DIANE H. HEITZ, Employee/Appellant, v. PAR 30 RESTAURANT & LOUNGE, INC., and STATE FUND MUT. INS. CO., Employer-Insurer, and BLUE CROSS/BLUE SHIELD OF MINN., Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
FEBRUARY 3, 2000

No. [REDACTED SSN]

HEADNOTES

CAUSATION - GILLETTE INJURY; EVIDENCE - EXPERT MEDICAL OPINION. Where the compensation judge erred by failing to consider the employee's doctors' opinions regarding causation for lack of foundation, remand is necessary for full consideration of these opinions in determining whether the employee's work activities were a substantial contributing cause of the employee's carpal tunnel syndrome.

Vacated and remanded.

Determined by: Rykken, J., Johnson, J., and Wheeler, C.J.
Compensation Judge: Jeanne E. Knight

OPINION

MIRIAM P. RYKKEN, Judge

The employee appeals from the compensation judge's determination that the employee's work activities between February 1997 and March 1998, or until December 31, 1998, do not represent a substantial contributing factor in her development of bilateral carpal tunnel syndrome. We vacate and remand to the compensation judge for reconsideration.

BACKGROUND

Diane Heitz, the employee, was employed by Par 30 Restaurant & Lounge, Inc., the employer, as a preparation cook between November 1995 and December 31, 1998. She earned an average weekly wage of $275.00 and was 57 years old on the date of her claimed injury, April 20, 1998. The employer was insured for workers' compensation liability by State Fund Mutual Insurance Company, the insurer, from February 1997 until December 31, 1998, when the employer discontinued business.

According to the employee's testimony, the employee's job as preparation cook involved chopping ingredients for the salad bar, including cutting meat and vegetables. She typically worked from 8:00 or 9:00 a.m. until 2:00 p.m. The employee testified that she began noticing pain in her left wrist in June 1996. She consulted Dr. Richard E. Olson, Fairview Jonathan Clinic, on June 17, 1996, who provided her with a cortisone injection and an ace wrap bandage for her left wrist. By September 1996, she was diagnosed with DeQuervain's tendinitis, and was

provided with a left arm cast for a three-week period. On October 1, 1996, Dr. Olson examined the employee, and noted swelling over the dorsum of the left wrist and over the forearm tendons above the radius. The employee reported some pain and tenderness in her hand. Dr. Olson recommended a left wrist splint, pain medications and an orthopedic evaluation.

By November 1996, the employee sensed that both hands were "locking up," and she sought further medical treatment from Dr. Valentina Kucher, also at the Fairview Jonathan Clinic. Dr. Kucher referred the employee to Dr. Mark Friedland, for an orthopedic consultation. Dr. Friedland made a preliminary diagnosis of "left wrist DeQuervain's syndrome with somewhat more diffuse extensor tendinitis," and "possible diabetic peripheral neuropathy in the radial nerve distribution," and referred the employee to Dr. Ivan Brodsky for an electromyogram (EMG). (Resp. Ex. 1.) The EMG, conducted on both arms on November 14, 1996, was positive for bilateral carpal tunnel syndrome, with findings that were "perhaps a little more pronounced on the right than the left." (Resp. Ex. 1.)

The employee received a second cortisone injection in her left hand on November 13, 1996. According to Dr. Friedland's chart note of November 20, 1996, (Resp. Ex. 1) the employee experienced one day's worth of relief from this cortisone injection. Examination on that date indicated continued soft tissue swelling and tenderness in her left wrist. Dr. Friedland prescribed a removable left thumb spica splint for the employee. He prescribed nonsteroidal anti-inflammatory medication, and recommended icing. Although the employee was scheduled for a follow-up appointment on December 18, 1996, Dr. Friedland's chart note indicates that the employee forgot this appointment and "will call to reschedule." (Resp. Ex. 1.)

There is no further reference to the employee's left wrist symptoms until January 26, 1998. In his chart note on that date, Dr. Olson, the employee's treating physician, quotes the employee as commenting about her left wrist tendinitis by stating "[I] just gave up on, didn't get any better." According to her testimony, the employee continued to perform her regular job duties for the employer, and was able to do so from November 1996 through March 1998. (T. 10.) By March 1998, the employee's hours increased for seasonal reasons. The employee testified that by April 1998, her hands began aching more and locking up more frequently. New symptoms developed, including a locking of her fingers on both hands into a claw-like position during the night. (T. 11-12.)

The employee sought follow-up medical treatment with Dr. Olson on March 18, 1998. His chart note states: "She is having some headache in the neck and back area. Also fatigue. Thinks this might be from her work schedule. She feels headache, hand pain, from work and thinking about changing jobs." (Resp. Ex. 1.) By her appointment on April 20, 1998, the employee's symptoms had increased. Dr. Olson's chart note indicates:

> For the past several months she has noted tingling, numbness of fingertips, lots of pains of the hands. Worse at night and in the morning. Takes her a long time just to loosen her hands up. She is

> working more hours at the restaurant, does lots of hand work, working in the kitchen. Sometimes up to 12 hours a day.

Dr. Olson diagnosed bilateral carpal tunnel syndrome/repetitive use syndrome. He prescribed bilateral splints, restricted the employee from work for five weeks, and restricted her to reduced hours when she returned to work. According to the employee's testimony, her symptoms did not subside. By April 28, 1998, Dr. Olson advised that the employee tested positively for arthritis. By May 18, 1998, the employee reported that she was "certainly better since she is not working," but that she still noted numbness and pain in her fingers, especially middle and fourth finger, and especially on the right side. An EMG taken on May 6, 1998, evidenced peripheral neuropathy [1] and definite changes in the median nerve bilaterally and in the right ulnar nerve at the elbow. Dr. Olson diagnosed peripheral neuropathy and carpal tunnel syndrome, as well as ulnar nerve entrapment on the right side.

Dr. Olson thereafter referred the employee to Dr. Robert C. Wilke, orthopedic surgeon. On June 23, 1998, the employee provided a history to Dr. Wilke that she had noted a five-month history of pain in her hands as well as numbness in her fingertips. Dr. Wilke prescribed injections, which did not alleviate her symptoms. He referred the employee to Dr. Frederick Strobl for a neurological consultation. Following his examination of the employee on June 30, 1998, Dr. Strobl determined that the employee's symptoms were related to her carpal tunnel condition, although he also diagnosed polyneuropathy. Dr. Strobl also commented that the EMG in 1996 showed no polyneuropathy at that time, but that the employee did have diabetes by that point. (The employee was first diagnosed with diabetes in June 1990.) (Resp. Ex. 1, Report of Frederick Strobl, M.D., June 30, 1998.)

Dr. Strobl recommended surgery and Dr. Wilke concurred with this recommendation. On July 14, 1998, the employee underwent carpal tunnel release surgery on her left wrist, together with trigger release of her left thumb and left middle finger. The surgery was successful, according to the employee's testimony and medical records.

By October 2, 1998, the employee returned to work for the employer, performing the same salad preparation tasks, and also receiving training to work as a cook and dishwasher. According to the employee's testimony, she is right-handed, she tended to favor her left hand, and noted persistent symptoms in her right hand. By then, the middle and ring fingers of her right hand had started "locking up more and more." (T. 15.) The employee, however, continued to work

[1] Neuropathy is defined as "a functional disturbance or pathological change in the peripheral nervous system, sometimes limited to noninflammatory lesions as opposed to those of neuritis; the etiology may be known or unknown. Known etiologies include complications of other diseases (e.g., diabetic n[europathy] . . .)." Diabetic neuropathy is defined as "any of several clinical types of peripheral neuropathy occurring with diabetes mellitus; there are sensory, motor, autonomic, and mixed varieties. The most common kind is a chronic, symmetrical sensory polyneuropathy affecting first the nerves of the lower limbs and often affecting autonomic nerves; pathologically, there is a segmental demyelination of the peripheral nerves." Dorland's Medical Dictionary 1132 (28th ed. 1994).

until December 31, 1998, when the employer discontinued business. Thereafter, the employee did not search for alternative employment because of her ongoing right hand symptoms.

On January 22, 1999, the employee underwent an independent medical examination with Dr. William Call. Dr. Call diagnosed diabetic peripheral neuropathy, bilateral diabetic carpal tunnel syndrome and diabetic trigger fingers, not related to the employee's work activities but instead consistent with the employee's diabetic condition. Dr. Call recommended steroid and Xylocaine injections to treat her right trigger fingers, and follow-up trigger release surgery if necessary, but stressed that such treatment should not be considered as causally related to any work activities.

Dr. Wilke recommended carpal tunnel release surgery for the employee's right wrist, which she underwent on March 9, 1999. The employee received six weeks of post-surgery physical therapy for her right wrist. As of the hearing on June 11, 1999, the employee had not yet been released to return to work by Dr. Wilke, due to her right wrist symptoms. At the time of the June 1999 hearing, the employee reported no ongoing symptoms in her left hand.

The employee filed a claim petition on September 8, 1998, alleging an injury on April 20, 1998, in the nature of a bilateral carpal tunnel syndrome, and claiming entitlement to temporary partial disability benefits from April 20 through July 7, 1998 and temporary total disability benefits from July 8, 1998 forward. The employer and insurer denied primary liability for the claimed injury, alleging in its Answer to Employee's Claim Petition that the employee's underlying diabetic condition was consistent with the diagnosis of polyneuropathy and, therefore, the claimed carpal tunnel syndrome was personal in nature and unrelated to her work for the employer. Hearing was held on June 11, 1999. The sole issue addressed at hearing was whether the employee's work activities between February 1997 and March 1998, or until December 31, 1998, represented a substantial contributing factor in the development of the employee's bilateral carpal tunnel syndrome.

The compensation judge determined that the employee's work activities during those time periods were not a substantial contributing factor in the development of the employee's bilateral carpal tunnel syndrome. The compensation judge denied the employee's claim for benefits in its entirety. The employee appeals from that denial.

STANDARD OF REVIEW

In reviewing cases 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 (1998). 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, "[f]actfindings are clearly erroneous only if the

reviewing court on the entire evidence is left with a definite and firm conviction that a mistake has been committed." Northern States Power Co. v. Lyon Food Prods., Inc., 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975). 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." Id.

DECISION

The compensation judge found that the employee's work activities for the employer from February 1997 through March 1998 or through December 31, 1998, were not a substantial contributing factor in her development of carpal tunnel syndrome. The compensation judge denied the employee's claim on two bases. First, the compensation judge agreed with the employer's contention that the employee already had developed carpal tunnel syndrome prior to this insurer being on the risk for the employer. The compensation judge also determined that medical opinions of Drs. Wilke and Olson, upon whom the employee relied to support her claim, lacked foundation.

The first dispositive issue in this case is whether the compensation judge's determination that the employee's work activities from February 1997 through March 1998 or through December 31, 1998, did not substantially contribute to the employee's carpal tunnel syndrome was supported by substantial evidence. The second dispositive issue is whether the compensation judge properly found that the medial opinions on causation, rendered by Drs. Wilke and Olson, lack foundation and therefore should not be considered.

The question of a Gillette[2] injury primarily depends on medical evidence. Marose v. Maislin Transport, 413 N.W.2d 507, 512, 40 W.C.D. 175 (Minn. 1987). The employee "must prove a causal connection between her ordinary work and ensuing disability. . . . Whether given by testimony or written report, an opinion by a medical expert as to the causal link between the claimant's disability and the job must be based on adequate foundation." Steffen v. Target Stores, 517 N.W.2d 579, 582, 50 W.C.D. 464, 467 (Minn. 1994). 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. 1994).

At hearing, the insurer against whom the claim was made was the insurer on the risk for this employer from February 1997 through December 31, 1998. The previous insurer, on the risk at the time the employee first developed symptoms in June 1996, was not joined as a party to the claim. The employer and insurer contend that the employee was diagnosed with bilateral carpal tunnel syndrome in 1996, before their period of coverage began, and therefore that they are not liable for any claimed benefits. The compensation judge agreed with this position. The judge stated in her Memorandum, p. 4-5, that:

> The employee then sought no more treatment [from 1996] until March 1998. She claims that her work activities up to that date were

[2] Gillette v. Harold, Inc., 257 Minn. 313, 101 N.W.2d 200, 21 W.C.D. 105 (1960).

> a substantial contributing cause of her carpal tunnel syndrome. The problem arises because the insurance coverage changed in February 1997. The present insurer was on the risk apparently from February 1997 until the employer closed in December 1998. Unfortunately, the insurer prior to State Fund Mutual was not joined in this matter. Part of the contention of the employer and insurer is that the employee already had carpal tunnel syndrome prior to their being on the risk.

Whereas it is true that the employee's November 14, 1996 EMG indicated bilateral carpal tunnel syndrome, and the employee noticed some right hand symptoms in 1996, she received only limited medical treatment for her left wrist in 1996, and no treatment for her right wrist until 1998. The employee's 1998 medical records and her hearing testimony document her ongoing and worsening symptoms in both wrists. Her medical records also document new types of symptoms in 1998, different from those the employee noted in 1996, such as aching and locking of fingers in both hands. An EMG taken on May 6, 1998, evidenced neurological changes newly-developed since the November 1996 EMG. The employee's symptoms worsened to the point that her doctors recommended and performed surgery on both wrists. On July 14, 1998, Dr. Wilke performed a left carpal tunnel release and release of left trigger thumb and middle finger, and on March 9, 1999, a right carpal tunnel release and release of two trigger fingers.

This court has repeatedly stated that injuries are compensable if the employment is a substantial contributing factor not only to the cause of the condition but also to the aggravation or acceleration of a pre-existing condition. Wallace v. Hanson Silo Co., 305 Minn. 395, 235 N.W.2d 363, 28 W.C.D. 79 (1975). Based upon the employee's worsening condition and new symptoms which developed while she continued to work from 1997 through December 31, 1998, it appears that the compensation judge could have determined that substantial evidence of record supports the employee's claim that her work activities during this period of time caused, or at least accelerated, her bilateral carpal tunnel syndrome.

Notwithstanding this evidence, however, the compensation judge agreed with the employer and insurer's contention that the doctors on whose opinions the employee relies do not have adequate foundation for their opinions that the employee sustained a Gillette injury which culminated in 1998. The employer and insurer argue that those doctors did not have a complete history of the employee's symptoms and complaints. Dr. Olson, the employee's treating physician, whom she consulted in 1996 and then again in 1998 after a hiatus in treatment, received a history on April 20, 1998 from the employee that she had noted symptoms for "the past several months." (Resp. Ex. 1.) Dr. Wilke, the surgeon to whom Dr. Olson referred the employee, and who examined the employee in June 1998, also received a history from the employee that she had noticed increasing hand pain and fingertip numbness for five months, plus more frequent locking of fingers on both hands over the past several months. These histories concerned the compensation judge, since the employee actually had noticed some symptoms since 1996. The compensation judge states in her memorandum, p. 5, that

> The other problem is that the doctors who support the employee's claim that her work activities led to her disability do not appear to have a complete history of her symptoms and complaints. The records for example of Dr. Wilke report in June 1998 that the employee had a 5 month history of complaints. A more accurate history should have been that she had a close to 2 year history of complaints.

Based on this perceived discrepancy, the compensation judge determined that the opinions of Drs. Wilke and Olson lacked foundation. For that reason, the judge denied the claim.

As stated by the Minnesota Supreme Court, "The competency of a witness to provide expert medical testimony depends upon both the degree of the witness' scientific knowledge and the extent of the witness' practical experience with the matter which is the subject of the offered testimony." Reinhardt v. Colton, 337 N.W.2d 88, 93 (Minn. 1983), as cited in Drews v. Kohl's, 55 W.C.D. 33 (W.C.C.A. 1996), summarily aff'd (Minn. July 12, 1996). To establish an adequate foundation, the facts upon which an expert relies for his or her opinions must supported by the evidence. McDonald v. MTS Sys. Corp., 43 W.C.D. 83 (W.C.C.A. 1990), summarily aff'd (Minn. July 13, 1990).

In this case, the employer and insurer have not challenged Dr. Olson's or Dr. Wilke's scientific expertise, but have instead focused on the history outlined in their 1998 chart notes as reflecting an incomplete history. However, Dr. Olson clearly had more than two years of "practical experience with the matter" at issue, since he had treated the employee since 1996. See, Jepsen v. Bayliner Marine Corp., 55 W.C.D. 370 (W.C.C.A. 1996) summarily aff'd (Minn. Oct. 29, 1996). Dr. Wilke refers to Dr. Strobl's June 30, 1998 report which notes the EMG performed in 1996, and also discussed the employee's condition directly with Dr. Strobl. This points to the probability that Dr. Wilke was thereby made aware of the employee's 1996 symptoms at least through Dr. Strobl, if not through review of Dr. Olson's reports.

The employer and insurer's concerns about the doctors' lack of reference to the employee's 1996 symptoms call into question neither the degree of the doctors' knowledge nor the extent of their experience; see Drews, 55 W.C.D. at 39; Reinhardt, 337 N.W.2d at 93; nor do they demonstrate an inadequate factual foundation for the doctors' opinions. See also McDonald, 43 W.C.D. 83. Thus, although these concerns may relate to the persuasiveness or weight accorded the medical opinions, they are insufficient to establish lack of foundation. Drews, 55 W.C.D. at 40. See also Stuhr v. Northwestern Travel Serv., Inc., 57 W.C.D. 352 (W.C.C.A. 1997), summarily aff'd (Minn. Dec. 15, 1997), citing Bossey v. Parker Hannifin, slip op. (W.C.C.A. Mar. 14, 1994) (while adequate foundation is necessary for a medical opinion to be afforded evidentiary value, the expert need not be made aware of every relevant fact).

Dr. Call, the independent medical examiner, opined that the employee's condition was diabetic peripheral neuropathy, diabetic bilateral carpal tunnel syndrome and diabetic trigger fingers, not related to the employee's work activities. The judge made no finding concerning the

medical opinion of Dr. Call. She instead denied the employee's claim based upon the timing of the employee's symptoms and the lack of foundation for Dr. Olson and Dr. Wilke's opinions.

In view of the medical evidence of record, and because the compensation judge's conclusion that Dr. Olson's and Dr. Wilke's opinions lacked foundation was erroneous, we vacate and remand the case to the compensation judge for full consideration of the weight to be accorded to the opinions of Dr. Olson and Dr. Wilke.