

LOMMEN, ABDO, COLE, KING & STAGEBERG, P.A.

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STATE OF MINNESOTA

WORKERS' COMPENSATION

WORKERS' COMPENSATION COURT OF APPEALS COURT OF APPEALS

No. WC10-5205

Janalee J. Jacobson,

Midwest Disability
Thomas A. Klint
William J. Marshall
408 Northdale Boulevard
Coon Rapids, Minnesota 55448

Appellant,

v.

Power Team and Broadspire,

Lommen, Abdo, Cole, King &
Stageberg, P.A.
Kay Nord Hunt
Richard L. Plagens
2000 IDS Center
80 South Eight Street
Minneapolis, Minnesota 55402

Respondents.

The employee's appeal from the Findings and Order of Compensation Judge Jane Gordon Ertl, served and filed October 18, 2010, was considered by Thomas L. Johnson, Debra A. Wilson, and David A. Stofferahn, Judges of the Workers' Compensation Court of Appeals.

Based upon the transcript of the testimony taken before the compensation judge, the exhibits admitted into evidence, and the briefs and arguments of counsel, the court concludes the Findings and Order of the compensation judge are in accord with the evidence and law in the case, and are AFFIRMED.

BY THE COURT:


THOMAS L. JOHNSON, Judge

OPINION

THOMAS L. JOHNSON, Judge

The compensation judge found the employee's work activities were not a substantial contributing cause of her bilateral hand, wrist, and arm symptoms. The employee appeals this finding contending the judge erroneously required the employee to prove a specific diagnosis as a condition of compensability. We affirm.

BACKGROUND

Janalee J. Jacobson, the employee, began working for Power Team, the employer, in 1988 as a customer service representative. The employee's job involved responding to telephone calls and preparing documents by entries by hand in a notebook as well as on a computer. All of the employee's computer work was done with keystrokes. Commencing in approximately November 1993, the employee noticed a gradual onset of symptoms including tingling and pain first in her right hand and arm and then in her left hand and arm. In November 1993, the employee filed a first report of injury.

The employee saw Dr. Brian Bunkers, her family physician at the Owatonna Clinic, in November 1993. Dr. Bunkers diagnosed early right carpal tunnel syndrome and prescribed wrist braces and an anti-inflammatory medication. The employee wore the wrist braces at work. An EMG examination in January 1994 was normal, but the employee testified her symptoms continued.

In December 1994, the employee was examined by Dr. Gordon Welke on referral from Dr. Bunkers. The employee complained of numbness and tingling in both hands greater on the right than the left. The doctor diagnosed carpal tunnel syndrome caused by work activity. A repeat EMG was normal in both arms.

Dr. Chris Tountas examined the employee in January 1995 at the request of the employer and insurer. The doctor stated his findings were inconclusive for carpal tunnel syndrome and recommended against surgery. Dr. Tountas thought it possible the employee had a generalized disease process which needed to be delineated before proceeding with further treatment and opined that the employee might be suffering from thoracic outlet syndrome or Raynaud's disease.

The employee returned to see Dr. Bunkers in January and again in February 1995. In his notes, the doctor stated the employee "has had a dramatic change in her symptomatology since our last visit." And this change "certainly changes the suspicion of what is going on with her." (Pet. Ex. C.) Dr. Bunkers diagnosed right upper extremity pain and swelling and possible thoracic outlet syndrome with underlying carpal tunnel syndrome.

Dr. Bunkers referred the employee to Dr. Eales, a vascular surgeon, who could not explain the employee's symptoms on the basis of a thoracic outlet syndrome. Dr. David Zoschke, a rheumatologist, also saw the employee on referral and diagnosed moderately severe fibromyalgia syndrome. Other than the fibromyalgia, the doctor found no evidence of any other underlying rheumatic or other significant medical condition.

In June or July 1995, the employee was promoted to a lead worker by the employer. In addition to her regular duties, the employee then assisted other customer service representatives. About the same time, the employee began noticing increased pain and swelling from her right shoulder down into her fingertips with associated discoloration in both arms. As a result of these symptoms, the employee was forced to keyboard with her left hand and the employer hired a secretary to assist the employee with the keying and writing aspects of her position.

In April 1996, Dr. Welke recommended a carpal tunnel release in an attempt to relieve her ongoing symptoms. The doctor acknowledged he hoped he was doing the right thing and that normally he preferred to have positive nerve conduction tests before surgery. Dr. Welke performed a carpal tunnel release on the employee's right hand in May 2008. Thereafter, the employee returned to work and was able to key but approximately three weeks later the swelling reoccurred.

Dr. Welke referred the employee to Dr. Michael Kearney for an evaluation of her bilateral wrist, hand, and arm symptoms. The doctor diagnosed status post-right carpal tunnel release with a good early result with persistent symptoms in the right upper extremity including cyanosis. Dr. Kearney stated the cause for the reoccurrence of the cyanosis in the right hand was not clear. He stated the employee had a residual pain syndrome in her right arm consistent with a repetitive stress injury at work and felt the symptoms would continue as long as the employee continued working. In an office note dated July 9, 1996, Dr. Kearney stated the employee's symptoms were caused by the repetitive tasks of writing and keyboard use in her job and recommended the employee avoid these activities. The employer was unable to accommodate the employee's work restrictions and she was terminated in July 1996. The employee has not worked since leaving the employer.

After leaving her employment, the employee testified her symptoms continued or worsened. In October 1996, the employee saw Dr. Bunkers complaining of swelling and pain and a blue discoloration in her right hand. The doctor opined the employee was disabled and recommended she be seen at the Mayo Clinic.

The employee was first seen at the Mayo Clinic in December 1996. An EMG of both arms was normal with no evidence for carpal tunnel syndrome or radiculopathy. A bilateral arm venogram in 1997 showed occlusion of both axillary veins. Thereafter, the employee saw several physicians at the Mayo Clinic. Dr. Andrea Adams stated a chronic pain syndrome as a result of repetitive stress was a reasonable diagnosis but acknowledged that other possibilities

needed to be explored. Dr. Kevin Moder suspected the employee had a problem with vascular outflow in the upper extremities and recommended an ultrasound of both subclavian veins. The doctor stated the employee's symptoms were not suggestive of Raynaud's disease and found nothing on examination suggesting an underlying connective tissue disease, fibromyalgia, or reflex sympathetic dystrophy. A bilateral arm venogram ordered by Dr. Adams reflected a reduced blood flow in both the left and right subclavian veins. By report dated February 28, 1997, Dr. Adams stated her neurological examination of the employee was normal and she stated she found nothing suggesting an underlying rheumatologic disorder or a neurologic disorder.

Dr. Catherine Willner, a neurologist with the Mayo Clinic, examined the employee in March 1997. The doctor diagnosed positional venous occlusion with forequarter swelling, dysesthetic neurogenic sensation, difficult to classify and significant myofascial shoulder pain. Thereafter, Dr. Willner recommended a plan of diagnostic therapy to neutralize the position in which the employee's veins were occluded and regain some function of her shoulder muscles.

Dr. Robert McBane of the Mayo Clinic examined the employee in September 1997 and diagnosed a very complicated case of chronic bilateral upper extremity pain syndrome of undetermined etiology. The doctor opined the employee's symptoms were neuropathic in origin but noted neurologic tests, including several EMGs, were negative for any chronic nerve injury. Dr. McBane further noted the employee had evidence of venous obstruction but was unclear how this condition related to her current symptomatology with the exception of the arm suffusion.

The employee returned to see Dr. Adams in November 1997. Her diagnosis remained positional venous occlusion, upper extremity pain, and paresthesias. Dr. Adams reported that she and the employee discussed "the relationship of her work to her symptoms and at the current state I do not know of any type of relationship we can claim for her symptoms." (Pet. Ex. A.) In December 1997, Dr. Adams wrote to Dr. Bunkers informing him that the employee had positional venous occlusion and reported the employee had met with Dr. Kenneth Cherry of the Mayo Clinic's vascular surgery department to consider possible thoracic outlet surgery but had been advised this surgery might make no difference to her symptomatology.

By letter dated April 9, 1998, Dr. Cherry stated the employee

has bilateral thoracic outlet syndrome, worse on the right than the left. More debilitating to her, however, is an idiopathic venous occlusion not thought to be related to thoracic outlet syndrome involving the right upper extremity. This is a very rare condition of which we have only seen a few, but does limit her ability to use that extremity. The correct treatment for this has not yet been determined.

(Pet. Ex. A.)

Dr. Cherry reexamined the employee on October 13, 1998, and noted her symptoms remained the same. They again discussed thoracic outlet surgery and Dr. Cherry noted the surgery "will probably not relieve her idiopathic venous obstruction and may not relieve all of the pain if this is not indeed thoracic outlet syndrome." (Pet. Ex. A.) The employee also saw Dr. McBane on October 13, 1998, and reported marked discomfort when curling her hair, brushing her teeth, driving, typing, or prolonged writing. The employee continued to have upper extremity swelling, numbness, and buzzing in her fingers and intermittent electric jolts in her arms. In his report, Dr. McBane stated,

This is a very complicated case of a patient with chronic bilateral upper extremity pain syndrome of undetermined etiology. She may in fact have neurogenic thoracic outlet syndrome. However, as previously noted this is a very difficult diagnosis to make in that there are no definitive tests to confirm the diagnosis. She does have evidence of dynamic vascular compression at the thoracic outlet; however this is primarily in the left upper extremity which is lesser symptomatic of the two. At this point from a standpoint of evaluation, I would recommend no further testing.

(Pet. Ex. A.)

By letter dated December 7, 1998, Dr. Cherry stated the employee's work "undoubtedly contributed to the bilateral neurogenic thoracic outlet syndrome both on the left and right, although as I stated it is not the sole cause." The doctor stated it would be "absolutely impossible" to determine whether the employee's work activities contributed to her idiopathic venous occlusion. Finally, Dr. Cherry stated the employee's "venous occlusion was more restrictive to Ms. Jacobson than the thoracic outlet syndrome." (Pet. Ex. A.)

The employee returned to see Dr. Bunkers in April 2000. She advised the doctor she had right arm pain on a daily basis which caused her to limit her activities. On examination, Dr. Bunkers noted full cervical range of motion with normal motor strength, reflexes, and sensation in both arms. However, the doctor noted bluish discoloration of the employee's right fingertips. His diagnosis was venous occlusive syndrome of the right arm, unchanged, and longstanding in nature. By letter dated September 21, 2000, Dr. Bunkers stated the pain and dysfunction of the employee's right arm limited her from obtaining any competitive employment. The employee saw Dr. Bunkers in October 2007 for evaluation of tingling in her left arm. The diagnosis was paresthesia of the left arm. The doctor stated he could prescribe no specific treatment until he knew what the origin of the symptoms was. In August 2008, the employee reported continued bilateral arm pain. Dr. Bunkers diagnosed a chronic upper extremity pain syndrome, venous occlusive disease, and a component of fibromyalgia.

In October 2008, Dr. Shawn Oxentenکو, a physiatrist, examined the employee on referral from Dr. Bunkers. On examination, the doctor noted normal reflexes in both arms and legs, normal upper extremity strength testing, and normal shoulder range of motion with no impingement signs. His diagnosis was chronic upper extremity pain syndrome and fibromyalgia. Dr. Oxentenکو recommended a referral to the Pain Rehabilitation Center.

Dr. Thomas Walsh, an orthopedic surgeon, examined the employee in October 2009 at the request of the employer and insurer. The doctor prepared a medical report and his deposition was taken in July 2010. The employee told the doctor she experienced buzzing or vibrating sensation in both hands and arms, numbness and tingling in her hands at night, weakness in her arms with swelling and blue discoloration and difficulty performing even light daily activities. Dr. Walsh diagnosed bilateral arm pain, right greater than left, undiagnosed, and stated he was unable to support the employee's subjective symptoms with any objective physical findings. The doctor opined the employee's condition was not related to her work activities for the employer, and stated the employee "has had a very thorough and comprehensive medical evaluation by multiple specialists in multiple areas of specialization and all of these investigations, laboratory and imaging studies, have not demonstrated with any consistency a medical diagnosis that can be related to any degree of certainty to work activity." The doctor noted that from the employee's history and medical records that her symptoms had remained the same or worsened since she stopped working which suggested to him that work activities were not a substantial contributing factor to her problems. Finally, the doctor stated, "It is my feeling to a reasonable degree of medical certainty that there is no way to objectively link her current symptomatic complaints with her work activities." (Resp. Ex. 1.)

The deposition of Dr. Michael Kearney was also obtained in July 2010. The doctor noted that he first examined the employee in June 1996 on referral from Dr. Welke and last examined the employee on October 3, 1996. The doctor diagnosed the employee's condition as a cumulative trauma disorder related to hyperirritability of the soft tissue of the arms. Dr. Kearney stated this was a description rather than a specific diagnosis because it describes a collection of symptoms without an understanding of the exact mechanism of cause of the problem. Dr. Kearney opined, however, that the employee's condition was substantially caused by her work for the employer. The doctor stated the employee needed to avoid repetitive hand or stressful upper extremity activities. He opined the employee had reached maximum medical improvement and had no recommendation for further treatment.

By report dated July 22, 2010, Dr. Bunkers stated his working diagnosis for the employee was a history of carpal tunnel syndrome status post bilateral release, positional venous occlusive disease of the arms, fibromyalgia, and myofascial pain syndrome. The doctor opined the employee's work activities with the employer played some role in her carpal tunnel syndrome. The doctor stated he had no opinion whether the employee's work activities were a contributing factor to the positional venous occlusive disease, the fibromyalgia, or the myofascial pain syndrome.

The employee filed a claim petition alleging a Gillette-type¹ personal injury on November 3, 1993, and claiming permanent total disability benefits from and after August 1, 2006, supplemental benefits, and payment of outstanding medical expenses. Following a hearing, the compensation judge found the employee's work activities were not a substantial contributing cause of her ongoing symptoms or disability. The employee appeals.

DECISION

The compensation judge noted in her memorandum that the medical records document the employee has a "rare and difficult to diagnosis problem." The judge went on to state, "As noted by Dr. Walsh, it is difficult to attribute an undiagnosed problem to her work activity. There is too much uncertainty in this case regarding the employee's range of symptoms, diagnoses, and causation." (Mem. at 7.) The compensation judge concluded the employee failed to prove her work was a substantial contributing factor to her disability. The employee contends that all of her treating doctors and Dr. Walsh agree she has chronic bilateral upper extremity pain. While the underlying basis for this pain may be complex and difficult to diagnose, that fact, the employee argues, is not a basis to deny her claim. The employee maintains that Dr. Walsh and the judge concluded the employee did not sustain a work injury because the employee's symptoms could not be objectively diagnosed. This, the employee contends, is an incorrect legal standard, and the compensation judge's decision is legally erroneous and unsupported by substantial evidence.

A personal injury may be established based upon the subjective complaints of the employee coupled with the opinion of a medical expert that the employee's disability arose out of and in the course of her employment. Brown v. State, Dep't of Transp., 56 W.C.D. 350 (W.C.C.A. 1997). "If an opinion by a medical expert in a respected, recognized field of medicine is given with reasonable medical certainty, that opinion may, if the trier of fact chooses to rely on it, support a causal link between the worker's disability and the job." Grunst v. Immanuel-St. Joseph Hosp., 424 N.W.2d 66, 67, 40 W.C.D. 1130, 1132 (Minn. 1988). Further, it is not necessary that a medical expert pinpoint the exact etiology of an unidentifiable disease or condition for the resulting disability to be compensable. Boldt v. Josten's, Inc., 261 N.W.2d 92, 30 W.C.D. 178 (Minn. 1977). In this case, different doctors have ascribed different diagnoses and, admittedly, the employee's medical condition is complex. We do not agree, however, that the basis for the judge's decision was that the cause of the employee's upper extremity pain is unknown.

Here, the compensation judge accepted, and chose to rely on, the medical opinion of Dr. Walsh. The doctor testified that he believed the employee experienced pain in her arms which worsened with activity. However, the doctor testified that he was unable to find any objective physical findings to support the employee's subjective symptoms. Dr. Walsh testified

¹ Gillette v. Harold, Inc., 257 Minn. 313, 101 N.W.2d 200, 21 W.C.D. 105 (1960).

that, to a reasonable degree of medical certainty, there was no way to objectively link the employee's current symptomatic complaints with her work activities. Further, the doctor noted the employee's symptoms have essentially stayed the same or worsened since she stopped working fourteen years ago. That fact, Dr. Walsh testified, suggested to him that work activities were not a substantial contributing factor to the employee's problems.

"[U]ntil the time comes when medical knowledge has progressed to such a point that experts in the field of medicine can agree, causal relation in determining compensable injury or disease will have to remain in the province of the trier of fact." Golob v. Buckingham Hotel, 244 Minn. 301, 69 N.W.2d 636, 639, 18 W.C.D. 275, 278 (1955). Dr. Walsh unequivocally opined there was no causal relationship between the employee's work activities and her bilateral arm symptoms. The opinions of the doctor were adequately founded and the compensation judge could reasonably rely upon them. Accordingly, the decision of the compensation judge is affirmed.