CRAIG L. PLADSON, SR., Employee/Appellant, v. PLADSON CONCRETE MASONRY and STATE FUND MUT. INS. CO., Employer-Insurer.

WORKERS' COMPENSATION COURT OF APPEALS
APRIL 9, 2001

No. [REDACTED SSN]

HEADNOTES

PERMANENT PARTIAL DISABILITY - BACK; PERMANENT PARTIAL DISABILITY - OBJECTIVE FINDINGS; RULES CONSTRUED - MINN. R. 5223.0390, SUBP. 3C(2). Where the judge's decision was supported by three expert medical opinions that, in effect, the employee's pain complaints were not "substantiated by persistent objective clinical findings," the compensation judge's conclusion that the employee had not sustained "an 'abnormality' shown on scans which is the result of the [e]ffects of the personal injury; and/or pursuant to the requirements [of Minn. R. 5223.0390,] subp. 3C(2)," was not clearly erroneous and unsupported by substantial evidence.

Affirmed.

Determined by Pederson, J., Johnson, J. and Rykken, J.
Compensation Judge: Bernard Dinner

OPINION

WILLIAM R. PEDERSON, Judge

The employee appeals from the compensation judge's denial of permanent partial disability benefits pursuant to Minn. R. 5223.0390, subp. 3C(2). We affirm.

BACKGROUND

In 1988, Craig Pladson sustained a work-related cervical injury for which he is apparently still being treated. Three or four years later Mr. Pladson developed some symptoms also in his low back, regarding which he underwent an MRI scan on January 27, 1992. The scan was read to reveal mild disc bulges at L2-3 and L3-4 without evidence of herniation, a moderate disc bulge at L4-5 without herniation, and an intact disc at L5-S1 without evidence of herniation. On February 6, 1992, Mr. Pladson began receiving treatment for his low back condition from occupational medicine specialist Dr. Joseph Wegner, from whom he had been receiving treatment for several years for his cervical condition. Noting that the employee's recent MRI had shown multilevel degenerative changes but no evidence of nerve root impingement, Dr. Wegner diagnosed "[m]echanical low back pain with right leg pain that . . . may represent referred pain secondary to his low back." Mr. Pladson was referred for physical therapy and was subsequently followed on a PRN basis.

On June 14, 1994, Mr. Pladson [the employee] sustained a work-related injury to his low back in the course of his work as a self-employed masonry contractor with Pladson Concrete Masonry [the employer]. The employee was forty-six years old on that date, with weekly earnings that are undetermined in the record. Subsequent to his injury, on July 5, 1994, the employee saw chiropractor Dr. Darrell Danielson for what he described as a "stiff and sore" back of sudden onset at work. Dr. Danielson diagnosed an "[a]cute lumbosacral sprain," prescribed a TENS unit, and released the employee to work without restrictions as of July 11, 1994. On October 6, 1994, Dr. Danielson issued a Health Care Provider Report, on which he indicated that the employee had reached maximum medical improvement [MMI] with regard to his June 14, 1994, work injury, with no consequent permanent partial disability.

On that same date, October 6, 1994, the employee was examined again by Dr. Wegner at the Physicians Neck and Back Clinic, for complaints of near constant low back and right leg pain, with numbness or tingling radiating below the knee. Dr. Wegner's clinical exam was essentially normal, except that range of motion and leg raising were somewhat restricted by complaints of low back pain, and there was some tenderness to palpation. Gait, heel walking, and toe walking were easy and normal, percussion was not painful, there was no muscle spasm, lower extremity reflexes were normal and symmetrical, and leg sensation was normal bilaterally. Dr. Wegner diagnosed mechanical low back pain and severe deconditioning syndrome, concluding that the employee's leg symptoms were referred and not radicular. He indicated that diagnostic testing had shown the employee's severe deconditioning syndrome to have left the employee with a 50% deficit when compared with a normal population, which the doctor saw manifested by the employee's "inability to do the normal activities of daily living." He indicated that the employee had lost 50% of his lumbar strength since previous testing in 1992 and that "[t]his, in my opinion, likely contributes to his ongoing symptoms. As his deficit is corrected I am optimistic he will be able to return to his bricklaying job." Concluding that the employee had not yet reached MMI, Dr. Wegner recommended "a program of progressive, resistive and mobility exercises, body mechanics instruction and home maintenance exercises combined with aerobic conditioning," indicating that "[t]reatment will only continue if the [employee] is making measurable progress towards functional improvements." Dr. Wegner released the employee to continue working during his rehabilitation, recommending that he restrict lifting to thirty-five pounds and avoid repetitive stooping and bending at the waist.

On February 13, 1995, while still treating with Dr. Wegner, the employee presented his symptoms to internal medicine specialist Dr. Jerrol Noller, who referred him for a CT scan and an orthopedic evaluation. The CT scan, conducted that same date, was read to reveal a normal disc at L5-S1 with moderate degenerative arthritis at that level; "mild posterior broad based bulging" of the disc at L3-4, which the radiologist expressly found "comparable to the findings on the previous MRI, (January 1992)"; and a "moderate posterior broad based bulging" of the disc at L4-5, which the radiologist also found "essentially unchanged when compared to the study from 1992." In his conclusion, the radiologist reiterated that the degeneration and bulging at L4-5 represented "no significant change over the past three years" when "compared to a previous MRI of the lumbar spine dated 01/27/92," finding the scan results to be "[o]therwise unremarkable." On February 15, 1995, the employee was examined by orthopedist Dr. Jon Wallestad, whose physical examination revealed "obvious muscle spasm and splinting in the lumbar area with significant restriction of motion." Dr. Wallestad diagnosed lumbar radicular syndrome with

degenerative discs at L3-4 and L4-5 and recommended that the employee continue treatment with the Physicians Neck and Back Clinic. The employee did so, and about seven months later, on September 13, 1995, after intermittent progress and relapse, Dr. Wegner reported to his file, "Once again, I've discharged [the employee] from our program" with regard to his low back condition,[1] indicating that the employee "likely will have good days and bad days."

On November 25, 1996, the employee was examined for the employer and insurer by neurologist Dr. Bruce Idelkope. Dr. Idelkope reviewed the employee's entire medical history, including the following: the employee's January 1992 lumbar MRI scan and February 1995 lumbar CT scan; medical records of Dr. Wallestad, Dr. Noller, Dr. Wegner, Dr. Danielson, Orthopedic Partners, Physicians Neck and Back Clinic, Associated Medical Consultants, Midwest Internal Medicine, and Mercy Health Care Center related to the employee's low back condition; and various other medical records related to the employee's cervical condition and various other maladies. Upon that review and a physical examination of the employee, Dr. Idelkope diagnosed "subjective discomfort in his . . . lumbar spine with restricted range of motion." While stating on this date that "[i]t appears that [the employee] suffered an exacerbation in June 1994 which persists to date as a permanent exacerbation," Dr. Idelkope indicated that the employee's present medical status disclosed "no objective abnormalities" nor "any loss of function."

Dr. Idelkope had recommended a pain management program, and on February 6, 1997, occupational health specialist Dr. Robert Clift, Ph.D., wrote to Dr. Wegner, reporting that he had evaluated the employee with regard to his possible need for pain clinic treatment. It was Dr. Clift's opinion that the employee had "a chronic, intractable pain problem," but the doctor stated, "I very much doubt that treatment in a chronic pain clinic would add anything to this gentleman's repertoire of pain management techniques."

On May 28, 1997, the employee commenced treatment with chiropractor Dr. James Napoli, for complaints of severe neck pain and sharp low back pain intermittently "for over a year now," for which the employee had found only temporary relief through physical therapy. About a year later, Dr. Napoli referred the employee for evaluation by a neurosurgeon, and another MRI scan was ordered. The scan was conducted on July 7, 1998, and was read to reveal the following: moderate degenerative disc disease at L2-3; moderate degenerative disc disease at L3-4, with a small disc protrusion indenting the thecal sac; moderately severe degenerative disc disease with a small broad-based disc bulge at L4-5, which appeared less than that described on the employee's February 1995 CT scan; mild degenerative disc disease with a small disc bulge at L5-S1, without evidence of disc herniation; and no evidence for central canal stenosis or significant neural foraminal narrowing.

On July 9, 1998, the employee was examined by neurosurgeon Dr. Edward Hames. On examination, Dr. Hames found a reduced range of motion in the lumbar spine but negative findings on straight leg raising tests and no neurological deficits. Motor exams with respect to tone, strength, coordinatory behavior, and gait were normal, a sensory exam was intact, and

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[1] Dr. Wegner subsequently saw the employee again, beginning in February 1996, but treatment was evidently confined primarily to the employee's neck condition, which is not a subject of the current appeal.

reflexes were symmetrical. Dr. Hames assessed a "very benign neurological examination and benign imaging," concluding that, "[i]n point of fact, there certainly is a paucity of any findings from a pathological perspective to establish the diagnosis for this patient's pain."

On July 28, 1998, the employee returned to see Dr. Noller, who noted that the employee's recent MRI scan had shown minimal anatomic derangement and that, despite the employee's "extreme pain," the employee "seems to be stuck with very little in the way of objective evidence on scans and films." Dr. Noller referred the employee to neurologist Dr. Daniel Randa, whom the employee saw on August 19, 1998. Upon examination, Dr. Randa found the employee to have supple lumbar musculature, to have no spasm, and to be neurologically normal, with excellent strength and symmetrical reflexes in both legs. Radiological scans revealed multilevel degenerative changes but no significant stenosis. Dr. Randa concluded that the employee had "pronounced pain complaints for which an adequate explanation is not apparent," noting that the employee's demeanor was inconsistent with his multiple severe pain complaints. Dr. Randa found the etiology of the employee's condition unclear, expressing "some concerns regarding [the employee's] regular use of narcotics" and regarding "a chronic pain syndrome with all of the psychosocial manifestations of that entity." He recommended only that the employee "proceed with a vigorous regular exercise program" and "remain as active as possible and continue his employment."

Over the course of eight days between September 2 and September 16, 1998, the employee was the subject of videotape surveillance conducted at the request of the employer and insurer. It was the conclusion of the president of the surveillance company, in his report to the employer's insurer, that the employee "demonstrated no signs of injury or disability as he walked, bent over, working on his knees, entered and exited trucks, operated machinery, lifted and carried items, including several large pieces of lumber and twisted and turned his body."

On March 5, 1999, the employee was examined again by Dr. Idelkope, who, upon review of the medical records of Drs. Hames and Clift, concluded that the employee's "history and clinical examination are identical to those reviewed in November 1996." The doctor diagnosed "cervical and lumbar strain," with "no evidence of any other abnormalities of the nervous system," concluding that the employee had reached MMI from both his 1988 and his 1994 injuries. He stated that the employee's "extremity complaints do not represent neurological change and his cervical and lumbar strain are of purely subjective origins at present." Dr. Idelkope indicated expressly that he did "not identify any permanent partial disability as a result of [the employee's] work-related injuries of 1988 and 1994." The doctor further concluded that the employee need not be subject to any work restrictions, noting "I do indeed believe there is some over-amplification of [the employee's] pain syndrome and agree that his subjective complaints continue to exceed his objective abnormalities," adding "nor would I anticipate that there would be any future deterioration from [the employee's] 1988 and 1994 injuries." Dr. Idelkope reiterated these and other conclusions in a letter to the employer/insurer's attorney on April 12, 1999, upon review of additional medical records and radiological studies.

On June 23, 1999, Dr. Napoli issued a Health Care Provider Report, on which he indicated his opinion that the employee was subject to a 10% whole-body impairment related to his June 1994 low back injury, pursuant to Minn. R. 5223.0390, subp. 3, consequent to lumbar

disc degeneration. Dr. Napoli listed no date of injury but indicated, under "[h]istory of injury or disease given by employee," "[i]njury to low back while at work." On September 3, 1999, the employee filed a Claim Petition, alleging entitlement to certain medical benefits, to the assistance of a QRC, and to compensation for a permanent partial disability to 10% of his whole body consequent to his August 1988 and June 1994 work injuries. The employer and insurer admitted the injuries but denied liability for the specific benefits claimed, contending that the employee had already been paid all benefits to which he was entitled and that any continuing disability or need for medical treatment was "solely the result of superceding/intervening injuries and/or non-work-related activities."

On December 15, 1999, the employee saw Dr. Idelkope for a third time. On that date, after reviewing additional medical records and taking an updated history and conducting an abbreviated examination, Dr. Idelkope indicated that his opinions were unchanged from his previous reports. Dr. Idelkope indicated that his examination revealed a supple lumbar spine with no spasm. He noted that the employee "voluntarily restricts his lower back flexion, bringing his hands only down to the level of his knees. When he does so, however, there is normal flattening of the lumbar lordosis and no sciatic notch tenderness nor radicular pains elicited with movement of his head upon his neck, nor with forward flexion at the waist." The doctor noted also that the employee's "strength, tone, and bulk remain normal and symmetrical in all four extremities," that his "reflexes are normal and symmetrical," and that "[h]is gait is natural." Dr. Idelkope concluded that the employee's "physical examinations have always been entirely normal" during the three-year period during which the doctor had followed the employee, and that they "do not even remotely support the level of discomfort that he indicates is present." He indicated further that he was unable to assign any permanent partial disability to the employee related to his low back condition, that the employee's lumbar MRI and CT scans "represent wear and tear changes," and that it was "unlikely that the diffuse degenerative changes originated following any trauma but likely emerged as . . . separate medical phenomena of degeneration." Dr. Idelkope added that any changes on the employee's radiological scans "do not impinge upon the lumbar nerve root, do not account for his symptoms, [and] may occur naturally with aging."

On January 24, 2000, Dr. Debra Peven, D.O., issued a Report of Work Ability indicating that the employee could work without restrictions, but a month later, on February 28, 2000, Dr. Peven issued a second Report of Work Ability, indicating that the employee could work only two hours a day two days a week, with substantial lifting and bending restrictions. On March 31, 2000, the employee underwent a myelogram/CT scan, evidently on referral from Debra Peven, D.O. The scan revealed mildly bulging discs at L2-3 and L3-4, a minimally bulging disc at L4-5, and moderate facet hypertrophic changes at L5-S1.

The matter came on for hearing on May 3, 2000. Issues at hearing included the employee's entitlement to permanent partial disability benefits under Minn. R. 5223.0390, subp. 3C(2), which provides for compensation for a 10% whole body impairment where there are

> [s]ymptoms of pain or stiffness in the region of the lumbar spine, substantiated by persistent objective clinical findings, that is, involuntary muscle tightness in the paralumbar muscles or decreased range of motion in the lumbar spine, and with any

> radiographic, myelographic, CT scan, or MRI scan abnormality not specifically addressed elsewhere in this part.

By Findings and Order filed June 21, 2000, the compensation judge concluded that the employee had not proven his entitlement to the benefits at issue, finding at Finding 14 in part as follows:

> That the employee has not proven by a preponderance of the evidence that "symptoms of pain or stiffness in the region of the lumbar spine," [are] " . . . substantiated by persistent objective clinical findings[,] that is, involuntary muscle tightness in the paralumbar muscles,["] and/or "with any radiographic, myelographic, CT scan[,] or MRI scan abnormality not specifically addressed elsewhere in this part." ([Minn.]R. 5223.0390, subp. 3C(2). . . . . Said diagnostic tests showed degenerative changes but with no proof of an "abnormality."

At Finding 15 the judge concluded also that the "employee's present evaluating physician at the Noran Neurological Clinic, Dr. Debra L. Peven, D.O.[,] does not express an opinion that the employee has a 10% permanent partial disability of the back as a result of the effects of the personal injury." At Finding 16 the judge concluded that the employee had not proven "that he has sustained an 'abnormality' shown on scans which is the result of the [e]ffects of the personal injury; and/or pursuant to the requirements [of Minn. R. 5223.0390,] subp. 3C(2)(3)."[2] The employee appeals.

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 (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, "[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.

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[2] There is no subpart 3C(2)(3) in any version of the rule. Neither party treats the citation as an issue; we presume that the addition of "(3)" to the citation is a simple typographical error.

DECISION

Arguing that the records of Drs. Wegner, Wallestad, Noller, Randa, and Hames contain "uncontroverted evidence" of "persistent, objective clinical findings in the nature of decreased range of motion in the lumbar spine for the purposes of applying Rule 5223.0390 Subp. 3C," the employee contends that "the compensation judge denied the employee's entitlement to permanent partial disability under Rule 5223.0390[,] subp. 3C[,] strictly based on the lack of evidence of an abnormal scan finding" (emphasis added) and that the latter was error on the part of the judge. We are not persuaded.

Implicit in the employee's appeal is the presumption that there is uncontroverted evidence in this case of "persistent objective clinical findings" that are causally related to the work injury and that the mere existence of an arguable "abnormality" on the scans would qualify the employee for benefits under the rule. Although a radiologically evident spinal "abnormality" is clearly a factor and potential issue with regard to entitlement to compensation under the rule at issue, such an abnormality is irrelevant unless the employee is ultimately deemed to have persistent objective clinical findings that are causally related to his work injury. The judge expressly concluded in Finding 14 that the employee "has not proven" that his lumbar symptoms are substantiated by persistent objective clinical findings "and/or" with any scan abnormality. Contrary to the suggestion of the employee, the judge's conclusion as to objective clinical findings is supported not only by the opinion of Dr. Idelkope but also by the reports of Drs. Randa and Hames, none of whom could identify any clinical findings to adequately substantiate the employee's pain complaints.

Dr. Randa found the employee to be neurologically normal, with supple lumbar musculature, no spasm, excellent leg strength, and symmetrical reflexes bilaterally, concluding that there was no apparent adequate explanation for his pronounced pain complaints. Dr. Hames did find a reduced range of lumbar motion, but he found no lumbar spine-related listing or spasm or otherwise negative or abnormal findings on any more objective tests, concluding that the employee had overall "a very benign neurological examination" and "a paucity of any findings from a pathological perspective" to establish a diagnosis. While initially reporting the employee to have sustained what he termed a "permanent exacerbation," already with his first examination in November 1996 Dr. Idelkope found the employee to possess "no objective abnormalities" or "any loss of function." Moreover, when he reexamined the employee in March 1999, Dr. Idelkope found the employee's extremity complaints nonrepresentative of any neurological change and the employee's lumbar strain to be "of purely subjective origins at present," indicating expressly that he did not identify any permanent partial disability as a result of the employee's work injury. Finally, in December 1999, Dr. Idelkope reiterated that the employee's "physical examinations have always been entirely normal," expressly concluding that the employee was "voluntarily" restricting the range of motion in his low back It was not unreasonable for the compensation judge to rely on the well founded opinions of Drs. Randa, Hames, and Idelkope. See Nord v. City of Cook, 360 N.W.2d 337, 342-43, 37 W.C.D. 364, 372-73 (Minn. 1985) (a trier of fact's choice between experts whose testimony conflicts is usually upheld unless the facts assumed by the expert in rendering his opinion are not supported by the evidence).

Whether or not the employee's MRI and CT scans may be read to manifest an "abnormality" under the rule,[3] there is substantial evidence to support the compensation judge's conclusion that any such abnormality is not "a result of the [e]ffects of the personal injury; and/or pursuant to the requirements [of Minn. R. 5223.0390,] subp. 3C(2)" (emphasis added), one of the requirements of the rule being that the employee's pain complaints be "substantiated by persistent objective clinical findings," a requirement not here met. On that basis we affirm the judge's decision. See Hengemuhle, 358 N.W.2d at 59, 37 W.C.D. at 239.

[3] Dr. Idelkope concluded that the minor changes evident on the employee's July 1998 scan not only did not account for the employee's symptoms but were such that "may occur naturally with aging."