IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT JACKSON
June 18, 2018 Session

**THOMAS D. FLATT v. WEST-TENN EXPRESS, INC., ET AL.**

**Appeal from the Chancery Court for Madison County**
**No. CH-71529 James F. Butler, Chancellor**

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**No. W2017-01727-SC-R3-WC – Mailed July 31, 2018; Filed August 31, 2018**

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Thomas D. Flatt ("Employee") alleged he injured his neck and shoulder in the course and scope of his employment with West-Tenn Express, Inc. ("Employer"). The trial court found Employee suffered a compensable injury and awarded 44 percent permanent partial disability to the body as a whole. Employer's appeal has been referred to the Special Workers' Compensation Appeals Panel for a hearing and a report of findings of fact and conclusions of law pursuant to Tennessee Supreme Court Rule 51. We reverse the trial court's judgment.

**Tenn. Code Ann. § 50-6-225(e) (2014) (applicable to injuries occurring prior to July 1, 2014) Appeal as of Right; Judgment of the Chancery Court Reversed**

DON R. ASH, SR.J. delivered the opinion of the court, in which HOLLY KIRBY, J. and WILLIAM B. ACREE, JR., SR.J., joined.

Geoffrey A. Lindley and Jennifer Vallor Ivy, Jackson Tennessee, for the appellants, West-Tenn. Express, Inc., et al.

Jay DeGroot, Jackson, Tennessee, for the appellee, Thomas Flatt.

## OPINION

### Factual and Procedural Background

*Trial Testimony*

Thomas Flatt ("Employee"), age 42 at trial, has a ninth grade education. However, he has vocational training in air conditioning and diesel mechanics and holds a CDL. Employee previously worked for Employer; he returned to work for Employer as a mechanic in approximately November 2011. As a mechanic, Employee "changed wheel seals, brakes. . . . fixed holes in floors in their trailers, and the roof[,] [a]nd [] helped change the oil in their trucks."

> Employee described the June 28, 2012 injury as follows:
> Me and another coworker was cleaning our shop out. And we had took the oil pain that we - - oil drain pain out of the pit that we work in. We set it aside. And then after we cleaned everything up, we were going to set it back in it. And he let go of his side and it took me down with it because I didn't let go of my side.

Employee described immediate pain in his back right above his neck with tingling in his left arm. That day, he reported the injury to his West-Tenn Express owner, Mike McFarland. He also reported the injury to his supervisor, Ron Fairchild, when Fairchild returned to work. Mr. McFarland suspected Employee had pulled a muscle and instructed him to return to work. That evening, Employee took a hot shower and laid down, but "couldn't get up" the next morning. Employee visited a local clinic on June 29 and was referred to Dr. Sweo. Dr. Sweo referred Employee to Dr. Rowland, who sent Employee to Dr. Weiss for a second opinion.

Dr. Weiss released Employee to return to work in March 2013, but Employee testified he "didn't think that [he] was able to come back to work because [he] still had the pain." According to Employee, Mr. McFarland informed him "if [he] was not 90 to [one] hundred percent [he] couldn't come back to work." A few weeks later, Mr. Fairchild telephoned Employee and "told [Employee] that [he] needed to come get [his] toolbox out of the shop." Employee did so believing he had been fired. However, when he was asked whether any "one at [Employer] ever told [him he was] terminated[,]" he responded, "No. Not those, words, no." Additionally, he acknowledged, while he was receiving medical care, Mr. Fairchild repeatedly confirmed Employee remained employed by Employer.

Employee did not return to work with Employer following his release from Dr. Weiss and remained off work for one year. However, he currently works as a semi-truck driver hauling daily from Memphis to Nashville. Employee testified he experiences

ongoing problems from the workplace injury, including stinging in his left arm and shoulder and an inability to "turn [his] neck to the left all the way without a lot of pain." He stated he "can't do a lot of yard work because that really afflicts [his] pain[,]" and he can no longer hunt or fish. He cannot drive for long periods without stretching and cannot load and unload his flatbed trailer as quickly.

Employee testified on June 27, 2011, he was involved in a motor vehicle accident. While Employee was stopped at a red light in his pickup truck, an 18-wheeler crashed into another pickup truck, causing the second pickup truck to rear-end Employee. Employee visited the Emergency Room complaining of "severe pain to [his] neck and upper back[.]" On June 29, 2011, he visited the Scotts Hill Clinic again complaining of neck and back pain and limited range of motion in his neck. He returned to the Scotts Hill Clinic on July 9, 2011, reporting pain in his neck and between his shoulder blades.

For the June 2011 accident, Employee received therapy and missed nine weeks of work. However, he agreed he had "completely recovered from the car wreck in 2011 at the time [of the 2012 workplace] injury[,]" and stated the 2011 injury did not cause him to miss work with Employer from his November 2011 rehire to the June 2012 injury.

Ron Fairchild testified Employee returned to light duty work in July 2012 with restrictions against lifting over five pounds. Although Employee told him he still had pain and could not do the work, Mr. Fairchild denied sending him home. Mr. Fairchild told Employee he still had a job on several subsequent occasions, but Employee said he could not do the work. He eventually told Employee to get his toolbox and tools because Employer did not have enough space to keep them and because Mr. Fairchild "didn't want to be responsible for the tools and the toolbox itself." Mr. Fairchild never told Employee he had been terminated.

*Medical Testimony*

Dr. Sweo, a physician board-eligible with the American Board of Orthopedic surgery, saw Employee on four occasions between July and September 2012. Employee chiefly reported pain going down the left arm; he described the June 2012 workplace incident, but did not report any prior problems.

Dr. Sweo performed a physical exam on July 20, 2012 and noted "some stiffness in [Employee's] neck and pain with neck compression. Shoulders were tender to touch but externally looked otherwise normal." Dr. Sweo reviewed prior left shoulder x-rays,

which were normal. He also reviewed the July 12, 2012 MRI which depicted "mild degenerative changes and possibly some nerve root involvement" as well as "dis[c] osteophyte complex" at C5-6. He stated the disc osteophyte complex—"bone and dis[c] that are sticking out a little bit"—is "not brand new." He opined osteophytes "take[] . . . at least several months from the initial injury . . . to develop" and therefore, the "[osteophyte] abnormalities on his MRI did not initially develop with that work injury." He further opined Employee more likely than not suffered degenerative changes in his cervical spine prior to the workplace injury on June 28, 2012. Dr. Sweo stated "the findings on the [July 12, 2012] MRI do not obviously explain [Employee's complaints. . . . And I didn't feel any of those abnormalities easily explained his amount of symptoms."

Dr. Sweo ordered an EMG study and prescribed anti-inflammatory pain medication. He stated the EMG study found no evidence of a pinched nerve in the left arm; however, he acknowledged "EMGs are not perfect for picking up radiculopathy" and a normal EMG study does not rule out injury to the cervical and/or thoracic spine.

Employee visited Dr. Sweo again on August 3, 2012. According to Dr. Sweo, Employee "was still having a lot of pain[,] but it had started to develop lower down in his body around his thoracic or chest level where it attaches to his lower back." He performed a second physical exam which revealed a "[l]ot of stiffness in his spine with rotation, still with neck pain, and otherwise normal." Dr. Sweo began to question the location of the problem and ordered a thoracic (lower spine) MRI.

A thoracic MRI was performed on August 13, 2012. The MRI "showed a disc protrusion at T1-2 which is just below where the neck attaches to the chest. And some Schmorl's nodes which . . . protrude into the bone a little bit." Dr. Sweo explained a congenital condition cause disc protrusion into bone. He agreed the protrusions "make[] sense" with Employee's symptoms being primarily in his left upper extremity.

Dr. Sweo met with Employee for a third time on August 15, 2012 to review the MRI results. Dr. Sweo stated he "couldn't explain [Employee's] symptoms with his MRI findings." He sought approval for an epidural steroid injection, which was performed by Dr. Ruben Fernandez.

At the fourth, and final, appointment with Dr. Sweo, Employee reported the injection had provided "just a few days of relief" and "significant pain in his neck and chest spine" persisted. Dr. Sweo "couldn't find anything on [Employee's] studies to explain why he was having the amount of pain that he was." Therefore, Dr. Sweo referred him to a neurologist to "see if [Employee] was a candidate for any type of

surgical treatment, although [Dr. Sweo] didn't see anything at that time that was possibly surgical." Dr. Sweo also wanted Employee to consider a work hardening program—a physical training program—to get him ready to return to work.

Ultimately, Dr. Sweo opined Employee problems at both his cervical and/or thoracic spine with the resulting left upper extremity complaints are consistent with his reported work injury history. He agreed the reported workplace incident "could have" aggravated or advanced the severity of Employee's preexisting degenerative changes in his cervical spine.

Dr. Rowland is a retired neurosurgeon who first examined Employee on November 15, 2012. Employee complained of "pain in his left shoulder, rhomboid [shoulder blade] area, some little neck pain and some tenderness and pain in his left arm." Dr. Rowland performed a physical exam which, among other things, showed Employee's "neck and head were normal except he had guarding motion in the neck in all directions. . . . He had guarding of motion with his left shoulder." Dr. Rowland found no muscle atrophy to suggest nerve damage. Dr. Rowland reviewed the July 12, 2012 MRI report showing mild degenerative changes; he agreed the changes are "ordinary and expected wear and tear for somebody [Employee's] age[.]" He also reviewed EMG nerve study from DR. Bingham which found no nerve damage. He believed Employee was experiencing muscle pain and recommended physical therapy.

Dr. Rowland saw Employee again at a follow-up visit on December 27, 2012. He reviewed the July 12, 2012 MRI and performed a physical examination. The exam revealed "limit[ed] neck and back motion all directions and tender[ness] to palpation in the lower thoracic spine, particularly on the left-hand side." Dr. Rowland noted Employee "had no motor loss, reflex or sensory loss." He could "found no evidence of any nerve damage" and could "not identif[y] anything of a neurological nature to account for [Employee's] difficulty[.]" However, due to his continued complaints of "pain in his neck, shoulder and back without any evidence of neurological disease" and his "x-rays show[ing] nothing of a surgical nature," Dr. Rowland recommended Employee seek a second opinion from another neurosurgeon.

Dr. Rowland again examined Employee on January 23, 2013. He complained of "pain [] in his lower thoracic spine and his left shoulder, [plus] neck pain." Dr. Rowland found Employee exhibited "limitation of movement of all of the left shoulder[,]" "tender to palpation left shoulder[,]" and "numbness of the left arm." Employee also showed "decreased pinprick and vibration in the left arm in a nonspecific dermatome pattern[,]" which Dr. Rowland explained "means it doesn't fit any pattern that I can associate with

nerve damage. It didn't follow any particular neurological reasoning." Dr. Rowland reviewed a January 22, 2013 MRI report which revealed nothing to explain Employee's symptoms.

On February 14, 2013, Dr. Rowland examined Employee a fourth time. His examination revealed a new finding: Employee walked with a marked limp. Dr. Rowland reviewed a February 11, 2013 MRI report which, again, revealed nothing to explain Employee's symptoms. In his notes, Dr. Rowland commented, "I'm at a loss to explain his difficulty on the basis of a neurological disease." On cross-examination, Dr. Rowland agreed the normal MRIs of January 22, 2013 and February 11, 2013 do "not necessarily exclude someone [] being symptomatic in their spine or upper extremity from a spinal condition[.]" Likewise, he stated a normal EMG would not "exclude . . . legitimate referable complaints in [the] spine or left upper extremity[.]" Ultimately, he "found [no] objective evidence . . . of any neurological issues that could correspond with [Employee's] symptomology" and he agreed if Employee, in fact, had any injury it was more of a myofascial [muscular] type injury.

Dr. Rowland provided a second deposition after reviewing Employee's July 12, 2011 MRI. Dr. Rowland stated the July 12, 2011 MRI shows "an anterior bulge" and "mild canal stenosis and bilateral foraminal stenosis" at the C5-C6 vertebrae as well as "[m]inimal central bulged dis[c]" and "[n]o canal or neuroforaminal stenosis" at the C6-C7 level.

Regarding the July 12, 2012 MRI, Dr. Rowland described "[v]ery mild dis[c] osteophyte complex with minimal bilateral foraminal stenosis" at C5-C6 with "[s]mall central protrusion. No stenosis" at C6-C7. Regarding the January 22, 2013 MRI ordered by Dr. Rowland, he found "[m]inimal bulge. Mild left foraminal narrowing" at C6-C7.

Comparing the 2011, 2012 and 2013 MRIs, Dr. Rowland opined "looking at all three together, there wasn't that much difference between the three as far as the significant changes over the . . . two-year period." He noted the MRIs depict worse foraminal stenosis on the right side and Employee never complained about right side symptoms. Dr. Rowland stated "[t]he type of injury [Employee] sustained by jerking his left arm in my opinion would not cause the x-ray changes we see on these x-rays. It's more consistent with trauma secondary to it, such as a car accident or a rear-end collision or a flexion/extension injury of the neck from a fall." When asked whether "the dis[c] bulge or protrusion at the C6-C7 level" caused Employee's symptoms, Dr. Rowland responded, "Not in my opinion, sir. It did not compress the spinal cord. It did not compress the spinal fluid or the canal. So it should not cause any irritation of the spinal

cord at all."

On cross-examination, Dr. Rowland conceded a neck injury from the work incident was not impossible, but he stated "it's more consistent with musculoskeletal muscle pain that it is nerve pain." He explained "muscle pain can have numbness and can have feelings of numbness with the muscle itself without having nerve damage." In conclusion, he stated "I can find no neurological cause for his disability."

Dr. Weiss, a neurological surgeon, examined Employee in March and August 2013. He reviewed the July 12, 2012, August 13, 2012 and January 22, 2013 MRI films. He "was unable to find any focal or lateralizing neurologic findings that . . . were consistent with the imaging studies." He opined "other than some kind of obscure demyelinating syndrome, that there really wasn't any objective evidence here of an injury. I couldn't find anything wrong with him." Dr. Weiss found "no rational explanation for [Employee's] symptoms , his finding on exam and the negative imaging studies, electrodiagnostics, et cetera." He "didn't come up with a relevant diagnosis [be]cause [he] couldn't find a neurosurgical problem." Regarding his March 27, 2013 examination, Dr. Weiss stated:

> He had some findings on exam that, you know, I felt were inconsistent. He had global left arm weakness, global left leg weakness, global left-sided numbness. He had these subjective paresthesias in the entire left arm.
>
> I said here he would not abduct the left arm beyond the anatomic position, which means he really wasn't able or willing to lift up the left arm at all. The reflexes were unremarkable. His gait and station appeared to be basically normal.
>
> Range of motion at the waist was unremarkable. And, again, he had this global weakness but pretty much normal sensation in that lower extremity with – with brisk deep tendon reflexes in the lower extremities. No pathologic reflexes.
>
> Nothing really made sense. In other words, there's no neuroanatomic substrate for that constellation of symptoms. You can't place an injury any particular spot in the nervous system or relate it to a

lifting incident. He just had too many complaints and deficits that were wide range and diffuse and disseminated.

Dr. Weiss saw Employee again on April 16, 2013 and, according to Dr. Weiss, "[i]t was pretty much the same situation." Dr. Weiss stated:

> I said here he was a well-developed, well-nourished male. Held himself slumped with a visage of pain. Shuffled and ambulated around the room with a concave twist to his left torso. All very dramatic.
>
> I said this time that strength and sensation in the upper extremities was globally diminished. That's both sides. But particularly so on the left with almost no resistance to my examining hand. Entirely nonanatomic numbness that extended from the fingertips. Involved the axillary. In other words, his armpit regions.
>
> Went up into the supraclavicular area and all the way up to the mastoid, which means behind the ear on the left. Extended down the torso. Involve the left leg and also nonanatomic. You know, the whole situation was just not something you would see with a specific neurologic injury and certainly not something you'd see with a lifting injury.
>
> I said here, [h]is gait and station appeared bizarre, as I had described above. No signs of myelopathy. Basically this was an exam rife with symptom magnification. No focal findings and nonanatomic numbness and weakness with negative imaging studies. So there's really not much a neurosurgeon could offer a situation such as that.
>
> . . .
>
> As I said before that, you know, an injury which would typically be considered trivial, or at least something one would resolve with some conservative expected treatment, had become incapacitating. There was no logical explanation for it. So you're not left with much to work with.
>
> I mean, it just was readily apparent that there was no objective structural substrate for all of this. If you can't find anything wrong with

> someone, there's not much you can do to help them. And obviously there was no impairment, no need for permanent restrictions.

He further stated, "I mean, either there's some process going on that we're not familiar with that's not been described in textbooks to this point in time or his symptoms are not real." Regarding injury classification, Dr. Weiss stated, "Nobody's come up with objective findings on him. Every one of his studies [is] negative. So he doesn't get to go beyond Class zero with no objective findings." Dr. Weiss concluded as follows:

> Well, he didn't have objective or focal or lateralizing findings, period, for T1, C4, C5 or anything. In other words, his exam was not capable of explication based on neuroanatomy. There's no neuroanatomic structure that could be affected and produce the symptoms he had.
>
> And that's why I think multiple clinicians were unable to come up with a specific plan to, as the patient would say, fix him. He couldn't be fixed because his symptoms just did not correlate with the objective findings, and his imaging studies were normal. They were normal for age.
>
> All – all these people in their 30s and 40s have the descriptors, the jargon that the radiologists use in their report. In this particular instance, they're normal findings.

Dr. Vaughan Allen's medical record was submitted as an exhibit at trial. Outside of workers compensation, Employee visited Dr. Allen on October 9, 2013. Employee complained of "neck pain, shoulder pain, left hand tingles and says he can't lift the left hand above his head." Dr. Allen examined Employee and noted Employee's arm weakness "is hard to quantitate. When I ask him to lift his arm, he says that he can't lift it above his head because it hurts and he points to his shoulder but I can manipulate the shoulder without any pain." Finding the source of Employee's neck and arm symptoms "not clear[,]" Dr. Allen ordered a cervical myelogram which produced normal results. He then recommended a shoulder MRI, which was also normal. Next, Dr. Allen referred Employee for an EMG, which was performed on November 18, 2013, and likewise produced normal results. In his November 21, 2013 report, Dr. Allen stated, "I really don't have a good explanation for his pain" and suggested Employee visit an orthopaedic doctor.

Dr. Chung is a physiatrist who conducted an Independent Medical Evaluation of Employee on January 28, 14. Dr. Chung reviewed the MRI *reports* from the July 12, 2012 and January 22, 13 MRIs; he did not review the actual MRI *films*. Dr. Chung agreed patient history is very important in reaching a medical opinion, but conceded Employee reported no prior history of neck injuries or radiculopathy. He did not review the 2011 MRI.

Dr. Chung was questioned regarding the July 12, 2012 MRI. He stated, "[t]he main findings were . . . there was a disc protrusion of the C5-6, as well as a disc protrusion of the C6 and C7. That's the two levels that actually clearly showed a left-sided disc protrusion that brought on the clinical light on his symptoms."

Dr. Chung testified regarding Dr. Allen's October 2013 myelogram CT study. He noted "clear disc protrusion"[1] in C6 and C7. He stated, "the C6 and C7 actually is the correlated symptom that he is experiencing clinically in his neck and his arm, left arm."

Dr. Chung also testified regarding a cervical epidural steroid injection administered by Dr. Ruben Fernandez on August 29, 2012. He stated the injection provided temporary, significant improvement in Employee's neck and left arm pain.

Dr. Chung acknowledged the EMG and nerve conduction study results were normal, but stated such results do not rule out radiculopathy.

During his physical exam, Dr. Chung noted left upper extremity weakness,[2] stiffness, decreased range of motion, decreased sensation, decreased reflexes and severe tissue texture changes. Based upon his examination, he identified the location in Employee's cervical spine injured in the work incident as C6 and C7. He noted, "what [Employee] exhibited and what he showed clinically is at only one level." On cross-examination he again stated the C6 and C7 levels were "the area [Employee] injured . . . when he had this incident that brought on his clinical symptoms" and diagnosing multiple levels "would be an overreach."

Dr. Chung diagnosed "[r]esidual from cervical injury with ongoing left cervical radiculopathy; to be specific, at the C6 and C7 level." Utilizing Table 17-2, under

[1]Dr. Chung described "bulging" as "[t]he disc is kind of squashed or pressed[;]" "'protrusion' is actually pushing the disc . . . further out into the annular fibrous material[;]" and "'herniation' is really the full rupture . . . having the disc material outside in the spinal canal."

[2]Dr. Chung "wasn't sure that was really clear objective weakness" because "when pain is involved, obviously the patient may not participate fully in their efforts."

Cervical Spine Regional Grid on page 564, he placed Employee in Class 2, Grade C and assigned 11 percent whole person impairment.

*Trial Court's Ruling*

In finding Employee suffered a compensable injury in the course and scope of his employment on June 28, 2012, the trial court accredited Employee's testimony and relied on Dr. Chung's testimony. The trial court reasoned: "It is illogical that[,] after the well documented accident in this case, somehow magically, the [Employee's] impairment problems arise from the 2011 accident." The trial court awarded 44 percent permanent partial disability to the body as a whole. Employer appeals both rulings.

## Standard of Review

Review of factual issues is de novo upon the record of the trial court, accompanied by a presumption of correctness of the trial court's factual findings, unless the preponderance of the evidence is otherwise. *See* Tenn. Code Ann. § 50-6-225(a)(2). Considerable deference is afforded to the trial court's findings with respect to the credibility of witnesses and the weight to be given their in-court testimony. *Richards v. Liberty Mut. Ins. Co.*, 70 S.W.3d 729, 733 (Tenn. 2002). When expert medical testimony differs, it is within the trial judge's discretion to accept the opinion of one expert over another. The reviewing court, however, may draw its own conclusions about the weight and credibility to be given to expert testimony when, as in this case, all of the medical proof is by deposition. *Krick v. City of Lawrenceburg*, 945 S.W.2d 709, 712 (Tenn. 1997). Questions of law are reviewed de novo with no presumption of correctness. *Gray v. Cullom Machine, Tool & Die*, 152 S.W.3d 439, 443 (Tenn. 2004).

## Analysis

Employer argues the trial court erred in finding a compensable injury because Employee "failed to prove that he suffered any anatomical change due to the work incident." Employee, however, contends the evidence does not preponderate against the trial court's judgment.

"A workers' compensation claimant must establish by expert medical evidence the

causal relationship between the alleged injury and the claimant's employment activity, '[e]xcept in the most obvious, simple and routine cases.'" *Cloyd v. Hartco Flooring Co.*, 274 S.W.3d 638, 643 (Tenn. 2008) (quoting *Orman v. Williams Sonoma, Inc.*, 803 S.W.2d 672, 676 (Tenn. 1991)). The claimant must establish causation by the preponderance of the expert medical testimony, as supplemented by the evidence of lay witnesses. *Id.* An employee "does not suffer a compensable injury where the work activity aggravates the pre-existing condition merely by increasing the pain." *Trosper v. Armstrong Wood Prods., Inc.*, 273 S.W.3d 598, 607 (Tenn. 2008). However, "if the work injury advances the severity of the preexisting condition, or if, as a result of the preexisting condition, the employee suffers a new, distinct injury other than increased pain, then the work injury is compensable." *Id.* at 607; *see also Cloyd*, 274 S.W.3d at 645–46. The claimant is granted the benefit of all reasonable doubts regarding causation of his or her injury. *See Excel Polymers, LLC v. Broyles*, 302 S.W.3d 268, 274–75 (Tenn. 2009).

After carefully reviewing the evidence in the record, we conclude Employee failed to prove he sustained a compensable injury. The initial treating physician, Dr. Sweo, testified Employee had pain and stiffness in his neck. Although he speculated the work incident in June 2012 "could have caused an aggravation, advancement of [a] preexisting condition," he concluded the results of an MRI and an EMG did not explain Employee's symptoms and he did not assign an impairment rating. Dr. Rowland likewise "found no objective evidence of any neurological issues that could correspond with [Employee's] symptomology." Employee's EMG was normal and the July 2012 MRI revealed only mild degenerative changes. Notably, Dr. Rowland stated "there wasn't that much difference" between MRIs performed in July 2011, July 2012, and January 2013. He stated Employee's symptoms were "more consistent with musculoskeletal muscle pain than nerve pain." Similarly, Dr. Weiss found no objective evidence of a neurological problem or permanent impairment, and he described Employee's symptoms as "inconsistent" and "rife with symptom magnification." Finally, Dr. Allen's records show Employee presented with neck, back, and arm pain, but he "[did not] have a good explanation as to his pain, the source of his pain."

Despite this proof, the trial court relied on the deposition of Dr. Chung, which conflicted with the deposition testimony and records of the four physicians who treated or examined Employee. Dr. Chung admitted, however, Employee did not disclose his prior neck injury and history of radiculopathy. He was unaware of Employee's June 2011 accident and, therefore, did not compare the MRI taken after the June 2011 injury to those taken after the June 2012 incident. Moreover, Dr. Chung based his impairment rating on a condition at C6-C7, which Dr. Rowland opined was present before the June

2012 incident. In short, no other physician found objective evidence of an injury stemming from the June 2012 incident.

The trial court accredited Employee's testimony with respect to his full recovery from the June 2011 accident and stated it was "illogical" to conclude Employee's "impairment problems arise from the 2011 accident." However, it is not Employer's burden to discover the actual cause of Plaintiff's condition. The relevant inquiry is whether Employee established a new, distinct injury or an advancement of a preexisting condition as a result of the June 2012 incident. Having reviewed the evidence, we conclude he did not. As a result, we reverse the trial court's judgment and find it unnecessary to review the trial court's award of 44 percent permanent partial disability.

## Conclusion

For the foregoing reasons, the judgment of the trial court is reversed. Costs are taxed to Employee, for which execution may issue if necessary.

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DON R. ASH, SENIOR JUDGE

IN THE SUPREME COURT OF TENNESSEE
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**Chancery Court for Madison County**
**No. 71529**

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**No. W2017-01727-SC-R3-WC – Filed August 31, 2018**

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**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 fact and conclusions of law are adopted and affirmed, and the decision of the Panel is made the judgment of the Court.

Costs are assessed to Employee, Thomas D. Flatt, for which execution may issue if necessary.

It is so ORDERED.

PER CURIAM