LINDA A. STEVENS, Employee, v. HENNEPIN CNTY., SELF-INSURED, Employer/Appellant, and MINN. PHYSICAL MED., P.A., Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
DECEMBER 15, 1999

No. [REDACTED SSN]

HEADNOTES

EVIDENCE - RES JUDICATA. The compensation judge properly held that the prior Findings and Order, served and filed December 24, 1996, was not *res judicata* with respect to the issues in this proceeding, where the prior dispute involved treatment for reproductive or colorectal pelvic organs, and the disputed treatment in this proceeding was reasonably found to involve treatment for musculoskeletal SI joint and pelvic/sacral pain and dysfunction.

EVIDENCE - EXPERT MEDICAL OPINION. The employee's treating physician, Dr. Ryan, had adequate foundation for her opinions regarding the employee's diagnosis and treatment based on her review of the employee's post-injury treatment records and her ongoing treatment of the employee.

MEDICAL TREATMENT & EXPENSE. The compensation judge reasonably found the evaluation performed by Drs. Gemlo and Spencer was secondary to the treatment of the employee's sacral pain and properly ordered the self-insured employer to pay their bills.

MEDICAL TREATMENT & EXPENSE - TREATMENT PARAMETERS; MEDICAL TREATMENT & EXPENSE - REASONABLE & NECESSARY. Substantial evidence supports the compensation judge's determination that the treatment provided by and under the direction of Dr. O'Neill and Dr. Hess at the United Hospital Pain Clinic, and treatment provided by and under the direction of Dr. Ryan, including extended physical therapy, massage therapy, and narcotic medication use, was reasonably and necessary, and was one of those rare instances where a departure from the treatment parameters is necessary to obtain proper treatment.

TEMPORARY PARTIAL DISABILITY - SUBSTANTIAL EVIDENCE. Substantial evidence supports the compensation judge's finding that the employee was restricted to half-time work as a result of recurrent SI joint and pelvic/sacral malalignment and pain that was causally related to her work injury, and his award of temporary partial disability benefits from November 6 through December 4, 1998.

Affirmed.

Determined by: Johnson, J., Wilson, J. and Wheeler, C.J.
Compensation Judge: Danny P. Kelly

OPINION

THOMAS L. JOHNSON, Judge

The self-insured employer appeals from the compensation judge's finding that the December 24, 1996 Findings and Order in this case was not *res judicata* with respect to the current proceeding before the court. The self-insured employer also appeals from the judge's award of medical expenses incurred by the employee for treatment provided by Dr. O'Neill and Dr. Hess at United Hospital Pain Clinic, for physical therapy at United Hospital, for evaluations by Dr. Gemlo and Dr. Spencer, for massage therapy provided by Charlene Terrana, and for treatment provided by the intervenor, Dr. Karen Ryan, Minnesota Physical Medicine, P.A. We affirm.

BACKGROUND

Linda A. Stevens, the employee, is a child protection social worker for the self-insured employer, Hennepin County. She sustained an admitted personal injury to her tailbone and low back on January 27, 1996, when she slipped on ice and fell, landing on her buttocks and back. The employee sought medical treatment at the Hennepin County Medical Center (HCMC) Urgent Care Clinic on February 6, 1996. The doctor diagnosed posterior superior iliac bruising on the left, and prescribed anti-inflammatory medication and rest. From mid-March to mid-May, 1996, the employee received follow-up care for low back, sacral and coccygeal pain at Hennepin Faculty Associates (HFA) and from Dr. Mary Arneson, an occupational medicine specialist at HCMC. A bone scan and an MRI study performed on April 24 and 25, 1996, indicated a possible left sacral fracture. The employee was later referred to Dr. Templeman, an orthopedist, who reviewed the scans and opined the employee did not sustain a fracture of her sacrum. A subsequent CT scan on May 16, 1996 was initially read as consistent with a healing fracture. In an addendum added May 19, 1996, however, the radiologist stated the CT scan did not reveal a definite fracture, but there did appear to be some abnormality in the left mid to lower sacrum on the bone scan.

In the meantime, on March 2, 1996, the employee was seen in Urgent Care at HCMC reporting abdominal pain for two weeks. Vicodin was prescribed for pain, and the employee was referred to the Ob-Gyn Clinic for follow-up. The employee was eventually referred to Dr. Mark Martens, an Ob-Gyn specialist at HCMC, whom she first saw on May 20, 1996. Dr. Martens diagnosed chronic rectal-vaginal pelvic pain, and on June 6, 1996, Dr. Martens performed a diagnostic laparoscopy and uterosacral ablation. The employee experienced a few days of relief, but her symptoms then returned. On July 1, 1996, Dr. Martens performed a second surgery in the nature of a presacral neurectomy and uterine suspension. The employee initially reported improvement of her abdominal/pelvic pain following the surgery, but in early October 1996, returned to the clinic reporting "raw abdominal pain." Dr. Mertens observed the employee's rectal pain had dramatically improved, but her uterine/vaginal pain had returned. On December 5, 1996, Dr. Martens performed a laparotomy, hysterectomy, bilateral oophorectomy, and repair of tears in the small bowel serosa. Multiple adhesions to the anterior abdominal wall and posterior aspect of the uterus were noted during the surgery.

On July 1, 1996, the self-insured employer filed a Notice of Intention to Discontinue Benefits (NOID), asserting the employee's rectal-vaginal pain was not causally related to her January 26, 1997 injury to the tailbone and low back. An Objection to Discontinuance was filed by the employee. A hearing was held on November 5, 1996 before Compensation Judge Kelly. In a Findings and Order served and filed December 24, 1996, the compensation judge rejected Dr. Martens opinion that the January 27, 1996 slip and fall resulted in a compression injury to the internal organs, finding the employee had failed to establish a causal relationship between her rectal-vaginal pelvic pain and the admitted work injury. (F&O 12/24/96, findings 13, 14, 16.) The compensation judge's findings and order was affirmed by this court in a decision served and filed June 18, 1997.

On December 22, 1996, the employee returned to the HCMC Urgent Care Clinic reporting worsening tailbone and back pain. The doctor diagnosed sacral pain and prescribed Ibuprofin and Vicodin. He noted the employee had a pain clinic appointment in St. Paul on Friday. The employee was last seen by Dr. Mertens on December 30, 1996. He noted the employee's uterine/vaginal pain had resolved following the surgery, but she continued to complain of back and coccyx pain. He prescribed Vicodin and indicated the employee would be seeing Dr. O'Neill at the United Hospital Pain Clinic for follow-up.

The employee was seen by Dr. O'Neill on December 27, 1996. She reported her uterine and rectal pain had disappeared following the most recent surgery, but complained of increasing sacral and coccygeal pain. The doctor noted chronic use of Vicodin, a narcotic medication, to control pain. The employee began treatment with Dr. Todd Hess at the pain clinic beginning January 14, 1997. On January 24, 1997, the employee underwent a diagnostic coccyx injection, without relief. Caudal epidural block injections were performed on January 29 and February 7, 1997. The employee experienced significant relief of her pelvic pain, but continued to experience left-sided sacroiliac (SI) pain radiating into the left leg. Dr. Hess also began modifying the employee's pain medication, discontinuing Vicodin and prescribing oxycodone[1] instead.

Noting records indicating a left sacral fracture, Dr. Hess ordered a bone tomogram and bone scan that were performed on February 21, 1997. The studies showed a normal sacrum and coccyx. The employee continued to have left sacrum and SI joint pain, and on March 6, 1997, Dr. Hess diagnosed probable left SI joint pathology with a piriformis component. He prescribed three physical therapy sessions focusing on the SI joint, pelvic asymmetry and the piriformis. The employee began physical therapy at United Hospital on April 1, 1997. At that time, she reported taking up to four Roxicodone per day for pain. The employee reported some improvement of pain with the treatment, but remained very tight following the last session.

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[1] Oxycodone hydrochloride is a narcotic pain medication variously labeled Percocet, Percodan or Roxicodone, depending on the manufacturer. See Physician's Desk Reference, 53rd ed. (1999).

On May 6, 1997, Dr. Hess referred the employee to Dr. Gemlo at Colon and Rectal Surgery Associates to evaluate the possibility of scar tissue in the colorectal area. Dr. Gemlo saw the employee on May 12, 1997, and reported a normal rectal examination, but noted pelvic floor muscle spasm. He diagnosed chronic pelvic pain likely sacral in origin. On June 2, 1997, anal rectal physiology studies were completed by Dr. Spencer, an associate of Dr. Gemlo. Dr. Spencer also noted pelvic floor muscle spasm, and similarly indicated the employee's symptoms were likely sacral rather than rectal.

The employee resumed physical therapy at United Hospital on June 4, 1996. In a follow-up visit with Dr. Hess on July 16, 1997, the employee reported that physical therapy had helped significantly, with much better range of motion and increased ease of movement, but continuing pain. Dr. Hess continued physical therapy and, noting the employee did not appear to be over-using her medications, increased her prescription for oxycodone, allowing up to 6 to 8 tabs per day. The employee returned to see Dr. Hess on a monthly basis, and continued to receive physical therapy focusing primarily on the left SI joint/sacrum and pelvic alignment, and including a home exercise program. The employee improved with the treatment, but continued to have difficulty controlling her pain, despite slowly increasing amounts of oxycodone. In September 1997, Dr. Hess referred the employee to Dr. Karen Ryan, a physical medicine and rehabilitation specialist, for further evaluation.

The employee was seen by Dr. Ryan on October 10, 1997. The employee reported continuing deep pelvic pain that increased with activity, and aching pain in the left SI region. Dr. Ryan believed the employee's history and symptoms suggested possible pudendal nerve involvement, or possible neuropathically mediated pain or some form of reflex sympathetic dystrophy. Further evaluation was deferred until after Dr. Ryan obtained the employee's medical records. The employee continued to receive physical therapy and treat with Dr. Hess in October and November 1997, with some improvement, allowing a reduction in oxycodone use.

The employee returned to Dr. Ryan on November 19, 1997, reporting increasing pain in the sacrum and SI joint. Dr. Ryan referred the employee to Dr. Congilosi at Colon and Rectal Surgery Associates for a pudendal nerve study, and prescribed trial of a compression belt for pelvic stabilization. Physical therapy was continued, and Dr. Hess continued to provide medication management. The employee's pain continued to worsen, and on November 24, 1994, Dr. Ryan requested a CT scan of the pelvis to rule out a non-union fracture, bony spur or other acute pathology. The CT study was normal. On November 29, 1997, Dr. Ryan prescribed a TENS unit to attempt to reduce the employee's left SI pain. Pudendal nerve testing, completed by Dr. Congilosi on December 2, 1997, showed normal pudendal nerve latencies.

On December 15, 1997, Dr. Ryan requested a diagnostic injection with contrast to the SI joint followed by a CT scan. The procedure resulted in replication of the employee's SI joint pain followed by relief with injection of local anesthetic into the joint. The scan showed extravasation of contrast into the ligamentous segment of the SI joint. Dr. Ryan concluded the CT-arthrogram confirmed the left SI joint as the employee's "pain generator," and diagnosed SI

joint and pelvic dysfunction. The employee continued to work with physical therapy two to three times a week, used her TENS unit, and was taking Flexeril, Klonopin, Tylenol, Relafen and Roxicodone, 6 to 8 tabs daily, to control her symptoms and pain. On December 19, 1997, Dr. Ryan noted that "[a]lthough [the employee] appears uncomfortable, she is dramatically better than when last seen."

The employee was last seen by Dr. Hess on January 15, 1998. He noted the employee's treatment with Dr. Ryan and continuing physically therapy had "helped immensely," and her medication use was down considerably. He stated the clinic had nothing further to offer, and the employee's medication management, including reduction and "weaning off" oxycodone, would be transferred to Dr. Ryan. The employee continued to treat with Dr. Ryan who prescribed ongoing physical therapy, various medications, including oxycodone, and a sacral brace to improve pelvic stabilization. Physical therapy notes reflect improvement in pelvic alignment and SI joint mobility, but increasing intensity of pain in the SI joint area. On February 20, 1998, Dr. Ryan reduced the employee's physical therapy from three times a week to once a week, adding pelvic floor/pudendal nerve stretching. A week later the employee reported excruciating, worsening pain, and Dr. Ryan approved increased use of oxycodone. On March 13, 1998, the employee returned to Dr. Ryan complaining of continued severe pain in the low back and left SI joint radiating down the left leg. She reported she had seen a massage therapist and felt better with the treatment. Physical therapy was continued on a weekly basis along with resumption of use of a TENS unit.

On review of the employee's prior treatment records from HCMC, Dr. Ryan noted the conflicting reports of a sacral fracture. She requested review of the 1996 studies from Dr. Gilbert, a radiologist. In a report dated March 20, 1998, Dr. Gilbert concluded the studies did *not* support a finding of a sacral fracture. On March 26, 1998, Dr. Ryan approved continuing weekly massage therapy. The employee discontinued physical therapy on April 13, 1998, but continued massage therapy, reporting decreased pain and increased mobility with the massage treatment. By May 6, 1998, Dr. Ryan reported noticeable improvement, with intermittent episodes of moderately severe pain, but reduced narcotic medication use overall.

On August 11, 1998, the employee was examined by Dr. Dowdle, an orthopedic surgeon, at the request of the self-insured employer. Dr. Dowdle diagnosed mechanical low back pain and a left SI joint inflammation as a result of the employee's slip and fall on January 27, 1996. Dr. Dowdle opined the appropriate treatment was a local injection of novocaine and cortisone to the SI joint, and did not believe treatment with massage therapy, pain medications or the like was reasonable or necessary. He further opined the employee's treatment with Dr. Ryan was neither reasonable or necessary.

The employee continued to see Dr. Ryan approximately once a month, with massage therapy once a week. Dr. Ryan prescribed trials of several new medications in an attempt to reduce the employee's use of oxycodone. The employee continued to experience intermittent flare-ups of pain, but was able to continue working full time in her job as a child protection social worker. In late September 1998, Dr. Ryan noted the employee was experiencing markedly

increased stress in her life, with an increase in pain and spasm in the SI joint and sacral/coccyx area. The employee continued to experience stress and fatigue with increasing SI joint and sacral/pelvic pain, and on November 2, 1998, Dr. Ryan restricted the employee to half-time work. The employee had several sessions of physical therapy, and resumed full-time work as of December 4, 1998.

Dr. Ryan also referred the employee to Dr. Siegel for consideration of a trial of an Interstim device. Dr. Ryan noted the employee had made major gains in her mobility and low back and hip range of motion during the past year, but continued to require significant levels of narcotic medication. It was Dr. Ryan's hope that the stimulator might decrease or eliminate the need for pain medications and muscle relaxants. The employee had several trials of the device, which appeared promising, with significant relief of her pain and sacroilliac/pelvic symptoms. As of the date of hearing, however, continuing use of the device was unresolved.

Following the issuance of the December 24, 1996 Findings and Order, the self-insured employer refused to pay for medical treatment for the employee's "pelvic complaints." On April 22, 1998, the employee filed a claim petition seeking payment of medical expenses. The matter was heard by a compensation judge on March 5, March 10 and March 15, 1999. In a decision served and filed June 10, 1999, the compensation judge awarded payment, *inter alia*, for the treatment provided by Dr. O'Neill and Dr. Hess, the treatment provided by Dr. Ryan, for physical therapy at United Hospital, for the evaluation of Dr. Gemlo and Dr. Spencer, and for the employee's massage therapy treatment. The compensation judge accepted Dr. Ryan's opinions of causation and the nature and extent of the employee's injury, and concluded the treatment was reasonable and necessary, and fell within the "rare case" exception to the permanent medical treatment parameters. The compensation judge further found that Dr. Ryan restricted the employee to half-time work in November 1998 due to recurrent SI joint/pelvic malalignment problems caused by the employee's personal injury, and awarded temporary partial disability benefits from November 6 through December 4, 1998. 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

The self-insured employer contends that the compensation judge's December 24, 1996 Findings and Order in this case is *res judicata* with respect to the issue of causation, and that the judge's award of medical expenses for treatment of the employee's pelvic pain complaints after that date is contrary to that decision. The self-insured employer further contends substantial evidence does not support the compensation judge's award of medical expenses for treatment at the United Hospital Pain Clinic and by Dr. Ryan, including the extended use of physical therapy, massage therapy and narcotic pain medications. We affirm.

Res Judicata

The self-insured employer argues that the compensation judge's award of medical expenses for treatment of the employee's "pelvic pain" is barred by the compensation judge's December 24, 1996 Finding and Order. We disagree. The prior hearing involved a request to discontinue wage loss benefits on the ground that the employee's lost time from work after June 6, 1996 was not causally related to her personal injury. During this period, the employee was being treated by Dr. Mertens for gynecological rectal-vaginal problems. In his prior findings and order, the compensation judge rejected Dr. Mertens' opinion that the employee sustained a compression injury to the internal organs as a result of her January 27, 1996 slip and fall. He, accordingly, concluded the employee failed to establish a causal relationship between her claimed periods of disability through the hearing on November 5, 1996, while being treated for rectal-vaginal pain by Dr. Mertens.

A careful review of the treatment records and reports of Dr. O'Neill and Dr. Hess at the United Hospital Pain Clinic between December 27, 1996 and January 15, 1998, and the treatment records of Dr. Ryan from October 10, 1997 through the date of hearing in March 1999, reflects a primary diagnosis of, and treatment for, musculoskeletal SI joint and pelvic/sacral pain and dysfunction, rather than treatment for reproductive or colorectal pelvic organ problems. The self-insured employer admitted liability for an injury to the tailbone and low back, and at the hearing agreed, based on Dr. Dowdle's opinion, that the employee does have left SI joint dysfunction. The compensation judge properly denied the ob/gyn treatments claimed by the employee in this proceeding, and reasonably concluded that the employee's treatment for musculoskeletal SI joint and pelvic/sacral pain and dysfunction was not barred by the December 24, 1996 findings and order. We, therefore, affirm the compensation judge's determination that the prior findings and order is not *res judicata* with respect to the employee's claims for medical expenses related to her treatment from and under the direction of the Drs. O'Neill and Hess at the United Hospital Pain Clinic, and her treatment from and under the direction of Dr. Ryan.

Dr. Ryan - Foundation

The self-insured employer argues that Dr. Ryan's opinions, accepted by the compensation judge, lack foundation, asserting she did not review records of the employee's treatment at HCMC and HFA after the injury, did not review the employee's pre-injury medical records relating to ob/gyn problems and treatment for anxiety and depression, and did not review the independent medical examination (IME) report of Dr. Beadle, an ob/gyn specialist, relied upon

by the compensation judge in his prior decision. We disagree.

While Dr. Ryan did not have the employee's medical records at the first evaluation, she obtained medical releases from the employee and eventually obtained the employee's post-injury treatment records, including records from HCMC and HFA, Dr. Mertens and the United Hospital Pain Clinic. (T. 130, 126-127, 145.) Dr. Ryan testified that her specialty was musculoskeletal injuries, particularly pelvic floor, low back and SI joint problems, and that she did not routinely treat or address gynecological problems. It is also apparent that Dr. Ryan knew of the employee's past and ongoing treatment for psychological problems, and appropriately referred the employee to her psychiatrist to address related issues. It is clear that Dr. Ryan was familiar with the employee's treatment and medical care following the January 26, 1997 work injury, and based on her review of the employee's treatment records and ongoing treatment of the employee, had adequate foundation for her opinions relating to the employee's SI joint and pelvic dysfunction problems. See Drews v. Kohl's, 55 W.C.D. 33 (W.C.C.A. 1996).

Evaluation by Drs. Gemlo and Spencer

The self-insured employer contends that the compensation judge erred in ordering the employer to pay the bills of Dr. Gemlo and Dr. Spencer at Colon and Rectal Surgery Associates for evaluation of pelvic pain, where the previous findings and order held that the employee's pelvic pain was not related to her work injury. The employee was referred to Dr. Gemlo by Dr. Hess at the United Hospital Pain Clinic. Dr. Hess had diagnosed left SI joint pathology, but referred the employee to Dr. Gemlo for a colorectal opinion to rule out possible scar tissue in the rectal area. Dr. Gemlo referred the employee to his associate, Dr. Spencer, for anal rectal physiology studies. Both Dr. Gemlo and Dr. Spencer concluded the employee's problem was likely sacral in origin. The compensation judge reasonably concluded that the evaluation performed by Drs. Gemlo and Spencer was secondary to the treatment of her sacral pain, and we affirm.

United Hospital Pain Clinic and Dr. Ryan

The employer and insurer contend that substantial evidence does not support the compensation judge's finding that the treatment provided by and under the direction of Drs. O'Neill and Hess at the United Hospital Pain Clinic, and by and under the direction of Dr. Ryan, was reasonable and necessary. They further assert the treatment provided is contrary to the permanent medical treatment parameters and is not compensable.

The employee was evaluated by Dr. O'Neill at the United Hospital Pain Clinic on December 27, 1996. She receive treatment under the direction of Dr. Hess from January 14, 1996 through January 15, 1997, including a diagnostic coccyx injection and two diagnostic and therapeutic caudal injections. In March 1997, Dr. Hess assessed a probable SI joint pathology. The employee was treated with physical therapy and various medications, including a prescription for oxycodone, a narcotic pain medication. The employee improved somewhat, and was then referred to Dr. Ryan, a specialist in physical medicine and rehabilitation with a particular interest in SI joint problems. Dr. Ryan assumed primary responsibility for the employee's care in

November 1997, although Dr. Hess continued to provide medication management through January 15, 1998. Treatment consisted of physical therapy, three times a week through February 1998, and once a week through April 13, 1998, massage therapy once a week from February 1998 through the hearing, prescriptions for various medications, including continuing monitored use of oxycodone, use of a TENS unit, a sacral brace, and just prior to the hearing, a trial of an Interstim device for control of pain. During this time, the employee continued to work as a child protection social work for the employer.

The self-insured employer argues that the treatment provided by Dr. Hess was unreasonable, in part, because Dr. Hess failed to follow through with a plan for an SI joint injection which, according to Dr. Dowdle's IME report, would have been diagnostic of the problem and should have led to treatment by way of a therapeutic SI injection. Dr. Hess, however, did assess an SI joint condition following the two caudal injections, and treated the employee for SI joint and pelvic/sacral dysfunction. Moreover, the compensation judge accepted Dr. Ryan's opinion that therapeutic SI joint injections would not have been appropriate in the employee's situation. Where a compensation judge's determination is based on a choice between differing medical opinions, this court must affirm where the opinion relied upon has adequate foundation. See Nord v. City of Cook, 360 N.W.2d 337, 342, 37 W.C.D. 364, 372 (Minn. 1985).

The self-insured employer similarly argues that substantial evidence does not support the finding that Dr. Ryan's treatment was reasonable and necessary because the treatment provided is contrary to the treatment recommended by Dr. Dowdle, that is, a sacroilliac injection. As noted above, Dr. Ryan did not believe that injection of cortisone into the SI joint would be appropriate in the employee's situation, and explained the basis for her opinion, both in her reports and in her testimony. The compensation judge adopted Dr. Ryan's opinion. See, Nord, id.

The self-insured employer further argues that the treatment provided under the direction of the United Hospital Pain Clinic and Dr. Ryan, including extended periods of physical therapy, massage therapy, and narcotic pain medication use, is not reasonable or necessary and is contrary to the permanent medical treatment parameters for chronic management of regional low back pain, including sacroilliac problems. The compensation judge accepted Dr. Ryan's opinions regarding the nature and extent of the employee's injury, and appropriate medical treatment for the injury. These were explained at length in Dr. Ryan's reports and her testimony at the hearing. The judge further concluded that the "complexity of the medical condition and the employee's ability to continue with her employment [compels] the determination that this case is an exceptional circumstance where a departure from the treatment parameter rules is allowed in those rare cases in which departure is necessary to obtain proper treatment." (Mem. at 10.)

In Jacka v. Coca Cola Bottling Co., 580 N.W.2d 27, 35, 58 W.C.D. 395, 408 (Minn. 1998), the supreme court recognized that "the treatment parameters cannot anticipate every exceptional circumstance" and held "a compensation judge may depart from the rules in those rare instances in which departure is necessary to obtain proper treatment." See also Asti v. Northwest Airlines, 588 N.W.2d 737, 59 W.C.D. 59 (Minn. 1999). In Martin v. Xerox Corp., slip op. (W.C.C.A. July 15, 1999) this court held that "rare case" medical treatment cases will be reviewed

under the standards set forth in Hengemuhle v. Long Prairie Jaycees, 358 N.W. 2d 54, 59, 37 W.C.D. 235, 239 (Minn. 1984) and Minn. Stat. § 176.421, subd. 1(3). Thus, the issue before us on appeal is whether the compensation judge's finding of a rare case exception is clearly erroneous and unsupported by substantial evidence in view of the entire record.

Here, the compensation judge was clearly persuaded by the employee's testimony regarding the severity of her symptoms and the effectiveness of the treatment provided, and by Dr. Ryan's explanation of the employee's condition and her opinion regarding the necessity for and reasonableness of the treatment provided to the employee. The case presents an unusual medical situation, and we cannot say that the compensation judge's acceptance of Dr. Ryan's opinions was so unreasonable as to be clearly erroneous. While the self-insured employer is reasonably concerned about the employee's long-term use of oxycodone, a narcotic medication, both Dr. Hess and Dr. Ryan were aware of and addressed dependency issues, monitored the employee's medication use and were satisfied that the employee did not demonstrate addictive behavior or medication abuse, and attempted to find alternative means of treating the employee's pain. The compensation judge clearly reviewed the evidence before him with some care, and, as it is supported by evidence that a reasonable mind might accept as adequate, must be affirmed.

Temporary Partial Disability Benefits

Finally, the self-insured employer argues the compensation judge erred in awarding temporary partial disability benefits from November 11 to December 4, 1998, asserting the employee was taken off work due to "personal stress" not related to the work injury. As noted by the self-insured employer, the employee had continued to work full-time as a child protection social worker for Hennepin County following the injury. However, on October 2, 1998, Dr. Ryan noted the employee, due to fatigue and multiple stressors in her life, was experiencing an escalation of SI joint and pelvic pain and symptoms, with increasing pain medication use. On October 23 and November 11, 1998, Dr. Ryan noted the employee appeared worn and fatigued, and was having trouble getting through the work day due to her increased pain. The doctor, accordingly, restricted the employee to half-time work. Dr. Ryan explained that "[f]atigue and muscle tightness and spasms and pain all go together. [The employee] was having more pain, she was having more spasm, . . . she really looked very fatigued. And work stress is one of the places we had not . . . intervened.." (T. 171-72.) Dr. Ryan stated that modifying the employee's work demands was one of the few variables that had not been pursued aggressively, and she believed it was appropriate treatment to try to break the cycle of pain and stress. (Int. Ex. 2: 11/2/98, 2/18/99 letter; Pet. Ex. 9: 11/2/98 Rx slip.) The compensation judge accepted Dr. Ryan's opinion, finding the employee's work was reduced due to recurrent SI joint/ pelvic malalignment caused by the January 27, 1996 personal injury. There is substantial evidence to support the award of temporary partial disability benefits from November 6 through December 4, 1998, and we affirm. See Nord at 342, 37 W.C.D. at 372.