TERRY SHERMAN, Employee/Appellant, v. LAFAYETTE CLUB and GENERAL CASUALTY CO., Employer-Insurer, and SHEET METAL #10 BENEFIT FUND, Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
DECEMBER 14, 1999

No. [REDACTED SSN]

HEADNOTES

CAUSATION - SUBSTANTIAL EVIDENCE. Where the employee had a long history of low back problems preexisting the date of her alleged work injury, where there was no clear radiological evidence of any February 1998 change in the her low back condition or any material abnormality in her mid back condition that might have caused her foot drop symptoms to appear at that time, and where there was expert medical opinion supporting the judge's decision, the compensation judge's denial of benefits for an injury causing foot drop symptoms in February 1998 was not clearly erroneous and unsupported by substantial evidence.

CAUSATION - PREEXISTING CONDITION. Where, by the treating doctor's own concession, wavy toes/painful legs syndrome is usually a consequence of a preexisting injury, and where, after the court's affirmance of a denial of benefits based on foot drop symptoms, the only demonstrable injury preexisting the employee's manifestation of wavy toes/painful legs symptoms also preexisted the date of the injury alleged on the employee's Claim Petition, the compensation judge's denial of the employee's claim for benefits based on her wavy toes/painful legs diagnosis was not clearly erroneous and unsupported by substantial evidence.

Affirmed.

Determined by Pederson, J., Johnson, J., and Wheeler, C. J.
Compensation Judge: Janice M. Culnane

OPINION

WILLIAM R. PEDERSON, Judge

The employee appeals from the compensation judge's conclusion that the employee failed to prove a disabling condition causally related to her employment. We affirm.

BACKGROUND

In about 1985, Terrie Sherman sustained a work-related injury to her low back while employed as a restaurant cook. In about 1989, Ms. Sherman sustained another work-related injury, this time to her neck, apparently while employed as both a manager in a private home and a janitor at a church. Ms. Sherman was ultimately paid workers' compensation benefits for a 10%

whole-body permanent partial disability related to her 1985 low back injury and benefits for a 3.5% whole-body impairment related to her 1989 neck injury.

In February of 1998, Ms. Sherman [the employee] was employed as a line cook at the Lafayette Club [the employer], where she had been employed for about a year and a half. She was at that time forty-three years old and was earning a weekly wage of $525.83. On February 26, 1998, she saw Dr. Melissa Beck with complaints of "left foot drop and lower leg numbness and tingling starting yesterday [February 25, 1998] morning." She also complained of a burning "right thigh pain just below the hip to just above the knee" beginning later that day and of an "odd sense of 'pelvic shifting,' as if some pelvic organs are momentarily settling or moving." Dr. Beck noted the employee's 1985 low back lifting injury and a history of some subsequent chronic pain and recurrent spasms, but "[n]o other recent trauma." She ordered a lumbar MRI scan and referred the employee to neurosurgeon Dr. Andrew Smith, noting that she was "most suspicious of a nerve root compression in [the employee's] back, although oddly she has no back pain or spasms at this time."

The ordered MRI scan, conducted on March 3, 1998, was read to reveal degenerative changes at the L4-5 and L5-S1 disc spaces, with moderate left neural foraminal narrowing. When he saw the employee on March 11, 1998, Dr. Smith noted the employee's 1985 low back injury and reported that "for the last month or so" the employee had had, "in addition to her chronic mechanical low back pain," a different kind of pain in her low back, "radiating down into the buttocks on both sides more so than it usually does." Her symptoms were of pain radiating down into both buttocks and of foot drop on the left side, and Dr. Smith expressly indicated that the employee did "not know of any injury at work that set this off." Dr. Smith diagnosed degenerative disc disease and a disc bulge at L5-S1 causing stenosis and pinching of a nerve at L5. He ordered a discogram of L4-5 and L5-S1, which was commenced on March 17, 1998. The test was read to reveal 10-out-of-10 concordant low back and bilateral buttock pain at L4-5, with moderate to markedly degenerated morphology at that level, but it was discontinued upon the employee's complaints of pain prior to completion of testing at the second level.

Two days later, on March 19, 1998, the employee was admitted to the hospital for an emergency MRI scan and examination pursuant to her complaints of continuing back pain secondary to her discogram and of new and increasing right lower extremity weakness. She was examined by Dr. Michael Seim, who noted chronic foot drop and some diminished strength on the left but essentially normal findings on the right. The MRI was read to reveal a small disc herniation at T11-12 with minimal impingement on the spinal cord, a minimal disc herniation at L5-S1 with no evidence of nerve root impingement, degenerative disc dehydration at L4-5 with minimal disc protrusion, and degenerative hypertrophic facet joint changes at all other lumbar levels. The scan also revealed minimal recess stenosis at L4-5, with minimal impingement on the right and left L5 nerve root. On that same date, March 19, 1998, the employee was also seen by Dr. Beck and Dr. Karla Kammueller, who noted a history of pain "starting in 1986," primarily at the L4-5 distribution, with spasms subsequent to discogram.

On March 21, 1998, the employee was seen by neurologist Dr. Sotirios Parashos,

on referral from Dr. Smith. Dr. Parashos noted that the employee had "suffered with back pain and back spasms for years following some kind of a work-related injury in 1983" and more recently had "developed a left foot drop quite subacutely as she was squatting down at work approximately three to four weeks ago." Upon examination, Dr. Parashos found the employee's symptoms "extremely hard to localize" and ordered a pelvic MRI and an EMG. The MRI, conducted on March 22, 1998, revealed only minimal degenerative changes, and the EMG, conducted March 23, 1998, was read to be within normal limits although consistent with mild chronic denervation. Plain x-rays of the employee's lumbar spine taken on that same date revealed bilateral facet disease at L5-S1, with marked disc space narrowing at that level and lesser disc space narrowing at L4-5. Upon the employee's discharge from the hospital on March 24, 1998, Dr. Smith took the employee off work on a diagnosis of low back and left lower extremity pain and weakness, for which he had prescribed physical therapy and medication.

On April 9, 1998, the employee was readmitted to the hospital with complaints of uncontrollable leg spasms and difficulty walking. On that date, Dr. Grainne Quinn noted that the employee was there for ongoing care for low back pain "which has been present since the early 80s." Dr. Parashos saw the employee on that same date, noting that the employee was complaining also "that her calves became tight and her feet turned down" and "that lately she has noticed some twitching in the right side of her face which she did not have before." Upon examination, Dr. Parashos found the employee's case "a rather puzzling situation," concluding that "[i]t is likely that the [employee] may suffer from a multifocal condition such as multiple sclerosis." The doctor ordered yet another MRI scan, this time of the cervical and thoracic spine and of the brain. The thoracic scan, conducted on that same date, was read to reveal mild spondylitic and degenerative changes at all levels, with a moderate disc herniation at T11-12 and mild flattening of the cord at that level but no impingement or signal abnormalities. The cervical scan, also conducted on that date, was read as essentially normal, and the brain scan, conducted the following day, revealed no definite abnormality or evidence of multiple sclerosis. Tests for various fungal and viral infections and cancer proved negative. In discharging the employee from the hospital on April 14, 1998, Dr. Parashos concluded that the employee's "gait disorder appears to be rather bizarre," noting also that Dr. Smith had found the employee's thoracic disc abnormality to be without any clinical consequence. On April 16, 1998, Dr. Parashos continued the employee's restriction from working and reported to the employee's primary care physician, Dr. William Tiede, "I am afraid I cannot offer an organic neurologic diagnosis for the [employee's] troubles," adding that the employee's gait disorder did not follow "any known gait pattern of organic neurological diseases."

On April 24, 1998, the employee saw Dr. Smith again, with continuing complaints of spasms in both legs, despite medication. Dr. Smith indicated that he "certainly ha[d] no plans to operate on her at this time," concluding that her problems were "far wider than could be explained on the original L5-S1 lateral stenosis basis," which he considered "the subordinate problem to whatever is going on more generally." Dr. Parashos released the employee to work within certain restrictions on May 10, 1998, but the following day he examined the employee again and reported to Dr. Tiede in part as follows:

> I am afraid I still do not have a good explanation for all of [the employee's] problems. Certainly the lateral recess stenosis may be contributing to the pain in the left lower extremity and that may have something to do with the footdrop. It cannot, however, explain the spasms, the pains and symptoms in the right lower extremity, and the cramps. It can also not explain the headaches, the tremors, the lack of energy, etc. As you know, her extensive workup failed to reveal any other causes for all of these symptoms.

Dr. Parashos indicated that "we are at a diagnostic impasse" and that he had recommended to the employee that she be evaluated at the Mayo Clinic.

On June 29, 1998, the employee saw Dr. Robert Fealey at the Mayo Clinic. Near the beginning of his report, Dr. Fealey indicated that "[t]he [employee] has very complicated medical records that she has carefully collected and documented spanning particularly the period of time over the last 4 months, but including some reports dating back to the mid 1980s concerning her story that she has delineated quite well in her typed summary." Noting that the employee's "most recent difficulties began in February of 1998 when at work she squatted down gathering product in a cooler and when she stood up her left foot seemed to be asleep and was numb," Dr. Fealey concluded that "[u]ndoubtedly, [the employee] still suffers from her chronic L5-S1 and L4-5 lumbar disc disease." Finding, however, no reason to proceed with a neurosurgical evaluation given the employee's examination findings and radiological records, Dr. Fealey diagnosed "a variable waving toes type dystonia of the right foot," pending further radiological review. On July 7, 1998, following the employee's return from an unremarkable EMG exam, Dr. Fealey diagnosed musculosketal back and right buttock pain and reiterated a "tentative diagnosis" of "waving toes and painful leg syndrome." Dr. Fealey prescribed a regimen of medication for the condition, indicating that it was "somewhat difficult to treat." Neither the June 29 report nor the July 7 report attributes causation of the waving toes/painful leg syndrome to any particular cause.

On July 22, 1998, the employee saw Dr. Parashos again, who reported to Dr. Tiede that "[s]ince the last time she saw me, she developed a syskinesia of the right lower extremity," for which she had been examined by Dr. Fealey and diagnosed with painful legs/moving toes syndrome. Dr. Parashos reported further as follows.

> The nature of this condition is rather obscure. It usually follows trauma and Dr. Fealey's opinion was that this might be related either to the thoracic disc or the discography that the [employee] underwent. Certainly, although this may be [a] phenomenon of trauma, it does not explain all of the other symptoms that the [employee] has experienced in the past.

Dr. Parashos reported also that the employee had stopped working since he last saw her. He indicated that the employee's symptoms were consistent with Dr. Fealey's diagnosis, explaining

that "[s]he is known to have a thoracic disc as well as lateral recess syndrome and degenerative disease of the back which also accounts for the buttock pain and the back muscle spasms."

On October 19, 1998, the employee filed a Claim Petition, alleging entitlement to various benefits consequent to a work-rated injury on February 21, 1998, which she identified as "[l]ow back pain with nerve damage and waving toes syndrome." On October 28, 1998, the employer and insurer denied primary liability for the employee's condition, affirmatively alleging that any current disability was due to a preexisting condition.

On November 24 and December 30, 1998, Dr. Parashos mailed reports to Dr. Tiede, indicating that the employee's symptoms had increased in complexity and now included, in addition to painful legs/moving toes syndrome, migraine headaches, depression, spells of feeling "dazed," weight loss, numbness and tingling in her upper extremities, and balance and continence problems suggestive of myelopathy. Dr. Parashos ordered yet another set of thoracic and cervical MRI scans to help in diagnosing the upper extremity problems and myelopathy symptomology. The MRIs were conducted on January 6, 1999, to rule out spinal cord compression. Neither scan was read to reveal any spinal cord mass, significant arthritic change, spinal stenosis, disc herniation, or any other abnormality. On January 18, 1999, Dr. Parashos wrote a letter to the employee's attorney, indicating, for the first time with any specificity in the medical records, that the employee's "most recent problems started on February 21, 1998, at which point she was crouched in a small area in a cooler reaching and holding a large pot, filling it with stock," in the course of her work for the employer. In his report, Dr. Parashos indicated that he found the following facts "indisputable": "that the [employee's] foot drop in the late winter/early spring 1998 was the result of [a February 1998 work] injury," that "it is entirely possible that the [employee's] painful legs and moving toes syndrome is more likely than not related to the injury of February 1998," and that the employee had a thoracic disc protrusion deemed inoperable by Dr. Smith that "could be very well the result of an injury and possibly the injury of February 1998."

On January 22, 1999, the employee underwent an independent medical examination by orthopedic surgeon Dr. Gary Wyard. After examining the employee and reviewing her records, Dr. Wyard found the employee neurologically intact and diagnosed longstanding degenerative disease of the cervical and lumbosacral spine and significant functional overlay. It was his opinion further that the employee's objective findings were consistent with the aging process and natural causes, that her "symptom complaints [we]re rather bizarre" and unrelated causally to any specific or Gillette-type work injury in February 1998, that she was not subject to any specific restrictions consequent to her work at the employer, that she "clearly has symptom magnification and functional overlay," "even . . . a hysterical component which may or may not be related to secondary gain."

On February 5, 1999, Dr. Parashos testified by deposition, without having reviewed the employee's January 6, 1999, thoracic MRI scan. In the course of his testimony, Dr. Parashos acknowledged that lumbar and cervical films taken subsequent to the date of employee's alleged injury were no different from those taken prior to that date. He acknowledged also that he had not been aware that the employee had previously been given a 10.5% whole-body permanency

rating for her low back, and he conceded that there was a possibility that the employee's symptoms were psychological rather than physical or organic. A medical journal article referenced in the doctor's deposition and appended to the transcript of it reports that waving toes/painful leg syndrome "may develop in the setting of spinal cord and cauda equina trauma, lumbar root lesions, injuries to body or soft tissues of the feet, and peripheral neuropathy" but that "no single aetiology or specific pathophysiological mechanisms have been found" and, in fact, "in 4 of the 20 cases in the present study, no definite cause was found" at all.

The matter came on for hearing on February 11, 1999, on which date the employee amended her claim to allege a "thoracic spinal cord injury, related symptoms," in addition to waving toes and painful leg syndrome. Issues at hearing included the following: (1) whether the employee had, at work on February 21, 1998, "sustained an injury to her thoracic spine, a lumbar spine exacerbation, and moving toes/painful leg syndrome"; (2) whether the employee's claimed medical expenses were reasonable, necessary, permissible under the treatment parameters, and causally related to a work injury on that date; and (3) whether the employee was temporarily totally and temporarily partially disabled as claimed. Following the hearing, the record was left open pending a post-hearing deposition of Dr. Wyard and submission of written final arguments of the parties.

On February 25, 1999, Dr. Wyard testified by deposition, reiterating his opinion that the employee's activities on February 21, 1998, did not constitute a substantial contributing factor in any work injury or disability or need for subsequent treatment or restrictions. It was also Dr. Wyard's opinion, based on his reading of the treatises appended to the transcript of Dr. Parashos's deposition testimony, that there is no evidence to

> suggest that a thoracic spine injury would cause the so-called moving toes syndrome, etc. The causation there, as outlined in those reports, in many cases isn't even found or clarified. And when they do feel that they have clarified, it's typically related to an injury to the legs or lumbar spine, specifically the cauda equina, the nerve rootlets, or the peripheral nerves.

Dr. Wyard conceded that Dr. Smith had found evidence of stenosis in the low back, but he concluded that "this is all consistent with the diagnosis of long-standing degenerative changes in the spine."

By Findings and Order filed May 12, 1999, the compensation judge concluded that the employee had current diagnoses of low back pain and of moving toes and painful leg syndrome but that she had failed to prove that either of these conditions was causally related to any injury or employment activities at the employer. In addition, the judge found that the employee had failed to prove a thoracic spine injury or any other injury causally related to her work for the employer. 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

In her brief, the employee argues that substantial evidence supports neither (1) "the court's findings as to the employee's foot drop" nor (2) "the compensation judge's finding of no causation as to the employee's waving toes and painful leg syndrome." The compensation judge made no findings specifically referencing any foot drop condition. What the judge did conclude was the following: at Findings 3, 4, and 5, that the employee had failed to prove that her current diagnoses of moving toes/painful leg syndrome and low back pain were causally related to her work for the employer; at Finding 6, that the employee had failed to prove a thoracic spine injury causally related to her work for the employer; and, at Finding 9, that "the employee did not sustain a work-related injury." In concluding her argument under what she describes as the "foot drop" issue, the employee states, "The only 'dispute' between Dr. Wyard and Dr. Parashos is that Dr. Wyard felt the foot drop was an aggravation of prior problems and Dr. Parashos felt the condition was caused by a herniated thoracic disc which he felt was a new injury." We presume that the "findings as to the employee's foot drop" referenced by the employee are essentially those at Findings 6 and 9.

Foot Drop

The employee contends that the compensation judge credited the employee's "testimony regarding the causation events," that the independent medical examiner and the treating doctor were both of the opinion that a work injury occurred as alleged in the event such testimony were found to be true,[1] and that the judge's refusal to find a work injury on February 21, 1999,

[1] On cross-examination, Dr. Wyard conceded that the employee would have sustained a work-related aggravation of her preexisting condition if the court were to find that, on the date alleged, she had bent over in the employer's walk-in cooler into a tightly flexed and crouching position to ladle stock into a stock pot weighing 30 to 40 pounds and had then arisen from that

was therefore clearly erroneous. We are not persuaded.

It is true that the compensation judge conceded substantial accuracy and consistency to the employee's testimony as to the symptoms she experienced soon after the date of her alleged injury. The judge did not, however, credit so clearly the employee's testimony as to the events that precipitated those symptoms - - the mechanism by which the employee ultimately contended that her alleged injury occurred. Indeed, after detailing in the second sentence of her Memorandum what she says the employee "recalls" to be the mechanism of her alleged injury, the judge emphasizes the fact that "Dr. Beck indicates the employee had no recent trauma" at the time of her first treatment. The judge's affirmation of the employee's testimony, to the extent that testimony is affirmed, is of the employee's report of her symptoms, not of her version of the "causation events." The issue before the judge was not whether the employee had the symptoms she alleged but "whether or not these symptoms had any causal connection to work activities and whether or not an injury occurred at work." The judge's focus in her decision is at all times not so much on the "causation events" attested to by the employee but on the medical causation of the employee's subsequent condition, not on whether the employee's activities at work could have caused the employee's symptomology subsequent to February 21, 1998, but on whether it is more likely than not that they did cause that symptomology. Because the judge's crediting of the employee's testimony as to her symptomology did not fully extend to the mechanism of injury proposed by the employee, and because there is evidence that the judge did not credit that mechanism, the employee's reliance on Dr. Wyard's arguable concession of a work injury in the event that mechanism should be credited is moot.

While the compensation judge may not have fully credited the employee's testimony as to the mechanism of her alleged injury, the employee has accurately argued that the judge did not make an express finding discrediting that testimony. Dr. Parashos did expressly credit the mechanism of injury proposed by the employee, and the employee relies on Dr. Parashos's opinion "that the foot drop developed as a result of the pressure that the [T11-12] disc exerted on the spinal cord" as the employee crouched ladling stock in the course of her work on February 21, 1998. Dr. Parashos testified expressly that the employee's low back condition was not causally related to any February 1998 work injury[2] and that there was no nerve root, as opposed to spinal cord, compression or impingement. In Finding 6, the compensation judge concluded that the employee had failed to prove a thoracic spine injury related to her work for the employer, explaining in her Memorandum that, "the medical records simply do not support a clinical correlation between the symptomatology which she is experiencing [and] the findings on the [January 6, 1999] MRI." This conclusion is supported by the testimony of Dr. Wyard, that he had reviewed hard copies of these more recent scans and found that they "clearly are normal."

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position to discover numbness in her foot and leg.

[2] Dr. Wyard found the initial symptoms related to the low back but due entirely to "long-standing degenerative changes" and to "wear and tear over a period of time" rather than to any new injury or exacerbation in February 1998.

Contrary to the suggestion of the employee, the compensation judge did not clearly credit the employee's version of the "causation events" so as to trigger Dr. Wyard's conditional concession of a work injury in February 1998. Moreover, there is in the medical records no clear radiological evidence of any February 1998 change in the employee's low back condition or any material abnormality in her mid back condition that might have caused her foot drop symptoms to appear at that time. Absent more definitive clinical and radiological findings, the mere fact that the employee's symptoms may have immediately followed her employment activities on a date in February 1998 does not prove that those symptoms were the result of either an aggravation of a preexisting low back injury or a new mid back injury on that date. For these reasons, particularly given the existence of supporting medical opinion, the compensation judge's implied conclusion that the employee did not sustain a foot drop injury consequent to her work activities on February 21, 1998, was not unreasonable. See Nord v. City of Cook, 360 N.W.2d 337, 342-43, 37 W.C.D. 364, 372-73 (Minn. 1985) (a trier of fact's choice between experts whose testimony conflicts is usually upheld unless the facts assumed by the expert in rendering his opinion are not supported by the evidence). Therefore we affirm that conclusion. See Hengemuhle, 358 N.W.2d at 59, 37 W.C.D. at 239.

Waving Toes and Painful Leg Syndrome

At Finding 5, the compensation judge concluded also that the employee had failed to prove that her waving toes/painful leg syndrome was causally related to any injury or work activity at the employer. The employee contends that "the compensation judge's finding of no causation as to the employee's waving toes and painful leg syndrome is without substantial evidentiary support." She summarizes her own argument as follows: "The court found the condition to exist; the only testimony on causation came from Dr. Parashos; the I.M.E. does not address causation; accordingly, Dr. Parashos must be believed." We do not agree.

Contrary to the employee's assertion, a compensation judge is not obligated to accept unopposed medical opinion. Although, under Flansburg v. Giza, 284 Minn. 199, 201-02, 169 N.W.2d 744, 746, 25 W.C.D. 3, 6 (1969), unopposed expert medical testimony cannot be disregarded, such testimony is not necessarily conclusive upon the trier of fact. See Tuomela v. Reserve Mining Co., 299 Minn. 203, 204, 216 N.W.2d 638, 639, 27 W.C.D. 312, 313 (1974). It is clear from the judge's detailed memorandum that she did not disregard the opinion of Dr. Parashos, although she did find the doctor's explanation of his opinion inadequate. Dr. Parashos himself testified that "in the vast majority of cases there is a pre-existing injury, usually." The employee has asserted only one date of injury, February 21, 1998, suggesting that Dr. Parashos's commencement of treatment about a month thereafter and about three months prior to Dr. Fealey's ultimate diagnoses of the syndrome places the date of the syndrome injury in February 1998. We have already determined, however, that no low or mid-back abnormality existed at that time sufficient to support a finding of an injury sufficient to result in foot drop symptoms. Dr. Parashos has cited in support of his wavy toes/painful legs diagnosis no spinal or other abnormality other than those he cited in support of his foot drop diagnosis. The employee argues that "[w]hile there are other cases where the causation is more obvious, there are a number

of areas where the link is just as cloudy and courts find causation." She argues that "Dr. Parashos testified that he had no doubt about causation," contending that "[t]here is no requirement in the Workers' Compensation Act that the employee is required to produce evidence of the precise biomechanical processes of an injury." Whatever truth there may be in these arguments for a softer definition of what constitutes "substantial" evidence, the compensation judge in this case was certainly not required to find a work-related injury on the date alleged on the basis of such nebulous evidence. Because, by Dr. Parashos's own concession, the wavy toes/painful legs syndrome is usually a consequence of a preexisting injury, and because the only demonstrable injury preexisting the wavy toes/painful legs symptoms in this case also preexisted the date of the injury alleged on the employee's Claim Petition, we conclude that the judge's denial of the employee's claim for benefits based on her wavy toes/painful legs diagnosis was not unreasonable and so should be affirmed. See Hengemuhle, 358 N.W.2d at 59, 37 W.C.D. at 239.