

TWILA J. HOULE, Employee/Appellant, v. ABBOTT NW. HOSP., SELF-INSURED/GALLAGHER BASSETT SERVS., Employer-Insurer.

WORKERS' COMPENSATION COURT OF APPEALS
JANUARY 16, 2001

No. [REDACTED SSN]

HEADNOTES

PERMANENT PARTIAL DISABILITY - SHOULDER. Substantial evidence, including medical records and expert medical opinion, supported the compensation judge's determination of a three percent permanent partial disability.

Affirmed.

Determined by: Wheeler, C.J., Wilson, J., and Pederson, J.
Compensation Judge: Gary P. Mesna

OPINION

STEVEN D. WHEELER, Judge

The employee appeals from the compensation judge's rating of the employee's permanent partial disability from her March 26, 1997 work injury at 3 percent consistent with the opinion of Dr. Thomas Litman, M.D., rather than at 23.5 percent as proposed by the employee's osteopath, Dr. Bryant R. Beehler, D.O. We affirm.

BACKGROUND

The employee, Twila Houle, was born in 1964 and is 36 years old. She graduated from high school in 1981, took pre-nursing courses at Pillsbury College in Owatonna, Minnesota, and then completed two years of nursing training at Anoka Ramsey Community College. In 1987 the employee began working for the employer, the Abbott Northwestern Hospital, as a staff nurse. On July 24, 1989, the employee sustained a work injury to her right shoulder while assisting a patient. As a result of this injury, the employee underwent right shoulder surgery in 1992 but was able to return to work without restrictions in 1993 in her job for the employer as a staff nurse. She was able to continue in her regular duties including lifting and moving of patients. She did not require further medical treatment for her right shoulder through March 27, 1997. (Finding 2; Exh. 4; Exh. D; T. 14-20.)

On March 27, 1997, the employee sustained a new injury to the right shoulder when she fell while she and a nurse's aide were trying to reposition a patient who had just had a stroke, so that the employee could administer emergency CPR. (Finding 1; T. 21-23.)

The employee was seen for treatment a few days later at the emergency room at Abbott Northwestern where she was diagnosed with a right shoulder sprain. She was then treated with one session of physical therapy at Abbott's occupational health department. About two weeks after the injury the employee developed increased pain, swelling, and greater difficulty moving her shoulder. She was referred by Abbott Northwestern to Dr. Daniel D. Buss, M.D., her treating physician for her prior shoulder injury. Dr. Buss saw the employee on April 10, 1997. He diagnosed a deltoid strain with a hematoma and recommended treatment at the Sister Kenny Institute. He imposed restrictions for use of the right arm including no lifting above shoulder level, no repetitive outstretched reaching and no lifting greater than three pounds from table top to shoulder level or greater than five pounds from floor to table. (Exh D.)

On April 16, 1997 the employee was evaluated for physical therapy by Frederick C. Hjelm, PT. Her shoulder range of motion was noted to be only "trace for all active movement", but joint mobility was within normal limits and passive range of motion was "full" without restriction. The employee, however, displayed no ability to elevate her right arm for any type of activity. (Exh. 4.)

The employee was next seen by Dr. Buss on April 29, 1997. He noted that she had developed a lateral deltoid hematoma and had rapidly expanding right shoulder pain and weakness. The employee was unable to work due to her symptoms. Her shoulder had diffuse anterior tenderness and diffusely positive impingement signs. Dr. Buss recorded range of shoulder motion as "30/30/45" degrees, but noted that "[h]er passive motion is being maintained." (Exh. D.)

On June 3, 1997, the employee again returned to Dr. Buss for a recheck on her right shoulder. He noted that she continued to be dysfunctional as far as active range of motion and functional use of her right shoulder. The doctor recorded the employee's active right shoulder range of motion as: forward flexion 40°, abduction 40°, external rotation 65° and internal rotation behind back to belt level. However, passive range of motion was recorded as "180/170/65/90 degrees." Dr. Buss diagnosed a dysfunctional right rotator cuff, status post right deltoid strain. He recommended physical therapy and that an EMG be done to rule out suprascapular nerve palsy or axillary nerve involvement. (Exh. D.)

On July 29, 1997 Dr. Buss recorded that the employee's EMG had been negative. He again examined the employee and noted that she could not bring her arm forward in abduction or forward flexion but when passive motion was done could hold it in place at different levels in her range. The passive range of motion was noted to be "180, 180, 75, 90 and to the belt level." The employee's work restrictions were modified to allow lifting 10 pounds from floor to table, but only one pound from table to mid chest. She was given a work release to work on the employer's IV team. (Exh. D.)

The employee was next seen by Dr. Buss on August 28, 1997. He reported that the employee "has been working with Sue Johnson and overall has had a decrease in her pain and has been working on her motion; however, she has a difficulty in a small range of above chest levels from about 90 degrees to 120 degrees where she can not lift her arm. In a passive supine program, she is able to make a complete arc with light weights but can not do this motion with resistance,

active against gravity.” The employee’s passive range of motion was found to be 180°, 180°, 80°. He again modified the employee’s restrictions to no restrictions for lifting floor to tabletop, lifting up to three pounds table to shoulder and one pound over shoulder level with no repetitive overhead use of the right arm. (Exh. D.)

The employee transferred her care to an osteopath, Dr. Bryant R. Beehler, D.O., on October 1, 1997. On that date Dr. Beehler noted that the employee had undergone extensive treatment including physical therapy without resolution of her symptoms. The employee complained of losing range of motion in her shoulder and strength in her arm movements. Dr. Beehler noted that she had a difficult time with active motion but that her shoulder had a good passive range of motion. He restricted lifting with the right arm to 4-10 pounds in upright position, and indicated that the employee could now perform repetitive use of the shoulder so long as she used good judgment. (Exh. B.)

On November 5, 1997 Dr. Beehler noted that the employee continued to have limitations on the active movement of her shoulder over the 180 degree mark, but could be placed through a full range of motion with passive activities. He diagnosed disability of the right shoulder secondary to previous deltoid and biceps muscle tears and recommended a continued exercise program. On November 17, 1997 the employee returned to Dr. Beehler complaining of increased right shoulder and arm pain after lifting a roll of copy paper from a countertop at work. The employee was virtually unable to move her shoulder above the 180 degree mark. However, Dr. Beehler noted that the employee had a good passive range of motion in the right shoulder. (Exh. B.)

The employee continued to treat with Dr. Beehler in 1997 and 1998. She participated in a work hardening program at Abbott Northwestern from January 12, 1998 until February 23, 1998 when Dr. Beehler took her off this program when the employee complained she could no longer physically tolerate it. Throughout 1998 the doctor continued to note limitations in active motion of the employee’s right shoulder. (Exh. B.)

Following the failure of the work hardening program to bring the employee up to a level of work restrictions consistent with the needs of the employer, the employee was terminated by the employer in early March 1998. The employee subsequently found an administrative job within her restrictions at the Cambridge Medical Center as a patient care representative. (T. 33-34.)

In early 1999 Dr. Beehler began considering the rating of the employee’s permanent partial disability. On January 10, 1999 he issued a health care provider report indicating that the employee had a permanent partial disability rating of 30 percent of the whole body under Minn.R.5223.0110, subp. 2E. On January 22, 1999 he was advised that he had made the rating under the old disability schedule. On February 3, 1999 Dr. Beehler wrote that the new disability schedule “does not really adequately identify her disfunction [sic] in the shoulder at this time because of passive versus active motion loss. She has more active motion loss at this time . . . she does have severe loss of her active function of the shoulder and upper right extremity.” He reevaluated the employee on February 4, 1999 and applied the new schedules and reissued his

rating in a health care provider report of March 12, 1999. He indicated that the employee had a 23.5 percent rating under Minn.R. 5223.0450, subp. 4A(1)(3) (12.5%) and subp. 4B(1)(d) (11%). (Exhs. A, B.)

The employee was examined on behalf of the self-insured employer by Dr. Thomas Litman, M.D., on May 5, 1999. Dr. Litman recorded that the motion of employee's right shoulder actively was from 15 degrees of abduction to 60 degrees of flexion with 70 degrees internal rotation and 60 degrees external rotation, 30 degrees abduction and 30 degrees of extension. Passive range of motion was 140 degrees of abduction, 160 degrees of flexion, 80 degrees of internal rotation, 70 degrees of external rotation, 30 degrees of abduction and 30 degrees of extension. Dr. Litman wrote that the employee's right shoulder strength was quite good when placed in a position of function but that the employee could not actively place her shoulder in a position of function to test shoulder strength in those positions she could reach actively. In Dr. Litman's opinion, the employee had sustained a soft tissue strain of right the shoulder in the 1997 work injury, superimposed on her pre-existing shoulder condition. He opined that she had reached maximum medical improvement. Dr. Litman rated the employee with a three percent permanent partial disability pursuant to Minn. R. 5223.0450, subp. 4B(1)(b),¹ based on passive motion of 30 degrees abduction and 140 degrees abduction. He noted that the workers' compensation guidelines did not afford further permanency, as they were specifically predicated on measurements of the passive range of motion, "which obviously makes a great deal of difference to Ms. Houle's rating since her passive [range of motion] is so much greater than her active [range of motion]." (Exh. 1.)

The employee filed a claim petition on August 3, 1999 seeking permanent partial disability for a 23.5 percent disability. (Judgment Roll.)

On April 27, 2000, Dr. Beehler wrote a letter stating that he had performed range of motion testing on several different visits to develop a disability rating, and expressing a continuing opinion that the employee should be rated with a 23.5 percent permanent partial

¹ Minn. R. 5223.0450, subp. 4B(1)(b), provides as follows:

Categories describing loss of function. Function at the shoulder is measured by the available passive range of motion in three arcs at the shoulder: flexion or extension, abduction or adduction, and rotation. Examination with goniometer is performed to determine the limits of passive range of motion in each arc. If there is an impairment in more than one arc, the ratings for each arc are added to determine the final impairment for loss of function.

* * *

B. Extent of range of abduction or adduction:

(1) adduction is greater than zero degrees and abduction is

* * *

(b) to between 121 degrees and 150 degrees, three percent.

disability.² Dr. Beehler reported that he had measured the employee's passive range of motion with a goniometer on April 18, 2000 and that he had found that passive abduction was greatly limited and measured less than 80 degrees, and that passive flexion measured less than 40 degrees. He further stated:

My opinion sharply differs from Dr. Litman's. My understanding of passive range of motion testing, I believe, is correct and differs apparently from that of Dr. Litman's technique. Apparently Dr. Litman's opinion of what passive motion means is more forcible than I appreciate. Forcibly moving a joint is always possible, but what is reasonable force to cause passive motion of a joint while assessing its range of passive motion. That question needs to be answered. A just interpretation of passive motion of a joint is the motion a joint allows without any involuntary resistance by the patient while the outside force is being applied to move the joint through its range of motion. When involuntary resistance occurs, this should be the limit of passive motion that is appreciated in that joint for that particular passive motion being tested.

(Exh. A.)

The employee's claim for permanent partial disability was heard by a compensation judge at the Office of Administrative Hearings on May 11, 2000. Following the hearing, the judge found that the employee had sustained a three percent permanent partial disability. The employee appeals.

STANDARD OF REVIEW

On appeal, this court must determine whether the compensation judge's findings and order are "clearly erroneous and unsupported by substantial evidence in view of the entire record as submitted." Minn. Stat. § 176.421, subd. 1(3) (1992). Substantial evidence supports the findings if, in the context of the record as a whole, they "are supported by evidence that a

² Dr. Beehler's rating is based on Minn. R. 5223.0450, subp. 4A(1)(e) and 4B(1)(d), which provide, in pertinent part, as follows:

- A. Extent of range of flexion or extension:
 - (1) extension is greater than zero degrees and flexion is:
* * *
 - (e) to between zero degrees and 50 degrees, 12.5 percent;
* * *
- B. Extent of range of abduction or adduction:
 - (1) adduction is greater than zero degrees and abduction is:
* * *
 - (d) to less than 81 degrees, 11 percent.

reasonable mind might accept as adequate." Hengemuhle v. Long Prairie Jaycees, 358 N.W.2d 54, 59, 37 W.C.D. 235, 239 (Minn. 1984). Where the evidence conflicts or more than one inference may reasonably be drawn from the evidence, the findings must be affirmed. Id. at 60, 37 W.C.D. at 240. Similarly, "[f]actfindings are clearly erroneous only if the reviewing court on the entire evidence is left with a definite and firm conviction that a mistake has been committed." Northern States Power Co. v. Lyon Food Prods., Inc., 304 Minn. 196, 201, 229 N.W.2d 521, 524 (1975). Factfindings may not be disturbed, even though this court might disagree with them, "unless they are clearly erroneous in the sense that they are manifestly contrary to the weight of the evidence or not reasonably supported by the evidence as a whole." Id.

DECISION

The compensation judge expressly adopted the passive range of motion findings of Dr. Litman and found that the employee had extension of 30 degrees and flexion of 160 degrees, abduction of 30 degrees and abduction of 140 degrees, and internal rotation of 80 degrees and external rotation of 70 degrees. There is no dispute that if the applicable rule from the disability schedules, Minn.R. 5334.0450, subp. 4, is applied to these passive range of motion figures, the employee is entitled to a rating of a three percent permanent partial disability.

The employee raises two factual objections to the validity of Dr. Litman's measurements of the employee's right shoulder passive range of motion. The employee first points to her testimony at the hearing that Dr. Litman was unable to locate a goniometer at the time of his examination on May 5, 1999, and did not use one in measuring her right shoulder range of motion, whereas Dr. Beehler, her treating physician, always used a goniometer³. (T. 30-33, 40.) The employee in essence asserts that in light of the employee's testimony that Dr. Litman did not use a goniometer, the opinion of Dr. Litman regarding her range of motion lacked adequate foundation, and does not provide substantial evidence to support the judge's finding as to her passive range of motion. The employee further argues that the measurements given by Dr. Beehler should also have been adopted in preference to those of Dr. Litman because the two physicians allegedly disagree as to the underlying definition of passive range of motion. Specifically, Dr. Beehler stated in his April 27, 2000 letter that his measurements of passive range of motion were predicated on the view that measurement should stop at the point where involuntary resistance is encountered to the motion, rather than measure any further range of motion beyond the initial resistance. Dr. Beehler further stated that, in his opinion, Dr. Litman does not share this view.

We do not find the employee's arguments persuasive. There is ample evidence to support the compensation judge's factual finding concerning the employee's passive range of motion. We note, as did the compensation judge, that in addition to the measurements made by Dr. Litman and by Dr. Beehler for the purpose of rating disability, the record is replete with other measurements of the employee's right shoulder passive range of motion made in the course of

³ While the employee's testimony is the only evidence as to whether Dr. Litman used a goniometer, the judge was not required to accept that testimony as credible. The judge's findings and order do not discuss the question of the use of a goniometer by Dr. Litman and do not indicate whether the employee's testimony on this point was considered to be credible.

diagnosis and treatment by various physicians and medical personnel. These measurements, including those previously reported by Dr. Beehler before April 2000, indicate relatively unimpaired passive motion. The record does not actually disclose whether Dr. Beehler and Dr. Litman differ with respect to the underlying definition of what constitutes a passive range of shoulder motion, as Dr. Litman does not discuss this matter in his reports. However, any difference in this definition would simply constitute a divergence in expert medical opinion, and this court has repeatedly held that the compensation judge's choice between the divergent opinions of medical experts should be affirmed unless unsupported by an adequate foundation. If Dr. Litman's medical view of passive motion involves proceeding to measure available motion past initial involuntary resistance, the trier of fact was not required to find the physician's technique to be inappropriate in the medical field and specifically in the measurement of range of motion and rating of disability.

Nor do we see a fatal foundational defect arising from Dr. Litman's alleged failure to use a goniometer in measurement. Given that Dr. Litman's measurements were very consistent with measurements performed by all other doctors in the case, including the measurements initially performed by Dr. Beehler, it does not appear that there is a basis to assume that the doctor's assessment of the degrees of motion was rendered inaccurate in that he may have depended upon experience and a "trained eye" rather than on a mechanical measurement aid. Accordingly, at least as an objection to the foundation to the judge's *factual* finding, we find no merit in the employee's arguments.

The employee also raises a legal objection to the use of Dr. Litman's measurements to rate the employee's disability, again on the basis that these measurements may not have been made with a goniometer. The employee asserts that measurement with a goniometer is a prerequisite, as a matter of law, to rating the employee's loss of function under Minn.R. 5223.0450, subp. 4, which states (emphasis added):

Subp. 4. Categories describing loss of function. Function at the shoulder is measured by the available passive range of motion in three arcs at the shoulder: flexion or extension, abduction or adduction, and rotation. **Examination with the goniometer is performed to determine the limits of passive range of motion in each arc.** If there is an impairment in more than one arc, the ratings for each arc are added to determine the final impairment for loss of function.

The language of this rule is somewhat ambiguous, in that the rule does not use words of command, such as "shall be performed" or "must be performed." We assume, however, that the inclusion of language about the use of a goniometer was not merely gratuitous. Nevertheless, we conclude that this provision should not bar the rating made in this case. Here, the measurements made by Dr. Litman, whether or not made using a goniometer, were markedly consistent with those made by all the other physicians except those made by Dr. Beehler for the purpose of rating the employee's permanency. The compensation judge expressed misgivings about whether the measurements given in Dr. Beehler's April 27, 2000 letter, which were

inconsistent with that physician's prior recorded measurement of passive range of motion, were entirely credible. Under the specific circumstances of this case, we believe that the judge's misgivings were not unreasonable. (See Mem. at 3.) We do not interpret the rule's language in a manner which would require that a compensation judge reject otherwise well-supported evidence of the employee's passive range of motion in favor of evidence specifically and reasonably considered questionable by the compensation judge, merely because of unsubstantiated testimony by an employee about the use or lack of use of a goniometer.

Both Dr. Beehler and Dr. Litman, as well as the compensation judge, noted that in light of the rather atypical response of the employee's shoulder condition, such that active motion is markedly impaired while passive motion is relatively unaffected, the disability schedules in effect for her injury, predicated solely on passive range of motion measurements, may not fully reflect the true extent of the employee's permanent functional impairment. With this observation we are fully in agreement. However, the employee's condition is one which is expressly rated under the disability schedules, and the workers' compensation courts are without authority to deviate from the rating provided.⁴

⁴ The finding in this matter does not preclude the employee from filing a subsequent claim for the same rating should her condition change and her passive range of motion decrease on a consistent and permanent basis.