HARLAN D. CHISHOLM, Employee/Appellant, v. CHISHOLM CONSTR. and MID-CENTURY INS. CO., Employer-Insurer, and TWIN CITY BRICKLAYERS H&W FUND and BRAINERD MED. CTR., Intervenors.

WORKERS' COMPENSATION COURT OF APPEALS
JUNE 7, 2000

No. [REDACTED SSN]

HEADNOTES

CAUSATION - SUBSTANTIAL EVIDENCE. Substantial evidence, including expert medical testimony, supports the compensation judge's finding that the employee's 1997 work injury was not causally related to the employee's dissection of right and left vertebral arteries and resulting need for medical treatment.

PERMANENT PARTIAL DISABILITY - SUBSTANTIAL EVIDENCE. Substantial evidence supports the compensation judge's finding that the employee has no rateable permanent partial disability attributable to the employee's 1997 work injury.

CAUSATION - TEMPORARY AGGRAVATION. Substantial evidence supports the compensation judge's finding that the employee's 1998 work injury to his low back was a temporary strain of his pre-existing condition.

Affirmed.

Determined by: Rykken, J., Johnson, J., and Wheeler, C.J.
Compensation Judge: Carol A. Eckersen

OPINION

The employee appeals from the compensation judge's findings determining the nature of the employee's injuries on May 29, 1997 and April 8, 1998, from the compensation judge's determination that the employee did not provide timely notice of his 1997 injury, and from the denial of the employee's claims for temporary total, temporary partial and permanent total disability benefits, as well as denial of claimed payment of medical bills. We affirm.

BACKGROUND

On May 29, 1997, Mr. Harlan Chisholm, the employee, was employed by Chisholm Construction, the employer, insured on that date by Mid-Century Insurance Company, insurer. Born on October 14, 1941, the employee was 55 years old at the time of his injury and earned an average weekly wage of $800.00. On that date, the employee was working as a bricklayer on a construction project at a Burger King restaurant location. He was struck in the back of the head by a large roll of waterproofing plastic film being carried on the shoulder of a coworker. The employee fell flat on his face when hit, and, according to testimony by a coworker, Sean Kenow,

laid on the ground for five minutes in a dazed condition. Thereafter, coworkers assisted the employee with getting up, and helped him to walk to the tailgate of a truck, where he sat for at least a portion of the remaining day. The employee was disoriented after this incident, and it is disputed as to whether he was able to work at all for the remainder of the day. The employee had a headache after this incident, but did not seek immediate medical attention. He continued to work at his regular duties in the weeks following this injury, but, according to the employee and his coworker, Mr. Kenow, the employee had difficulty focusing to read sight lines in measurement equipment, a task he previously performed. Following the May 1997 incident, the employee's coworkers, wife and son also noticed that the employee reported dizzy spells, blurred vision, disorientation, headaches and decreased energy; that he rested during work hours; and that he frequently forgot to bring needed supplies or equipment to the work site, all of which were newly-developed behavior and symptoms after the May 1997 incident.

The employee continued to work as a bricklayer for Chisholm Construction until July 5, 1997, and worked for Johnson-Nelson Masonry from July 6-25, 1997. The employee testified that he left his job at Johnson-Nelson due to lightheadedness and dizziness he experienced while working on scaffolds. The employee returned to work for Chisholm Construction from July 27, 1997 through June 19, 1998.

On July 14, 1997, the employee reported to the emergency room at St. Joseph's Hospital in Brainerd, Minnesota for nose bleeds, which he had experienced for a few days. He did not report the May 29, 1997 incident or any work injury to the emergency room staff. On August 12, 1997, he again treated at the emergency room with a cough and runny nose, diagnosed as allergic sinusitis. Three days later, on August 15, 1997, Mr. Chisholm reported to the emergency room with dizziness, lightheadedness, headache and weakness. He was diagnosed with peripheral vertigo or sinusitis. Two days later, he returned to the emergency room with the same complaints; examining doctors there felt he was having atypical spells or panic attacks.

The employee had received previous treatment at the Mayo Clinic, prior to the May 1997 incident, and again consulted the Mayo Clinic by telephone on August 23, 1997, reporting neck pain, headaches, fatigue, weakness, blurred vision and diaphoresis associated with headaches. He was diagnosed as having symptoms compatible with viral encephalitis. Dr. Munger approved a temporary increase in Paxil, an antidepressant medication first prescribed for the employee in May 1996. On September 22, 1997, the employee returned to the Mayo Clinic, with similar complaints. He underwent a transcranial Doppler study, which indicated elevated velocities on the left. The employee was prescribed Coumadin, an anticoagulant medication. On October 5, 1997, Dr. Jimmy R. Fulgham, Department of Neurology, Mayo Clinic, began treating the employee, who reported multiple episodes of gait unsteadiness, right arm weakness and circumoral paresthesias (prickling or tingling sensation near the mouth). An October 6, 1997 angiography of the carotid arteries, left vertebral basilar and indirect right vertebral arteries showed arterial sclerotic cerebral vascular disease. Dr. Fulgham diagnosed the employee as having 50 to 65 percent arterial stenosis in the level of the dural insertion. Further findings led Dr. Fulgham to diagnose small vessel atherosclerotic disease within the posterior fossa intracranial circulation. Dr. Fulgham explained that this bilateral vertebral artery disease was due to a dissection or tear in

the artery as opposed to atherosclerosis being the underlying cause. (Fulgham Depo., Pet. Ex. I, p. 7, 11.)

The employee underwent an MRI and MR angiography on December 22, 1997, which showed essentially no change in the right vertebral artery with continued high grade stenosis. On December 23, 1997, Dr. Fulgham examined the employee, who reported blurred vision and unsteadiness. Dr. Fulgham recommended continued anticoagulant medication. On February 17, 1998, the employee reported to Dr. Dale G. Hadland, Brainerd Medical Center, that he had sustained a work injury five or six months ago while working at Hardee's.[1]

On April 8, 1998, the employee fell approximately five to six feet from a scaffolding ladder, while working for Chisholm Construction. On that date, he earned an average weekly wage of $1,000.00. He landed on his low back and right side, and noted pain in his low back, right side and right leg. The employee did not recall how he fell, and does not recall slipping or falling. He landed on his back, and found himself on the ground, which led him to the conclusion that he had an attack similar to ones he had experienced while working during the Burger King construction project, where, from time to time, he would suddenly fall to the ground. He noted increased low back pain, and consulted Dr. Hadland on April 15, 1998, who diagnosed an acute low back strain. Dr. Hadland recommended bed rest, and restricted the employee from working until April 29, 1998.

The employee returned to his job at Chisholm Construction. In June 1998, the employee discontinued work, as he was experiencing increasing difficulties performing his regular job duties as a bricklayer, and even experienced difficulties trying to perform lighter jobs. The employee continued to treat at the Mayo Clinic. On June 1, 1998, the employee reported to Dr. Thomas Munger that six weeks after he had been hit on the back of the head, he began to notice TIA (transient ischemic attack) symptoms. Dr. Munger noted that the September 1997 Doppler study suggested arterial stenosis which was a new finding as compared to studies done in March 1996. The employee also consulted Dr. Fulgham on June 1, 1998, and again reported the onset of TIA symptoms after his injury. On June 2, 1998, the employee saw Dr. Fulgham for a recheck. On that date, Dr. Fulgham wrote that he suspected the employee had vertebral artery dissections, referring to a normal transcranial Doppler pre-injury, and an abnormal Doppler reading and onset of symptoms post-injury. On June 18, 1998, Dr. Hadland opined that he suspected the employee's work-related injury and his lightheadedness were related. In a report dated August 6, 1998, Dr. Fulgham wrote that it was more likely than not that the "significant head trauma to the posterior neck in May of 1997" resulted in vertebral artery dissection.

As of August 12, 1998, Dr. Hadland determined that the employee was completely disabled from his construction work and recommended that the employee be placed on full disability immediately. On August 21, 1998, Dr. Fulgham again opined that the employee's condition was related to his work-related injury in May 1997 when the employee was struck in the back of the head.

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[1] This reference is apparently to the May 29, 1997, incident at the Burger King construction site.

On November 11 and 12, 1998, the employee underwent a functional capacities evaluation (FCE) with the Spine Rehabilitation Center. The physical therapist who conducted that study, Doug Westrem, reported that Mr. Chisholm was not able to return to work in masonry, due to balance instability and memory loss. Dr. Westrem stated that he did not feel the employee could re-enter the work force in any productive or safe capacity. The employee applied for and was awarded Social Security disability income, with benefits commencing January 1999. In addition to SSDI, the employee receives payments from his private pension policy.

On April 26, 1999, Dr. Hadland wrote that the employee was completely disabled from construction work and bricklaying due to his back and leg condition, due to his "severe neck trauma suffered in May 1997 and a scaffolding fall sustained in April of 1998," and due to the resulting dissection of right and left vertebral arteries and resultant medical treatment. (Pet. Ex. F.)

Dr. Fulgham also wrote that the employee was 100 percent disabled from his work as a mason. In a report dated June 15, 1999, Dr. Fulgham stated that the employee "clearly has unrelenting disequilibrium and vertigo." Dr. Fulgham recommended that the employee avoid carrying heavy loads or working on scaffolding or in high places, and found the employee 100 percent disabled from working as a mason. Dr. Fulgham assigned a rating of 10 percent permanent partial disability of the body as a whole for vestibular loss with vertigo or disequilibrium.[2]

On July 1, 1999, Dr. Stephen R. Bardolph examined the employee. He diagnosed the employee as having subtalar arthritis of the right foot, a fused right ankle and torn medial meniscus in the right knee. He opined the right knee condition could be repaired. He further noted that the employee's subtalar arthritis was not caused by his April 8, 1998, fall from the scaffolding but that the fall aggravated his arthritis. He also opined that any abnormalities in the employee's knees resulted from the fall off the scaffolding. Following an examination on July 22, 1999, Dr. Bardolph stated, in a July 30 report, that he concurred with recommendations from the functional capacities evaluation.

In a deposition taken July 22, 1999, Dr. Fulgham testified that the employee experienced significant trauma in the May 1997 incident. He explained that dizziness and blurred vision are symptoms associated with posterior circulation ischemia. Dr. Fulgham testified that he did not find the employee's delay in seeking medical treatment following that incident to be significant. Dr. Fulgham opined that the employee is disabled in view of the type of work he performed and also because he is on an anticoagulant medication (Pet. Ex. I.)

The employee has a significant pre-existing medical history. He was involved in a motor vehicle accident in 1959, during which he struck his head on the windshield and reportedly sustained a concussion. In 1966, he was involved in a second motor vehicle accident, during which he broke his femur, crushed his right ankle and injured his abdomen. He was hospitalized in

[2] Dr. Fulgham's letter dated June 15, 1999, does not refer to a specific Rule but cites "subpart 5, section A of the Central Nervous System Disability." That language is included in Minn. R. 5223.0360, subp. 5.A, effective July 1, 1993.

traction for 93 days post-injury, but eventually was able to return to work as a bricklayer following recovery from that accident. In 1979, the employee was involved in a third motor vehicle accident, for which he was treated for headaches, neck and shoulder pain. He underwent a cervical fusion surgery in April 1980, due to traumatic arthrosis at the C3-4 level. In 1980, the employee was involved in a fourth motor vehicle accident, which caused a low back and right ankle injury. He underwent right ankle fusion surgery in March 1984. The employee was unable to return to bricklaying work until approximately 1985 as a result of injuries from his 1980 motor vehicle accident.

As early as 1981, the employee was examined following an episode of difficulty breathing, at which time he underwent a pulmonary workup. In 1988 or 1989, the employee sustained an injury to his low back when 18 to 20 panels of Sheetrock tipped and fell on him, striking him from behind and knocking him to the floor; he was pinned down from his knees downward, and noted pain between his shoulder blades. In 1989, the employee sustained an admitted work-related injury in the nature of a hernia after lifting some scaffolding at work. In 1989, he was treated at the Mayo Clinic for rapid heart beat, and was seen in 1990 for chest pain, along with pain and tightness in his throat. His physicians' concluding diagnosis at that time was that of a stress-related psychosomatization disorder with atypical chest and neck discomfort, along with borderline hypertension.

Since 1990, the employee has reported various symptoms including dyspnea, sweating, a lump in his throat, a numbness occurring three to four times per week, episodes of lightheadedness associated with sweats, and headaches. In 1995, the employee reported lightheadedness and chest pain. In April 1996, the employee underwent a comprehensive evaluation at Mayo Clinic for lightheadedness, weakness, sweats and tachycardia sensations. A neurologist ruled out a seizure disorder and vertebral basilar ischemia. By May 1996, Dr. Munger diagnosed paroxysmal supraventricular tachycardia, a nonmalignant mediastinal mass, asbestos related pleural disease, and anxiety. Dr. Thomas Munger diagnosed Paxil as well as Klonopin, a medication to treat panic and seizure disorder. The employee continues to take Paxil; Klonopin was discontinued in September 1996.

By history, the employee was a Golden Gloves boxer while a sophomore in high school, and did not wear any headgear but only participated in approximately four bouts and claims to have had no head injuries nor sustained any concussions while boxing.

At the request of the employer and insurer, the employee underwent an examination with Dr. Bruce Van Dyne on December 9, 1998. In summary, Dr. Van Dyne diagnosed the following:

> 1. Work-related incident of May 29, 1997, which appears to have resulted in a rather minor closed head injury with no symptoms suggestive of cerebral concussion or transient neurological deficit.
> 2. Atherosclerotic cerebral vascular disease.

3. Past history of many years' of multiple spells likely related to possible episodes of tachyarrhythmia along with a history of episodes that possibly were related to panic-like attacks with hyperventilation and anxiety.
4. Reported chronic neck pain most likely related to mechanical neck syndrome due to age-related degenerative disc disease, superimposed upon previous posterior cervical fusion at the C3-4 level in 1980, and possible chronic tension myalgia syndrome (all unrelated to the employee's May 29, 1997 work incident).
5. Recent work-related incident in April, 1998, that may very well have been secondary to a brief syncopal episode that was possibly cardiogenic in origin.
6. Demonstrated areas of encephalomalacia, as far back as 1996, of unknown etiology, perhaps related to cerebral vascular disease, or significant head injury and brain trauma in the past, possibly related to previous motor vehicle accident or history of boxing as a teenager.
7. Intermittent headaches which may represent late-life onset migraine.

(Resp. Ex. 1.)

It is Dr. Van Dyne's opinion that the sole injury sustained by the employee as a result of his May 29, 1997 work incident was a very minor closed head injury with no significant cerebral concussion or any other neurologic injury. Dr. Van Dyne found no causal relationship between that injury and the employee's later paroxysmal spells. The basis for Dr. Van Dyne's opinion is that the employee returned to work immediately after the incident without any neurologic symptoms, and continued to work for the next two and a half months "during which time he was completely asymptomatic with respect to any neurologic symptoms." (Resp. Ex. 1.) By contrast, however, the employee's family and coworkers detected symptoms and behavioral changes immediately following the May 1997 incident.

Dr. Van Dyne further explained that had the injury of May 1997 resulted in a vertebral artery dissection, he would have expected the employee to have noted either immediate onset of symptoms or within one to two days. Dr. Van Dyne did not find the changes between the 1996 and 1997 transcranial Doppler studies to be dispositive of injury-related changes.

Dr. Van Dyne determined that the employee had reached maximum medical improvement from his May 29, 1997 work incident, at least as of the examination of December 9, 1998, that the employee had a completely normal neurologic examination with no residual neurologic deficit related to that incident, and that he had no rateable permanent partial disability as a result of that incident. Dr. Van Dyne recommended continuation of anticoagulant therapy, albeit unrelated to the May 1997 injury. Dr. Van Dyne assigned work restrictions of no work on

scaffolding, and no work over heights of three feet, due to the employee's dizzy spells and imbalance. He also stated that the employee was not medically permanently disabled from the active employment market, not even in view of the prescribed anticoagulant medication.

In a follow-up letter dated March 10, 1999, Dr. Van Dyne addressed the employee's April 1998 fall from a scaffolding ladder. Dr. Van Dyne found the cause for that injury to be somewhat unclear, although the sudden occurrence of the episode without warning and without any sustained loss of consciousness or confusion led him to believe that the episode represented a "momentary syncopal episode" most likely on a cardiogenic basis. Dr. Van Dyne referred to the employee's medical records which documented a long-standing history of possible syncopal attacks and near syncope for which he was evaluated in 1996. Dr. Van Dyne further opined that the employee possibly sustained a mild and temporary musculoligamentous lumbar strain, but no cervical strain as a result of that April 1998 incident, and that the employee was not disabled from employment as a result of this incident.

At the request of the employer and insurer, the employee underwent a vocational evaluation with Jan Lowe on January 22, 1999. Ms. Lowe reported that the results from the employee's vocational testing are similar to individuals diagnosed with a learning disability, but found that his strengths were in the areas of math development and mechanical perception. Upon a review of the medical records, Ms. Lowe determined that "[a]n opinion about Mr. Chisholm's employability rests with a medical determination about his capacity for work activity." (Resp. Ex. 2.) Ms. Lowe confirmed that if Drs. Hadland and Fulgham's restrictions were followed, the employee was not released to work in any capacity. She also noted under Dr. Van Dyne's restrictions, the employee would be employable. Ms. Lowe made no further independent determination about the employee's employability from a vocational standpoint, other than her reference to the doctors' opinions on employability.

On October 7, 1998, the employee filed a claim petition, claiming entitlement to temporary total disability and permanent total disability benefits due to a head, neck and back injury on May 29, 1997. On December 1, 1998, the employee filed a rehabilitation request for provision of rehabilitation services, claimed due as a result of a neck injury on May 29, 1997. On January 4, 1999, the employee amended his claim petition to include an injury date of April 8, 1998, claiming rehabilitation services.

The employer and insurer denied primary liability for and notice of an injury on May 1997, and admitted a temporary injury of April 8, 1998. The claims were consolidated and were addressed at hearing held on August 6, 1999. At hearing, the issues were expanded by agreement of the parties, to include claims for temporary partial, temporary total, and permanent total disability benefits; permanent partial disability benefits, rehabilitation services and payment of medical bills and reimbursement of intervention claims.

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). 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, 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

Injury of May 29, 1997

The primary issues addressed at hearing were whether the employee sustained a closed head and neck injury on May 29, 1997, and what was the nature and extent of that injury. The compensation judge determined that the employee did not sustain a closed head and neck injury on May 29, 1997, which caused a dissection of his vertebral arteries. Instead, the compensation judge determined that the employee sustained a minor head trauma. As a result, the compensation judge concluded that the "employee has not shown by a preponderance of the evidence that the work incident of May 29, 1997 was a substantial contributing cause or aggravation of his condition." (Memo, p. 10.) The employee appeals from both findings, claiming that the employee sustained a significant trauma as a result of his May 1997 injury, which caused a dissection of his vertebral arteries.

Where evidence is conflicting or more than one inference may reasonably be drawn from the evidence, the findings of the compensation judge are to be upheld. Redgate v. Sroga's Standard Serv., 421 N.W.2d 729, 734, 40 W.C.D. 948, 957 (Minn. 1988). We note that it is the compensation judge's responsibility, as trier of fact, to resolve conflicts in expert testimony. Nord v. City of Cook, 360 N.W.2d 337, 342, 37 W.C.D. 364, 372 (Minn. 1985).

In her memorandum, the compensation judge specifically stated that she found Dr. Van Dyne's opinions more persuasive. The compensation judge contrasted Dr. Van Dyne's opinions with those of Dr. Fulgham. The compensation judge commented that Dr. Fulgham did not find the employee's delay in seeking medical attention after his May 29, 1997 incident to be significant, and found that opinion inconsistent with Dr. Fulgham's characterization of the incident as a serious trauma. The compensation judge also pointed out the discrepancy between Dr. Fulgham's opinion that this incident had rendered Mr. Chisholm unconscious, as opposed to the employee's testimony that he "saw stars" but did not lose consciousness, even though at his deposition Dr. Fulgham testified that his opinions remained the same whether or not the employee lost consciousness on May 29, 1997. The compensation judge also referred to the employee's

written employment application submitted to Johnson-Nelson Masonry, July 1, 1997, in which he denied that he had sustained any work injuries, had other injuries that resulted in hospitalization, surgery or lost work time, and that he was on any medication.

Dr. Van Dyne concluded that based on various testing, including the employee's transcranial Doppler and MRI scans, the employee's diagnosis was that of arteriosclerotic vascular disease affecting the carotid arteries and 50-65% stenosis of the right vertebral artery. The compensation judge pointed to Dr. Van Dyne's conclusion that based on the results of those studies, and his history of "spells" or similar symptoms, that the employee's condition was due to atherosclerotic cerebral vascular disease, and not due to a traumatic work injury.

The compensation judge also relies upon Dr. Van Dyne's opinions concerning the employee's disability status. Whereas the treating physicians, Drs. Hadland and Fulgham, both found the employee to be totally disabled from working, Dr. Van Dyne recommended minimal physical work restrictions. The compensation judge found Dr. Van Dyne's opinion that the employee is not medically permanently disabled from employment as being credible and persuasive.

The employee relies on the opinions of Drs. Hadland and Fulgham, and also on the opinion of the physical therapist who conducted the physical capacities evaluation, who concluded that the employee was not likely to reenter the work setting in any productive or safe capacity. The compensation judge determined that the FCE form shows that the employee has some physical abilities, and that the "determination of whether the employee could find work within his abilities as a vocational not medical one." (Memo at 11.) The employer's vocational expert, Jan Lowe, conducted vocational tests on the employee and reviewed his medical records, and determined that an opinion about the employee's employability rests with a medical determination about his capacity for work activity. Her opinion points out the various, conflicting medical opinions in this matter.

After thorough review of the record, we must acknowledge that this is a close case. However, we note that there is substantial evidence in the record to support the compensation judge's findings. On the dispositive issue in the case, medical causation, the compensation judge accepted Dr. Van Dyne's opinion. Questions of medical causation fall within the province of the compensation judge. Felton v. Anton Chevrolet, 513 N.W.2d 457, 50 W.C.D. 181 (Minn. 1984). The compensation judge's conclusion that the medical records do not establish the requisite causal connection is adequately supported by the evidence. See Hengemuhle, 358 N.W.2d at 59, 37 W.C.D. at 239. In addition, since the compensation judge finds Dr. Van Dyne's opinion to be more persuasive, and since it is within the compensation judge's responsibility, as trier of fact, to resolve conflicts in expert testimony, Nord v. City of Cook, 360 N.W.2d at 342, we must affirm.

The compensation judge also determined that the employee is not entitled to payment of medical bills incurred after the employee's May 29, 1997 injury, as the medical care and treatment was not causally related to that injury. Since we have affirmed the compensation judge's determination concerning the nature of that injury as being a minor head trauma as opposed

to the claimed closed head and neck injury resulting in a dissection of his vertebral arteries, we affirm the compensation judge's denial of the employee's and intervenors' claims for payment of medical expenses related to the employee's May 29, 1997 injury.

Injury of April 8, 1998

The compensation judge determined that the employee sustained a mild temporary musculoligamentous lumber strain on April 8, 1998, which was a temporary strain of his preexisting low back condition. Dr. Van Dyne testified that he believed that the employee's back complaints resulting from his temporary strain did not prevent the employee from being gainfully employed. Dr. Van Dyne also determined that the employee reached maximum medical improvement from both his 1997 and 1998 injuries by December 18, 1998. The compensation judge relied upon the medical opinion and testimony of Dr. Van Dyne in concluding that the employee's April 8, 1998, injury caused a temporary strain, and in denying the employee's claim for any temporary disability benefits claimed as a result of that injury. As it is within the compensation judge's responsibility to resolve conflicts in expert testimony, Nord v. City of Cook, 360 N.W.2d at 342, we also affirm the compensation judge's determination that the employee's April 8, 1998, injury resulted in only a temporary aggravation of the employee's preexisting condition, and affirm the compensation judge's denial of any temporary or permanent total disability benefits flowing therefrom.

The employee also appealed from the compensation judge's denial of reimbursement to an intervenor, Twin City Bricklayers Health and Welfare Fund, for $689.58 claimed as a result of the April 8, 1998 injury. That denial was based upon the claim not being filed in a timely manner. Whereas that intervenor timely filed a claim for other medical expenses paid as a result of the employee's May 29, 1997, injury, this additional portion of $689.58 was not claimed until the day of hearing. The employee also appealed from the compensation judge's denial of Brainerd Medical Center's intervention claim for reimbursement of expenses pursuant to Spaeth v. Cold Spring Granite, 560 N.W.2d 92, 56 W.C.D. 136 (Minn. 1997). Since the employee did not address these issues in his brief on appeal, the employee's appeal of these issues is deemed waived, and the compensation judge's denial is affirmed.[3]

Additional Claims

The employee also appealed from the compensation judge's determination that the employee did not give timely notice of the injury, that he voluntarily withdrew from the labor market, that he reached maximum medical improvement on December 16, 1998, and that he has not diligently sought work. We have made no determination on those issues, in view of our affirmance of the compensation judge's denial of the employee's temporary total, temporary partial and permanent total disability benefits based on lack of causal relationship.

[3] Pursuant to Minn. R. 9800.0900, Subp. 1, "[i]ssues raised in the notice of appeal but not addressed in the brief shall be deemed waived and will not be decided by the court."