RICK FIECKE, Employee, v. MADISON CAP. PARTNERS/PAWNEE ROTATIONAL MOLDING CO. and FIREMAN'S FUND INS. CO., Employer-Insurer/Appellants.

WORKERS' COMPENSATION COURT OF APPEALS
JUNE 28, 2000

No. [REDACTED SSN]

HEADNOTES

MEDICAL TREATMENT & EXPENSE - CHANGE OF PHYSICIAN. Substantial evidence supports the compensation judge's approval of a change of physician from Dr. Dick to Dr. Smith based on the employee's loss of confidence in Dr. Dick, his lack of improvement, and evidence of communication problems between the employee and Dr. Dick.

TEMPORARY TOTAL DISABILITY - SUBSTANTIAL EVIDENCE. Substantial evidence, including the opinions of the employee's family physician, Dr. Jacobson, and his current treating physician, Dr. Smith, taking the employee off work, supports the compensation judge's award of temporary total disability benefits after September 10, 1999.

Affirmed.

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

OPINION

THOMAS L. JOHNSON, Judge

The employer and insurer appeal the compensation judge's order permitting the employee to change physicians, and her finding that the employee was entitled to temporary total disability benefits from and after September 10, 1999. We affirm.

BACKGROUND

Rick Fiecke, the employee, sustained an admitted personal injury to his cervical spine and left shoulder on August 4, 1997, in the course and scope of his employment with Madison Capitol Partners/Pawnee Rotational Molding Company, the employer. The employer was insured for workers' compensation purposes by Fireman's Fund Insurance Company.

The employee continued to work following the injury, but sought medical treatment at the Maple Plain Clinic when his symptoms progressively worsened over the next several days. A left shoulder strain was diagnosed. The employee was given work restrictions and referred for physical therapy. When he did not improve, the employee was referred to Dr. D. Daniel Rotenberg, an orthopedist, who saw the employee on November 12, 1997 and January 7, 1998.

Dr. Rotenberg diagnosed rotator cuff tendinitis and a rhomboid strain and referred the employee for additional physical therapy.

On January 16, 1998, the employee returned to the Maple Plain Clinic, reporting increasing left arm pain. The doctor diagnosed overuse syndrome, but stated he could not rule out a cervical disc. The employee then saw Dr. Alan Markman for a second opinion on January 20, 1998. The employee reported little progress with physical therapy, and complained of pain at the base of his neck, left arm weakness and numbness or tingling in his fingers. Dr. Markman diagnosed a possible cervical strain and recommended some changes in the employee's physical therapy program.

When the employee did not improve, he was referred to Dr. Jeffrey Dick, an orthopedic surgeon, who first examined the employee on February 25, 1998. The doctor noted a six month history of left neck, shoulder and arm symptoms following the work injury. Dr. Dick diagnosed a probable left-sided radiculitis at C7, referred the employee for an MRI scan, and took the employee off work for the next two weeks. The cervical scan, taken March 5, 1998, revealed a large, left-sided disc herniation at C5-6. Dr. Dick recommended an anterior cervical discectomy and fusion with instrumentation at C5-6. The employee agreed to the surgery, and the operation was performed on April 7, 1998.

The employee was seen by Dr. Dick, following the surgery, on May 14, 1998. He appeared to be doing well and the doctor released him to return to light-duty work with restrictions. The employer provided work within the employee's restrictions and he returned to full time work with the employer. On July 1, 1998, the employee returned to Dr. Dick reporting left shoulder and arm symptoms different from his pre-surgery symptoms. He stated the arm fatigued easily, which he noticed at work, and his symptoms were worse at night causing significant difficulty sleeping. Dr. Dick referred the employee for physical therapy, twice a week for a month, but did not change his work restrictions. Following completion of physical therapy, the employee returned to Dr. Dick, on August 5, 1998, reporting some improvement, but continuing left shoulder and arm pain which was, at times, quite bothersome at night. Dr. Dick continued physical therapy, prescribed medication to help sleep, and released the employee to return to work without restrictions.

On September 28, 1998, the employee was seen by his family physician, Dr. Dennis Jacobson, complaining of significant neck pain, for which Dr. Jacobson prescribed pain medication. The employee was seen two days later by Dr. Dick, again reporting recent significant neck pain with occasional radiating symptoms into his arms. The employee stated he had been off work that week and felt somewhat better having been off work. X-rays showed some lucency in the bone graft, and Dr. Dick was concerned that the employee might be developing a pseudoarthrosis. On October 16, 1998, Dr. Dick noted the employee continued to have a significant amount of problems with neck and arm pain and symptoms. The employee reported he had attempted to return to work for one day, but his symptoms increased and he had been off work since that time. Dr. Dick observed the employee was "quite exacerbated with his lack of progress." (Pet. Ex. C, Resp. Ex. 1: 10/16/98.) The doctor referred the employee for a repeat MRI

scan and an EMG of the upper extremities. The employee was taken off work until the studies were completed.

The employee returned to Dr. Dick on November 25, 1998. The MRI scan, taken October 22, 1998, showed no significant change from the prior scan. The EMG was consistent with a mild C5-6 radiculopathy which Dr. Dick did not believe correlated with the employee's symptoms. Concluding the only finding that might correlate with the employee's symptoms was a small annular tear at C6-7, the doctor referred the employee for a discogram at that level. At the request of the employer's case manager, Dr. Dick also completed a physical capacities form releasing the employee to return to full time work as of November 25, 1998, with restrictions of no driving more than 30 to 60 minutes, no lifting over 10 to 20 pounds occasionally, only occasional bending, squatting, reaching, twisting and rotating, no kneeling or climbing, and avoid static positioning of the head and neck, changing positions every 15 minutes. The employee again returned to work with the employer.

On February 10, 1999, the employee reported to Dr. Dick that the pain from the discogram was minimal and did not reproduce his current pain complaints. His neck and arm symptoms remained unchanged. Dr. Dick concluded the employee most likely had a delayed union at C5-6 and recommended a bone growth stimulator for the fusion. The doctor took the employee off work "as he has been unable to even return to the lightest duty work," and requested the employee to return in three months. (Pet. Ex. C, Resp. Ex. 1: 2/10/99.) At the follow-up visit on May 19, 1999, the employee reported a recent increase in his shoulder and arm symptoms with bilateral neck pain and numbness radiating down the left arm. He continued to have difficulty sleeping secondary to the pain. Dr. Dick noted the employee "has had no real improvement in his preoperative pain and has had chronic problems since that time." (Pet. Ex. C, Resp. Ex. 1: 5/19/99.) The doctor noted the employee's full cervical spine work up did not really explain the symptoms he was having, and referred the employee for an MRI scan of the left shoulder "to rule out any pathology there." (Id.) The doctor discussed the employee's diagnosis and treatment with the employee and his girlfriend, noting the insurance company informed him the employee was attending technical college, apparently without difficulty. Dr. Dick observed the employee's reported inability to tolerate light-duty work coupled with his ability to attend college "put me in an awkward position with the insurance company and it is difficult to understand how he can do one, but not the other." (Id.) The employee stated he was willing to try a return to work, and Dr. Dick released the employee to return to work on May 24, 1999, with restrictions of no lifting over 10 pounds and frequent position changes, beginning with four hours a day for two weeks, progressing to six hours a day for two weeks, and then eight hours a day. The employee returned to work, but did not increase beyond 20 to 25 hours a week, instead voluntarily requesting part-time status, testifying that going to school and working full time became "too much of a load." (T. 30-31.)

The employee was next seen by Dr. Dick on June 30, 1999. He continued to have a significant amount of pain that remained unchanged from his previous visits. The employee reported many nights without sleep due to his pain, missing work the following day. Dr. Dick refused to change the employee's work restrictions or give him off work slips due to his sleep

problems. However, the MRI scan of the left shoulder revealed significant abnormalities, and Dr. Dick therefore referred the employee to Dr. Carlos Guanche for evaluation and treatment of the left shoulder.

Dr. Guanche saw the employee on July 7, 1999. After examination and review of the MRI scan, Dr. Guanche recommended arthroscopic surgery on the shoulder. The operation, performed on August 2, 1999, revealed acromioclavicular (AC) joint arthritis, impingement of the left shoulder and a glenoid labral cyst with significant fraying of the glenoid labrum. The rotator cuff was normal. In a follow-up examination on August 11, 1999, the employee reported mild pain anteriorly. Active motion was improved, and he had some resolving ecchymosis. Dr. Guanche referred the employee for physical therapy two times a week for six weeks, and advised the employee to increase activities as tolerated. He released the employee to return to work on August 16, 1999, with no lifting over 10 pounds, no above-shoulder use, no repetitive use, and no outstretched reaching. The employee did return to work as scheduled, but again voluntarily requested part-time status.

The employee testified his symptoms increased substantially over Labor Day weekend 1999. He returned to see Dr. Dick on September 8, 1999, reporting a marked increase in neck pain with continuing numbness in the left arm. Dr. Dick again surmised the employee's symptoms might be related to a pseudoarthrosis, although he believed it unlikely since the fusion at C5-6 appeared solid in x-rays. Dr. Dick's notes indicate he wanted to wait until the employee fully recovered from his shoulder surgery before proceeding with further diagnostic procedures such as a high-resolution CT scan or discogram at the adjacent levels. He believed the employee's restrictions were reasonable and saw no reason why the employee should not continue working as he was. The employee was frustrated and upset, and Dr. Dick recommended he obtain a second opinion, providing the names of three orthopedic surgeons to him.

The employee testified he attempted to return to work the next day, but was able to work only an hour and twenty minutes to an hour and a half before the burning and aching in his neck increased to the point that he could no longer continue working. The following day, September 10, 1999, the employee was seen by his family physician, Dr. Jacobson. The employee reported that Dr. Dick did not think he could do anything more for him and had suggested a second opinion. Dr. Jacobson agreed a second opinion was a good idea, and recommended he see a neurosurgeon, Dr. Andrew Smith. Dr. Jacobson prescribed pain medication, and took the employee off work until the neck problem was resolved.

The employee was seen by Dr. Smith on October 22, 1999. Dr. Smith noted the employee's work up since the surgery appeared to show a solid fusion at C5-C6. He observed no findings consistent with a C6 radiculopathy, and diagnosed a chronic cervical sprain syndrome. Dr. Smith recommended the employee see Dr. Ryken, a physiatrist in the same clinic, or some other physical medicine specialist, for consideration of non-surgical treatments such as acupuncture, cortisone injections, motor point blocks, prolotherapy, exercise therapy or others, stating "I think that that has a good or better a chance of helping his current problem than attempts at further discography, surgery at other levels and so forth." (Pet. Ex. D.) He continued the

employee off work until he was seen by a physiatrist and was given a release to return to work by the physiatrist.

On October 14, 1999, the employee filed an "Objection to Discontinuance" seeking temporary total disability benefits from and after September 10, 1999. The employee amended his request on November 24, 1999, seeking approval of a change of physicians from Dr. Dick to Dr. Smith. Following a hearing on January 11, 2000, a compensation judge at the Office of Administrative Hearings issued a findings and order, on January 25, 2000, finding the employee had established a reasonable basis to change physicians from Dr. Dick to Dr. Smith, and that the employee was temporarily totally disabled from September 10, 1999 through the date of hearing. The employer and insurer appeal.

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

1. Change of Physicians

The employer and insurer appeal from the compensation judge's approval of a change of physicians from Dr. Dick to Dr. Smith. They argue the approval contravenes Minn. R. 5221.0430, subp. 4.A. (1993), providing that a compensation judge may not approve a request to change physicians where "a significant reason underlying the request" is "to avoid acting on the provider's opinion concerning the employee's ability to return to work." The employer and insurer contend a fair reading of the evidence requires the conclusion that the sole reason for the employee's request to change from Dr. Dick to Dr. Smith is because Dr. Dick would not take the employee off work and Dr. Smith would allow the employee to remain off work indefinitely. We do not agree.

As a general rule, employees have been afforded great latitude in choosing and changing physicians. See Maronde v. Robert Carr Constr. Co., 306 Minn. 529, 235 N.W.2d 207, 28 W.C.D. 129 (1975). Loss of confidence in a doctor's ability to effectively treat the employee, lack of improvement in the employee's condition, and a breakdown in communication have been accepted as reasonable grounds for a change of physicians. See, e.g., Roland v. Search Resources,

slip op. (W.C.C.A. Nov. 23, 1998); Olson v. Quality Pork, slip op. (Nov. 21, 1996); Stucky v. Crystal Cabinet Works, slip op. (W.C.C.A. May 1, 1996); Jarshaw v. United Parcel Serv., slip op. (W.C.C.A. May 4, 1994). Whether a change of physicians should be permitted is a question of fact for the compensation judge and remains, as under prior case law, a question of reasonableness under the circumstances peculiar to each case. Id.

Here, the compensation judge found the employee had lost confidence in Dr. Dick following a long-delayed recovery, and a communication breakdown occurred. There is substantial evidence in the record to support the judge's findings. The employee received treatment from Dr. Dick, an orthopedic surgeon, from February 25, 1998 through September 8, 1999. Dr. Dick's records reflect no real improvement in the employee's chronic neck, shoulder and arm pain despite two surgeries. By October 16, 1998, Dr. Dick noted the employee was "quite exacerbated with his lack of progress." (Pet. Ex. C, Resp. Ex. 1: 10/16/99.) On July 23, 1999, Dr. Jacobson indicated the employee was "having trouble with Dr. Dick and getting adequate follow-up of this problem." (Pet. Ex. B: 7/23/99.) Finally, on September 8, 1999, Dr. Dick suggested a second opinion. The employee, not unreasonably, sought a referral from his family physician who referred him to Dr. Smith. Dr. Smith recommended a non-surgical approach to treatment. In so doing, he took the employee off work until he was able to meet with a physiatrist and the physiatrist had made recommendations regarding the employee's return to work.

The compensation judge found the testimony of the employee and his girlfriend credible, and concluded the employee was not seeking to avoid a return to work, but reasonably sought treatment from another doctor given his lack of improvement and his difficulty communicating with Dr. Dick. It is the provenance of the compensation judge to assess witness credibility, and this court may not reverse a finding based on credibility absent a clear error on the part of the compensation judge. Even v. Kraft, Inc., 445 N.W.2d 831, 42 W.C.D. 220 (Minn. 1989). While different inferences could be drawn from the evidence, we cannot say the compensation judge's conclusions are manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole.

The employer and insurer further argue that Dr. Smith, a neurosurgeon, should not have been approved as the employee's treating physician because he has nothing personally to offer the employee, instead recommending treatment by a physiatrist. Under Minn. R. 5221.0430, the "primary health care provider" is responsible for "directing and coordinating medical care to the employee." The provider need not, and often does not, provide treatment him or herself, but may refer the employee to another health care provider, such as a physical therapist, surgeon, or physiatrist as appropriate. The employee testified he wanted to continue treating with Dr. Smith because he was "willing to deal with the pain" and had alternative ideas for treatment. (T. 54.) We do not believe, under the circumstances in this case, that the compensation judge erred in approving a change of physicians to Dr. Smith. We, therefore, affirm.

2. Temporary Total Disability

The compensation judge found the employee had not been released to return to work by his current treating physician, Dr. Smith, and was temporarily totally disabled from and after September 10, 1999. The employer and insurer argue that the opinions of Dr. Jacobson and Dr. Smith lack adequate foundation and were improperly relied upon by the compensation judge. We are not persuaded. Dr. Jacobson was the employee's family physician and was familiar with the employee's work-related injury and treatment. Dr. Jacobson completed the pre-operation history and physical for both of the employee's surgeries, and had treated the employee on several occasions for his neck and shoulder pain. He took the employee off work based on the employee's continuing neck pain. Dr. Smith conducted an initial evaluation, taking a history of the employee's injury and his employment, as well as performing a physical examination. He was clearly aware of at least some of the employee's previous treatment for his neck, shoulder and arm condition. Based on his examination, he concluded the employee was "completely disabled" and unable to work "[f]or the time being," at least until he had seen a physiatrist and was cleared to return to work by the physiatrist. (Pet. Ex. D.) There is at least minimally adequate foundation for their opinions, and the compensation judge did not clearly err in relying on their determinations that the employee was unable to work after September 10, 1999.

The employer and insurer argue, however, the employee was not entitled to temporary total disability benefits because he was attending school and had voluntarily chosen to work a part-time schedule after May 1999, citing Le v. State, University of Minnesota, 330 N.W.2d 453, 35 W.C.D. 665 (Minn. l983). In Le, the supreme court reversed an award of temporary *partial* disability benefits where the employee, who was *not* totally disabled by his work injury, had elected instead to attend a training course in electronics. The court specifically emphasized that Le could have returned to work, and there was no medical or other evidence that Le was prevented by his condition from returning to work.

The employee, here, began attending vocational school in 1997, prior to his work injury. (T. 30.) After the work injury, he continued to work full time, when released to do so, and attend school until June 1999, when he requested part-time work explaining that working full time and attending school had become "too much of a load." (T. 30-31.) The employee made no claim for temporary partial disability benefits for the periods in which he voluntarily elected to work part-time. After September 10, 1999, however, the employee was taken off work by Dr. Jacobson and Dr. Smith, and was totally unable to work as a result of his work injury. There is nothing in the workers' compensation act or case law that would make the employee ineligible for temporary total disability benefits under these circumstances. We, accordingly, affirm.