denied liability on the basis that the employee's hip condition was unrelated to the work injury.

The matter came on for hearing before a compensation judge of the Office of Administrative Hearings on November 19, 1998. The parties stipulated that the employee's medical treatment for the right hip had been reasonable and necessary and that the employee's right hip condition warranted a 13 percent whole-body permanency rating. The sole issue before the compensation judge was whether the work injury was a substantial contributing factor in aggravating or accelerating the employee's hip condition and in the need for right hip replacement surgery. (Judgment Roll; Finding 2.)

Following the hearing, the compensation judge found that the work injury was an aggravating factor that caused the employee's preexisting hip condition to become symptomatic. (Findings 12, 13.) The employer and insurer appeal.

STANDARD OF REVIEW

On appeal, this court must determine whether the compensation judge's findings and order are "clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted." Minn. Stat. § 176.421, subd. 1(3) (1992). Substantial evidence supports the findings if, in the context of the record as a whole, 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 the evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings must 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). Factfindings may not be disturbed, even though this 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 sole issue in this case is whether substantial evidence supports the compensation judge's finding that the employee's 1993 work injury was a substantial contributing factor in aggravating or accelerating the course of the employee's preexisting hip condition and in the need for the right hip replacement surgery.

The compensation judge accepted the expert medical opinion of Dr. Henry over that of Dr. Davis. Generally, this court will not reverse a compensation judge's choice between opposing expert medical opinions unless the opinion relied upon lacks adequate foundation. Nord v. City of Cook, 360 N.W.2d 337, 37 W.C.D. 364 (Minn. 1985). The employer and insurer argue that Dr. Henry's opinion lacked foundation in that it relied on a history of an onset of symptoms related to a hip problem shortly after the employee's 1993 work injury. They point out that complaints of groin pain were not recorded by any of the employee's physicians until 1995, and contend that the foundation for Dr. Henry's opinion was not in accordance with the facts of the case.

We note, first, that contrary to assertions in the employer and insurer's brief, Dr. Henry did not base his opinion on a mistaken view that hip problems were mentioned in the medical records shortly after the injury. During his deposition he was asked on cross-examination whether he was aware of any mentions of hip problems in the medical records prior to some time in 1996. He responded that he was not aware of any mention prior to January 1996. (Exh J at 19.)

Dr. Henry did not focus specifically on groin pain as a necessary prerequisite for a diagnosis of a hip-related problem. On cross-examination, counsel for the employer and insurer asked Dr. Henry only whether right groin pain was "a hallmark symptom of a significant right hip problem," to which he responded only that "[i]t certainly can be." Dr. Henry did not state that his opinion was dependent on the existence of a consistent history of groin pain from the date of injury. In his deposition testimony and written opinions explaining his views on causation, Dr. Henry simply referred to a history of "hip pain," "leg pain," or "pain in the hip and leg." (See Exh. 3: 12/4/96, 4/7/98 and 4/8/98 letters; Exh. J at 13, 15-16.)

While the testimony is not entirely clear, it appears that Dr. Henry's opinion was founded primarily on the history provided by the employee of the absence of hip and right lower extremity pain prior to the work injury and its onset some time following the injury. This history is consistent with that given by the employee in his hearing testimony. As the compensation judge accepted the opinion of Dr. Henry, it is clear that the judge similarly accepted the employee's

testimony despite the lack of specific references to groin pain or hip complaints in the medical records until June 29, 1995. We also note that in 1993 and 1994 the employee did complain of an inability to lie on his right side. (T. 28.)

The employee testified that shortly after the accident he experienced significant pain, including groin pain and bilateral leg pain. He testified that he mentioned all of his symptoms to each of his physicians. The employer and insurer argue that the compensation judge clearly erred in accepting the employee's testimony as to the nature and onset of his symptoms. They contend that the absence of any mention of groin pain complaints in the medical records for about two years after the work injury compels the conclusion that the employee's testimony was concocted after-the-fact in order to justify a claim for further benefits. At the hearing, the employer and insurer made this argument to the compensation judge, who nonetheless accepted the employee's testimony. The employer and insurer's argument simply goes to the credibility of the employee's testimony. Credibility determinations are for the compensation judge, and, generally, a judge is free to accept all or any part of a witness's testimony. See, e.g., Even v. Kraft, Inc., 445 N.W.2d 831, 42 W.C.D. 220 (Minn. 1989); Proffit v. Minnesota Harvest Apple Orchard, 48 W.C.D. 215, 219-20 (W.C.C.A. 1992), quoting City of Minnetonka v. Carlson, 298 N.W.2d 763, 767 (Minn. 1980). We find nothing in the record that would allow us to overturn the compensation judge's acceptance of the employee's testimony as to the course of his symptoms.

Finally, the employer and insurer argue that Dr. Henry's opinion lacked sufficient medical certainty to constitute a valid basis for the compensation judge's finding of a causal relationship between the injury and an aggravation or acceleration of the employee's hip condition. They point out that Dr. Henry did not couch his opinion in terms of "reasonable medical certainty." They point further to deposition testimony in which Dr. Henry acknowledged that he could not say with medical certainty that the employee's underlying hip condition might not have progressed to the point where hip replacement was needed even without the March 1993 work injury. (Exh. J at 20-21.) In Pommeranz v. State, Dep't of Public Welfare, the Minnesota Supreme Court discussed the requisite certainty for demonstrating causation by expert medical opinion in a workers' compensation case, and noted that "[i]t is well established that a medical opinion does not have to express absolute certainty, its truth need not be capable of demonstration, and it is sufficient if it is probably true." 261 N.W.2d 90, 91, 30 W.C.D. 174, 176-177 (Minn. 1977). Here, where the employee had various right lower extremity symptoms which were first documented in the medical records immediately following the date of injury, and which persisted despite low back surgery until they were entirely relieved by the hip surgery, the judge did not err in accepting Dr. Henry's opinion that linked an aggravation of the employee's hip condition with the work injury. We affirm.