JOHN SULLIVAN, Employee/Appellant, v. BOISE CASCADE CORP., SELF-INSURED, Employer, and MEDICARE, Intervenor.

WORKERS' COMPENSATION COURT OF APPEALS
OCTOBER 3, 2001

No. [REDACTED SSN]

HEADNOTES

OCCUPATIONAL DISEASE–ASBESTOSIS. Substantial evidence, including expert medical opinion, supports the compensation judge's finding that the employee had not sustained asthma, bronchitis, or asbestosis as a result of his work activities at this time.

OCCUPATIONAL DISEASE–CAUSATION. Where the compensation judge indicated that the employee had sustained interstitial fibrosis, a remand is necessary for findings on whether this was an occupational disease sustained as a substantial result of his exposure while working for the employer, whether any of the employee's medical treatment was reasonable and necessary to cure or relieve the effects of interstitial fibrosis, whether the intervention claim brought by Medicare is compensable for that portion which is related to treatment for that condition or disease process, whether the employee has sustained any ratable permanency relative to the employee's claimed interstitial fibrosis, and whether the employee is entitled to reimbursement of costs and disbursements.

Affirmed in part, vacated in part, and remanded.

Determined by Rykken, J., Wheeler, C.J., and Pederson, J.
Compensation Judge: Donald C. Erickson.

OPINION

MIRIAM P. RYKKEN, Judge

The employee appeals from the compensation judge's finding that he did not sustain an occupational lung disease as a result of his employment with the employer. We affirm in part, vacate in part and remand in part.

BACKGROUND

John Sullivan, the employee, claims to have sustained an occupational disease on or about January 2, 1997, as a substantial result of his work with Boise Cascade, the self-insured employer. Born on March 30, 1929, the employee was 67 years old on the date of his claimed injury.[1]

[1] The employee originally claimed an injury date of December 6, 1984, as that was his last day of employment with the employer. The compensation judge utilized an injury date of

In 1954, the employee began working for the employer's predecessor, the Minnesota and Ontario Paper Company (MANDO). The employee continued working with MANDO and Boise Cascade Corporation, the employer, until December 1984, working in the Insulite division as a machine tender. The Insulite division produced ground wood products such as building sheeting, siding and ceiling tile. The machines the employee worked with included a forming machine that pressed ground wood fibers into appropriate shapes, a kiln that dried the wood fibers and a trimmer for cutting products. In an unappealed finding, the compensation judge found that the employee was exposed to asbestos between 1954 and 1984, stating that

> Asbestos covered pipes . . . extended throughout the employee's work area and over his work career. Many times the asbestos insulation became friable. In addition, the asbestos insulation had to be reworked or repaired from time to time. When asbestos pipe coverings fell, it was a common practice for the workers to clean the area by blowing the insulation away with compressed air and by sweeping it up.

(Finding No. 6.) The employee testified that he never saw the pipe insulators put up any plastic covers or take protective measures while removing pipe covering. (T. 67, 84-85, 90.) In addition, the employee and coworkers used an air hose, located near the employee's machine, to blow dust off their work clothes. (T. 70-71, 85.) Although the employees were provided paper masks at some point in the 1970s, prior to that time no masks or respirators were provided to the employees in the Insulite division.

The Insulite division was closed in 1984; from 1986 to the date of the hearing, the employee has worked as a maintenance person for an apartment building and medical clinic. In 1990, the employee underwent an asbestos screening, but was not advised that he had an asbestos-related disease following that screening.[2] The employee was examined periodically for his respiratory symptoms since 1990, complaining of increasing shortness of breath. The employee's physician at the Falls Clinic referred the employee to Dr. Peter Franklin, Department of Pulmonary Medicine, at the Duluth Clinic. On April 24, 1996, the employee was examined by Dr. Franklin, complaining of a general decline in his breathing and problems climbing stairs. X-rays taken on that date reflected "some fine increased interstitial markings of a minimal degree." Dr. Franklin concluded that the employee had both obstructive and restrictive components to his shortness of breath. Dr. Franklin believed the obstructive disease may represent some underlying chronic bronchitis or asthma and that the restrictive component could be due, in part, to obesity or "some underlying interstitial fibrosis from asbestosis." The employee underwent further pulmonary function evaluation at the referral of Dr. Franklin. A CT scan of his chest taken on May 8, 1996,

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January 2, 1997, as that is the date of the medical report that first notified the employee of the potential causal connection between his work exposure and respiratory condition.

[2] Dr. Brian Dolan conducted that screening, and his 1990 report was referred to at hearing but was not separately made an exhibit by either party.

indicated "interstitial fibrotic changes and small bullous changes in the lung bases with more normal appearing lung in the upper lobe regions. Slight pleural thickening is present, bilaterally, but there is no evidence of masses." The radiologist reviewing the CT scan concluded that there were "changes in the lung bases consistent with interstitial fibrosis and emphysema." (Ee. Ex. F.)

Dr. Dolan conducted a review of the employee's medical records, and issued a report dated January 2, 1997, in which he concluded that the employee's

> 38 year history of occupational exposure to dirt, smoke, multiple chemicals and asbestos appears to be the main identified factor in his lung disease. His obstructive disorder, effecting both large and small airways, was likely to have been adversely effected, if not caused, by workplace irritants. His restrictive disease is almost certainly primarily due to asbestosis.
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> The diagnosis of asbestosis is based on a 38 year history of occupational asbestos exposure beginning almost 50 years ago, a lack of significant cigarette smoking history, progressive respiratory symptoms, basilar crackles heard on auscultation of the lung, restrictive lung disease and decreased DLCO on pulmonary function testing, interstitial fibrosis noted on both plain chest X-ray and on CT scan, and the finding of pleural plaques on chest CT scan.

(Ee. Ex. A.)

By April 23, 1997, the employee provided notice to the employer of his claim that his lung condition was work-related.

The employee was hospitalized March 9-13, 1998, due to shortness of breath. Dr. Berlin's chart notes on March 13, 1998, report a "long-standing history of pulmonary fibrosis, secondary asbestosis and COPD [chronic obstructive pulmonary disease]." The employee was admitted to the hospital due to suddenly worsened shortness of breath, in part to rule out possible acute myocardial infarction. The employee was treated with nebulizer therapy and intravenous steroids. An x-ray of the employee's chest "raises suspicion for congestive heart failure." Dr. Berlin concluded that the employee still had rales,[3] rhonchi[4] and bronchial breath sounds with some wheezes at the time of his discharge on March 13, 1998. Dr. Berlin assigned a final diagnosis of chronic obstructive pulmonary disease.

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[3] Rales are defined as "discontinuous sound[s] consisting of a series of short nonmusical noises, heard primarily during inhalation; called also crackle." Dorland's Illustrated Medical Dictionary, 1516 (29th ed. 2000).

[4] Rhonchi are defined as "continuous sound[s] consisting of a dry, low-pitched, snore like noise produced in the throat or bronchial tube due to a partial obstruction such as by secretions." Dorland's Illustrated Medical Dictionary, 1574 (29th ed. 2000).

On April 28, 1998, the employee reported to Dr. Berlin that he could not sleep lying down and could not walk very long without stopping to rest. Dr. Berlin's chart notes reflect that he found rales and rhonchi in the left lower lobe and the employee's nasal passages were swollen shut. A chest x-ray taken on April 28, 1998, did not show pneumonitis or pneumonia in the left lower lobe, nor did it show the cause of the rales or rhonchi heard by Dr. Berlin. Dr. Berlin concluded that the employee had a possible congestive heart failure causing fluid in his left lobe and also had an allergy component to his lung condition. He prescribed medications, and referred the employee to Dr. Franklin for follow-up. The employee's symptoms were improved by May 1, 1998.

On August 2, 1999, the employee was examined by Dr. David Bonham, a specialist in pulmonary medicine. Dr. Bonham conducted pulmonary function testing and concluded that the testing reflected "the presence of a severe obstructive ventilatory defect and in addition there is a mild restrictive ventilatory defect." Dr. Bonham concluded that the employee had restrictive lung disease in the nature of mild asbestosis and asbestosis-related pleural disease. He also diagnosed obstructive lung disease in the nature of occupational bronchitis and occupational asthma. Dr. Bonham assigned a permanency rating utilizing the portion of the permanency schedules that refer to asthma and pulmonary conditions with an asthma component. He assigned a rating of 50 percent permanent partial disability of the body as a whole due to the employee's lung disability, and an additional 3 percent permanent partial disability of the body as a whole for an asthmatic component due to the employee's need for significant inhaled steroid therapy.[5] (Ee. Ex. B.) In Dr. Bonham's opinion, the employee's asbestos exposure at work through 1984 represented a significant cause of the employee's development of asbestosis. (Bonham Depo. p. 26).

Dr. Ronald Vessey examined the employee on December 10, 1999, at the request of the self-insured employer. Based on his examination and test findings, Dr. Vessey concluded that the employee did not have asbestosis, as he did not meet all of the criteria necessary for diagnosis of asbestosis, which Dr. Vessey identified as rales present when listening to the lungs, pulmonary function testing that shows a vital capacity less than 80 percent of the predicted vital capacity and diffusing capacity, and a chest x-ray that shows category 2/1 or greater reticular nodular opacities. (Er. Ex. 1.) Dr. Vessey also concluded that the employee did not have "true significant interstitial fibrosis" in part because the fibrosis was not visible on x-ray and the employee's diffusing capacity was too high to indicate interstitial fibrosis. (T. 244.) Dr. Vessey concurred with both the 50 percent and the 3 percent permanency ratings, although he concluded that the employee's adult onset asthma was not related to the employee's exposure to dust and airborne materials while working for the employer. Dr. Vessey concluded that the employee's late onset adult asthma was idiopathic in nature.

The employee was examined by Dr. Berlin on January 7, 2000, reporting shortness of breath that increased in November 1999, with exposure to cold air and activity. The employee also experienced chest discomfort by that time, occurring mostly with activity. At Dr. Berlin's

[5] Pursuant to Minn. R. 5223.0560, subp. 3.B.(12) and C, "Asthma and pulmonary conditions with an asthmatic component."

referral, the employee underwent a Bruce Protocol treadmill stress test, a type of cardiac stress test, on January 7, 2000, which had positive results. He was hospitalized from February 9-15, 2000, and was diagnosed with atherosclerotic coronary artery disease, with one of his secondary diagnoses listed as "asbestosis." The employee underwent quadruple coronary artery bypass surgery and later received outpatient cardiac rehabilitation.

By March 22, 2000, the employee reported to Dr. Franklin that he was "feeling wonderful," his activity level was increased, and his breathing was "good," with no cough or phlegm. A chest x-ray taken on March 22, 2000, was interpreted as showing elevation of the left hemi diaphragm, probably due to a pleural adhesion in the costophrenic angle, and "patchy interstitial scarring in the left base with minimal left basilae pleural thickening present." The radiologist stated that all the findings described were new since January 20, 1999. (Ee. Ex. G.) By July 20, 2000, the employee reported irregular heart rate and fatigue after taking increased medication, but he also reported that he was sleeping well and was able to walk two miles per day (Ee. Ex. E), which was an improvement from the limited distance he could comfortably walk prior to surgery.

Dr. Dolan reviewed updated medical records, and, in his report dated August 16, 2000, provided the following comment and opinion:

> Dr. Vessey argued that asbestosis was not present. He felt that the absence of asbestosis diagnosable by "B" readers on the plain chest x-ray was a critical point. While this is often the case, Mr. Sullivan is unusual in that he is obese, has a large chest, and has unusual configuration of the ribs which make evaluation of the presence of pleural plaques extremely difficult. It is proper in such a case to use a more sophisticated test, the CT scan, for better evaluation. The CT scan was done on 5/8/96 and showed interstitial fibrotic changes in the lung bases and slight pleural thickening bilaterally. In addition he cited an author who recommended that three of four criteria be present for a diagnosis of asbestosis. Of the four diagnoses, three of them (rales, FVC[6] < 80 percent, and DLCO [diffusing capacity] < 80 percent) have been documented to be present and the fourth criteria, 2/1 interstitial fibrosis, is difficult to determine due to the factors noted above.
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> The complete cause of his COPD, or chronic obstructive pulmonary disease, is difficult to determine. Certainly the Insulite board mill where [the employee] worked for more than 30 years was known to contain a variety of respiratory irritants.

[6] FVC means the forced vital capacity as measured by a spirometric test performed as described in the A.M.A. Guide, 3rd ed., pp. 111-12. The measurement is expressed as a percentage of the normal value. Minn. R. 5223.0310, subp. 30.

* * *

> Although his workplace exposures to respiratory irritants may not be only [sic] factor in the development of his COPD, the fact that he worked in an environment contaminated with respiratory irritants for decades and developed symptoms of COPD around the time he last worked there suggests that workplace exposures were a causal factor, and indeed the only identifiable factor.

(Ee. Ex. A.)

On May 4, 1998, the employee filed a claim petition, claiming that his exposure to asbestos while working for the employer represented a substantial contributing factor to the development of an occupational disease in the nature of asbestosis. The self-insured employer denied liability for the employee's claim, and this matter was addressed at a hearing before a compensation judge on August 22-23, 2000. In a Findings and Order served and filed November 20, 2000, the compensation judge concluded that the employee had provided the employer with statutory notice of his claims in a timely manner, and that his claims were not barred by the statute of limitations, but that he had "failed to sustain his burden of proof that he is suffering from an occupational lung disease, either asbestosis, asthma or bronchitis, at this time." (Finding No. 42.) 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.

"[A] decision which rests upon the application of a statute or rule to essentially undisputed facts generally involves a question of law which [the Workers' Compensation Court of Appeals] may consider de novo." Krovchuk v. Koch Oil Refinery, 48 W.C.D. 607, 608 (W.C.C.A. 1993).

DECISION

Evidentiary Ruling

The compensation judge admitted deposition testimony from other employee's at the Boise Cascade plant, as offered by the employee, but advising the parties at hearing that he might grant only limited weight to that testimony. The issue before this court is whether the compensation judge erred by assigning limited weight to those exhibits, a legal question that this court may consider *de novo*. Krovchuk v. Koch Oil Refinery, 48 W.C.D. at 608 (W.C.C.A. 1993.)

At hearing, the employee offered into evidence multiple transcripts from depositions taken of co-workers of the employee, primarily to present evidence of the air quality and environment conditions in the employer's plant. Those depositions were taken during separate products liability litigation instituted by the co-workers. The employer objected, arguing, in part, that some of the deponents were deceased and therefore unavailable for cross-examination, that the employer was not represented at the depositions as it was not a party in interest to that separate litigation, and that the testimony was not material or relevant to the employee's claim. Over the objection of the employer, the compensation judge admitted the deposition transcripts into evidence, advising the parties, "but that does not mean that I will give them much weight." The compensation judge explained that he tends "to give far greater weight to witnesses that appear live and are subject to cross-examination by the parties of interest in the current matter." (T. 23.)

The employee argues that the compensation judge erred in giving limited weight to the deposition testimony allowed into evidence. The employee argues that, even though the compensation judge specifically allowed the record to remain open to provide an opportunity for the employer to cross-examine those deponents who are alive, the employer conducted no such cross-examination. The employee therefore argues that the weight of the deponents' testimony should not be diminished, since the testimony was allowed into evidence, since the testimony provided specific information concerning the level of the employee's asbestos exposure at work, and since the employer had an opportunity to cross-examine the living deponents.

The employer argues that the deposition testimony was submitted to demonstrate evidence of the dusty, dirty conditions at the employer's plant, and that the testimony does not change the fact that the employee's medical records do not support a causal connection between the work environment and the employee's lung condition. The employer further argues that one must assume that the compensation judge considered the transcripts when making his decision.

"[T]he purpose of the proceeding is disclosure of the true facts, a purpose better served by acceptance of all competent, relevant and material evidence." Scalf v. LaSalle Convalescent Home, 481 N.W.2d 364, 366, 46 W.C.D. 283, 286 (Minn. 1992); see Jendro v. Braun Boveri Turbo Machinery, 355 N.W.2d 716, 719, 37 W.C.D. 158, 161 (Minn. 1984). The compensation judge allowed the deposition transcripts into evidence. In his findings and memorandum, the compensation judge did not specifically state that he granted less weight to the deposition testimony provided by coworkers, in spite of his comments made during the hearing. Under the Minnesota Rules of Evidence, which do not bind the compensation judge, the depositions would most likely be ruled admissible because they were taken by litigants with a

similar interest. The defense at those depositions had an interest similar to the employer and insurer in this case and the deponents were subject to cross-examination in the nature of cross-examination the employer and insurer would have used in this case. See Minn. R. Evid. 804(b)(1) or (5). The weight to accord particular evidence was within the judge's discretion, as evidentiary rulings are generally within the sound discretion of the compensation judge. Ziehl v. Vreeman Constr. Co., slip op. at 5 (W.C.C.A. Oct. 5, 1991). We therefore defer to his evaluation in this case, and conclude that the compensation judge did not err by potentially granting limited weight to the deposition testimony.

We note that the compensation judge made a specific finding that the employee was exposed to asbestos at work, and referred to asbestos piping, friable asbestos insulation, dusty work environment, and lack of masks or respirators for the employee. We also note that, in view of the compensation judge's recognition that the employee was exposed to asbestos, the weight the compensation judge accorded the deposition testimony appears to be irrelevant to the ultimate outcome of his finding concerning asbestos exposure.

Occupational Disease Claim

The employee appeals from the compensation judge's determination that he sustained no occupational lung disease as a substantial result of his work for the employer between 1954 and 1984. As defined by Minn. Stat. § 176.011, subd. 15,

> "[o]ccupational disease" means a disease arising out of and in the course of employment peculiar to the occupation in which the employee is engaged and due to causes in excess of the hazards ordinary of employment and shall include undulant fever. . . . A disease arises out of the employment only if there be a direct causal connection between the conditions under which the work is performed and if the occupational disease follows as a natural incident of the work as a result of the exposure occasioned by the nature of the employment. . . .

The compensation judge concluded that the employee "has failed to sustain his burden of proof that he is suffering from an occupational lung disease, either asbestosis, asthma or bronchitis, at this time." (Finding No. 42.) The issue before this court is whether the compensation judge's conclusion is supported by substantial evidence and is not clearly erroneous.

In order to recover workers' compensation benefits, an employee must establish that his work-related injury is a substantial contributing factor to his current disability. Steinhaus v. F.B. Clements, 47 W.C.D. 22, 30 (W.C.C.A. 1992); Tolzmann v. McCombs-Knutson Assocs., 447 N.W.2d 196, 198, 42 W.C.D. 421, 424 (Minn. 1989). The record available for the compensation judge's review included the medical reports in the record, the employee's testimony, testimony of coworkers, and specific medical opinions concerning causation, rendered by Dr. Dolan, Dr. Bonham and Dr. Vessey. The compensation judge relied upon the medical opinion of Dr. Vessey in reaching his findings that the employee has not sustained an occupational lung disease as a result of his work with the employer.

1. Asthma and Bronchitis Claims

The compensation judge concluded first that the employee did not develop asthma and bronchitis as a substantial result of his work for the employer. The compensation judge stated that he found no mention in the medical records of treatment for asthma and bronchitis during the period the employee was working and exposed to dust, smoke and other chemicals. The employee's medical records refer to initial treatment for asthma and bronchitis in 1998, many years after he was laid off in 1984. The compensation judge apparently concluded that the delay in the employee's development of asthma and bronchitis vitiated any causal connection to the employee's work exposure. The compensation judge acknowledged that the employee had been diagnosed with asthma and bronchitis; however, relying in part on Dr. Vessey's opinion, he concluded that those conditions were not causally related to the employee's exposure while working for the employer. In his memorandum, the compensation judge concluded that the "mere fact the employee was exposed while he was working and later, when he was no longer working for the employer, developed bronchitis and asthma is insufficient to establish the necessary causal connection." (Memo., p. 8.) As it is the compensation judge's responsibility, as trier of fact, to resolve conflicts in expert testimony, Nord v. City of Cook, 360 N.W.2d 337, 342, 37 W.C.D. 364, 372 (Minn. 1985), and as substantial evidence of record, including Dr. Vessey's testimony, supports the judge's conclusion that the employee has not sustained asthma and bronchitis as a result of his work for the employer, we affirm those conclusions.

2. Asbestosis Claim

The compensation judge also concluded that the employee did not sustain asbestosis as a substantial result of his work for the employer. Although both Drs. Bonham and Vessey followed the American Thoracic Society's standards and criteria for diagnosis of asbestosis, Dr. Bonham concluded that the employee has sustained asbestosis, and Dr. Vessey reached the opposite conclusion. As described by Dr. Vessey, those criteria for a diagnosis of asbestosis are presence of rales, pulmonary function testing below predicted values, and chest x-ray findings of the presence of lower zone reticulo-nodular opacities. (T. 191-193.) Dr. Vessey found that because all of these criteria were not met by the employee, he had not sustained asbestosis as a result of his exposure while working at Boise Cascade Corporation. [7]

The compensation judge specifically relied on Dr. Vessey's opinion and found that the employee's medical records, including various testing results from tests performed since 1990, did not demonstrate asbestosis. In his memorandum, the compensation judge stated that:

> As to the claims for asbestosis, the Compensation Judge finds Dr. Vessey's opinions to be better founded. The employee's x-rays and CT scan do not reflect lower lobe opacifications, *but do reflect some interstitial fibrosis, as would be expected from a lengthy period of asbestos exposure*. Furthermore, most of the x-ray

[7]Dr. Dolan also referred to the same criteria that he reviewed when reaching his conclusion that the employee had sustained asbestosis. (Ee. Ex. A.)

> evidence is limited to the left lower lobes, rather than is bilateral. This is significant because left lower lobe changes are more consistent with congestive heart failure than with asbestosis. With asbestosis, one would expect the changes to be in both lungs, not primarily the left. It is also significant that there are no opacifications and that changes are apparent only on CT scan. This suggests that the employee does not have a significant disease process from asbestos that is causing his restriction in his lung capacity; whereas, opacifications would suggest significant damage to the lower lung lobes.

(Memo., p. 8, emphasis added.) The compensation judge specified in his memorandum that the employee's physical examinations "do not reflect the presence of rhonchi or rales that persist between examinations." (Memo., p. 9.) The compensation judge explained that this suggests an acute process, such as flu or congestive heart failure, rather than a chronic process such as asbestosis.

The compensation judge also referred to the pulmonary function testing performed at Duluth Clinic and Abbott Northwestern Hospital which reflected that the employee does not have a significant loss, less than 80 percent, of his diffusing capacity. The compensation judge, in his memorandum, stated that he "thus finds that the evidence at this point and time does not reflect a significant loss of diffusing capacity. This, likewise, suggests the employee's restrictive component to his lung problem is not asbestosis, but another disease process." The compensation judge relied on Dr. Vessey's testimony that the employee had not sustained the "disease known as asbestosis," based on the following criteria:

> . . . I heard no rales when I listened, the x-rays showed no abnormalities compatible with asbestosis, and the diffusing capacity when performed at Abbott Northwestern Hospital was 90 plus percent of predicted, which is -- all those mitigate against asbestosis being a clinical feature of the patient's shortness of breath.

(T. 219-220.) The compensation judge found that the evidence, "at this point and time," does not meet the generally accepted criteria for the diagnosis of asbestosis, and denied the employee's claim. (Memo., p. 9.)

The employee asserts that his exposure to asbestos in the employer's plant was more extensive and varied than recognized in the compensation judge's findings. The employee argues that the compensation judge's findings are incomplete, in that he made no findings regarding whether the employee suffers from asbestos-related pleural disease. In addition, the employee argues that the findings are inconsistent, arguing that, even though the compensation judge found that the employee failed to prove he suffers from the occupational disease of asbestosis, the compensation judge later stated that the employee suffers from work-related interstitial fibrosis, "as would be expected from a lengthy period of asbestos exposure." (Memo., p. 8.) The employee claims that Dr. Vessey used the terms "asbestosis" and "interstitial fibrosis" interchangeably during his testimony, that interstitial fibrosis is a type of occupational lung disease

and that the compensation judge needs to make further findings concerning the import of that diagnosis. The employee also argues that the trial court erroneously characterized and construed evidence in denying a causal link between the employee's interstitial scarring and his restrictive lung disease. In addition, the employee specifically argues that the compensation judge must make findings as to whether any of the employee's claimed medical expenses are reasonable and necessary to cure or relieve the effects of the employee's interstitial fibrosis, and as a result whether the intervenor is entitled to reimbursement and whether the employee is entitled to payment for his costs and disbursements for establishing primary liability for permanent lung scarring such as interstitial fibrosis.

The employer argues that the references to interstitial fibrosis in the employee's medical records do not indicate that the fibrosis is significant, and that the employee's pulmonary function testing and x-ray findings do not demonstrate significant interstitial fibrosis. The employer also argues that the employee's respiratory problems are related to some sort of cardiac asthmatic condition, as demonstrated by the employee experiencing relief from inhalers or broncho-dilators, treatment which usually would have no effect on asbestosis symptoms.

The employee argues that the medical evidence of record requires a finding that the employee has sustained asbestosis as a substantial result of his work exposure. Pursuant to this court's standard of review, however, the issue is not whether the evidence will support alternative findings but whether substantial evidence supports the compensation judge's findings. Where evidence conflicts or more than one inference can be drawn from the evidence, the compensation judge's findings are to be affirmed. Hengemuhle, 358 N.W.2d at 60, 37 W.C.D. at 240. In addition, we note that it is the compensation judge's responsibility, as trier of fact, to resolve conflicts in expert testimony. Nord v. City of Cook, 360 N.W.2d 337, 342, 37 W.C.D. 364, 372 (Minn. 1985). The compensation judge reviewed the employee's medical records and, in reliance upon Dr. Vessey's opinion, concluded that the employee, at this time, had not yet sustained the occupational disease of asbestosis as a substantial result of his work for the employer. There is substantial evidence in the record to support the compensation judge's finding, and, therefore, we affirm that finding as it specifically relates to the diagnosis of asbestosis at this time.

However, the compensation judge referred to the diagnosis of interstitial fibrosis in his memorandum, and stated that the employee's x-rays and CT scan findings were consistent with exposure to asbestos. (Memo., p. 8.) Both Drs. Bonham and Vessey recognized that there are different disease processes that can result from asbestos exposure. One of those processes is interstitial fibrosis. According to Dr. Vessey's testimony, interstitial fibrosis includes various forms of pulmonary fibrosis, including pneumoconiosis. Pneumoconiosis refers to the presence of a fibrotic lung disease brought on by inhalation of fiber, such as asbestos; asbestosis is a variety of pneumoconiosis. (T. 185.) Even though Dr. Vessey testified that he does not agree that the employee has sustained "true significant interstitial fibrosis," (T. 244.) it appears that the compensation judge concluded that the employee has sustained a type of lung disease or condition, specifically interstitial fibrosis, as a substantial result of the asbestos exposure he experienced while working for the employer. The compensation judge, however, made no specific finding concerning that asbestos-related medical condition. In addition, in his memorandum, the compensation judge referred to a potential causal connection between the employee's restrictive

lung disease and his cardiac condition. Those references are not explained nor do they seem to be supported in the medical record.[8]

We therefore remand this matter to the compensation judge for a finding on the issue of whether the employee's findings on x-ray and CT scan constitute an occupational disease, whether the employee has sustained an occupational disease in the nature of interstitial fibrosis as a substantial result of his exposure while working for the employer, and the basis for his conclusions. The compensation judge has the discretion to take additional testimony as needed.

We also remand this matter to the compensation judge for a determination whether any of the employee's medical treatment was reasonable and necessary to cure or relieve the effects of interstitial fibrosis, and for a determination whether the intervention claim brought by Medicare is compensable, for that portion which is related to treatment for that condition or disease process.[9] The compensation judge's determinations concerning these medical issues are predicated upon whether he finds that the employee's interstitial fibrosis rises to the level of an occupational disease. We also request that the judge determine whether the employee has sustained any ratable permanency relative to the employee's claimed interstitial fibrosis. We also request that the compensation judge determine whether the employee is entitled to reimbursement of costs and disbursements relative to this litigation.

[8]The employee underwent heart surgery in January 2000, and therefore the medical records in evidence included records from that surgery and related diagnostic testing.

[9]Medicare was joined as an intervenor to the employee's claim, claiming reimbursement for medical expenses paid between 1994 and 2000, totaling $31,037.25.