RICHARD FOX, Employee, v. MINNEAPOLIS PARK AND RECREATION BD., SELF-INSURED/BERKLEY ADM'RS, Employer/Appellant, and HEALTHPARTNERS, INC., Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
APRIL 12, 2000

No. [REDACTED SSN]

HEADNOTES

TEMPORARY TOTAL DISABILITY - SUBSTANTIAL EVIDENCE. Substantial evidence supports the compensation judge's finding that the employee was entitled to temporary total disability from May 9, 1998 through 90 days post MMI where the employee was medically unable to continue working as a result of his 1989 low back injury, the employee cooperated with rehabilitation, and was diligently seeking work through the rehabilitation process in an attempt to return to work with the employer.

CAUSATION; PRACTICE & PROCEDURE - REMAND. Where the compensation judge's findings are inconsistent with statements in her memorandum referring to a doctor's opinions regarding a left shoulder injury and the foundation for his opinions, remand is necessary for reconsideration of the employee's claim for a left shoulder injury.

MEDICAL TREATMENT & EXPENSE - SUBSTANTIAL EVIDENCE. Substantial evidence supports the compensation judge's denial of a second surgical opinion and treatment at Physician's Neck and Back Clinic where the doctor who originally recommended this treatment changed his opinion.

EVIDENCE - ADMISSION. The admission of a doctor's report into evidence was within the compensation judge's discretion where the doctor testified that he destroyed the notes he took during the employee's examination after making his report where the compensation judge considered any prejudice that the lack of notes could have created in cross-examination and considered the doctor's foundation for his opinion.

Affirmed in part, as modified, and vacated and remanded, in part.

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

OPINION

MIRIAM P. RYKKEN, Judge

The self-insured employer appeals the compensation judge's award of temporary total disability benefits relative to the employee's low back injury on March 22, 1989. The employee cross-appeals the compensation judge's denial of the employee's claimed left shoulder

injury, the denial of payment for certain medical expenses related to treatment of the employee's low back, and the compensation judge's admission into evidence of the report and deposition testimony of Dr. William Simonet. We affirm in part, modify in part, vacate in part and remand in part.

BACKGROUND

Richard Fox, the employee, began working for the Minneapolis Park and Recreation Board, self-insured employer, in the mid-1970's. On March 22, 1989, the employee sustained an admitted injury to his low back. On that date, the employee earned an average weekly wage of $558.44. The employee also sustained an admitted right shoulder injury on May 8, 1996, on which date he earned an average weekly wage of $658.00. Born on July 4, 1958, the employee was 30 at the time of his first injury in 1989.

The employee initially worked seasonally in the employer's maintenance department during summer vacations while in senior high school. He was certified as a full-time employee in 1984, and worked in the forestry department until 1991. He planted and removed trees, cleared away tree trimmings and debris, and also trimmed tree branches either by hand climbing in the trees or standing on the ground. To trim trees, the employee used a hydraulic trimming wand, chain saw, hand-pull pruner and pole saw, and also climbed trees or used a motorized bucket to lift him when necessary to trim upper branches.

On March 22, 1989, the employee injured his low back when lifting a pile of logs and brush. He received initial medical treatment at Park Nicollet Medical Center, underwent physical therapy, and was prescribed a TENS unit and pain medication. On May 22, 1989, Dr. Brutlag recommended continued conservative care and two additional weeks off work. X-ray films taken on June 20, 1989, showed spondylolisthesis at the L5-S1 level. As of that date, the employee remained off work due to ongoing symptoms, at which time Dr. Brutlag prescribed facet injections and a formal work hardening program, due to failure of conservative treatment.

By November 1989, the employee returned to work on a light-duty work-hardening basis, working within physical work restrictions. Dr. Brutlag determined that the employee reached maximum medical improvement by April 9, 1990, and by August 1990 assigned a rating of 7 percent permanent partial disability to the body as a whole.

The employee continued working for the employer for approximately two and a half years, between August 1990 and March 1993, and received no ongoing medical treatment for his back during that period. In approximately 1991, the employee commenced working as a Park Keeper for the employer's maintenance department. While working as Park Keeper, the employee's duties included setting up hockey rinks, which included loading and unloading barricades, barrels, hockey boards, chairs and tables onto a flatbed truck. The tables weighed up to 150 pounds, and the hockey boards measured 16 to 18 feet long. The employee's duties also included shoveling asphalt and removing graffiti from park structures.

The employee testified that numerous tasks required of him as a Park Keeper bothered his shoulders, including lifting the edge of the hockey boards onto the truck, overhead lifting and pushing, and shoveling asphalt out of the truck beds. The employee also testified that he lifted an axe overhead to chop the hockey boards out of the ground before loading them onto trucks. He also installed wire netting backstops by stretching and nailing the wire net at both ends of each hockey rink. He also lifted and pushed 55 gallon barrels; all of these tasks bothered his shoulders.

On March 31, 1993, the employee consulted Dr. Samson at Park Nicollet, due to ongoing low back symptoms. The employee reported to Dr. Samson that he had experienced chronic back pain since last seen in 1990, and that an earlier facet injection did not reduce his low back symptoms. The employee reported that his chronic back pain had slowly worsened, that getting in and out of his truck at work increased his symptoms and that he recently aggravated his symptoms while working on a machine at work. Dr. Samson recommended anti-inflammatory medication, and assigned physical work restrictions. X-rays taken on March 31, 1993, detected spondylolisthesis, grade I. On April 7, 1993, Dr. Parker referred him for physical therapy and a surgical consultation. On May 18, 1993, Dr. Cox conducted a neurosurgical evaluation, and recommended follow-up x-rays and a lumbar myelogram CT scan.

Dr. Richard Hadley conducted an orthopedic evaluation of the employee on May 27, 1993, recommended a one-level lumbosacral fusion as an attempt to improve the employee's symptoms and performed that surgery on June 30, 1993. The employee's back pain continued, without radiating symptoms. By October 1993, Dr. Hadley recommended physical therapy. By December 1, 1993, the employee reported improvement in his low back symptoms, but numbness in his lower extremities, for which Dr. Hadley recommended an EMG. An EMG conducted on December 9, 1993, indicated normal results. The employee also reported a long history of intermittent numbness in both hands, especially after using a chain saw. Dr. Hadley recommended an EMG of the upper extremities also, but the record includes no report from any upper extremity EMG study in 1993.

By December 16, 1993, Dr. Hadley recommended a work hardening program and functional capacities evaluation (FCE). The employee ultimately underwent an FCE on May 18, 1994. Based on the physical restrictions outlined in the FCE, the employee returned to work with the employer, transferring to a position in the maintenance department. By August 11, 1994, Dr. Hadley determined that the employee had reached maximum medical improvement (MMI) from his 1989 low back injury, and that he had sustained a total of 17.5 percent permanent partial disability of the body as a whole, as a result of his March 22, 1989, injury. The employee sought no further care for his low back symptoms between August 1994 and May 1998.

The employee injured his right shoulder on May 8, 1996, as he loaded 24 empty 55-gallon barrels into the back of a flatbed truck. According to the employee's testimony, he asked the flatbed truck driver to lower the truck bed so that the barrels could move forward; by mistake, the truck driver raised the flatbed instead. At that point all the barrels at the back of the load shifted toward the back of the truck, forcing the employee to catch the barrels with both hands to prevent

them from rolling off the flatbed. The employee reported this incident to his supervisor and completed a First Report of Injury, stating on the written report that he injured his right shoulder.[1] The employee later reported to his doctors, and also testified, that both shoulders "were burning and very painful" after this incident, but that his right shoulder was more painful than the left.

On May 9, 1996, the employee consulted Dr. Dunne at Park Nicollet Medical Center, and gave a history of right shoulder pain. By May 14, 1996, the employee reported symptoms in both shoulders, but advised Dr. Dunne that his right symptoms were worse than the left. Dr. Dunne diagnosed a bilateral shoulder strain, right greater than left. Dr. Dunne recommended an MRI of the right shoulder; on June 3, 1996, the employee underwent an MRI scan of his right shoulder, which indicated a small full-thickness tear. Dr. Dunne referred the employee to Dr. Jeffrey Husband, who examined the employee on June 17, 1996. The employee reported symptoms of bilateral shoulder pain for at least five years, with an increase in severity on or about May 8, 1996, when doing repetitive overhead lifting of 55-gallon barrels. Dr. Husband diagnosed "full thickness cuff tear, right shoulder." Dr. Husband performed a right rotator cuff repair on July 25, 1996. Post-surgery, the employee contracted an infection which complicated his recovery, and underwent physical therapy, but continued to experience right shoulder pain.

The employee continued to consult Dr. Dunne and Dr. Husband for post-surgery evaluations. On November 26, 1996, the employee reported that he was "progressing satisfactorily in therapy until he developed increasing pain that appeared to be related to upright rowing strengthening exercises." (Jt. Exh. 1) The employee also reported that he felt worse than before the surgery. Dr. Dunne therefore discontinued physical therapy, and scheduled the employee for a right shoulder MRI, to determine if he again had torn his rotator cuff. A follow-up MRI scan was scheduled for December 16, 1996, for further evaluation. According to Dr. Dunne's chart note of January 6, 1997, there was no definite recurrent tear, although there was "mild to moderate residual compromise at the musculotendonous junction." Dr. Dunne recommended that the employee remain off work, and prescribed pain medication.

Dr. Husband conducted a follow-up examination on January 10, 1997, and reviewed the MRI scan which showed evidence of a small osteophyte off the undersurface of the clavicle. Dr. Husband diagnosed ongoing rotator cuff pathology in the right shoulder, and recommended a second surgery. The employee was referred to Dr. George Osland for this surgery. Due to Dr. Osland's illness, his colleague, Dr. Rolf Hauck commenced treating the employee, and on May 20, 1997, performed a right shoulder arthroscopy and subacromial decompression.

By June 20, 1997, the employee reported persistent left shoulder pain, increasing with activities. Dr. Hauck conducted an arthrogram of the employee's left shoulder on June 24, 1997, which was normal and showed no evidence of a rotator cuff tear. Dr. Hauck prescribed

[1] The employee testified that he injured his right and left shoulders as a result of this incident, but was "told to hurry up and fill out the report because they [the supervisors] were on their way to a meeting. And they're supposed to give you a ride to the clinic if you're injured." The employee testified that he hurried to fill out the report and for that reason did not report a left shoulder injury. (T. 47-48.)

exercises for both shoulders. By August 8, 1997, Dr. Hauck diagnosed impingement syndrome in the left shoulder, most likely secondary to degenerative rotator cuff disease. He performed a subacromial injection, prescribed physical therapy for three weeks, and by September 12, 1997 recommended decompression surgery for the left shoulder. On December 10, 1997, Dr. Hauck performed a left shoulder subacromial decompression arthroscopically.

Following surgery on his left shoulder, the employee underwent physical therapy and began noting increased low back pain. On May 26, 1998, the employee consulted Dr. Ralph Hauck again, reporting that his shoulder symptoms had considerably improved, but that his back pain had worsened. The employee reported that his legs were going numb and that his back pain had significantly worsened while he performed work hardening exercises. The employee reported that he noticed pain in his low back with standing, bending, lifting and sitting.

X-rays taken on May 26, 1998, showed a solid lumbosacral fusion. Dr. Hauck referred the employee to his partner, Dr. Paul Crowe, for further evaluation. Dr. Crowe examined the employee on June 3, 1998, at which time the employee again reported onset of increasing shooting pain down his left leg while he was performing work hardening exercises for his shoulders. The employee reported this pain had been present for five to six weeks before the examination, and extended all the way to the employee's left foot. Dr. Crowe diagnosed a left leg radiculopathy following a flare-up of a prior back injury. Dr. Crowe restricted the employee from work and recommended an MRI scan. An MRI taken on June 13, 1998 indicated no evidence of nerve root compression and indicated that the employee's L5-S1 fusion was solid. On September 15, 1998, a CT scan and myelogram again showed a solid fusion and no evidence of nerve root compression.[2]

Dr. Crowe recommended physical therapy and advised that the employee was not a candidate for additional back surgery. According to Dr. Crowe's chart note of October 14, 1998, the employee "expressed his wish for a second opinion;" Dr. Crowe referred the employee to Dr. James Ogilvie for a second surgical opinion, recommended that the employee attend a physical rehabilitation program at the Physicians Neck and Back Clinic and also recommended that the employee obtain a functional capacities evaluation (FCE). According to Dr. Crowe's December 8, 1998, chart note, insurance coverage was denied for the recommended second opinion, the physical rehabilitation program and the FCE. By December 8, 1998, Dr. Crowe released the employee to return to work, with specific instructions that the employee shovel no snow and that he perform no work over his shoulders. No other physical work restrictions were advised by Dr. Crowe at that point.

On November 23, 1998, the employee filed a claim petition asserting claims based upon March 22, 1989 and May 8, 1996 injuries. The employee alleged a back, hand and wrist

[2] Finding No. 8, line 5, states that the September 15, 1998, CT scan and myelogram "showed evidence of nerve root compression." It appears this is a typographical error, as Dr. Crowe's medical records indicate that the CT scan and myelogram showed *no* evidence of nerve root compression. We therefore modify Finding No. 8 to be consistent with Dr. Crowe's report of October 14, 1998, and to state "no evidence of nerve root compression."

injury on March 22, 1989, and a bilateral shoulder injury, exacerbation of back and exacerbation of hands and wrists on May 8, 1996. The employee claimed entitlement to temporary total disability benefits from May 9, 1998, to the present and continuing, requested approval for treatment of hand and wrist conditions, and requested a second opinion consultation with Dr. James Ogilvie and rehabilitation treatment at the Physicians Neck and Back Clinic as recommended by Dr. Crowe.

In its answer to the employee's claim petition, the self-insured employer admitted a low back injury on March 22, 1989, and a right shoulder injury on May 9, 1996, but denied the employee's entitlement to the claimed temporary total disability benefits and denied the employee's entitlement to the claimed medical expenses. The self-insured employer denied notice of the claimed hands and wrists injuries and denied notice of the employee's claimed left shoulder injury. The employee subsequently withdrew his claim for hands and wrists injuries.

Hearing was held on March 11, 1999 before a compensation judge. According to the Findings and Order served and filed June 11, 1999, the compensation judge determined that the employee did not reach maximum medical improvement (MMI) until March 3, 1999, and awarded the employee's claim for temporary total disability benefits from May 9, 1998 through March 11, 1999, and continuing for ninety days post-MMI, as a result of his low back injury. The judge also awarded payment of certain medical expenses related to the employee's low back and right shoulder conditions, but denied the employee's claim for a specific or Gillette-type injury to his left shoulder, and denied his claim for any medical expenses related to his alleged left shoulder injury. The compensation judge also denied the claim for a second opinion consultation with Dr. James Ogilvie and for treatment at the Physician's Neck and Back Clinic. The self-insured employer appeals from the compensation judge's decision; the employee cross-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). 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

Temporary Total Disability Claim

The compensation judge concluded that the employee is entitled to temporary total disability benefits from May 9, 1998, through March 11, 1999, and continuing as a result of his low back injury. The compensation judge concluded that the employee was medically unable to continue working as a result of his 1989 low back injury, and further concluded that the employee had cooperated with rehabilitation and was diligently seeking work through the rehabilitation process, in an attempt to return to work with the employer. The compensation judge determined that the employee reached maximum medical improvement as of March 3, 1999, based on Dr. Simonet's deposition testimony, and ordered payment of continuing temporary total disability through 90 days post maximum medical improvement, pursuant to Minn. Stat. § 176.101, subd. 3e.

On appeal, this court is to affirm the compensation judge's factual determinations 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. at 201, 229 N.W.2d at 524. As there is substantial medical and testimonial evidence of record to support the compensation judge's award of temporary total disability benefits, we affirm.

According to Dr. Hauck's chart notes of May 26, 1998, the employee reported that he had aggravated his low back condition while performing work hardening exercises. Dr. Hauck referred the employee to his partner, Dr. Paul Crowe, orthopedic spine specialist in Dr. Hauck's medical practice group. Dr. Crowe's records thereafter report the radiographic studies done to evaluate the employee's condition, and the orthopedic examinations conducted to further evaluate this exacerbation of symptoms.

Dr. Crowe first examined the employee on June 3, 1998, and found a slightly positive straight leg raising test and a small amount of spasm. X-rays taken of the employee's low back indicated that the employee's fusion was solid; an MRI, ordered by Dr. Crowe, also had normal results. Dr. Crowe testified that since the MRI scan indicated no nerve root compression or impingement, that he expected the employee to have a prolonged course of nonoperative treatment. He also testified that "the potential for [the employee] to make a complete recovery is I think very high[.]" (Crowe depo., p. 24.) In his deposition, Dr. Crowe agreed that the employee had a normal neurological examination on August 3, 1998, but also testified that the employee's low back injury in 1989, and the fusion that he underwent on June 30, 1993, were substantial contributing causes of the employee's ongoing back problems. Dr. Crowe explained why the employee continued to experience pain, and stated that:

> [Y]our biomechanics of your back are altered by [a surgical fusion]. You have less motion segments, and then you also have the muscular problem secondary to the operation itself, that can result in tightening or scarring of the muscles, and I think more susceptibility to strains, and then there's the anterior disc problems, that can flare up and have nerve endings in the disc that can cause

> pain. The exact answer isn't completely clear, but it's from no doubt so many multiple possible causes, you can't really pin that down.

(Crowe depo., p. 17-18.) Dr. Crowe further testified that many of the multiple possible causes were the result or consequences of the employee's fusion surgery.

By October 14, 1998, Dr. Crowe advised the employee that no surgery was indicated and testified that he instead would recommend therapy and exercises, and follow-up care if needed. Based upon the employee's interest in obtaining a second opinion, Dr. Crowe referred the employee to Dr. Ogilvie for a second opinion concerning surgery. Dr. Crowe's records also reflect that he restricted the employee from returning to work as a result of his low back condition, until December 8, 1998. At that point, Dr. Crowe released the employee to return to work, in part due to the employee's request to provide such a release, and in part due to denial of insurance payment for Dr. Crowe's recommended consultation with Dr. Ogilvie, further medical rehabilitation treatment and FCE.

The employer argues that the employee's determination or "request" of Dr. Crowe to release him to return to work as of December 8, 1998 indicates that the employee's condition did not change from May 1998 to December 1998, and that this "proves" that the employee had been capable of working since May 1998. We disagree. The self-insured employer's argument fails to take into account the evidence in the medical records between May and December 1998. The compensation judge relied on both the employee's testimony and his medical records concerning his exacerbation of symptoms commencing May 1998, and the resulting restrictions from work placed upon him by Dr. Crowe. There is substantial evidence in the employee's medical records during the summer and fall of 1998 to indicate that his low back symptoms were severe enough to cause Dr. Crowe to restrict the employee from employment.

After Dr. Crowe released the employee to return to work in December 1998, the employer required the employee to be examined by Dr. Dunne at Park Nicollet Medical Center. (T. 61.) Dr. Dunne placed restrictions on the employee which were more stringent than those given by Dr. Crowe, and the employer was unable to accommodate those restrictions. (T. 113-114.) Dr. Crowe then reviewed and approved a job description for the employee's previous park keeper position. Thereafter, the employer scheduled the employee for a functional capacities evaluation to determine whether he could perform that job. (T. 115.) The employee's QRC monitored the employee's medical progress, and testified that a meeting between the QRC and the employer was scheduled for the day after the hearing, to discuss the employee's return to work. There is ample support for the compensation judge's conclusion that for the period commencing May 9, 1998, the employee was temporarily totally disabled from employment as a result of his 1989 back injury, and that he cooperated with rehabilitation and was diligently attempting to return to work with the employer.

The compensation judge found that Dr. Crowe had an accurate factual history of the employee's low back condition, reviewed his own medical records and those of Dr. Hauck, and therefore had sufficient foundation for his opinions. In her memorandum, the compensation

judge further explained that the employee's testimony was consistent with his medical records, and found Dr. Crowe's opinion to be more persuasive, that the employee had some objective findings on his examination and that he was medically unable to return to work due to his exacerbation. Whereas the employer and insurer rely on Dr. Simonet's opinion that the employee was not temporarily totally disabled due to lack of objective findings on examination, it was reasonable for the compensation judge to rely upon the employee's treating physician, Dr. Crowe, in determining that the employee was temporarily totally disabled from employment for a period of time. 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). 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).

The question on appeal is whether the compensation judge reasonably could conclude that the employee was temporarily totally disabled from employment in 1998 and 1999, as a result of his low back injury in 1989, based upon the medical evidence in record and based upon the employee's testimony. As there is substantial evidence to support the compensation judge's conclusion, we affirm.

Left Shoulder Injury Claim

The compensation judge stated that the employee failed to prove that he sustained a specific or Gillette injury to his left shoulder arising out of and in the course and scope of his employment on May 8, 1996, contrary to Dr. Rolf Hauck's opinion that the employee sustained a work-related injury to his left shoulder. The compensation judge's references to Dr. Hauck's opinions on causation are inconsistent, and she refers to Dr. Simonet's medical causation opinion in her memorandum but does not specifically indicate whether she relies upon his opinion. As a result, the basis for her denial for the left shoulder injury is not clear, and we remand to the compensation judge for clarification.

Dr. Hauck, who performed surgery on the employee's left shoulder on December 10, 1997, testified by deposition and his medical records from Northwest Orthopedic Surgeons were also admitted into evidence. In Dr. Hauck's opinion, the employee's left shoulder symptoms and related medical treatment were causally related to the employee's work performed for the employer. The compensation judge found that Dr. Hauck's medical opinion was supported by medical records, and that the employee testified consistently with his medical records concerning his left shoulder symptoms resulting from his May 8, 1996 injury. (Hauck dep. P. 23-24) In Finding No. 10, the compensation judge stated as follows:

> Dr. Rolf Hauck gave his opinions by a deposition taken on March 8, 1999. He treated the employee from May 5, 1997 to July 14, 1998, had a sufficient factual history by the hypothetical and reviewed the records of Northwest Orthopedic, Park Nicollet Medical Center, Occupational Medicine and Drs. Husband and Dunne. He had an

> adequate foundation for his opinions. Dr. Hauck opined that the employee's bilateral shoulder conditions were related to his work activities and found that Mr. Fox sustained Gillette injuries. He noted that the employee's congenitally down-sloping acromion of the left shoulder was also a contributing factor to his impingement syndrome Dr. Hauck felt that the employee sustained a Gillette injury of his left shoulder caused by his heavy work.

(Finding No. 10.)

By contrast, in her memorandum, the compensation judge states that the employee did not seek treatment of his left shoulder for a significant period of time following the May 8, 1996 incident. The compensation judge further stated that:

> Dr. Hauck's opinion lacks adequate foundation in that he did not review all of the relevant medical records. Further his opinion is not persuasive. He argues that the employee's heavy work is the type he sees leading to shoulder injuries. However, the employee did not miss time from work, seek medical attention or change job duties due to his left shoulder complaints."

(Memo. p. 7.)

On appeal we are charged with determining whether substantial evidence of record supports the compensation judge's conclusion that the employee sustained no specific or Gillette-type injury to his left shoulder on May 8, 1996. We are to look at the medical evidence of record, to review the entries in the medical record which document the employee's reports of left shoulder symptoms and the medical treatment received for that condition. The employee's medical records show that he received more comprehensive treatment of his right shoulder in 1996, but that his treating doctors also evaluated his left shoulder symptoms. Park Nicollet Medical Center records from May and June, 1996, show that the employee reported left shoulder symptoms post-injury. Dr. Jeffrey Husband reported on June 17, 1996, that the employee provided a specific history of symptoms of bilateral shoulder pain for five years. Dr. Dunne first examined the employee on May 9, 1996, and last saw the employee on December 30, 1998. At that point, he indicated that the employee still had left shoulder problems, diagnosed the employee's condition as a left shoulder impingement syndrome, and refers to this condition as being a continuation of initial problems noted in May 1996.

It is unclear from the compensation judge's decision as to the basis for her conclusion that the employee did not sustain a specific or Gillette injury to his left shoulder. At Finding No. 10, the compensation judge states Dr. Hauck "had a sufficient factual history by the hypothetical and reviewed the records of Northwest Orthopedic, Park Nicollet Medical Center, Occupational Medicine and Drs. Husband and Dunne." He had an adequate foundation for his opinions. However, in the first paragraph of her memorandum she states "Dr. Hauck's opinion

lacks adequate foundation in that he did not review all of the relevant medical records." It is not clear from the compensation judge's memorandum whether she erroneously concluded Dr. Hauck's opinion lacked adequate foundation and that Dr. Hauck's opinion was not persuasive. We therefore vacate the compensation judge's Conclusions of Law Nos. 1, 3A and 4 concerning the employee's left shoulder injury, and remand to the compensation judge for further determination of the employee's claim for a left shoulder injury on May 8, 1996, and for explanation as to what support exists in the record for her determination concerning that injury.

Denial of Medical Expenses for Low Back Treatment

Although the compensation judge determined that the employee was temporarily totally disabled from employment in 1998 and 1999 as a result of his work-related low back condition, she denied the employee's claim for payment of a second surgical opinion with Dr. Ogilvie and for treatment at the Physician's Neck and Back Clinic. This denial was based upon Dr. Paul Crowe's testimony concerning the need for a surgical consultation and additional treatment. Dr. Crowe testified that he originally suggested a second surgical opinion, when the employee expressed a desire for a surgical cure, even though Dr. Crowe had already concluded that the employee was not a surgical candidate. By the time of his deposition on March 22, 1999, Dr. Crowe testified that he believed that a second opinion would be "probably not very helpful." (Crowe depo. p. 33) Dr. Crowe instead opined that a non-surgical opinion, such as a chronic pain clinic evaluation, could be a very useful second opinion.

Dr. Crowe also originally recommended additional rehabilitation treatment for the employee, at the Physician's Neck and Back Clinic, as treatment that would be helpful in assisting the employee with a return to work. At his deposition, however, Dr. Crowe admitted the likelihood that the employee would "fail" at that clinic, given that he had failed the previous physical therapy. Dr. Crowe further explained his basis for his change in opinion concerning the efficacy of treatment at the Physician's Neck and Back Clinic:

> Well, if he's working, I don't know that it would help him much. Since we released him to work, I wouldn't feel so strongly about it any more. They are pretty good at getting people going, back to work and living with their pain, but if he's gone back to work, and is living with his pain, I don't feel too strongly about that today.

(Crowe depo. p. 36-37)

The compensation judge based her denial of this medical treatment on the deposition testimony of Dr. Crowe, reasonably relying on the medical opinions of the physician who had originally recommended the specific treatment. Substantial evidence of record, including medical deposition testimony, supports the compensation judge's denial, and we accordingly affirm.

Admissibility of Medical Report and Deposition Testimony
Modification of Conclusion of Law

In Conclusion of Law No. 5, the compensation judge states that "Dr. *Crowe's* report and deposition testimony are admissible." (Emphasis added.) Finding No. 13 refers to the employee's objection to the admissibility of Dr. *Simonet's* report and deposition. The parties argue in their appellate briefs whether Dr. Simonet's report and deposition testimony are admissible. We therefore modify Conclusion of Law No. 5 to substitute Dr. Simonet's name for Dr. Crowe's name.

Evidentiary Issue

At issue on appeal is whether Dr. Simonet's medical report and deposition testimony were properly admitted into evidence, even though Dr. Simonet destroyed the notes made contemporaneously with his examination. The employee argues that the destruction of these notes rendered the employee unable to confront the doctor through cross-examination as to what was exactly contained in those office notes.

"[W]hen a compensation judge . . . conducts a hearing, the compensation judge is bound neither by the common law or statutory rules of procedure." Minn. Stat. § 176.411, subd. 1. In addition, "[e]videntiary rulings are generally within the sound discretion of the compensation judge." Ziehl v. Vreeman Constr. Co., slip op. at 5 (W.C.C.A. Oct. 15, 1991). "[T]he purpose of the proceeding is disclosure of the true facts, a purpose better served by acceptance of all competent, relevant and material evidence." Scalf v. LaSalle Convalescent Home, 481 N.W.2d 364, 366, 46 W.C.D. 283, 286 (Minn. 1992); see Jendro v. Braun Boveri Turbo Machinery, 355 N.W.2d 716, 719, 37 W.C.D. 158, 161 (Minn. 1984). In this case, the compensation judge determined that Dr. Simonet's medical report and deposition testimony should be admitted into the hearing record; we affirm.

Dr. Simonet, who examined the employee at the request of the self-insured employer on February 24, 1999, prepared a medical report dated February 26, 1999. Dr. Simonet opined that, *inter alia*, the employee was not disabled from employment in 1998 and 1999 as a result of his low back injury, and that the employee did not sustain a left shoulder injury or Gillette-type injury to his left shoulder as a result of his employment, and also stated that his opinion was based upon the employee's medical records as not demonstrating either a specific or Gillette-type injury to the left shoulder. Dr. Simonet's opinion was also based upon his belief that the employee's job imposed no unusual demands or repetitive activity on his shoulders, and that the employee's left shoulder impingement syndrome was congenital in nature.

On cross-examination, Dr. Simonet was asked to produce the notes he made contemporaneously with his examination. He replied that he did take notes "and then I purposely destroyed those notes just so I am not quizzed on them by attorneys." (Simonet depo. p. 81.) On further cross-examination, Dr. Simonet was then asked if he purposely destroyed those notes so that the attorney for the employee "wouldn't be able to look at them" and ask questions about them. (Simonet depo. p. 82.)

The questions and testimony concerning the doctor's examination notes are as follows:

Q Do you have office notes or records concerning your examination and history that you took from him?

A The history and notes are transcribed into the record, and then I do not keep them.

Q So there are no individual separate handwritten notes from you concerning the history that was taken and what exactly this individual said to you when he appeared in front of you for this examination?

A I stated to you immediately after I see the patient - - I do take notes while I see the patient. Immediately after I see the patient I dictate the report and then I purposely destroy those notes just so I'm not quizzed on them by attorneys. . . .

Q You said you purposely destroy those notes so when you get into a deposition like this you're not asked questions about those?

A As I stated to you, I just take notes on whatever scrap of paper I have handy because I walk out of the room and I dictate the report based primarily on my recollection of the events that immediately precede it. On that basis the notes would really not ever be a part of the medical record. I don't consider them part of the medical record. The medical record is actually what I've produced in terms of a transcript. As such, I do not like those reports, which again, are handwritten and jotted and are not an accurate word for word description of what went on. I do not like to consider those to be taken out of context and used inappropriately.

Q So your answer is - - I guess you told me that once already - - you purposely destroy them so I wouldn't be able to look at them and ask you questions about them?

A So anybody wouldn't. They're not what I would consider part of the medical record, sir.

Q On your own patients, when you're examining them and taking a history from them, do you write down the history and findings on examination and keep those?

A No. I use the same procedure. I destroy those notes and the only record that appears in the medical records is the dictated record. . . .

Q So the information included in the notes, is that information specifically then included in the report?

A Every word, plus more.

> Q So when you throw away the notes, you're not throwing away information, is that correct, because the information is still in the report?
>
> A Correct. I would consider those notes to be the equivalent of scratch paper. All of the information contained in those notes is dictated into the report in a more eloquent and grammatically correct manner than in the somewhat scribbly notes that I may handwrite.

(Simonet depo. 80-83, 104)

The compensation judge, in Finding No. 12, determined that Dr. Simonet "did a sufficient physical examination as part of the foundation for his opinions. He had all relevant medical records and reviewed the films and scans from Northwestern Orthopedic Surgeons and Methodist Hospital. He had a detailed and accurate factual history of the employee's alleged injuries." The compensation judge stated in her memorandum that

> Dr. Simonet's practice of destroying his notes for the purpose of avoiding attorneys' questions about his reports raises questions about the accuracy of his recording and his credibility. In this case, [the employee's attorney] was able to address any discrepancies on cross-examination and was able to overcome any possible prejudice that lack of a complete IME file could have created."

(Memo. P. 8)

The judge further stated that she weighed the lack of availability of Dr. Simonet's contemporaneous notes in considering his credibility and the adequacy of the foundation for his opinions. She addressed the employee's objections concerning possible prejudice that lack of the doctor's notes could have created and made an evidentiary ruling which was in her discretion to do as the trier of fact. See Ziehl, slip op. at 5 (W.C.C.A. Oct. 15, 1991) The compensation judge reasonably explained her basis for that evidentiary ruling, and also outlined her independent assessment of the medical opinions expressed by Dr. Simonet and the weight accorded to his opinion. In view of the compensation judge's explanation of her ruling, we find that she acted reasonably within her discretion, and therefore affirm the admission of Dr. Simonet's medical report and deposition testimony into the hearing record.