JOANNE L. WISCOVITCH, Employee/Petitioner vs. BORDEN, INC., and ACE USA f/k/a CIGNA, Employer-Insurer.

WORKERS' COMPENSATION COURT OF APPEALS
MARCH 28, 2001

No. [REDACTED SSN]

HEADNOTES

VACATION OF AWARD - SUBSTANTIAL CHANGE IN CONDITION. The petitioner has established good cause sufficient to vacate the Award on Stipulation filed July 15, 1996, based on a substantial change in condition since the parties entered into the stipulation for settlement and the award is vacated.

Petition to vacate granted.

Determined by: Johnson, J., Wheeler, C.J., and Rykken, J.

OPINION

The employee petitions this court to vacate an Award on Stipulation filed July 15, 1996, contending she has experienced a substantial change in her medical condition since the time of the award. The employee further argues the award should be vacated because she was not represented by counsel and was mentally incompetent to enter into a settlement.

BACKGROUND

Joanne L. Wiscovitch, the employee, sustained an admitted personal injury on October 21, 1994, while working for Bordon, Inc., the employer, insured by CIGNA. The First Report of Injury reflects a weekly wage of $461.00. The employer and insurer admitted liability and commenced payment of wage loss benefits. In addition, the employer and insurer paid the employee for a 10 percent whole body disability under Minn. R. 5223.0370, subp. 4.C.(2). (Ex. 16.)[1]

On November 4, 1994, the employee saw Dr. Marvin A. Brooks complaining of numbness and pain in her left arm, shoulder and elbow which she attributed to working on the employer's assembly line. Dr. Brooks diagnosed a left shoulder and arm sprain and placed the employee on light duty work. The employee returned to see Dr. Brooks on December 15, 1994, and the doctor noted the employee's symptoms were consistent with left shoulder sprain tendinitis and a mild cervical sprain. The doctor prescribed a tennis elbow-type brace, assigned work restrictions and prescribed physical therapy. (Ex. 7.) Dr. Alan W. Markman examined the

[1] All references to exhibits are the exhibits submitted by the employer and insurer (1 - 20) in their responses to the employee's petition.

employee on February 1, 1995 at the request of the employer. The doctor diagnosed medial epicondylitis of the left elbow and recommended job modifications. (Ex. 15.)

An MRI scan of the cervical spine on June 8, 1995, showed a moderated sized disc protrusion at C5-6 with mild flattening of the spinal cord and moderate narrowing of the left C5-6 neural foramen. The scan also showed small osteophytes at C4-5 without cord compression or foraminal narrowing. (Ex. 7.) On June 20, 1995, Dr. David Danoff examined the employee at the request of Dr. Brooks. The employee complained of left arm pain running from her neck to her hand but maximal at the left elbow. The doctor's neurologic examination was normal. He reviewed the MRI scan which he interpreted as showing a bulging disc at C5-6. Dr. Danoff concluded the employee's problems were due to a combination of epicondylitis and cervical disc disease. The doctor felt the employee could work subject to restrictions for both her cervical problems and epicondylitis.

A functional assessment was performed on July 11, 1995 at Northworks Occupational Health Services. The assessment indicated the employee was able to sit, stand and walk for a combination of six to eight hours a day. She was able to occasionally lift up to 25 pounds on the left side and frequently lift up to ten pounds on the left side and 30 to 40 pounds on the right side. (Ex. 5.) By report dated December 20, 1995, Dr. Brooks concluded the employee had reached maximum medical improvement and rated a ten percent permanent partial disability of the cervical spine secondary to her work injury. The doctor diagnosed chronic medial epicondylitis and degenerative changes at C5-6 with some flattening of the spinal cord, and assigned permanent restrictions consistent with the Northworks functional assessment on December 27, 1995. (Ex. 7.)

In January 1996, the employee began working with Kathleen Jordan, a qualified rehabilitation consultant (QRC). A Rehabilitation Plan was prepared with a vocational goal of a return to work with a new employer. On March 29, 1996, the QRC stated she thought the employee would probably find employment in the $5.00 to 6.00 an hour range given her prior work history, education and restrictions. The employee began a job search. (Ex. 2.)

On May 22, 1996, the employee was seen by Dr. Brian R. Koller for a psychiatric evaluation of depression. Dr. Koller reported the employee came to the clinic post-hospitalization after cutting her legs with numerous superficial lacerations. Dr. Koller diagnosed post traumatic stress disorder (PTSD), major depressive disorder, recurrent type, alcohol abuse and borderline personality disorder. The doctor prescribed Prozac, avoidance of alcohol and recommended follow-up counseling through the clinic. (Ex. 10.)

In June 1996, the parties entered into a stipulation for settlement. The parties stipulated the employee sustained a personal injury to her neck, shoulder and upper extremities. The employee contended she remained entitled to temporary total or temporary partial disability benefits and required rehabilitation and/or retraining. The employer and insurer contended the employee was then more than 90 days past maximum medical improvement, that she voluntarily removed herself from the labor market and denied the employee was entitled to either retraining or rehabilitation benefits. In exchange for a $19,000.00 payment, the employee agreed to settle on a full, final and complete basis, all claims for benefits arising out of the injury of October 21, 1994,

with the exception of claims for future medical benefits. The employee was not represented by an attorney. An Award on Stipulation was filed on July 15, 1996.

The employee returned to see Dr. Koller on August 19, 1996, reporting no significant benefit from the Prozac. The doctor's impression remained major depressive disorder, recurrent type, PTSD and borderline personality disorder. Dr. Koller changed the medication to Effexor. (Ex. 10.) On February 15, 1997, the employee was treated at Fairview Riverside Hospital for multiple self-inflicted cuts on her arms and legs. (Ex. 11.) The employee was then hospitalized at Abbott Northwestern Hospital on February 16, 1997. Dr. Gerald Peterson diagnosed depressive disorder, chemical dependency, hypothyroidism, appropriately treated, and impulse control disorder. The doctor recommended continuing Zoloft and a chemical dependency treatment program. (Ex. 12.) The employee returned to see Dr. Koller on February 24, 1997, and reported she was in a treatment program at Riverplace Counseling Center. Dr. Koller's diagnosis remained unchanged. (Ex. 10.) The employee was discharged from the Riverplace Counseling Center on March 10, 1997, with a guarded prognosis. (Ex. 13.) On May 6, 1997, Dr. Koller prescribed Paxil and discussed the possibility of other mood-stabilizing drugs. Thereafter, the employee apparently left the program. (Ex. 10.)

The employee had returned to see Dr. Brooks on October 21, 1996. Dr. Brooks noted the employee had settled her claim with the employer and was now working at a new job with some light lifting. The employee reported she was no longer having neck pain or numbness although she felt her left hand was weaker than the right, and she complained of continued pain in the left medial epicondyle. On examination, the doctor noted no tenderness to palpation along the spine or the cervical muscles, but the employee's left elbow was tender to palpation. The employee demonstrated full range of cervical motion and her reflexes were normal. Dr. Brooks diagnosed improved neck pain and chronic medial epicondylitis. (Ex. 7.)

On May 21, 1997, the employee saw Dr. James Guyn at Valley Creek Family Physicians complaining of neck pain radiating into her left arm. Dr. Guyn diagnosed chronic neck pain, probably secondary to protrusion of cervical discs and prescribed pain medication. A cervical MRI scan on June 9, 1997 showed degenerative disc changes at C5-6 with a posterolateral disc protrusion and spur formation. The radiologist noted the spurring was slightly larger than that seen in the last MRI scan. On August 16, 1997, the employee went to the emergency room at Fairview Ridges Hospital complaining of increasing neck pain after cleaning carpets over the past two days. Dr. Thomas Egger's diagnosis was C5-6 degenerative disc disease with an exacerbation. The doctor prescribed Motrin and referred the employee back to her primary physician.

On April 9, 1998, Dr. Brooks diagnosed a cervical sprain with underlying disc disease and paresthesias. The employee returned on July 6, 1998, complaining of increased pain in her neck along with numbness, tingling and weakness in her arms. On examination, the doctor found the employee was tender over the lower cervical spine and cervical muscles and noted paresthesia in the left upper arm, grip weakness in the left hand and pain in the epicondylar area. Dr. Brooks diagnosed a cervical sprain secondary to the 1994 work injury with "further progression clinically with her underlying degenerative disease associated with this." The doctor referred the employee to the Midwest Spine Institute. (Ex. 7.)

The employee was examined by Dr. Thomas B. Rieser at the Midwest Spine Institute on November 4, 1998. The employee complained of constant neck, left shoulder, left arm and left scapular pain with varying degrees of intensity depending on activity. The employee stated the pain had become more intense and persistent over the past five to six months. On examination, Dr. Rieser noted pain on cervical motion, biceps weakness and decreased sensation in the left hand. His diagnosis was C4-5 and C5-6 degenerative disc disease with suspected C6 radiculopathy secondary to compression of the C6 nerve root. The doctor ordered another MRI scan which was not obtained until June 8, 1999. The scan showed C4-5 degenerative disc disease with a disc protrusion progressed from the June 9, 1997 study, C5-6 degenerative disc disease and a small disc protrusion at C6-7 which was reported as new since the prior examination. On June 18, 1999, Dr. Rieser re-examined the employee. The doctor stated the MRI scan showed a three-level degenerative disc disease with a C6-7 lateral disc herniation and foraminal stenosis. Dr. Rieser recommended a three-level cervical fusion to which the employee consented. On July 30, 1999, Dr. Rieser performed an anterior cervical fusion from C4 through C7. The employee was seen in follow-up on October 8, 1999. Her cervical pain was improved but the employee continued to complain of left shoulder pain. (Ex. 14.)

On November 3, 1999, the employee saw Dr. Mark A. Wikenheiser at Midwest Spine Institute complaining of numbness in her left shoulder with radiation and paresthesia into the left arm. On examination, the doctor noted full range of motion of the left shoulder with mildly positive impingement signs and tenderness over the anterior acromion. Dr. Wikenheiser injected the subacromial space to rule out the possibility of impingement associated with the cervical complaints. The doctor observed if the employee's symptoms did not improve, it was likely the majority of her symptoms were cervical in nature. The employee saw Lisa M. Fritz, a physician's assistant on November 17, 1999. The employee gave a history of doing well until the prior week when she noted an onset of left neck and arm pain with numbness and tingling into her left arm. On examination, Ms. Fritz noted limited cervical flexion, loss of sensation in the left arm and absent triceps reflex. The employee returned to see Dr. Wikenheiser on January 3, 2000, with continued complaints of left shoulder and arm pain and discomfort. The doctor felt the employee's problems were not primarily due to her shoulder. (Ex. 14.)

A January 10, 2000 MRI scan showed lateral recess stenosis at C5-6 and C6-7. On January 14, 2000, the employee saw Dr. Rieser complaining of persistent pain in her neck and left arm. The doctor was concerned about a nonunion at C6-7 and ordered a CT/myelogram of the cervical spine. On March 10, 2000, Dr. Rieser reported the January 10th MRI scan revealed some mild changes below the fusion but the grafts were intact. The CT/myelogram showed no significant problems and the doctor felt the problem was mechanical pain. Dr. Rieser recommended a posterior cervical fusion. The doctor also noted left shoulder discomfort, ordered an MRI scan of the shoulder, and referred the employee to Dr. Glenn Buttermann and Dr. Dean Olsen for further evaluation.

Dr. Olsen examined the employee on March 24, 2000. The employee's chief complaint was left shoulder and neck pain which she described as radiating down her left arm to her elbow. On examination, the doctor noted a very positive impingement sign which reproduced pain. X-rays demonstrated a Type II acromion with some cystic and degenerative changes in the AC joint. An MRI scan of the left shoulder demonstrated some impingement anatomy of the

subacromial bursitis, thickening of the inferior AC joint capsule and some inferior osteophytes. The scan confirmed a Type II acromion. Finally, the doctor noted the employee had some partial thickness tearing of the articular surface of the rotator cuff in the supraspinatous area. Dr. Olsen diagnosed left shoulder impingement syndrome, partial thickness rotator cuff tear and AC arthrosis. Dr. Olsen injected the left subacromial space with Lidocaine and recommended the employee return in about six weeks. (Ex. 14.)

On March 31, 2000, Dr. Glenn Buttermann examined the employee at the request of Dr. Rieser for a second opinion regarding her neck pain. The doctor stated her continued pain was from multi-level pseudoarthrosis. The doctor opined the employee's left arm symptoms were a radiculitis and not a true radiculopathy. Dr. Buttermann also recommended a posterior fusion. On May 5, 2000, Dr. Olsen re-examined the employee's left shoulder and again diagnosed impingement and pain at the AC joint. The doctor felt subacromial decompression surgery with a distal clavicle excision was warranted. (Ex. 14.)

On June 27, 2000, the employee was examined by Dr. John A. Dowdle at the request of the employer and insurer for a second opinion on the advisability of a second fusion surgery. On examination, the doctor noted a stiff range of cervical motion with decreased lateral bending and rotation. Reflexes were normal but the doctor noted a slight decrease in grip strength on the left. Dr. Dowdle diagnosed mechanical cervical pain and concluded a C5-6 decompression and fusion was reasonable. (Ex. 17.)

On September 1, 2000, Dr. Rieser performed a foraminal decompression at C5-6 and C6-7 with a posterior cervical fusion from C4 through C7 with internal fixation, screws and a rod. Initially, the employee was placed in a body cast following the surgery and then wore a Philadelphia collar. On November 16, 2000, Dr. Rieser recommended left shoulder surgery. (Ex. 19.)

The employee was examined by Dr. Joel I. Gedan on January 11, 2001, at the request of the employer and insurer. The employee complained of continued left-sided neck pain which radiated into her left arm and left shoulder pain. The employee was not then working. On examination, the doctor noted moderately restricted cervical range of motion in all directions with a decrease in the left biceps and brachioradialis reflex consistent with a prior history of left C6 radiculopathy. Dr. Gedan diagnosed degenerative changes in the cervical spine with multi-level degenerative disc disease and spurring. The doctor opined the employee's symptoms were basically unchanged over the last five years. He concluded the employee's need for the anterior and posterior fusions resulted from a natural progression of degenerative disc disease demonstrated on the 1995 MRI study. The doctor further opined it may reasonably have been anticipated in 1995 that the employee would require surgery at some point in the future. The doctor further stated, however, it would "be unknown as to whether or not the cervical spine degenerative changes would progress to the point where she would need surgery, although this certainly happens as a part of the natural history of degenerative changes in the neck." Dr. Gedan opined there was no medical evidence to suggest any significant change in the employee's diagnosis between 1995 and 2000. The doctor stated the employee might be able to return to work six months following the fusion surgery and would require a ten-pound lifting restriction and the avoidance of repetitive and prolonged neck flexion and extension. (Ex. 19.)

DECISION

Minn. Stat. §§ 176.461 (Supp. 1993) and 176.521, subd. 3 (1992) govern this court's authority over petitions to vacate. For the court to exercise this authority, an employee must demonstrate good cause. Stewart v. Rahr Malting Co., 435 N.W.2d 538, 539, 41 W.C.D. 648, 649 (Minn. 1989). "Good cause" to vacate an award is limited to:

> (1) a mutual mistake of fact;
> (2) newly discovered evidence;
> (3) fraud; or
> (4) a substantial change in medical condition since the time of the award that was clearly not anticipated and could not reasonably have been anticipated at the time of the award.

Minn. Stat. § 176.461. The employee here contends she has experienced a substantial and unanticipated change in her medical condition since the time of the award justifying a vacation of the award on stipulation.

In determining whether a substantial change in the employee's condition has occurred, this court examines such factors as:

> (1) Change in diagnosis.
> (2) Change in employee's ability to work.
> (3) Additional permanent partial disability.
> (4) Necessity of more costly and extensive medical care/nursing services than initially anticipated.
> (5) Causal relationship between injury covered by the settlement and current worsened condition.
> (6) Contemplation of parties at time of settlement.

Fodness v. Standard Café, 41 W.C.D. 1054, 1060-61 (W.C.C.A. 1989) (citations omitted). These factors must be applied in a manner consistent with Minnesota Statutes § 176.461 which requires the change be "clearly not anticipated and could not be reasonably anticipated at the time of the award."

1. Change in Diagnosis

The Award on Stipulation was filed on July 15, 1996. An MRI scan on June 8, 1995, showed a moderate-sized disc protrusion at C5-6 with mild flattening of the spinal cord and narrowing of the neural foramen. The scan also showed small osteophytes at C4-5 without cord compression or narrowing. In December 1995, Dr. Brooks diagnosed degenerative changes at C5-6 and medial epicondylitis. Dr. Danoff diagnosed cervical disc disease at C5-6 and epicondylitis. Dr. Markman also diagnosed left medial epicondylitis. On October 21, 1996, Dr. Brooks noted the employee's neck pain had improved and she was no longer having neck pain or numbness but continued to have chronic medical epicondylitis.

An MRI scan on June 8, 1999, showed C4-5 degenerative disc disease with a disc protrusion, progressed from the June 9, 1997 scan, C5-6 degenerative disc disease and a small disc protrusion at C6-7, reported as new since the last study. Dr. Rieser diagnosed degenerative disc disease at C4-5, C5-6 and C6-7 with a small disc protrusion at C6-7 and recommended a cervical fusion. Following the fusion, an MRI scan showed lateral recess stenosis at C5-6 and C6-7. Dr. Rieser and Dr. Dowdle diagnosed mechanical cervical pain and recommended a second fusion surgery. In March 2000, Dr. Olsen diagnosed left shoulder impingement syndrome with a partial rotator cuff tear and arthrosis. The employee's cervical condition now includes degenerative disc disease at levels above and below the original injury at C5-6. The left shoulder diagnosis is new since the award and surgery has been recommended. The employee has established a substantial change in her diagnosis since the award on stipulation.

2. Change in Ability to Work

The employee's work history since the date of the award on stipulation is less than clear. On October 21, 1996, Dr. Brooks noted the employee was working at a new job. In an affidavit dated August 16, 2000, the employee states neck pain caused her to miss work on several occasions prior to her June 17, 1999 surgery. Following surgery, the employee was off work until November 1999, when she states she was released to return to work three hours a day, with restrictions. The employee contends she was again taken off work on March 10, 2000, but later released to return to work at reduced hours. Finally, the employee averred she was again taken off work on August 3, 2000, pending the second fusion surgery. The employee was deposed on September 18, 2000, and stated she was last employed in July 2000. Dr. Rieser performed a second fusion surgery on September 1, 2000, and the employee has apparently been off work since that time. (Ex. 1, p. 4-5.) Prior to the settlement, the employee was released to work eight hours a day, subject to a ten-pound restriction on frequent lifting and carrying. (Ex. 5.) On March 31, 2000, Dr. Buttermann opined the employee could go back to work with restrictions of only five pounds of lifting and no overhead activities. Dr. Gedan opined the employee can work subject to a ten-pound lifting restriction due to her shoulder and avoidance of repetitive and prolonged cervical flexion and extension. The employee has lost time from work due to her worsened condition. Her restrictions on lifting may now be greater, and Dr. Gedan would limit the employee to jobs which do not require repetitive or prolonged cervical flexion or extension. Although the evidence is equivocal, we conclude the employee does have a change in her ability to work.

3. Additional Permanent Partial Disability

The employee was rated and paid for a 10 percent permanent partial disability of the cervical spine prior to the award on stipulation. Minn. R. 5223.0380, subp. 5.B. provides for an additional 5 percent for a fusion at multiple levels for treatment of cervical pain or a radicular syndrome. The employee further contends she has additional permanency by reason of the rotator cuff tear. See Minn. R. 5223.0450, subp. 3.A.(2), plus additional permanent disability under Minn. R. 5223.0370 due to radicular pain or paresthesia. The employee is clearly entitled to at least an additional 5 percent for a fusion surgery.

4. Unanticipated Medical Care

The employee has undergone two cervical fusions since the award and Dr. Olsen has recommended shoulder surgery in the future. We find no evidence in the medical records or the stipulation that either party anticipated the employee's injury would require two fusion surgeries or a shoulder surgery. Medical expenses were, however, kept open in the settlement and the insurer has paid the medical expenses related to the two surgeries.

5. Causal Relationship

The employer and insurer have accepted liability for the employee's cervical spine condition and acknowledge the employee's current worsened condition relates to her cervical spine condition. The employee has established good cause to vacate the Award on Stipulation filed July 15, 1996 and the award is accordingly vacated.