IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT KNOXVILLE
August 21, 2014 Session

TONEY R. GONZALES v. J. W. CARELL ENTERPRISES, LLC d/b/a CAREALL HOME CARE SERVICES-KNOXVILLE/McMINNVILLE ET AL.

Appeal from the Circuit Court for Knox County
No. 136612 Dale Workman, Judge

No. E2013-02072-SC-R3-WC-MAILED-OCTOBER 15, 2014
FILED-DECEMBER 17, 2014

In this workers' compensation action, the employee alleged that he suffered a compensable injury to his lower back. The trial court ruled for the employer, finding that the employee was not a credible witness and had failed to carry his burden of proof. The employee appealed 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. At issue in this appeal is whether the trial court abused its discretion by admitting into evidence records from the employee's Social Security Disability proceedings and whether the evidence preponderates against the trial court's decision that the employee failed to sustain his burden of proof. After a careful review, we find no error and affirm the trial court's decision.

Tenn. Code Ann. § 50-6-225(e) (2008 & Supp. 2013) Appeal as of Right; Judgment of the Circuit Court Affirmed

SHARON G. LEE, C.J., delivered the opinion of the Court, in which DON R. ASH, SR. J., and DEBORAH C. STEVENS, SP. J., joined.

Steve Erdely, IV, Knoxville, Tennessee, for the appellant, Toney R. Gonzales.

Lee Anne Murray, Nashville, Tennessee, for the appellee, J. W. Carell Enterprises, LLC d/b/a CareAll Home Care Services-Knoxville/McMinnville.

OPINION

Factual and Procedural Background

In June 2011, Toney Gonzales ("Employee") was hired by CareAll Home Care Services ("Employer") as a field nurse. He was promoted to the position of Director of Patient Services in late July or early August of the same year. Employee alleged that he injured his lower back on October 18, 2011, while bending over to listen to a patient's heart with a stethoscope. Employer denied Employee's claim for workers' compensation benefits. The parties were unable to resolve their differences at a Benefit Review Conference, and Employee filed this action in the Circuit Court for Knox County on July 12, 2012.

On July 2, 2013, a trial was held. Employee testified that, on October 18, 2011, he was accompanied on two patient calls by another employee, Lisa Johnson. Employee claimed that on the second patient call, as he was bending over to listen to a patient's heart with a stethoscope, he felt a "click" in his back. Employee testified that he immediately felt pain in his back and left leg. The pain was so severe that he had difficulty driving his vehicle back to Employer's office. Employee further stated that when he returned to the office, he reported the incident to his immediate supervisor, Cheryl Ramsey, and advised her that he was taking the rest of the day off. According to Employee, he called Ms. Ramsey the following day and told her "exactly what happened" the previous afternoon.

Employee's co-worker, Ms. Johnson, testified that she was unable to recall any details concerning the day of the alleged injury. Ms. Ramsey testified that Employee did not mention a work injury on October 18, 2011, and that he did not report an injury to her until October 20, 2011. She explained that Employee told her that he remembered the night before that his injury occurred at a patient's house. On October 20, 2011, Ms. Ramsey completed an "Employer's First Report of Work Injury or Illness" and an accident investigation report. She testified that she offered Employee a panel of physicians at that time, but that he declined, stating that he wanted to use his own doctors and have his own insurance pay for it. Employee denied that he was offered a panel of physicians.

On October 21, 2011, Ms. Ramsey drafted a memorandum concerning her conversations with Employee and had him sign the document. Ms. Ramsey testified that Employee had been absent from or late for work due to back pain on several occasions before October 18, 2011. In addition, she verified that Employee had completed a form known as a "Daily Report of Visits" for October 18, 2011. On that form, Employee indicated that he had not sustained an injury on that date. Employee explained this contradiction by saying he had filled out the form before the date of injury. Employee also claimed that before his

October 18, 2011 injury, he had no problems with his lower back while working for Employer.

Employee saw his personal physician, Dr. Stephen Lorino, on October 20, 2011. Dr. Lorino's notes indicate that Employee did not report a work injury, but did complain of "acute left-sided back pain with radiculopathy, numbness into his second left toe and some tingling symptoms across his foot." Dr. Lorino prescribed medication and physical therapy and placed restrictions on Employee's activities. He subsequently ordered an MRI study, which showed an enlarged nerve root at L4-5 and scar tissue from a previous surgery.

In November of 2011, Employee went on a previously scheduled vacation to the Virgin Islands. While there, he was involved in a car accident and injured his hand. He again visited Dr. Lorino, whose note from November 29, 2011, states that Employee reported an increase in his back pain after the accident. Employee, however, denied making that statement. Employee also consulted Dr. William Reid, a neurosurgeon, on the same day. Dr. Reid diagnosed a herniated disc at L4-5 and recommended surgery, which was performed on December 20, 2011.

In February of 2012, Dr. Reid imposed temporary work restrictions on Employee's activities. Employee attempted to work for a day or two, but had difficulty turning and moving patients. Dr. Reid determined that Employee was unable to work until March 15, 2012, and later placed permanent restrictions on his activities. Employer was not able to accommodate those restrictions. Employee did not return to work and later entered a program to obtain certification as a nurse practitioner. He was enrolled in that program at the time of the trial.

At trial, evidence was introduced that Employee had a previous back injury. In August of 2003, he sustained herniated discs at the L4-5 and L5-S1 levels of his spine, the result of a car accident in Michigan. After conservative treatment, Dr. Richard Easton performed surgery on November 16, 2004. Employee also received pain management treatment from Dr. Alexander Imas from February 2004 until June 2006. In a December 2005 report, Dr. Imas noted diagnoses of failed back syndrome, radiculopathy, facet syndrome, and sciatica. Further, Dr. Imas determined that Employee's pain was severe and that it prevented the attention and concentration required for simple, unskilled work tasks. A "Voc Rehab Questionnaire" completed by Dr. Imas in February of 2006 stated that Employee was capable of lifting no more than ten pounds and could only sit or stand for twenty minutes at a time. Dr. Imas's records also stated that he recommended neurosurgical evaluations for Employee in June and September of 2006 and an MRI in October of 2006.

On cross-examination, Employee claimed not to recall much about his 2003 back injury and subsequent treatment. He did not remember receiving any permanent restrictions

as a result of the injury, nor did he recall undergoing the MRI and neurosurgical evaluations reflected in Dr. Imas's records. Further, Employee admitted that he had not disclosed certain aspects of his treatment during discovery. In his July 2, 2013 response to Employer's interrogatories, Employee failed to identify Dr. Imas and his primary care physician in Michigan as doctors who had treated him within the past ten years. Employee also contradicted himself at times during his trial testimony. For instance, he originally testified that he returned to work at a Detroit casino after his 2004 surgery, later admitting that he only worked for a short time after the accident and that he did not work after the surgery. Employee did not return to any form of employment until 2010.

Employee applied for Social Security Disability benefits in August of 2005. At a June 7, 2007 hearing in support of his application, Employee testified that the November 2004 surgery had made his condition worse. After this hearing, Employee was awarded Social Security benefits. The administrative law judge who presided over the hearing described Employee's testimony about his condition as follows:

> The claimant testified that he uses a brace sometimes when standing. . . . [H]e prefers a wheelchair instead of a cane when going somewhere because nerve damage behind his knee causes his leg to go out quickly. He stated that if he goes anywhere with his sisters, he uses the wheelchair because he is petrified of taking a fall. He stated he has fallen numerous times since his surgery. He said he can walk around the house with a counter near him where he can grab it for support.
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> [He] testified that he is in pain constantly, every day, all day long. . . . [T]he pain is in the lower back, going through his hips, down his left leg, in his kneecap and into the top of his left foot. . . . [H]e spends about 3/4 of his day lying down on the sofa and the bed. He testified he does not do chores but has tried to help with the cooking. He added that a jug of detergent is too hard on his spine to lift and said there is too much bending over for him to do laundry. He described being able to shower for a couple of minutes on some days but on others he just washes off and one of his sisters will rinse his hair for him.

In contrast to the evidence presented at the Social Security Disability benefits hearing, Employee testified in his February 2013 deposition that, as of 2007, he considered himself physically able to work. Nonetheless, Employee continued to receive Social Security Disability benefits up to the time of trial. In 2006, Employee moved to Tennessee and attended nursing classes, and in January 2011, he obtained employment as a nurse in the

emergency department of the University of Tennessee Medical Center in Knoxville. Employee testified that he was permitted to continue receiving Social Security Disability benefits under a nine-month trial work program, and his benefits payments never ceased, as his alleged work injury occurred in October of 2011.[1]

After moving to Tennessee, Employee came under the care of Dr. Chang-Wen Chen in Knoxville. Dr. Chen recommended pain management treatment and physical therapy for Employee's chronic back pain. In November of 2008, Dr. Chen released Employee from his care, and Employee became a patient of Dr. Lorino in January of 2010. At that time, he reported taking Diclofenac (a nonsteroidal anti-inflammatory medication) and Tizanidine (a muscle relaxer) as needed, but the record does not reflect who prescribed these medications. Dr. Lorino reported that on June 1, 2010, Employee complained of "acute on chronic low back pain," which Employee had exacerbated by moving furniture two or three weeks prior. At trial, Employee denied having hurt his back by moving furniture. Dr. Lorino prescribed a Prednisone dose pack and Valacyclovir and recommended that Employee have an MRI. However, Employee chose not to have the MRI because he "didn't feel the need for it."

Employee saw Dr. Lorino again on August 9, 2010, complaining of acute back pain radiating into his left leg. On May 24 and July 15, 2011, Employee saw Dr. Lorino for unrelated medical problems, and on each of those occasions, Dr. Lorino's records include a diagnosis of lumbago with frequent recurrences. Employee visited Dr. Lorino on October 20, 2011, two days after his alleged work incident, but Dr. Lorino's records do not indicate that Employee's injury was exacerbated by the October 18 incident or that the injury was in any way work related.

Dr. William Kennedy, an orthopaedic surgeon, conducted an independent medical evaluation on April 5, 2012, at the request of Employee's attorney. Dr. Kennedy's evaluation consisted of reviewing various medical records, taking a history from Employee, and conducting a physical examination. He stated that the medical records showed Employee had a chronic L5 radiculopathy prior to his work injury and that the November 2011 MRI revealed a large disc herniation at L4-5. While noting that the medical records he reviewed indicated no "specialized" treatment from 2005 until 2011, Dr. Kennedy concluded that the October 18, 2011 incident had caused the disc herniation.

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[1] Employee acknowledged a two-month period between the end of his nine-month trial period and the occurrence of his injury in which he mistakenly received benefits payments, but he explained that he was required to repay these disbursements through incremental deductions in his monthly Social Security check.

Dr. Kennedy opined that Employee retained a 13% permanent physical impairment to the body as a whole from the injury and surgery. He testified that the Sixth Edition of the American Medical Association Guides to the Evaluation of Permanent Impairment ("AMA Guides") provides for apportionment of impairment among causes, but he insisted that apportionment is only appropriate when the resulting impairment is made greater by the previous condition. Dr. Kennedy also recommended restrictions, including no repeated bending or stooping, no work with hands elevated above the shoulders, and no occasional lifting or pulling above 20 pounds or frequent lifting above 10 pounds.

During cross-examination, Dr. Kennedy agreed that the accuracy of his evaluation depended on receiving an honest and thorough history from the patient. He testified that Employee did not mention Dr. Imas as one of his prior treating physicians and that he had not seen Dr. Imas's medical records. Additionally, Dr. Kennedy claimed he was neither aware of Employee's application for Social Security Disability benefits nor the medical information serving as the basis for that application. In fact, Dr. Kennedy testified that he had been advised by Employee that before the October 2011 injury, Employee had been able to control his back pain with over-the-counter medications such as Aleve. However, Dr. Kennedy was aware that Employee had received prescriptions for Diclofenac and Tizanidine prior to the alleged injury. Further, Dr. Kennedy acknowledged that Dr. Lorino's records from October 20, 2011, provided no indication that the injury occurred as a result of the October 18 incident or that the injury was work related. Moreover, he was not aware that other physicians had twice recommended MRIs of Employee's lower back prior to the alleged injury and did not know that Employee had been referred to a pain management program by Dr. Chen in 2008.

At the request of Employer, Employee was examined on March 20, 2013, by Dr. Patrick Bolt, an orthopaedic surgeon. After reviewing medical records and conducting a physical examination of Employee, Dr. Bolt concluded it was not clear when Employee's herniated L4-5 disc occurred, "as the patient's symptoms were largely similar and ongoing, based on the reports from his physicians." Dr. Bolt noted that all records indicated that Employee had an active radiculopathy before October 18, 2011, and that Dr. Lorino's records described similar symptoms before and after the alleged work injury. Dr. Bolt also pointed to Dr. Imas's diagnosis of "failed back syndrome" and Employee's 2005 application for Social Security Disability benefits, which described symptoms more severe than those he was experiencing in October of 2011. In addition, Dr. Bolt testified that his review of MRI reports, though not the images themselves, indicated to him that Employee had a recurrent issue. He cited conflicting reports concerning Employee's November 9, 2011 MRI. Dr. Reid's report indicated a "herniated nucleus pulposus," which Dr. Reid recovered during the December 20, 2011 surgery, but the original radiology report failed to note the herniated disc. According to Dr. Bolt, these records evidenced an ongoing preexisting condition. Ultimately, Dr. Bolt determined there was nothing in the medical record

establishing that Employee's chronic back and leg pain had resolved before October of 2011. Those symptoms were essentially the same before and after the alleged work injury. Finally, he testified that it was also possible that the November 2011 car accident had damaged Employee's spine, as Dr. Lorino's records referred to increased pain after that event.

Dr. Bolt disagreed with Dr. Kennedy's opinion that the apportionment provision of the AMA Guides should not be applied in this case. Because Employee's symptoms had increased around the time of the alleged injury, Dr. Bolt believed that an aggravation could have occurred. Using the methodology in the AMA Guides, Dr. Bolt determined that Employee had a total impairment of 13%, of which 3% could be attributed to the alleged work injury.

At the close of the proof, the trial court found that Employee lacked credibility:

> The Court finds that the plaintiff's credibility has been impeached significantly, repeatedly[,] and seriously. Even today the plaintiff said one thing in response to a question and then turned around and said something else immediately thereafter. So the Court finds the plaintiff's credibility is lacking about a lot [of] things in this case.

The trial court held that Employee had declined Employer's offer of authorized medical treatment, and that Employer, therefore, was not liable for medical expenses. The trial court concluded that Employee had failed to sustain his burden of proof that the alleged work injury of October 18, 2011, caused the herniated disc or that the injury had caused any increase in his preexisting disability. Judgment was entered for Employer, and Employee has appealed.

Analysis

In this appeal, Employee contends that the trial court erred in two respects: by admitting into evidence documents pertaining to his application for and award of Social Security Disability benefits; and by finding that Employee failed to sustain his burden of proof that he suffered a compensable injury.

We review a trial court's factual findings "de novo upon the record of the trial court, accompanied by a presumption of the correctness of the finding, unless the preponderance of the evidence is otherwise." Tenn. Code Ann. § 50-6-225(e)(2) (2008 & Supp. 2013). Following this standard, we examine a trial court's factual findings and conclusions in-depth. *Padilla v. Twin City Fire Ins. Co*., 324 S.W.3d 507, 511 (Tenn. 2010); *Crew v. First Source Furniture Grp*., 259 S.W.3d 656, 664 (Tenn. 2008). We give considerable

deference to a trial court's findings of fact based upon assessment of witnesses who testified before the court, but the same deference is not warranted for findings based upon depositions and other documentary evidence. *Padilla*, 324 S.W.3d at 511; *Glisson v. Mohon Int'l, Inc./Campbell Ray*, 185 S.W.3d 348, 353 (Tenn. 2006). We review conclusions of law de novo with no presumption of correctness. *Wilhelm v. Krogers*, 235 S.W.3d 122, 126 (Tenn. 2007); *Perrin v. Gaylord Entm't Co.*, 120 S.W.3d 823, 826 (Tenn. 2003). Although workers' compensation law must be liberally construed in favor of an injured employee, the employee must prove all elements of his or her case by a preponderance of the evidence. *Crew*, 259 S.W.3d at 664; *Elmore v. Travelers Ins. Co.*, 824 S.W.2d 541, 543 (Tenn. 1992).

Employee first contends that the trial court erred by admitting into evidence two documents associated with his 2005 application for Social Security Disability benefits. These were an application for benefits, called a "Function Report," and the decision of the Social Security Administration granting his application. He argues that these documents were inadmissible based on *Bingham v. Dyersburg Fabrics Co., Inc.*, 567 S.W.2d 169 (Tenn. 1978). In that case, an employee sought to introduce a finding by the Social Security Administration that he was totally disabled in support of his application for workers' compensation benefits. *Id.* at 170. The trial court refused to consider the evidence, and the Tennessee Supreme Court affirmed, reasoning that awards or findings by the Social Security Administration are not admissible in workers' compensation cases to show the existence or extent of an employee's permanent disability. *Id*. at 171. The Supreme Court explained that there were "many reasons" for this exclusion, but primarily emphasized that the employer was not a party to the disability proceedings and the criterion for determining disability for Social Security purposes differs greatly from the workers' compensation standard in Tennessee. *Id*.

Unlike *Bingham*, Employer in this case offered the Social Security Disability evidence to impeach Employee's credibility, not to establish the existence of his permanent disability. In the Function Report, Employee describes, in his own handwriting, his symptoms and assesses his ability to perform various activities of daily living, such as dressing, bathing, and feeding himself. Thus, it is admissible as an admission of a party-opponent pursuant to Tennessee Rule of Evidence 803(1.2). The decision of the Social Security Administration contains a lengthy summary of Employee's testimony at the hearing concerning his application for benefits. The information contained in each of these documents conflicts with portions of Employee's in-court testimony. It also conflicts with the history given by Employee to Dr. Kennedy. Thus, the evidence was admissible, as it was relevant both to Employee's credibility and to the validity of Dr. Kennedy's opinion. In Tennessee, a trial court maintains a substantial degree of discretion when determining the admissibility of evidence, and such a decision will only be overturned when there is abuse of that discretion. *Otis v. Cambridge Mut. Fire Ins. Co.*, 850 S.W.2d 439, 442 (Tenn.

1992). We conclude that the trial court did not abuse its discretion by admitting evidence concerning Employee's application for Social Security Disability benefits.

Employee also contends that the trial court erred by finding that he did not sustain his burden of proof as to causation when it concluded his testimony was not credible. There were internal contradictions in Employee's trial testimony, conflicts between his trial testimony and various medical records, and conflicts between his trial testimony and pretrial discovery. There were also material omissions in his discovery responses. Perhaps most significantly, there were material omissions in the information he provided to Dr. Kennedy, as well as contradictions between that information and various medical records. Dr. Kennedy testified that he assumed the history given to him "was reasonably accurate and thorough" and that his opinion concerning causation was only as accurate and valid as the information he was provided.

It is appropriate for a trial court to consider the accuracy and completeness of information relied upon by an expert in evaluating the expert's testimony. *See Orman v. Williams Sonoma, Inc.,* 803 S.W.2d 672, 676 (Tenn. 1991). The trial court explicitly referred to the fact that Dr. Kennedy did not have all of the relevant information. The trial court also referred to the similarity of Employee's reported symptoms after the alleged work injury in October of 2011 to various episodes described in his medical records from 2005 through 2010. In light of those similarities, the trial court found Dr. Bolt's assessment, which took the similarities into account, to be more credible. We agree with this finding. Accordingly, we hold that the evidence does not preponderate against the trial court's decision that Employee failed to sustain his burden of proof.

Conclusion

The judgment of the trial court is affirmed. Costs are taxed to Toney R. Gonzales and his surety, for which execution may issue if necessary.

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SHARON G. LEE, CHIEF JUSTICE

IN THE SUPREME COURT OF TENNESSEE
AT KNOXVILLE

TONEY R. GONZALES v. J.W. CARELL ENTERPRISES, LLC

Circuit Court for Knox County
No. 136612

No. E2013-02072-SC-WCM-WC-FILED-DECEMBER 17, 2014

Judgment Order

This case is before the Court upon the motion for review filed by Toney R. Gonzales pursuant to Tennessee Code Annotated section 50-6-225(e)(5)(A)(ii), 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.

It appears to the Court that the motion for review is not well taken and is, therefore, denied. The Panel's findings of fact and conclusions of law, which are incorporated by reference, are adopted and affirmed. The decision of the Panel is made the judgment of the Court.

Costs are assessed to Toney R. Gonzales and his surety, for which execution may issue if necessary.

It is so ORDERED.

PER CURIAM

Sharon G. Lee, C.J., not participating