DUANE D. STRANTZ, Employee, v. CYLINDER CITY/INTERTECH and TRAVELERS INS. CO., Employer-Insurer/Appellants, and HEALTHPARTNERS, INC. and MIDWEST SPINE & ORTHOPEDICS, Intervenors.

WORKERS' COMPENSATION COURT OF APPEALS
MARCH 6, 2001

No. [REDACTED SSN]

HEADNOTES

PERMANENT PARTIAL DISABILITY - SUBSTANTIAL EVIDENCE. Where the first of two MRI scans showed the requisite nerve root impingement but the most recent did not, the compensation judge's determination, supported by medical expert testimony, was supported by substantial evidence in awarding a PPD rating of 21% under Minn. R. 5223.0390, subp. 4D(1)(4) and 4E.

CAUSATION - SEXUAL DYSFUNCTION; SUBSTANTIAL EVIDENCE. Where several medical experts opined that the employee's sexual dysfunction problem was caused by his back injury, the compensation judge was supported by substantial evidence in the record in finding a causal relationship.

CHANGE OF PHYSICIANS. Where the treatment provided by the physician, for whom prior approval was not obtained, was reasonable and necessary, the compensation judge is permitted to approve the change and award payment for the treatment.

Affirmed.

Determined by: Wheeler, C.J., Wilson, J., and Pederson, J.
Compensation Judge: William R. Johnson

OPINION

STEVEN D. WHEELER, Judge

The employer and insurer appeal from the compensation judge's findings of causation for the employee's sexual dysfunction condition, from the 21 percent permanent partial disability rating of the employee's low back condition and from the award of reimbursement for certain medical expenses. The employer and insurer also object to the judge's finding as to the amount of the employee's weekly wage, which was not at issue below. We affirm, as modified.

BACKGROUND

The employee, Duane D. Strantz, began working for the employer, Commercial Intertech, as a machinist in December 1993. On April 22, 1996 the employee sustained an admitted

work-related injury to the low back, while helping a co-worker carry a hydraulic cylinder, when he fell backwards against a pile of steel tubing and was simultaneously struck in the chest by the cylinder. At the time of the injury, the employee was 26 years old. The employee initially did not seek medical attention and did not lose time from work. Over the next several weeks, however, the employee began gradually to experience pain and numbness in the legs, and some pain in his buttock and back. (T. 21-30.)

On May 20, 1996 the employee was seen for his symptoms by Dr. John Larkin, an orthopedic surgeon. As of June 7, 1996, the employee's pain was 25 percent in the back and 75 percent in the left leg. Dr. Larkin's impression was of left lumbar radiculitis. He ordered an MRI scan of the employee's lumbar spine, which was performed on June 17, 1996 at the Center for Diagnostic Imaging. The scan revealed that the employee had degeneration of the L4-5 and L5-S1 discs associated with juvenile discogenic disease and thoracolumbar Scheuerman's disease. In addition, however, there was a moderate-sized central disc herniation at the L4-5 level with moderate compression of the thecal sac and mild subarticular compression of the left L5 nerve root. At the L5-S1 level, there was a central annular tear and broad-based moderate central bulging of the disc annulus, which resulted in mild to moderate central spinal stenosis and mild subarticular impingement of both S1 nerve roots. Finally, an increased signal intensity at the L5-S1 level was read as suspicious for a possible spondylolysis at L5. (Exhs. F, I.)

In the early summer of 1996 the employee began to notice problems with sexual function. Dr. Larkin's records reveal that the employee telephoned on July 30, 1996 asking that his scheduled appointment be moved up due to his back problems and because of sexual problems which he was concerned might be related to the back injury. Dr. Larkin saw the employee on October 4, 1996 for these concerns and administered an epidural injection. (T. 34-37; Exh. F.)

On October 7, 1996 the employee began treating chiropractically with Dr. Jerrold Wildenauer, D.C., at the suggestion of Dr. Larkin. The intake forms from that date indicate problems with back pain and erectile dysfunction. The employee continued to treat chiropractically with Dr. Wildenauer until December 9, 1996, after which he treated chiropractically with Dr. John M. Hapka, D.C., whose offices were nearer his home. (Exhs. G, N; T. 87-89.)

When the employee returned to Dr. Larkin on October 28, 1996, the doctor recorded that he now had right radicular pain. The employee reported that he was still having problems with sexual function. Dr. Larkin referred the employee to a urologist, Dr. Christopher J. Knoedler. Dr. Knoedler saw the employee on June 13, 1997, but referred him on to Dr. Kevin Billups, a urologist at the University of Minnesota. (Exh. F.)

On May 5, 1997 the employee was again seen by Dr. Larkin and presented with ongoing problems with numbness into the right lower extremity, and spasms in the right buttock. He told the doctor that he still had problems sustaining erections and felt a tingling sensation into the perineum. The doctor noted that the MRI scan showed herniations at L4 and L5. On examination, the employee had hamstring tightness with straight-leg raising and hypesthesia over the S1 nerve distribution on the left, as well as "weakness in the left triceps surae" muscle, both of which the doctor characterized as S1 nerve root problems. The employee reported that his epidural

injection had helped for three days and then the same symptoms returned. Dr. Larkin rated the employee was a 21 percent whole body disability to the low back under Minn. R. 5223.0390, subds. 4D (1) and (4). (Exh F.)

The employee was seen by Dr. Billups on July 10, 1997. Dr. Billups ordered various tests, including chemical testing for testosterone levels, a duplex ultrasound, nocturnal testing with a rigiscan device, and biothesiometry to assess sensation. (Exh. E.)

On February 2, 1998 Dr. Larkin saw the employee and noted that he had been getting some help from chiropractic treatment and had been seen by Dr. Billups regarding his penile dysfunction. Dr. Larkin recorded that he agreed with Dr. Billups' view that the employee's sexual dysfunction problems were organic and related to his disc herniation. Dr. Larkin rated the employee's permanency for a penile dysfunction at 10 percent of the whole body under Minn. R. 5223.0600, subp 6(B)(1). (Exh. F.)

The employee was seen for a medical evaluation on behalf of the employer and insurer on May 11, 1998 by Dr. Mark C. Engasser. Dr. Engasser diagnosed multilevel lumbar degenerative disc disease, particularly at L4-5 and L5-S1, a lumbar disc herniation at L4-5, and sexual impotence. He opined that the employee's underlying degenerative condition predated the work injury, but that the central disc herniation at L4-5 was at the very least aggravated if not caused by the work injury. He rated permanency for the low back at 11 percent under 5223.0390, subp 4D(1). Dr. Engasser further opined that the employee's sexual dysfunction could be due to the employee's central canal compression at L4-5 causing decreased sensation in the penis. In Dr. Engasser's opinion, the employee did not need additional chiropractic treatment, but might require another epidural block injection if he should develop a recurrence of low back and leg symptoms. (Exh. 1.)

The employee was last seen by Dr. Larkin on September 4, 1998. At this time he was still reporting persistent problems with impotence. Dr. Larkin treated the employee's back by epidural injection. As Dr. Larkin was retiring from practice, he discussed with the employee choosing another physician for the treatment of his back condition. (Exh. F.)

On January 14, 1999 the employee initiated treatment with Dr. John Dowdle, M.D. Dr. Dowdle noted that the employee had a restricted range of motion in the lumbar spine. No focal deficits were noted but the straight leg raising was restricted at 70 degrees bilaterally. Dr. Dowdle's impression was of mechanical low back pain with lumbar degenerative disc disease. He recommended another MRI scan to help him to determine whether further care and treatment was needed. (Exh M.)

On January 21, 1999 the employee underwent a second MRI scan of his lumbar spine. The radiologists read the scan as showing:

> Juvenile discogenic disease, with specific findings as follows:
>
> 1. L5-S1: Posterior high signal intensity zone annular tear at L5-S1 with broad-based disc bulging posteriorly. Because of an overall

> small central canal, there is mild central canal narrowing with the disc bulge. This creates mild subarticular recess stenosis. At this same level, there is moderate intervertebral nerve root canal narrowing, without ganglionic impingement, secondary to up-down stenosis.
>
> 2. L4-5: 3.8 mm anteroposterior dimension disc herniation seen on image 17 of sequence 3, without neural compromise, but with some minimal central canal narrowing. The extended disc protrusion is less than on the previous study.

(Exh. I.)

Dr. Dowdle saw the employee in follow-up on January 28, 1999. He suggested that the employee take care in bending and lifting, watch his activities, and use anti-inflammatory medication. Dr. Dowdle's notes state that he did not anticipate a need for further treatment. (Exh. M.)

The employee filed a claim petition on January 14, 1999, alleging injury to the low back, impotence and radicular symptoms and seeking permanent partial disability for the low back at 21 percent, less 11 percent previously paid by the employer and insurer, as well as reimbursement for various unpaid medical expenses. The employer and insurer answered denying that the employee's impotence was related to the low back injury, denying that unreimbursed medical treatment was reasonable, necessary or causally related to the employee's low back injury, and denying permanency beyond the 11 percent already paid. (Judgment Roll.)

On April 1, 1999 the employee returned to Dr. Dowdle, who recorded that the employee was still having mechanical low back symptoms and complaints of impotence. Dr. Dowdle's notes reflect that the doctor now thought more aggressive treatment, perhaps even surgical treatment, would be required. (Exh. M.)

The employee saw Dr. Bruce M. Tennenbaum, a neurologist at the Noran Clinic, on May 11, 1999, on referral by his chiropractor, Dr. Hapka. Dr. Tennenbaum recorded the employee's complaints as mid and low back pain, neck pain and difficulty with sustaining an erection. Examination showed mild limitation of forward flexion and extension, and an absence of knee and ankle jerk. Dr. Tennenbaum recommended a cervical and thoracic scan to rule out the possibility that a lesion at a higher level of the spine might also be present to cause the employee's sexual dysfunction problems. (Exh. J.)

On May 27, 1999 the employee returned to Dr. Dowdle for a scheduled appointment. Dr. Dowdle noted that the employee would need further care and might be in need of an epidural injection. He asked the employee to contact him again after he reviewed Dr. Tennenbaum's notes. On June 24, 1999 Dr. Dowdle saw the employee again and noted that the employee continued to have the same ongoing back problems and erectile dysfunction. He agreed with Dr. Tennenbaum's suggestion recommending a scan of the cervical and thoracic spine. The scan, however, revealed no occult lesions at higher levels of the employee's back. On July 21,

1999, Dr. Dowdle saw the employee and recommended he simply continue on the anti-inflammatory medications. (Exh. M.)

On September 9, 1999 the employee began treating for his low back with Dr. Glenn R. Butterman, a orthopedist at the Midwest Spine Institute. The employee admits that he made this change of physicians without authorization from the insurer. The employee told Dr. Butterman that he was dissatisfied with Dr. Dowdle, who had merely told him to learn to live with his symptoms. The employee's principal complaints were a pressure type of pain in his low back, typically at the waist line, bilateral groin region numbness and erectile dysfunction. Dr. Butterman diagnosed degenerative disc disease at L4-S1 and a herniated disc at L5-S1. He noted that no etiology was present on the recent MRI scans to account for the employee's erectile dysfunction or groin numbness, and that most of his pain was probably due to the degenerated disc in the lower lumbar spine. He prescribed Indocin but noted that if this failed to relieve the employee's pain epidural injections might be needed. (Exh. L.)

The employee was seen back by Dr. Tennenbaum on November 4, 1999. Dr. Tennenbaum reviewed the low back MRI scan of January 21, 1999 and the cervical and thoracic scans of July 1999. He recorded that the employee continued to have back pain, pain and numbness down his legs, and erectile dysfunction. There was mild limitation of forward flexion and extension in the employee's low back. Knee and ankle jerks were 2+, the employee's toes were "down-going" bilaterally, and sensitivity to pinprick was mildly decreased in both feet. Dr. Tennenbaum thought it might be advisable to do an MRI scan of the employee's head to rule out any possibility of a demyelinating syndrome or other intercranial process that could result in erectile dysfunction, but otherwise deferred to the employee's urologist about a specific diagnosis. (Exh J.)

In a report dated November 5, 1999, the employee's chiropractor, Dr. Hapka, noted his agreement with the 21 percent permanent partial disability for the low back assigned by Dr. Larkin and also agreed with the view that the employee's sexual dysfunction problems were related to the work injury. This report was written in response to a letter from the employee's attorney on September 23, 1999, which forwarded the medical records available through that date, including the January 21, 1999 lumbar MRI scan. (Exhs. B, G.)

The employee returned to Dr. Butterman on December 30, 1999. He reported only a little improvement from the Indocin. Dr. Butterman concluded that the only reasonable treatment option was an intradiscal steroid injection. (Exh. L.)

On December 13, 1999 the employee's attorney wrote to Dr. Larkin summarizing the employee's medical history and enclosing a full set of medical records to date. He asked Dr. Larkin to review the records and to render his opinion about the nature and extent of the employee's injury, about his need for ongoing treatment and about his permanent partial disability rating. On December 16, 1999, the employee's attorney wrote a similar letter to Dr. Billings requesting his opinion about the employee's sexual dysfunction problems. (Exhs. B, C, D.)

Dr. Larkin responded with a report, dated February 2, 2000, in which he set out his own treatment history with the employee and rendered opinions in light of the further medical

history and records provided. He reiterated his diagnosis of a disc herniation at L4-5 with central stenosis and a disc herniation at L5-S1 with subarticular recess stenosis and central stenosis, and noted various examination findings of persisting radicular problems which he related to pressure on the S1 nerve root on the left. He also diagnosed a penile dysfunction related to nerve root pressure bilaterally, as testing conducted by Dr. Billups had demonstrated that this dysfunction was not a psychological problem. Dr. Larkin stated that he had reviewed all of the medical information provided, and that nothing in it changed his opinion about the diagnosis or his rating of permanency for a two-level low back problem at 21 percent and penile dysfunction rating of 10 percent of the whole body. (Exh. F.)

Dr. Billups responded by a letter report dated May 8, 2000. He recounted the employee's history of erectile dysfunction beginning following the work injury and discussed the testing he performed, including a rigiscan nocturnal study showing abnormal tumescence and rigidity consistent with erectile dysfunction and a penile duplex ultrasound showing adequate penile cavernosal artery velocity with venous leak. He stated that

> I have given him a diagnosis of organic impotence secondary to vascular problems. Based on my clinical judgment as a urologist who specializes in ED, Mr. Strantz' impotence was caused by his back injury in April of 1996 and is permanent. I do not expect him to improve any beyond this point and in fact he is at increased risk for developing more severe ED as he gets older. He will need to take medication for the rest of his life to treat his ED and may at some point require penile implant surgery should medical treatment fail. I would rate Mr. Strantz as a Class 2 (15%) disability under subpart 6, penis. He has objectively demonstrated organic impotence due to an objectively demonstrated neurological lesion.

(Exh. E.)

The employee was seen by Dr. James Meyer, M.D., on June 6, 2000 for an examination and an opinion about his sexual dysfunction problems on behalf of the employer and insurer. Dr. Meyer diagnosed an erectile dysfunction, vascular in nature, and concluded that it was not related to the employee's low back injury in light of the absence of a specific neurologic lesion on the January 1999 MRI scan. (Exh. 2.)

A hearing was held before a compensation judge of the Office of Administrative Hearings on May 19, 2000. The issues at that time were whether the employee had sustained a compensable consequential sexual dysfunction related to the work injury of April 22, 1996, the extent of the employee's permanent partial disability for the low back injury, and reimbursement for unpaid medical expenses. Following the hearing, the judge found that the employee's sexual dysfunction was causally related to the work injury, and that the employee had sustained a 21 percent permanent partial disability to the low back and a further 10 percent permanency related to his sexual dysfunction condition. The judge also awarded reimbursement of the contested medical expenses, except for amounts alleged still owing to the Wildenauer Chiropractic Clinic,

which the judge found had not been proven because the bills from that provider were confusing and unclear. The employer and insurer appeal.

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 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

1. Causation for the Employee's Sexual Dysfunction

The compensation judge accepted the opinions of Dr. Billups and Dr. Larkin who considered the employee's sexual dysfunction problems causally related to his low back injury. The judge found additional support for this conclusion in the records of Dr. Hapka and in the report of the employer and insurer's examiner, Dr. Mark Engasser. The judge discounted the contrary opinion of the employer and insurer's examiner, Dr. Meyer. The compensation judge also relied in part upon the absence of such problems prior to the employee's injury and the onset of the sexual dysfunction problems shortly after the injury. Generally, this court must affirm a finding which is based upon the compensation judge's choice between divergent expert opinion unless the opinion relied upon was without adequate foundation. Nord v. City of Cook, 360 N.W.2d 337, 37 W.C.D. 364 (Minn. 1985).

On appeal, the employer and insurer argue that the compensation judge's determination of this issue is not supported by substantial evidence. The essence of their position is the claim that none of the doctors relied upon by the compensation judge had adequate foundation to render an opinion on the causation for this condition, which is in turn based solely on the argument that there is no proof that Dr. Billups, Dr. Larkin, or Dr. Hapka were aware of the specifics of the employee's January 21, 1999 lumbar MRI scan, and that Dr. Engasser, whose report was prepared in 1998, clearly could not have been aware of that information. Unlike the employee's prior lumbar scan in 1996, the scan in 1999 failed to show nerve root impingement at that time, which the employer and insurer assert is clearly material to forming a medical opinion regarding causation for the employee's sexual dysfunction condition.

We note, however, that the letters sent to Dr. Larkin and to Dr. Billups in December 1999 both quoted the text of the radiological report from the January 21, 1999 scan, and that the letters indicate that the medical records concerning this scan were enclosed. Dr. Larkin's report was written in response to one of these letters and specifically stated that he had read all of the reports provided to him and nothing in those materials changed his opinion. While Dr. Billups did not discuss the 1999 scan in his report, he, like Dr. Larkin, wrote in response to one of these letters, which, again, quoted and forwarded the record of this scan. The letter sent to Dr. Hapka requesting his report did not quote from the January 21, 1999 scan report, but did enclose it and mentioned that this follow-up scan had been done. The compensation judge was not clearly erroneous in concluding that these physicians had an adequate foundation for their opinions. The suggestion that they were unaware of the January 21, 1999 scan is mere speculation. The contrary conclusion is well-supported by the evidence and the compensation judge was not required to conclude that these physicians were unaware of the findings from this MRI scan.

The employer and insurer's appeal from the that portion of the award of reimbursement for medical expenses relating to treatment of the employee's sexual dysfunction was based solely upon the foregoing causation argument, as was the appeal from the permanency awarded for the sexual dysfunction condition. Therefore we affirm not only the finding of causation but the award of permanency for that condition and that portion of the award of reimbursement for medical expenses pertaining to the treatment for that condition and the award of permanency.

2. Permanent Partial Disability for the Employee's Low Back Condition

The compensation judge accepted the opinion of Dr. Larkin and adopted the 21 percent permanent partial disability rating proposed by that physician. Specifically, the compensation judge relied upon the following parts of Minn. R. 5223.0390, subp. 4, in rating the employee's condition:

> Subp. 4. Radicular syndromes.
>
> D. Radicular pain or radicular paresthesia, with or without lumbar pain syndrome, and with objective radicular findings, that is, hyporeflexia or EMG abnormality or nerve root specific muscle weakness in the lower extremity, on examination and myelographic, CT scan or MRI scan evidence of intervertebral disc bulging, protrusion, or herniation that impinges on a lumbar nerve root, and the medical imaging findings correlate anatomically with the findings on neurologic examination, nine percent with the addition of as many of the following subitems (1) to (4) as apply, but each may be used only once:
>
> > (1) if chronic radicular pain or radicular paresthesia persist despite treatment, add three percent;
>
> * * *

> (4) additional concurrent lesion on contralateral side at the same level or on other side at other level, which meets all of the criteria of this item or item E, add nine percent.
>
> E. Radicular pain or radicular paresthesia, with or without lumbar pain syndrome, and with objective radicular findings, that is, hyporeflexia or EMG abnormality or nerve root specific muscle weakness in the lower extremity, on examination and myelographic, CT scan or MRI scan evidence of spinal stenosis, as defined in part 5223.0310, subp. 47, that impinges on a lumbar nerve root, and the medical imaging findings correlate with the findings on neurological examination, nine percent with the addition of as many of the following subitems (1) to (4) as apply, but each may be used only once:
>
> (1) if chronic radicular pain or radicular paresthesia persist despite treatment, add three percent;
>
> * * *
>
> (4) additional concurrent lesion on contralateral side at the same level or on other side at other level, which meets all of the criteria of this item or item D, add nine percent.

Specifically, the judge found that the employee had a two-level problem involving the combination of a herniated or bulging disc at each of two levels which combined with the employee's congenitally small spinal canal and juvenile disc disease, produces stenosis resulting in nerve root impingement at each level, and that the employee's radicular symptoms had persisted despite treatment, thus resulting in a rating of 9 percent for the first level plus 9 percent for the second level plus 3 percent for the persistent symptoms, giving 21 percent. This rating is well-supported by the medical records and opinions of the employee's treating physicians.

The employer and insurer do not dispute that the medical records contain objective radicular findings. Instead, they argue that the compensation judge erred in applying subpart 4 since no radicular impingement was shown on the employee's January 21, 1999 MRI scan and a rating under this subpart requires *radiologic evidence* of impingement in addition to the employee's objective radicular findings. While the employer and insurer do not dispute that such radiologic evidence was provided by the 1996 MRI scan, they argue, in essence, that the absence of impingement on a more recent scan negates the evidentiary value of the impingement shown on the prior scan for purposes of rating under the permanency schedules. The employer and insurer argue that the appropriate rating is 10 percent for mechanical back pain and degenerative disease at two levels under Minn. R. 5223.0390, subp. 3C(2). (Brief at 17.)

Certainly the absence of impingement on one of multiple scans is evidence which the compensation judge should consider on the issue of an employee's permanency rating under these rules, but it is not conclusive evidence in denial of such a rating where other scans do show such impingement and the other prerequisites of the rule are met. Under such circumstances, a compensation judge must consider both scans as well as the employee's symptoms, examination findings, treatment history and prognosis and diagnoses as shown in the record as a whole and make a factual determination whether a rating based on impingement, or one based on the absence of impingement, more reasonably reflects the disability resulting from the employee's injury. The rule itself merely requires radiologic evidence of impingement, which there is in this case. Here, we cannot say that the compensation judge erred in rating the employee's low back condition at 21 percent in light of the employee's medical history, symptoms, examination findings and persistent radicular problems.

3. Unauthorized Change of Physicians

The employee discontinued treatment with Dr. Dowdle after June 1999. He received treatment for his low back on one occasion at Health Partners in June 1999 and then began treating for his low back with Dr. Butterman in September 1999. The employee does not dispute that he failed to seek authorization from the employer and insurer for the change of treating physician. The employer and insurer appeal from the award of reimbursement for the medical expenses for the low back treatment rendered after the employee's change of primary health care provider.

A "primary health care provider" is that provider who directs and coordinates the employee's medical care after an injury. Minn. R. 5221.0430, subp. 1. "If the employee receives medical care after the injury from a provider on two occasions, the provider is considered the primary health care provider if that individual directs and coordinates the course of medical care provided to the employee." Id. Pursuant to subpart 2 of the same subdivision, an employee may change the primary health care provider once within the first 60 days after initiation of medical treatment for the injury without the need for approval, but any subsequent change must be approved by the insurer, the department or a workers' compensation judge.

Pursuant to Minn. R. 5221.0430, subp. 3, "[i]f the employee or health care provider fails to obtain approval of a change of provider before commencing treatment where required by this part, the insurer is not liable for the treatment rendered prior to approval unless the insurer has agreed to pay for the treatment." This court has previously held that this rule allows an employer and insurer to refuse payment for disputed medical care prior to approval of a change of physicians. However, the employer and insurer may subsequently be ordered to pay for that treatment if and when approval is granted, so long as the treatment provided was reasonable and necessary. Henschel v. Interfaith Social Servs., slip op. (W.C.C.A. Oct. 2, 1995).

Pursuant to Minn. R. 5221.0430, subp. 4A, a compensation judge has discretion to allow the change of physicians unless "a significant reason underlying the request is an attempt to block reasonable treatment or to avoid acting on the provider's opinion concerning the employee's ability to return to work." The employee has continued to work for the employer since the date of

injury, and there is no evidence of any of these factors precluding the judge from allowing the change of physicians.

The compensation judge below considered the circumstances of the case and, in his discretion, allowed the change of physicians. The employer and insurer appeal. Whether a change of physicians should be permitted is a question of reasonableness under the circumstances in each case. Hernandez v. Heartland Foods, 53 W.C.D. 372 (W.C.C.A. 1995). The employee testified that Dr. Dowdle had told him that he had no further treatment options to offer. The records of Dr. Dowdle are consistent with this testimony. The compensation judge here concluded it was reasonable for the employee to change from Dr. Dowdle to another physician who was prepared to continue the employee's treatment. We cannot conclude that this is an unreasonable conclusion under the facts of this case.

Having approved the requested change of physicians, the compensation judge properly ordered payment for reasonable and necessary medical expenses. The findings and order of the compensation judge are affirmed on this issue.

4. Weekly Wage

The compensation judge made a finding setting the amount of the employee's weekly wage on the date of injury. The employer and insurer appeal from this finding on the basis that the issue of weekly wage was not before the compensation judge, and the finding was therefore not within the scope of the hearing. The employee concedes that the employee's weekly wage was neither directly nor indirectly at issue. We therefore modify the compensation judge's findings and order to vacate that portion stating the amount of the employee's weekly wage.