

CAROL A. HUGHES, Employee, v. EDWARDS MFG. and CINCINNATI INS. COS.,
Employer-Insurer/Appellants, and ORTHOPAEDIC & FRACTURE CLINIC, Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
JULY 2, 2001

No. [REDACTED SSN]

HEADNOTES

CAUSATION - SUBSTANTIAL EVIDENCE. Substantial evidence, including the testimony of the employee and the adequately founded opinions of her treating physician, support the compensation judge's determination that the employee's C6-7 disc herniation and need for medical treatment from and after August 12, 1999 were causally related to her July 13, 1998 work injury.

PRACTICE & PROCEDURE. The compensation judge's decision is sufficient under Minn. Stat. § 176.371, where the compensation judge did not neglect to rule on any claims or defenses presented by the parties, and the rationale for his decision is amply evident from the decision as a whole, providing sufficient basis for review.

INTERVENTION. The compensation judge did not err in awarding payment or reimbursement of medical expenses to non-intervening medical providers where the employee, pursuant to Minn. Stat. § 176.291, directly asserted claims for the medical expenses awarded.

Affirmed.

Determined by: Johnson, J., Wilson, J., and Pederson, J.
Compensation Judge: Rolf G. Hagen

OPINION

THOMAS L. JOHNSON, Judge

The employer and insurer appeal the compensation judge's finding that the employee sustained a cervical spine injury on July 13, 1998, arising out of and in the course of her employment with Edwards Manufacturing. The appellants further appeal the compensation judge's reimbursement of medical expenses to medical providers who failed to intervene in this proceeding. We affirm.

BACKGROUND

Carol A. Hughes, the employee, began working for Edwards Manufacturing, the employer, in January 1992. On January 11, 1994, the employee saw Wallace A. Winegar, D.C., complaining of pain in her lower cervical and upper dorsal muscles. The doctor recorded the employee was sitting on the couch when the pain came into her left shoulder. The doctor reported

the employee had had the same pain previously. On examination, Dr. Winegar noted pain and tenderness at T4 and T5 with muscle spasm. Dr. Winegar prescribed diathermy, a spinalator treatment and a spinal adjustment. The employee returned on January 12, 1994, and Dr. Winegar noted she was 75 percent improved with some residual pain in her left shoulder and neck. On January 14, 1994, the doctor noted the employee was 80 percent improved and provided further treatment. (Pet. Ex. U.) The employee testified she did not return to see Dr. Winegar because she felt fine. She received no further treatment for her neck or shoulder between January 14, 1994 and July 13, 1998. (T. 30-31.)

Initially, the employee worked 30 hours a week for the employer assembling rain gauges. Sometime thereafter, she increased her hours to 40 hours a week and also shipped rain gauges. In 1996, the employee went back to her job as an assembler and reduced her hours to 30 hours a week. (T. 33-35.) To perform her job, the employee stood at a waist-high bench and assembled small plastic parts with her arms in front of her. When assembled, a rain gauge weighed less than one pound. (T. 37-39.) On July 13, 1998, the employee was placing rain gauges into a box which held twelve gauges. She testified she reached across the table with her right hand for a box when she heard a pop and felt a pain sensation in her left shoulder area and felt spasms in her left shoulder and on the left side of her neck and back. (T. 45-47.) The box for which the employee was reaching was empty and weighed one-half pound or less. (T. 49.) The employee finished her shift on July 13, 1998, and went home. She went to work the next morning, reported an injury and then left to seek medical treatment. (T. 49-50.)

The employee saw Terry I. Judd, D.C., on July 14, 1998. In a history form, the employee reported reaching for a box and feeling a pop in her left shoulder blade area with muscle spasms and soreness in the left side of her neck and upper shoulder. On examination, Dr. Judd noted tenderness from C5 through T7 with muscle spasm and limited range of cervical motion. Dr. Judd commenced a regimen of chiropractic treatment. Ultimately, Dr. Judd referred the employee to Dr. Teresa M. Plucinski at the Albert Lea Clinic. (Pet. Ex. 1.)

The employee saw Dr. Plucinski on November 9, 1998. The doctor recorded a history of a popping sensation on July 13, 1998, with constant pain thereafter over C7 into the cervical paraspinal muscles. The doctor diagnosed a chronic cervical strain and ordered an MRI scan which showed a focal disc herniation at C7 to the left with some edema of the C7 nerve root and extrusion of the C7 nerve root sleeve. The diagnosis remained chronic cervical strain. Dr. Plucinski prescribed Motrin and continued physical therapy. (Pet. Ex. B.)

The employee was examined by Dr. Sunny S. Kim on January 5, 1999. The employee gave a history of a work injury on July 13, 1998, while reaching forward for a box. On examination, the doctor noted a full range of shoulder motion with no impingement signs and normal reflexes, motor function and sensation in the arms. Dr. Kim reviewed the MRI scan which he interpreted to show a slight left-sided C6-7 herniation without significant nerve root or spinal cord impingement. The doctor diagnosed chronic cervicgia secondary to a work injury. Dr. Kim did not believe the employee was a surgical candidate and recommended home cervical traction and physical therapy. (Pet. Ex. D.)

Dr. Christopher T. Daley of the Orthopaedic & Fracture Clinic, P.A., examined the employee on March 2, 1999, on referral from Dr. Judd. The employee gave a history of her work injury when reaching for a box, with continued pain around C7 with radiation into her shoulders. On examination, the doctor noted no significant radicular type features or signs of impingement. Dr. Daley referred the employee to Dr. Paul Hergott for a strengthening program. The employee participated in twenty-one rehabilitation sessions. By report dated June 8, 1999, Dr. Hergott diagnosed cervical strain/sprain, deconditioning syndrome and cervical disc syndrome. The doctor noted the employee had a small disc herniation but it did not impinge on any nerve or the spinal cord and her symptoms were more that of a strain pattern. The doctor observed the employee had an 85 to 95 percent improvement in her symptoms with normal strength and normal range of motion. The doctor opined the employee had reached maximum medical improvement without any permanent disability and could return to her regular work duties without restriction. Dr. Hergott's report was served on the employee on June 23, 1999. (Pet. Ex. F.)

On August 12, 1999, the employee and her family left for a vacation in Montana. The family drove from Albert Lea to Philip, South Dakota, where they stayed in a motel overnight. The next morning as the employee sat up to get out of bed, she felt excruciating pain and spasms in her neck, back and left shoulder with numbness down her arm and into her hand. The employee testified this was the same area where she had previously felt pain, although it was much more intense. (T. 78-80.) Later that day, she sought treatment at the Belle Forche Clinic. The employee was given Demoral by injection to relieve her muscle spasm. (Pet. Ex. H.) The employee then returned home to see her doctor. (T. 82.) The employee saw Dr. Daley on September 2, 1999, and reported she was doing well until August 12, when she sat up in bed and felt an acute onset of neck, left shoulder and radicular pain. The doctor ordered an EMG which was compatible with a lesion of the left C7 nerve root. A repeat MRI scan showed a small left C6-7 disc herniation with mild impingement of the C7 nerve and flattening of the left ventral cord. On October 7, 1999, Dr. Daley opined the studies showed a C7 nerve root problem and referred the employee to Dr. Gene Swanson in the Mankato office of the Orthopaedic & Fracture Clinic. Dr. Daley opined the employee's condition was not new, but was an exacerbation of her previous work injury. (Pet. Ex. F.)

Dr. Swanson examined the employee on October 26, 1999, and reviewed the EMG and MRI studies. The doctor concluded the employee had a left-sided disc herniation at C6-7 with significant extrusion of fragments into the left foramen. He recommended an anterior discectomy and inner body fusion which was performed on November 22, 1999. By December 28, 1999, Dr. Swanson noted the employee had excellent cervical range of motion with normal reflexes and normal motor strength. He released the employee to return to light-duty work, three hours a day with a gradual increase in work hours over the next four weeks to full-time. By report dated July 21, 2000, Dr. Swanson opined the employee had reached maximum medical improvement and rated an 11.5 percent permanent disability. (Pet. Ex. G.)

The employee was examined by Dr. Mark Friedland at the request of the employer and insurer on February 22, 2000. The doctor's deposition was taken on September 26 and October 26, 2000. As part of his examination, Dr. Friedland reviewed the employee's medical records, obtained a history from the employee and conducted a physical examination. Based on

his review of the records, Dr. Friedland opined that in July 1998 he would have diagnosed the employee's work injury as an upper thoracic parascapular/trapezius strain. This injury, the doctor opined, was a temporary aggravation of a pre-existing degenerative disc disease. The doctor stated the November 1998 MRI scan demonstrated chronic degenerative disc disease and showed no significant nerve root impingement. Dr. Friedland concluded the employee sustained a muscle strain on July 14, 1998, which injury resolved at least by June 8, 1999, when Dr. Hergott stated the employee was at MMI. The Belle Forche Clinic records on August 13, 1999, document complaints of pain radiating into the left arm. Dr. Friedland opined this was the first evidence of any C7 radiculopathy and, prior thereto, the employee had showed no symptoms of a C6-7 disc herniation. Accordingly, Dr. Friedland concluded the July 14, 1998 injury was not a cause of the C6-7 disc herniation or the employee's need for treatment from and after August 13, 1999. (Resp. Ex. 1.)

Dr. Swanson prepared a medical report dated November 1, 2000. The doctor outlined the history obtained from the employee of a work injury on July 13, 1998, while reaching for a small box in her work area. The doctor stated the 1998 MRI scan showed a disc herniation at C6-7, but noted the employee demonstrated no evidence of neurological impairment on examinations. Dr. Swanson reported the employee improved, as noted by Dr. Hergott, until August 13, 1999, when she awoke with complaints of muscle spasm. The subsequent MRI scan showed a significant C6-7 disc herniation on the left which correlated with examination findings of an absent triceps reflex on the left and triceps muscle weakness. Based on these findings, the doctor performed surgery. Dr. Swanson opined the work injury was a contributing cause of the C6-7 disc herniation shown on the 1998 MRI scan. The employee did not, however, have any neurological findings at that time. In August 1999, the disc further herniated without any additional trauma. Dr. Swanson concluded there was a causal relationship between the work injury and the subsequent disability and need for surgery. (Pet. Ex. W.)

The employee's claim for benefits was heard on September 29, 2000. In a Findings and Order filed November 29, 2000, the compensation judge found the employee sustained an injury to her left shoulder and cervical spine on July 13, 1998, and awarded wage loss benefits and permanent partial disability benefits to the employee. In addition, the compensation judge ordered the employer and insurer to pay certain medical expenses. The employer and insurer appeal.

DECISION

The compensation judge found the July 13, 1998, injury permanently weakened the employee's cervical spine resulting in a C6-7 disc herniation. (Finding 8.) In his memorandum, the compensation judge stated the work injury set in motion a "process of degeneration" which resulted in the ultimate breakdown on August 12, 1999, with the resultant surgery. (Memo at p. 9.) The compensation judge found the work injury was a substantial contributing cause of the employee's disability and need for medical care. (Finding 16.) The appellants assert the compensation judge's finding of causation is unsupported by the record. They contend there is no evidence or testimony that the employee's cervical spine condition deteriorated from July 1998 to August 1999. Rather, they argue the evidence is more consistent with Dr. Friedland's opinion that the work injury was temporary and resolved by June 1999. The worsening of the employee's

condition in August 1999, appellants argue, was not related to the work injury but rather the employee's pre-existing degenerative disc disease. Accordingly, the appellants ask we reverse the compensation judge's causation finding.

It is well settled that injuries are compensable if the employment is a substantial contributing factor to the cause of the condition or 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). An employee need not prove the employment was the sole cause, only a substantial contributing cause of the disability for which benefits are sought. Swanson v. Medtronics, Inc., 443 N.W.2d 534, 536, 42 W.C.D. 91, 94-95 (Minn. 1989).

The employee reported a history of left scapular pain following the July 1998 work injury. The doctor stated that in his experience "an initial painful episode along the medial border of the scapula . . . is frequently associated with significant disc herniation. In this instance, this patient reported a significant pain along the medial border of her scapula on the left side as a part of her initial symptomatology." Dr. Swanson concluded the employee's work injury was consistent with a C6-7 disc herniation which initially responded to conservative care, but in August 1999 herniated further requiring surgical decompression. Dr. Swanson opined a relationship between the employee's work injury and the subsequent necessity for treatment and surgery. Dr. Swanson's opinions were adopted by the compensation judge.

The appellants contend Dr. Swanson's opinions lack foundation because he did not review the employee's pre-injury medical records. We disagree. The employee's attorney requested a report from Dr. Swanson and provided the doctor with pages 29 through 38 of Dr. Friedland's deposition. (Resp. Ex. 1.a.) These pages include a hypothetical question and refer, at length, to the employee's treatment with Dr. Winegar in 1994. In his report, Dr. Swanson specifically noted the employee had historical evidence of neck discomfort for which she received chiropractic care. Clearly, Dr. Swanson considered the employee's pre-injury medical history in rendering his opinions. Dr. Swanson's opinions were adequately founded and the compensation judge could reasonably rely on those opinions. The compensation judge's causation finding is supported by substantial evidence and is affirmed.

The employer next argues the judge failed to comply with Minn. Stat. § 176.371,¹ because the judge did not explain *why* he found the causation opinions of Dr. Swanson more

¹ Minn. Stat. § 176.371 provides as follows:

The compensation judge to whom a petition has been assigned for hearing, shall hear all competent, relevant evidence produced at the hearing. All questions of fact and law submitted to a compensation judge at the hearing shall be disposed of and the judge's decision shall be filed with the commissioner, except where expedited procedures require a shorter time, within 60 days after the submission, unless sickness or casualty prevents a timely filing, or the chief administrative law judge extends the time for good cause.

persuasive than the opinion of Dr. Friedland, and because the judge's decision did not mention Dr. Friedland's testimony. We disagree. The judge's rationale is amply evident from his decision as a whole, and nothing in Minn. Stat. § 176.371 necessarily mandates an explanation by the judge regarding his basis for choosing one expert over another. Case law authority² cited by the employer relative to this issue is not dispositive because, in the present case, the judge's findings and memorandum provide sufficient basis for our review and the judge did not neglect to rule on any claims or defenses presented by the parties.

Finally, the employer and insurer appeal the compensation judge's award of medical benefits to the non-intervening medical providers. The appellants cite Minn. R. 1415.1200 which deals with intervention in a workers' compensation case. Subpart 6 of the rule states that failure to comply with the rule will result in a denial of the claim for reimbursement unless the compensation judge determines that the noncompliance is merely technical. Since all the medical providers except the Orthopaedic & Fracture Clinic failed to intervene, the appellants contend the compensation judge erroneously awarded payment of their bills. We disagree.

Intervention is governed by Minn. Stat. § 176.361. Subpart 7 of the statute states: "Failure to comply with this section shall not result in a denial of the claim for reimbursement unless the compensation judge, or commissioner, determines that the noncompliance has materially prejudiced the interests of the other parties." Regardless of intervention by a provider, the employee has the right, under Minn. Stat. § 176.291 to assert directly any claims for medical expenses. The employee did so here. Petitioner Exhibit Q consists of copies of medical bills from the medical providers. The exhibit was admitted at the hearing without objection, and the employer never disputed the reasonableness or necessity of the claimed medical expenses. The compensation judge properly awarded reimbursement to the medical providers.

The compensation judge's decision shall include a determination of all contested issues of fact and law and an award or disallowance of compensation or other order as the pleadings, evidence, this chapter and rule require. A compensation judge's decision shall include a memorandum only if necessary to delineate the reasons for the decision or to discuss the credibility of witnesses. A memorandum shall not contain a recitation of the evidence presented at the hearing but shall be limited to the compensation judge's basis for the decision.

² Olson v. Menasha Corp., 59 W.C.D. 14 (W.C.C.A. 1998); Fox v. Micro Machine, Inc., slip op. (W.C.C.A. May 1, 1986). In cases involving complex legal issues, a detailed explanation by the judge is sometimes necessary to allow for adequate appellate review. See LaBrocca v. Children's Health Care, slip op. (W.C.C.A. Mar. 4, 1997). However, the present case involves purely factual issues that are not particularly complicated.