ALVINA WEIDNER, Employee/Appellant, v. LSI CORP., SELF-INSURED/BERKLEY ADM'RS, Employer, and INST. FOR ATHLETIC MEDICINE and ORTHOPEDIC MED. & SURGERY, LTD., Intervenors.

WORKERS' COMPENSATION COURT OF APPEALS
DECEMBER 13, 1999

No. [REDACTED SSN]

HEADNOTES

CAUSATION - MEDICAL TREATMENT; MEDICAL TREATMENT & EXPENSE - SURGERY. Substantial evidence, including expert opinion and medical records, supported the compensation judge's findings that the arthroscopic surgery proposed by the employee's physician was not causally related to the effects of the employee's 1998 work injury, but was solely related to the effects of her pre-existing condition and prior surgery.

Affirmed.

Determined by Wilson, J., Johnson, J., and Wheeler, C.J.
Compensation Judge: Bernard Dinner

OPINION

STEVEN D. WHEELER, Judge

The employee appeals from the compensation judge's determination that the employee failed to prove the necessity of proposed arthroscopic surgery for her right knee. We affirm.

BACKGROUND

In approximately 1984 the employee, Alvina Weidner, sustained a non-workers' compensation injury to the right knee when she twisted it while performing as a professional dancer. She was treated by arthroscopic surgery and then by open lateral meniscectomy. After six weeks in recovery the employee resumed her professional dancing activities until about 1987. (T. 81-82; Exhs. 5, A3 at 7.)

From about 1987 to about 1990 the employee worked as a cage cashier for a casino, and from about 1990 to 1991 she worked as a bartender, without experiencing any knee problems. In 1991 the employee moved to Minnesota, where, before she began working for the employer, LSI Corporation, she worked in a variety of jobs, including as a dietary aide in a hospital, a gas station cashier, a department store cashier, a laborer packaging eggs on an assembly line for

employer Sunny Fresh Foods and as a housekeeper at a motel. During this period the employee experienced no problems with her right knee, although she did sustain a work-related injury to her left arm at Sunny Fresh Foods. (T. 82-89.)

In 1996 the employee began working for the employer, LSI Corporation, as a laborer in the employer's drawer department, making cabinet drawers. This job required the employee to use a hammer, a screw gun and a staple gun on a repetitive basis. After some time in this job, the employee began to experience a shooting pain up the right arm to the elbow. The employer sent the employee for treatment at Now Care, which referred her to Dr. Engasser. Dr. Engasser treated the employee's arm with injections, but she did not experience relief from her symptoms and started treating with Dr. Mark Holm. Dr. Holm diagnosed chronic epicondylitis of the right elbow and performed surgery in the form of a lateral epicondylectomy on August 5, 1997. After the surgery, the employee was off work for several weeks and then returned to work under restrictions. In about October 1997 the employer transferred the employee to its parts department, where her duties consisted of moving parts and tools using a rolling cart. (Exh. A9; T. 89-99.)

The employee continued to follow up with Dr. Holm after her elbow surgery, who last saw her on May 1, 1998, when she was noted to have full range of motion of her right elbow. At that time the employee requested that her remaining work restrictions be lifted entirely. Dr. Holm released her to return to work without restrictions concerning the use of the elbow and advised that further medical treatment should be on an as-needed basis. (Exh. A9.)

In the meantime, on April 1, 1998, the employee was moving a large stack of doors onto a cart in the employer's door department, when the stack rolled back and the employee was struck on the right upper thigh by the hinge on one of the doors and pinned between two rollers. She initially noted only a cut on her leg, but later that evening the inside of her right knee began to swell. The following day at work the employee's knee was sore and she was limping. The employee continued to work in her regular job over the next several days but her knee did not improve, and on April 10, 1998 she was seen by a physician's assistant at the urgent care clinic at WestHealth. On examination, there was right knee effusion with tenderness along the medial joint line and medial collateral ligament. McMurray's sign was positive, with positive valgus strain of the medial collateral ligament. The employee was diagnosed with a right knee sprain, and internal derangement and possible meniscus tear could not be ruled out. The employee was provided with a knee immobilizer, taken off work and advised to follow up with the occupational medicine clinic within 72 hours. (T. 106-114; Exh. A5.)

The employee was seen by Dr. Julia Halberg at the Occupational Health Services of Allina on April 13, 1998. On examination, there was tenderness over the medial aspect of the right knee but without effusion, instability or any signs of bruising or deformity. The employee reported discomfort but without locking or catching with McMurray's testing over the medial aspect of the knee. Dr. Halberg diagnosed a knee strain without direct trauma to the knee. She placed the employee on restrictions including limits on pushing, pulling and lifting and avoidance of kneeling, squatting and climbing. She referred the employee for physical therapy three times

a week for three weeks, and provided the employee with a neoprene knee support to wear with activity in lieu of the knee immobilizer, which the employee did not wish to wear. (Exh. A6: 4/13/98.)

The employee was next seen at the Occupational Health Services of Allina on April 20, 1998 by Dr. A.M. Nathani. The employee reported that there had been no improvement in her knee symptoms, and that she continued to experience pain with walking or twisting motions and occasional clicking sounds and catching sensations in the knee. Dr. Nathani noted no swelling, bruising or ecchymosis in the right knee and palpation revealed no tenderness in the patella or patellar ligament. There was definite tenderness on the medial side of the knee joint but no obvious crepitus or hematoma. Flexion was slightly restricted because of pain. Dr. Nathani continued to diagnose a right knee joint sprain, but referred the employee to a specialist to consider the possibility of a meniscus tear because of the lack of response to conservative treatment. (Exh. A6: 4/20/98.)

On April 22, 1998 the employee was seen by Dr. Jay S. Johnson at Orthopedic Surgery and Medicine, Ltd. On examination he noted a mild effusion to be present but McMurray's sign was negative, range of motion was good, and there was no instability at full extension, although the employee did report that this proved slightly painful. The employee was noted to be "exquisitely tender" over the medial collateral ligament (MCL) of the right knee. Dr. Johnson diagnosed a grade I-II MCL strain on the right side. He did not think the employee continued to need work restrictions. The employee was provided with a hinged knee brace and asked to follow up in four weeks. (Exh. A8: 4/22/98.)

The employee returned to the Occupational Health Services of Allina on April 28, 1998 where she was seen by Dr. Ronald Ercolani. The employee stated that her knee pain was improving slightly. On examination, the knee appeared grossly normal, but medial collateral ligament stress testing produced pain. No gross instability was apparent and there was no knee effusion. Stress testing of the lateral collateral ligament and the cruciate ligament were negative. Dr. Ercolani continued the diagnosis of a medial collateral ligament strain and returned the employee to her regular work duties. He advised the employee that she could discontinue use of the splint. On May 20, 1998, the employee returned to Dr. Johnson. He noted that tenderness over the medial side of the knee over the medial collateral ligament area was much improved. No effusion was present and McMurray's sign was negative. There was good range of motion. The employee did note some pain when the doctor stressed the medial collateral ligament but this was not as significant as it had been before. On the same date, May 20, 1998, the employee was seen by Dr. Ercolani after her appointment with Dr. Johnson. She reported that the pain in her right knee was minimal and that she felt she could resume her normal activities. Dr. Ercolani projected a maximum medical improvement date of June 17, 1998 and authorized the employee to resume her regular activities. (Exh. A6: 4/28/98, 5/20/98; A8: 5/20/98.)

The employee next returned to Dr. Ercolani slightly more than three months later on September 1, 1998. She reported that she had been having knee pain for two weeks, that it was severe again, and that the pain made it difficult to negotiate stairs, squat or climb.

Dr. Ercolani thought it advisable to rule out internal derangement, and referred the employee to Dr. David R. Olson, a colleague of Dr. Johnson at Orthopedic Medicine and Surgery, Ltd. Dr. Olson ordered an MRI scan to rule out a tear of the medial meniscus. The MRI, performed on September 14, 1998, revealed right knee effusion, degenerative osteoarthritic changes, and the absence of the posterial horn of the lateral meniscus secondary to the employee's prior knee surgery. The medial meniscus was not torn. Dr. Olson concluded that there was no indication for arthroscopic surgery. He recommended a cortisone injection, and the employee underwent the injection on September 22, 1998. The employee was off work for various dates during September 1998 for medical treatment and on medical recommendations. (T. 119; Exh. A1; Exh. A6: "Progress Record," 9/1/98 chart note; Exh. A8: 9/8/98, 9/22/98.)

On October 29, 1998 the employee filed a claim petition seeking temporary partial disability compensation for various dates in September 1998 and payment of medical expenses in an unspecified amount. Further dates of temporary total disability were subsequently added by amendment. The self-insured employer answered on November 28, 1998 denying liability on the basis that any uncompensated disability was causally unrelated to the work injuries and was instead the result of the employee's 1984 knee injury. (Judgment Roll.)

The employee began treating with Dr. Thomas Litman, an orthopedic surgeon, beginning with an initial examination on October 13, 1998. On December 1, 1998 she returned to Dr. Litman after the doctor had obtained her prior medical records. On that date, she was unable to achieve full extension of the knee joint and clicking was present on deep flexion. Moderate effusion was present. The employee experienced medial pain, but no lateral or patellar pain. No instability was present. Dr. Litman opined that the employee's examination findings were unmistakable signs of an internal derangement in the knee. He suggested a repeat MRI of the knee. The MRI, performed on December 7, 1998, showed the postoperative changes from the prior knee surgery, osteoarthritis of the lateral compartment, and a small popliteal cyst, but was otherwise normal. When the employee returned to Dr. Litman's office on December 16, 1998, where she was seen by Dr. Nolan M. Segal, effusion was no longer present in the right knee and the employee had full extension and full flexion of the knee. McMurray's test was negative. Dr. Segal diagnosed a low grade bursitis under the proximal medial collateral ligament area and recommended physical therapy. (Exh. A4.)

The employee returned to Dr. Segal on February 15, 1999 and reported that she had not been able to undergo physical therapy because payment had been denied by the employer. Dr. Segal treated the employee's knee with an injection of cortisone. (Exh. A3 at 15.)

The employee was seen for a medical evaluation on behalf of the self-insured employer on February 6, 1999 by Dr. Paul T. Wicklund, an orthopedic surgeon. Dr. Wicklund diagnosed chronic medial joint tenderness without evidence for a medial meniscal tear. He attributed the employee's current knee symptoms to the 1984 non-work injury and subsequent degenerative changes. In his opinion, the employee sustained a contusion but no damage to the structure of the knee in the April 1, 1998 work injury. He considered only medical treatment for the first two months following the April 1, 1998 work injury to have been related to that incident.

Dr. Wicklund stated that the suggestion for diagnostic arthroscopic surgery was "not inappropriate" but opined that the arthroscopy would be unrelated to any effects of the April 1, 1998 injury and was causally related solely to the 1984 non-work injury. (Exh. 1.)

The deposition of Dr. Litman was taken by the employee's attorney on March 2, 1999. In his deposition testimony, Dr. Litman offered the opinion that the employee had sustained an aggravation of her preexisting knee condition as a result of the April 1, 1988 work injury, in the form of an internal derangement of her knee. He recommended that the employee undergo arthroscopic surgery to determine the specific nature of the knee problem and to attempt to repair it. On cross-examination, Dr. Litman acknowledged that, except for the finding of knee effusion, the employee's MRI findings were entirely consistent with the objective findings being wholly related to the 1984 knee surgery. Dr. Litman further admitted that it would be an unusual but "not unexpected" consequence following surgery of the kind the employee had in 1984 for effusion to appear in the knee at some later time even absent later trauma. Dr. Litman acknowledged that without the arthroscopic surgery he recommended, he could not determine whether the employee's 1998 work injury caused any permanent injury to the knee, and that it would be difficult to differentiate any new tear that might be found in the ligaments from tearing that "might have been there for . . . many years." (Exh. A3 at 19-22, 25-27, 32.)

A hearing was held before a compensation judge of the Office of Administrative Hearings on March 10, 1989. At the hearing, the employee also requested that the judge make a finding that she requires additional evaluation and treatment by Dr. Holm for her right elbow injury of November 18, 1996. (T. 19-20.) The compensation judge found that the employee had failed to prove by a preponderance of the evidence that the personal injury sustained on April 1, 1998 aggravated the employee's preexisting right knee condition, or that the proposed arthroscopic surgery was reasonable and necessary to cure or relieve the effects of the April 1, 1998 injury. The compensation judge further found that the employee failed to prove a need for further evaluation or treatment of the right elbow through the date of the hearing. The employee appeals.

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

Right Knee Surgery

On appeal, the employee's principal argument is that the evidence supports the conclusion that the arthroscopic procedure proposed by Dr. Litman is medically reasonable to diagnose and treat the employee's right knee condition. The employee cites cases supporting the proposition that diagnostic procedures needed for the evaluation of an injury are compensable. The employee also discusses in some detail the opinions of those physicians who did not consider surgery to be needed for the employee's condition, and gives arguments why these views should not prevail.

The issue central to this appeal, however, is not whether the proposed surgery may be a reasonable approach to the evaluation and treatment of the employee's knee condition, but rather whether the 1998 work injury was a substantial contributing cause of the condition for which the surgery has been proposed. Accepting the opinion of Dr. Wicklund, the compensation judge found that the employee's ongoing right knee problem for which arthroscopic surgery has been proposed was causally unrelated to the effects of the 1998 work injury and instead was the result of the 1984 non-work injury and related knee surgery. (Findings 5, 6; Mem. 6-8.)

The history relied upon by Dr. Wicklund was consistent both with the employee's testimony and with the history demonstrated in the employee's prior medical records. No contention is made by the appellant that Dr. Wicklund's opinion was lacking adequate foundation, and we see no foundational defect. Although Dr. Litman attributed the employee's current knee symptoms to an internal derangement, the specifics of which are unknown, and opined that the employee's stated history of symptoms supported a likelihood that the 1998 work injury was a substantial contributing cause of aggravating the employee's preexisting knee condition, we note that Dr. Litman admitted that it was possible, though in his view less likely, that the objective findings relating to the employee's knee condition were entirely the result of the prior injury and surgery. We cannot say that the judge clearly erred in accepting the opinion of Dr. Wicklund, and this court must affirm the compensation judge's choice between the divergent opinions of medical experts unless the opinion relied upon was without adequate foundation. Nord v. City of Cook, 360 N.W.2d 337, 37 W.C.D. 364 (Minn. 1985).

Need for Treatment to the Right Elbow

The sole evidence offered by the employee to support her claim that further treatment was currently needed for the right elbow was her own testimony that the surgery helped her arm "for a while, but now it's starting to bother me again," and that she was "still having a lot of pain shooting up through the elbow again." (T. 93, 122.) The employee offered no specific testimony concerning the frequency and level of her pain or whether her symptoms had significantly worsened since she last saw Dr. Holm on May 1, 1998. At that examination she displayed full range of motion and grip strength on the right close to that shown on the left, and on which date Dr. Holm released her to work with no restrictions related to the right arm and

elbow. Further treatment at that time was for recheck "if needed." (Exh. A9: 5/1/98.) The employee did not testify that her elbow condition affected her ability to function in either her personal or work activities. Given the lack of specificity in the employee's testimony, and the resolution of treatment suggested by the prior medical records, the compensation judge did not commit clear error in finding that the employee had failed to demonstrate that she had required further evaluation and treatment for her right elbow through the date of hearing.

We note that the compensation judge's finding in no way precludes the employee from seeking treatment for the right elbow as her condition may warrant subsequent to the date of hearing.