**IN THE SUPREME COURT OF TENNESSEE**
**SPECIAL WORKERS' COMPENSATION APPEALS PANEL**
**AT KNOXVILLE**

FILED

**August 19, 1999**

**Cecil Crowson, Jr.**
**Appellate Court**
**Clerk**

| | | |
|---|---|---|
| GLENDA JOHNSON, | ) | |
| | ) | HAMILTON CHANCERY |
| Plaintiff/Appellee | ) | |
| | ) | |
| v. | ) | NO. 03S01-9803-CH-00031 |
| | ) | |
| NORTH PARK HOSPITAL | ) | |
| | ) | HON. R. VANN OWENS, |
| Defendant/Appellant | ) | CHANCELLOR |

**For the Appellant:**

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**M E M O R A N D U M O P I N I O N**

**Members of Panel:**

Justice Frank F. Drowota, III
Senior Judge John K. Byers
Special Judge Roger E. Thayer

AFFIRMED

BYERS, Senior Judge

**OPINION**

This workers' compensation appeal has been referred to the Special Workers' Compensation Appeals Panel of the Supreme Court in accordance with Tenn. Code Ann. § 50-6-225(e)(3) for hearing and reporting to the Supreme Court of findings of fact and conclusions of law.

Review of the findings of fact made by the trial court is *de novo* upon the record of the trial court, accompanied by a presumption of the correctness of the findings, unless the preponderance of the evidence is otherwise. Tenn. Code Ann. § 50-6-225(e)(2); *Stone v. City of McMinnville,* 896 S.W.2d 548, 550 (Tenn. 1995). The application of this standard requires this Court to weigh in more depth the factual findings and conclusions of the trial court in a workers' compensation case. *See Corcoran v. Foster Auto GMC, Inc.,* 746 S.W.2d 452, 456 (Tenn. 1988).

The trial judge found the plaintiff to be permanently disabled and ordered payments to be made until the plaintiff reaches the age of 65 years.

This case has some convoluted proceedings in the trial court, as well as in the filing of the appeal. However, the essential matters for us to determine are whether the trial judge's finding that the plaintiff suffered permanent vocational disability and whether the trial court properly ordered the defendant to pay a medical bill in the amount of $7,084.60.[1]

We affirm the judgment of the trial court.

**FACTS**

The plaintiff, age 55 at the time of trial, received her LPN licensure in 1974 and her RN licensure in 1989. She also took nursing courses at U.T. towards a B.S. degree. She held nursing positions in several hospitals throughout the years.

On June 1, 1993, she began working for the defendant as a home health care nurse. Her job required her to keep supplies in her car for emergencies, to carry a large bag on her shoulders into the patients' homes, and to roll over or pull patients. On

[1] The trial judge entered judgment in this case on March 27, 1998 and June 11, 1998. On October 30, 1998, the trial judge amended the judgment to provide that payments be made until the plaintiff reached age 65. The defendant says the trial court had no authority to amend the order after 30 days. We find no need to go into this because the amended order corrected an oversight in the original judgment. We would have entered this judgment if the trial judge had not.

November 26, 1993, she was traveling from a patient's home when she was in an auto accident. The plaintiff returned to work on December 13, 1993, but that night she was in tremendous pain. She has not worked since that time because she does not feel able to work.

The plaintiff saw a series of doctors for her complaints after the auto accident. Dr. J. Eugene Huffstutter diagnosed her with fibromyalgia. Sometime after seeing Dr. Peter Boehm, the plaintiff had to go to the ER because of severe chest and head pains. The defendant had been paying her medical bills prior to this but stopped after the ER visit. The plaintiff testified that she had to get loans from her mother and ex-husband in order to live.

Prior to the auto accident, the plaintiff played tennis, cleaned house, worked in the garden, and ran. The plaintiff and several other witnesses, including relatives and friends, testified that since the auto accident she lacks stamina, has sleep problems, cries frequently, feels depressed, and is less outgoing. The plaintiff testified that she still has pain in her muscles in her knees, feet, hands, shoulders, hips, neck, and spine and that she still has migraines.

**MEDICAL EVIDENCE**

_____Dr. David B. Dodson, a board certified internal medicine specialist, testified by deposition. Dr. Dodson has been the plaintiff's doctor since 1982. After the November 26, 1993 auto accident, Dr. Dodson first saw the plaintiff on December 3, 1993. At that time, she was suffering from neck problems and muscle spasms between her shoulder blades and later her left shoulder and right hip began hurting. Dr. Dodson reviewed x-rays from the date of the accident, but they showed no evidence of acute injury. He ordered a bone scan and MRIs of the cervical, thoracic, and lumbar spines. To a reasonable degree of medical certainty, Dr. Dodson testified that the trauma of the auto accident caused the plaintiff to have fibromyalgia. He explained that "the relationship of her injury to the onset of her symptoms would indicate that her motor vehicle accident was a precipitating factor as she did not have those symptoms before." He pointed out, however, that no one knows exactly what causes fibromyalgia. As of June 27, 1996, Dr. Dodson testified that she was unable to work. He offered no opinion as to any

impairment that the plaintiff might have, but he did feel that her condition is permanent. Dr. Dodson disclaimed expertise in medical impairment ratings.

Dr. Richard Pearce, a spine specialist, testified by deposition. Dr. Pearce first saw the plaintiff on January 10, 1994. Upon review of the bone scan, he found arthritic changes but no evidence of "any increased abnormal uptake in her skeleton." He opined that these changes were not caused by the auto accident. His review of the MRI of the thoracic spine showed no abnormalities, but his review of the MRI of the cervical spine showed a degenerative/arthritic spur and small disc herniation at the C4-C5 level. He stated that the spur would have been developing prior to the auto accident and that there was no way to know whether the herniation was present prior to the auto accident. Dr. Pearce's clinical examination revealed a strain of her thoracic spine. He believed that her symptoms from the auto accident related to strained muscles and ligaments in her upper back and the base of her neck. After a March 17, 1994 visit, Dr. Pearce ordered an MRI of her shoulder. Although the MRI was normal, he referred her to Dr. Perkins because of her continuing complaints. Dr. Pearce last saw the plaintiff on August 31, 1995 and performed a repeat examination and x-rays. At this time, his clinical impression was "diffused spinal pain, complaints most likely related to soft tissue injury versus her fibromyalgia." He recommended that she be seen by a neurologist and continue her treatment by Dr. Huffstutter for fibromyalgia. Dr. Pearce found that the plaintiff reached maximum medical improvement on June 8, 1995 and gave her a 5 percent permanent partial impairment to the whole person based on the muscle and ligament strains. This impairment rating did not take into account the plaintiff's fibromyalgia. He offered no opinion on restrictions, but he did recommend that she do office or desk work.

_____The medical records of Dr. Thornton Perkins, an orthopedic surgeon, were introduced into evidence. Upon a referral from Dr. Dodson and Dr. Pearce, Dr. Perkins first saw the plaintiff on May 9, 1994. In his examinations, he found no objective evidence of injury but felt her discomfort was genuine. Dr. Perkins indicated that she had right trochanteric bursitis secondary to direct trauma, bilateral tendinitis of the shoulder, worse on the left. He encouraged her to return to work even on a half day

basis. On July 12, 1994, he ordered a repeat of her bone scan. He recommended that she submit to psychological testing and interviewing, but she was resistant to the suggestion. Dr. Perkins also recommended treatment for fibromyositis.

Dr. J. Eugene Huffstutter, a rheumatologist, testified by deposition. On August 30, 1994, Dr. Huffstutter diagnosed the plaintiff as having "fibrositis or soft tissue rheumatism." He defined fibromyalgia/ fibrositis as follows: "It is a chronic painful condition. It is a collection of symptoms. A syndrome that produces pain. The patients will complain of weakness, poor sleep habits. Many of these patients can get depressed because they hurt and it interferes with their activities of normal living." The plaintiff's treatment included the administration of muscle relaxants and antidepressant medication. Dr. Huffstutter last saw her on April 3, 1995 and she continued to be quite symptomatic. Although he pointed out that fibromyalgia is a disease of unknown etiology, he testified that the plaintiff's auto accident "may have caused her to become symptomatic where she wasn't symptomatic before" and that the auto accident "was a precipitating factor which unmasked her symptoms." Regarding impairment for fibromyalgia, Dr. Huffstutter stated that such patients "have no impairments caused by the fibromyalgia syndrome." With respect to restrictions secondary to fibromyalgia, Dr. Huffstutter stated that he does not give formal work restrictions but allows patients to do as much as possible while setting their own limits.

The medical records of Dr. Peter Boehm, a neurosurgeon, were introduced into evidence. Upon a referral from Dr. Pearce, Dr. Boehm evaluated the plaintiff on March 21, 1995. He detected no reflex changes, no atrophy, and no motor deficit, but he did find subjective symptoms. His impression was that the plaintiff had "mid thoracic pain representing probable thoracic strain" and "cervical disc and joint disease with superimposed recent cervical strain."

The medical records of Dr. Bruce Kaplan, a neurologist, were also introduced into evidence. Dr. Kaplan saw the plaintiff on October 9, 1995 and found that she was "neurologically normal." He recommended a yoga program and "urged patience and emphasized that there is no evidence of any serious underlying pathology." He also made the following findings: "There is no indication of cervical radiculopathy at any level

nor of mid-thoracic paraspinal denervation in her area of maximum discomfort. There is no indication of carpal tunnel syndrome or other median neuropathy as alternative explanations for the numbness she experiences in her hand."

Dr. Walter King testified by deposition. Dr. King saw the plaintiff for an independent medical evaluation on June 19, 1997 at the request of her attorney. With respect to medical impairment and disability, Dr. King made the following opinion:

> I thought she had cervical and lumbar strain, strain of the right lower extremity. Noted there was fibromyalgia that was brought on by this accident and osteoporosis secondarily. At the time, I thought she had a 21 percent whole body impairment secondary to injuries received in the stated accident. These were according to the AMA Guidelines and felt to be permanent. There is a functional capacity evaluation, states she might be able to return to some kind of administrative position. I didn't feel that she could return to her original position. I released her to light-duty work per the functional capacity evaluation.

Dr. King explained that fibromyalgia is not specifically covered by the *AMA Guides*, so his impairment rating refers to the pain and loss of range of motion sections of the *AMA Guides.* To a reasonable degree of medical certainty, Dr. King testified that the auto accident either caused the plaintiff's problems or aggravated a preexisting condition causing those problems.

Andrew L. Marini, a physical therapist, did a functional capacity evaluation. The October 29, 1996 evaluation stated the following about the plaintiff:

> the patient should be able to sit between eight and ten hours an day with positional changes every two to four hours. She should be able to stand four to five hours per day, and continuously for 20 minutes. She is able to ambulate for ten minutes at 1.2 miles per hour continuously and should be able to ambulate short distances over a four- to five-hour time frame. Alternating sit to stand appears to be her most compatible position in an eight- to ten-hour work day.

The evaluation also stated that "she does qualify for an occupational categorization of 'light'."

**CAUSATION AND DISABILITY AWARD**

The trial judge had before him the testimony and medical records of the physicians, as well as a report of a physical therapist. The findings of the experts are set out above and they encompass opinions about the cause of the plaintiff's condition, which appears most obviously to be fibromyalgia, and its relationship to the injury.

There were various views expressed concerning the medical impairment rating. Dr. Pearce found the plaintiff had a 5 percent partial permanent impairment to the body

as a whole. He did not, however, relate any impairment for the fibromyalgia. Dr. King found the plaintiff suffered a 21 percent medical impairment to the body as a whole.

The trial judge may accept the testimony of one or more expert witnesses over that of others. *Kellerman v. Food Lion, Inc.,* 929 S.W.2d 333 (Tenn. 1996). Obviously, the trial judge accepted the opinion of Dr. King as to the amount of impairment. Further, Dr. Huffstutter testified the auto accident "may have caused [the plaintiff] to become symptomatic where she wasn't symptomatic before" and "was a precipitating factor which unmasked her symptoms." He further testified there is no impairment from fibromyalgia syndrome.

In addition to the expert witnesses, the trial judge heard testimony from the plaintiff and other lay witnesses, who described the lack of ability the plaintiff now suffers in doing tasks and hobbies she did before.

We find the record supports the findings of the trial judge on the matter of causation and on the award of total permanent disability. Further, the order of the trial judge on October 30, 1998, which orders the defendant to pay compensation until age 65 is in accordance with Tenn. Code Ann. § 50-6-207(4)(A)(I). And if the trial judge had no authority to make such amendment, we approve the order and would have amended the order to conform to the statute.

**MEDICAL BILLS**

The defendant raises questions about the manner in which the Clerk and Master filed a report on medical bills in response to a referral from the trial court. As we read the record, counsel for the plaintiff and the defendant agreed to the manner of establishing the amount of medical bills incurred by the plaintiff for treatment of her injuries.

The defendant further complains that the treatment encompassed in the medical bill of $7,084.60 was for treatment of angina. Dr. Dodson testified that the treatment for the heart problem was a result of a not unexpected side effect to the medication given the plaintiff to treat her injuries from the accident. Based upon this, we find the trial judge properly ordered the defendant to pay the bill.

The cost of this appeal is taxed to the defendant.

_____
John K. Byers, Senior Judge

CONCUR:

_____
Frank F. Drowota, III, Justice

_____
Roger E. Thayer, Special Judge

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| | ) | |
| NORTH PARK HOSPITAL | ) | |
| | ) | |
| Defendant-Appellant | ) | |

JUDGMENT ORDER

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 facts and conclusions of law are adopted and affirmed and the decision of the Panel is made the Judgment of the Court.

Costs on appeal are taxed to the defendant, North Park Hospital and Joseph C. Wilson, III, surety, for which execution may issue if necessary.

08/19/99