IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT NASHVILLE
OCTOBER 13, 2000 Session

TOMMY C. SMITH, v. CONTINENTAL CASUALTY INSURANCE COMPANY AND LEGGETT AND PLATT, INC., ET AL.

Direct Appeal from the Chancery Court for Rutherford County
No. 98WC-1658 Don R. Ash, Chancellor

No. M2000-00574-WC-R3-CV - Mailed - January 4, 2001
Filed - January 5, 2001

This Workers' Compensation Appeal has been referred to the Special Workers' Compensation Appeals Panel of the Supreme Court in accordance with Tennessee Code Annotated § 50-6-225(e)(3) for hearing and reporting to the Supreme Court of findings of fact and conclusions of law. The plaintiff, Tommy C. Smith, appeals the judgment of the Chancery Court of Rutherford County where the trial court found that the plaintiff failed to carry his burden of proof that he sustained a compensible injury as defined by Tennessee Code Annotated § 50-6-102(12). For the reasons stated in this opinion, we affirm the judgment of the trial court.

Tenn. Code Ann. § 50-6-225(e) (1999) Appeal as of Right; Judgment of the Chancery Court affirmed.

TOM E. GRAY, SP.J., delivered the opinion of the court, in which FRANK F. DROWOTA, III, J. and JOHN K. BYERS, SR.J., joined.

Christopher K. Thompson, Murfreesboro, Tennessee, for the Plaintiff/Appellant, Tommy C. Smith

Terry L. Hill, Nashville, Tennessee, for the Defendant/Appellees, Continental Casualty Insurance Company and Leggett & Platt, Inc.

MEMORANDUM OPINION

Plaintiff was employed with Leggett & Platt when he suffered an accident to his back on the 26th day of October, 1994. This accident was accepted as a compensible injury under the Tennessee Workers' Compensation statutory law by the employer. The employee received medical treatment from Dr. Gary Daniels and then came under the care of Dr. Robert Weiss who diagnosed a ruptured disc.

A series of diagnostic tests were ordered by Dr. Weiss, and on the 22nd day of November, 1994 Dr. Weiss reported that the patient's myelogram and post myelogram CT scan confirmed a left

lateralizing L2-3 disc herniation. The doctor also found a diffuse protrusion at L4-5 with findings suspicious for bilateral stenosis and a disc bulge at L5-S1.

Surgery with its risks and benefits and alternative means of treatment were discussed with Mr. Smith, and Dr. Weiss performed a L2-3 hemilaminotomy, medial facetectomy and diskectomy on claimant on the 1st day of December, 1994.

Plaintiff followed up post-operatively with Dr. Weiss, and returned to work at Leggett & Platt on light duty. He continued to be under the care and treatment of Dr. Weiss reporting good days and bad days and recurrent symptoms. In May, 1995 plaintiff was having recrudescent left leg pain and feeling as though a "knife" was cutting his foot open. Dr. Weiss ordered an MRI scan which was done on the 5th day of May, 1995 and described by Dr. Weiss as "an essentially unremarkable study revealing only some postoperative change on the left at L2-3, the site of his prior surgery."

On the 7th day of June 1995, Dr. Weiss saw Mr. Smith noting that he still has occasional radicular leg pain but was at maximum medical improvement. According to the AMA Guidelines a 10% permanent partial impairment to the body as a whole was ascribed to Mr. Smith by Dr. Weiss. Permanent restrictions of no lifting more than 40 pounds, except on an occasional basis, no repetitive bending, stooping, squatting, twisting and no maintenance of a single posture for prolonged periods of time were imposed by the doctor. Mr. Smith was to return on an as needed basis. In July, 1995 Mr. Smith did return for analgesics, and Dr. Weiss provided Naprosyn.

Claimant requested to see another physician and went under the treatment of Dr. Rex H. Arendall, II, M.D., a neurological surgeon. Dr. Arendall saw Mr. Smith on the 13th day of September, 1995 and Mr. Smith reported to Dr. Arendall that on Monday he stepped off a machine and felt like a sword went through him. After examination, the doctor's impression was possible recurrent disc herniation. He recommended a myelogram, post-myelogram, EMG which were approved by the workers' compensation carrier. The tests were performed on the 2nd day of October, 1995. Results of the CT scan was that it was an unremarkable CT scan of the lumbar spine from L1 to S1 and no abnormalities at L4-5. Impression of the lumbar myelogram was a questionable poor filling of the nerve roots at L4-5 bilaterally and at L5-S1 on the left. A small extradural defect was found at L2-3 on the left, and it was noted that otherwise it was an unremarkable lumbar myelogram. On the lumbar spine series the views showed very mild disc space narrowing at L5-S1 with other disc spaces well maintained and no evidence of spondylollsthesis or spondylolysis.

Plaintiff continued under the care of Dr. Arendall and according to office notes dated October 19, 1995 Dr. Arendall agreed with the restrictions placed by Dr. Weiss but was of the opinion that the total impairment rating was a 12% to the body as a whole.

On January 18, 1996 plaintiff reported to his employer that he had suffered another accident on the job. He saw Dr. Arendall on January 22, 1996 and Dr. Arendall recommended an MRI which was authorized. The MRI was negative.

A CT of the lumbar spine (L1-S1) with multi-planes reconstruction was performed on plaintiff at the end of January, 1996. This test revealed a disc bulge.

Compensability was accepted by the defendant, and medical treatment was provided with plaintiff remaining under the care of Dr. Arendall.

While being treated by Dr. Arendall plaintiff negotiated a settlement for the 1994 back injury. The Davidson County Circuit Court approved on the 13th day of February, 1996 the settlement plaintiff had reached with Legget & Platt concerning the workers' compensation claim for the accident in 1994.

Following court approval of the settlement, plaintiff continued under the care of Dr. Arendall. Mr. Smith went through physical therapy, and on April 1, 1996 Dr. Arendall released plaintiff to return to work for no more than 8 hours per day and no lifting more than 25 pounds on a repetitive basis. The last visit to Dr. Arendall was April 19, 1996 when plaintiff requested something for pain.

In August, 1996 plaintiff requested to be seen by a physician other than Dr. Arendall. Patsy Wrenne with Continental Casualty Insurance Company referred claimant back to Dr. Weiss. On August 16, 1996, Dr. Weiss saw plaintiff and performed a physical examination. Dr. Weiss had been informed that Mr. Smith had suffered another injury at work in January, 1996. Dr. Weiss found nothing new upon physical examination and reviewed all of the diagnostic studies that had been done in 1994, 1995 and 1996 and was of the opinion that there were no anatomical changes or new problems since 1994. Dr. Weiss informed the worker's compensation carrier that he could offer nothing further to the patient.

Claimant maintained that his visit to Dr. Weiss was not helpful, and he wanted to see another physician. Defendant provided a panel of three physicians, and claimant chose Dr. Robert Clendenin.

It was on the 3rd day of September, 1996 that plaintiff had his first appointment with Dr. Clendenin. Conservative treatment was provided, and it was the opinion of Dr. Clendenin that plaintiff had experienced an increase in pain as a result of the incident on the 18th day of January, 1996. The doctor found no anatomical changes as a result of the incident in January, 1996. Plaintiff was released to return to limited duty work on the 4th day of October, 1996.

Plaintiff continued to see Dr. Clendenin in 1997, and diagnostic studies were conducted in February, 1997. The MRI findings of 1997 were compared with those of May, 1995, and no significant differences were noted. A functional capacity assessment was made, and Mr. Smith was found to be capable of performing work in the moderate to heavy extension categories. Plaintiff last saw Dr. Clendenin on the 9th day of September, 1997.

Requesting another physician, plaintiff was authorized to return to Dr. Weiss. He decided against returning to Dr. Weiss and went to see Dr. William Ledbetter on March 25, 1998 without informing the defendants.

Dr. Ledbetter examined plaintiff and ordered an x-ray of the lumbar spine. Subsequently, under the treatment of Dr. Ledbetter multiple studies were performed. They included an MRI of the lumbar spine, a lumbar myelogram and a post-myelogram CT and an EMG.

When the plaintiff first saw Dr. Ledbetter in March, 1998 he told Dr. Ledbetter that about three (3) months previous he was walking up steps when he felt a sharp pain in his back. In deposition Dr. Ledbetter said that if there were any changes in plaintiff's physical condition from 1995 to 1996 it would be borderline. Dr. Ledbetter did opine that the condition for which he saw Mr. Smith was an aggravation of a pre-existing condition with that aggravation being the episode which occurred three (3) months prior to the first visit.

Dr. Ledbetter made no testimony connecting any aggravation of pre-existing condition to plaintiff's work.

On or about the 2nd day of July, 1998 Dr. Ledbetter referred Mr. Smith to Dr. Frank Berklacich, who saw plaintiff on July 14, 1998. A discogram was ordered by Dr. Berklacich, and based upon examination of plaintiff and the discogram, Dr. Berklacich recommended fusion surgery at L5-S1 level. The surgery was performed on the 16th day of December, 1998.

Dr. Berklacich was not an authorized treating physician by defendants.

In deposition Dr. Berklacich testified that he had access to prior CT scans, myelograms, and other spinal studies done on Mr. Smith and that based on these studies no ruptured disc was shown and based upon the prior studies surgery was not warranted. Dr. Mark Friedman did the discogram and reported the results to Dr. Berklacich. That report showed that it was a normal discogram at L3-4 and normal at L4-5. It was a positive discograph at L5-S1 appearing somewhat equivocal in terms of reproducing patient's pain symptomatology. Dr. Friedman was not impressed with the test results.

In answer to a question as to what caused the problem for which the fusion surgery was performed, Dr. Berklacich testified that he could not say exactly. The trauma in 1994 could have caused low back and left leg pain, and it could have been present in 1995 and 1996. He testified that the surgery performed by him on Mr. Smith could have been degenerative and not developmental and that technically it was just a leaky disc.

The standard review of factual issues in workers' compensation cases is de novo upon the record of the trial court with a presumption of correctness, unless the preponderance of the evidence is otherwise. Tenn. Code Ann. § 50-6-225(e)(2)(1998) Henson v. City of Lawrenceburg, 851 S. W. 2d 809, 812 (Tenn. 1993). Under this standard, this court is required to conduct an in depth examination of the trial court's findings of fact and conclusions of law to determine where the preponderance of the evidence lies. Thomas v. Aetna Life & Casualty Company 812 S. W. 2d 278, 282 (Tenn. 1991). In making such determination, this court must give considerable deference to the findings of the trial judge regarding the weight and credibility of any oral testimony received.

Humphrey v. David Witherspoon, Inc., 734 S. W. 2d 315 (Tenn. 1987)

The trial judge found Mr. Smith not to be credible in some of his testimony. In review of plaintiff's testimony this Court finds that the opinion of the trial judge is supported by the evidence. Plaintiff is a mechanic and an operator of heavy equipment. When he failed to repair a tow-motor, he testified that he did not know how to operate the lift which would raise the tow-motor so that he would not have to stoop or bend to make the repair.

James Douglas Brown, assistant plant manager at Parthenon Metal Works, the place of employment for plaintiff, testified that the electric lift was not a complicated piece of machinery and said, "It was an up and down button."

In making a determination of where the preponderance of evidence lies from testimony of medical experts testifying by deposition this Court makes its own assessment of the credibility and weight to be given to such testimony. Cooper v. INA 884 S. W. 2d 446, 451 (Tenn. 1994); Landers v. Fireman's Fund Ins. Co. 775 S. W. 2d 355, 356 (Tenn. 1989).

Four physicians testified by deposition in this matter. All were credible. Most helpful to plaintiff's case was Dr. William H. Ledbetter who testified that the injury to plaintiff was an aggravation of a pre-existing condition. The aggravation according to Dr. Ledbetter was three months prior to March 25, 1998 which was well after the date of January 18, 1996 claimed as date of new injury by plaintiff.

The plaintiff in a workers' compensation suit has the burden of proving every element of the case by a preponderance of the evidence. Talley v. Virginia Ins. Reciprocal 775 S. W. 2d 587, 591 (Tenn. 1989). Roark v. Liberty Mutual Insurance Co. 793 S. W. 2d 932, 934 (Tenn. 1990).

Aggravation of a pre-existing condition may be compensible under the Workers' Compensation Laws of Tennessee, but it is not compensible if it results only in increased pain or other symptoms caused by the underlying condition. Cunningham v. Goodyear 811 S. W. 2d 888, 890 (Tenn. 1991) Smith v. Smith's Transfer Corp. 735 S. W. 2d 221, 225-226 (Tenn. 1987). Boling v. Raytheon Co. 223 Tenn. 528, 448 S. W. 2d 405, 408 (1969). It has been otherwise stated that to be compensible, the pre-existing condition must be "advanced," (Springfiled v. Eden 1995 W. L. S95601) 1995 Tenn. LEXIS 67 (W.Comp. Appeals Panel) or there must be an "anatomical change" in the pre-existing condition. Talley supra at 591.

Plaintiff failed to carry the burden of proof. The trial court is affirmed, and costs are assessed to appellant.

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TOM E. GRAY, Special Judge

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JUDGMENT

This case is before the Court upon the entire record, including the order of referral to the Special Workers' Compensation Appeals Panel, and the Panel's Memorandum Opinion setting forth its findings of fact and conclusions of law, which are incorporated herein by reference.

Whereupon, it appears to the Court that the Memorandum Opinion of the Panel should be accepted and approved; and

It is, therefore, ordered that the Panel's findings of fact and conclusions of law are adopted and affirmed, and the decision of the Panel is made the judgment of the Court.

Costs will be paid by the appellant, for which execution may issue if necessary.

IT IS SO ORDERED.

PER CURIAM