IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT NASHVILLE
February 24, 2014 Session

JERRY SIMONS v. A.O. SMITH CORPORATION

Appeal from the Chancery Court for Montgomery County
No. MCCHCVWC121 Laurence M. McMillan, Jr., Chancellor

No. M2013-01350-WC-R3-WC - Mailed July 16, 2014
Filed August 20, 2014

An employee alleged he injured his back on two occasions during late 2008. His employer initially accepted the second claim as compensable, but then denied the claim after receiving records from the employee's primary care physician. The Department of Labor and Workforce Development denied the employee's Request for Assistance. This civil action was subsequently filed in the Chancery Court for Montgomery County. That court awarded workers' compensation benefits to the employee. The employer has appealed, contending that the evidence preponderates against the trial court's findings concerning causation and permanency. The 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 in accordance with Tennessee Supreme Court Rule 51. We affirm the judgment of the trial court.

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

J. B. COX, SP.J., delivered the opinion of the Court, in which WILLIAM C. KOCH, JR., J. and DON HARRIS, SP.J., joined.

Lee Ann Murray, Nashville, Tennessee, for the appellant, A.O. Smith Corporation.

Peter M. Olson, Clarksville, Tennessee, for the appellee, Jerry Simons.

OPINION

Factual and Procedural Background

When the trial of this case took place on February 25, 2013, Jerry Simons ("Employee") was fifty-four years old. He was a high school graduate and had attended two years at Austin Peay State University, where he studied computer science. He had worked for A.O. Smith Corporation, also known as State Industries ("Employer"), in Ashland City for twenty-eight years as a fabricator and seam welder. He had previously sustained a compensable back injury while working for Employer in 2003. He was surgically treated for that back injury by Dr. Daniel Burrus in 2004. Employee was able to return to work for Employer, and his workers' compensation claim was settled.

Dr. Burrus placed restrictions on Employee's activities as a result of the 2003 injury and surgery. Employer was able to accommodate those restrictions, and Employee returned to the same job he held prior to the injury. He continued to have back pain and left leg pain thereafter. He wore a back brace at work 90% of the time. He occasionally sought medical treatment for his symptoms between his return to work in 2004 and the alleged injuries in 2008.

Employee testified that he reinjured his back in October 2008 while lifting fifty-pound bags of welding flux. He told his lead man, Mr. Dotson, about the injury and went to the first aid station. He told Laura Wallace Cole, the plant medical assistant, about his injury. According to Employee, Ms. Cole did not initiate the paperwork for a work injury. An unnamed person, described by Employee as the Safety Director, told him to treat the back with ice packs. Employee said that he returned periodically to the first aid station for pain medication during the following weeks. Ms. Cole testified at trial and denied that Employee had reported a work injury to her in October 2008. She said that it was her uniform practice to complete a first report of injury any time that a work injury was reported to her. She had not completed such a report for Employee in October 2008. Ms. Cole also testified that any employee who came to the first aid station was required to sign a log. As part of the subsequent investigation of Employee's claim, she had reviewed the log for October 2008. Employee's name did not appear in the log. The actual log no longer existed at the time the trial took place, having been destroyed in the May 2010 floods in Middle Tennessee.

Employee testified that he continued to work after the October 2008 incident. He did not recall seeing his personal physician on either October 6, 2008 or October 31, 2008. Employer introduced medical records showing that Employee had seen his doctor on those dates. Neither of those documents contains any reference to back pain. Employee continued to work until Saturday, December 6, 2008. On that date, he and others worked a half-day

cleaning machinery. Employee testified that he experienced extreme pain while bending over to clean under a machine. He reported the situation to his supervisor, Mark Corbitt. Mr. Corbitt testified at trial and denied that the conversation took place. The first aid station was not open at the time. Employee completed his half-day and went home.

Employee testified that he had a "horrible" weekend and spent most of his time sitting or lying down. On Monday morning, he was preparing to go to work. He was getting ready to walk out of his home when he sneezed. His back "went out," and he fell to the floor. He got into bed and couldn't get up. He reported to Employer that he would not be coming to work. His wife drove him to Premier Medical, where he was seen by Dr. Korivi, a partner of his primary care physician, Dr. Silkowski. Dr. Korivi's note for that date, December 8, 2008, contains the following history: "low back since this [a.m.], had a sneeze and pulled his back[,] since then [it's] hurting." Dr. Korivi prescribed various medications. Employee remained off work for one week. On December 12, Employee returned to Dr. Silkowski. Dr. Silkowski completed a "Disability Management Form," containing work restrictions. Dr. Silkowski also answered "No" to the question "Is this condition work related?" on the document.

Employee took the form to work on Monday, December 15. Because of the medical restrictions, Mr. Corbitt referred him to the first aid station. There, Ms. Cole informed Employee that Employer's policy was to accommodate work restrictions only for work-related injuries. Employee then told her he had injured his back on Saturday, December 6, while cleaning a machine. Ms. Cole prepared an injury report and presented Employee with a panel of physicians. He selected Dr. Stanley Hopp, an orthopaedic surgeon, from that list.

Dr. Hopp first saw Employee on December 19, 2008. Employee gave this history to Dr. Hopp:

> He said he had had previous back surgery in 2004. He had had episodic back pain over the two years previous to my seeing him.
>
> He had a spell two months prior to my seeing him; had a few days off work and seemed to improve.
>
> The present problems for which he was complaining of when he saw me began on approximately December 6, 2008. He said he was at home getting ready for work, and his back went out on him when he leaned over his right side.

Dr. Hopp ordered an MRI. That study showed no recurrent disc herniation at L5-S1, the level of his 2004 surgery. However, it did reveal a new disk protrusion at the L4-5 level. Dr. Hopp recommended conservative treatment. He believed the L4-5 disc was the source

of Employee's symptoms. The results of an EMG study performed on March 31, 2009 were consistent with that conclusion. In early January 2009, Dr. Hopp received a letter from an adjuster for Employer's workers' compensation insurer requesting his opinion about the cause of Employee's symptoms. He responded that "The patient is diagnosed with a disc protrusion at L4-5 above his previously operated level of L5-S1. I feel that the work activity of claim under the equipment at work on 12/06/08 is the approximate cause of his present back difficulties."

In March 2009, Dr. Hopp received a second letter from the adjuster. That letter was accompanied by documents from Employee's primary care physicians. The letter again requested Dr. Hopp's opinion on causation, in light of the additional information. At that time, he changed his previous opinion, stating, "I feel that in reviewing this entire history again, it is not clear that this gentleman has a work-related injury to his back and it is more than likely the activity at home, sneezing, and getting ready for work when he sustained his back injury." The insurer thereafter denied the claim, and Employee sought medical and chiropractic care through his health insurance.

Employee returned to Dr. Hopp on July 23, 2009. An MRI scan had been taken on June 24. According to Dr. Hopp, that study showed improvement in the condition of the L4-5 disk from the December 2008 MRI. He opined that Employee had reached maximum medical improvement as of July 23. Dr. Hopp reviewed an EMG that had been performed on August 8, 2009. That study showed an active radiculopathy in the L5-S1 dermatome. Based on the June MRI and August EMG, Dr. Hopp opined that the L5-S1 disc, rather than the L4-5 disk had become the primary cause of Employee's symptoms. He opined that the L4-5 condition was temporary and had resolved by the summer of 2009. He opined that Employee had no permanent impairment and required no permanent restrictions as a result of the December 2008 incident. On cross-examination, Dr. Hopp testified that he did not call Employee after receiving the additional medical records, nor did he contact Dr. Silkowski.

Employee did not return to work for Employer after December 15, 2008. He reported that his back injury had "dramatically" changed his life. He was no longer able to coach his youngest son's football team, and was limited in his ability to attend his older son's sporting events. He did not fish, jog or play basketball. He "slowed down" when performing household chores. He sometimes used a cane and the back brace he had worn before the injury. He did not think he was capable of performing any of his previous jobs.

Dr. David Gaw, an orthopaedic surgeon, examined Employee on April 16, 2012 at his attorney's request. He completed a C-32 Standard Form Medical Report. In that report, he opined that "the incidents which [Employee] describes as occurring while working at A.O. Smith in October and December of 2008 are the most likely cause of his present condition in that these incidents aggravated and advanced the pre-existing degenerative disc disease."

He found that Employee had a permanent impairment of 13% to the body as a whole due to his S1 radiculopathy. Employer exercised its right pursuant to Tennessee Code Annotated section 50-6-235(c)(1) to conduct a cross-examination deposition of Dr. Gaw. During that deposition, Dr. Gaw agreed that an MRI taken on March 23, 2011 showed a recurrent disc herniation at L5-S1. He also agreed that the August 8, 2009 EMG showed an active S1 radiculopathy. He found atrophy in the muscles of the left leg, which could have been the result of the 2003 injury. He agreed that Dr. Korivi's note of December 8, 2008 did not refer to a possible work injury. He also agreed that the records of Premier Medical for December 8 and 12, 2008 were inconsistent with the history given to him by Employee. He restated that his impairment rating was based on the presence of a herniated disc at the L5-S1 level.

After hearing this evidence, the trial court issued its findings from the bench. It found that Employee had sustained compensable injuries in both October and December of 2008. It found that Employee was a credible witness. It accepted Dr. Gaw's impairment rating of 13% to the body as a whole and awarded permanent partial disability benefits of 26% to the body as a whole. Judgment was entered in accordance with those findings. Employer has appealed, raising two issues. First, it contends that the trial court erred by finding that Employee sustained a compensable injury as alleged. In the alternative, it asserts that the trial court erred when it found that he had sustained a permanent disability as a result of his work injury.

Standard of Review

Courts reviewing an award of workers' compensation benefits must conduct an in-depth examination of the trial court's factual findings and conclusions. *Wilhelm v. Krogers*, 235 S.W.3d 122, 126 (Tenn. 2007). When conducting this examination, Tenn. Code Ann. § 50-6-225(e)(2) requires the reviewing court to "[r]eview . . . the trial court's findings of fact . . . 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." The reviewing court must also give considerable deference to the trial court's findings regarding the credibility of the live witnesses and to the trial court's assessment of the weight that should be given to their testimony. *Tryon v. Saturn Corp.*, 254 S.W.3d. 321, 327 (Tenn. 2008); *Whirlpool Corp. v. Nakhoneinh*, 69 S.W.3d 164, 167 (Tenn. 2002). However, the reviewing courts need not give similar deference to a trial court's findings based upon documentary evidence such as depositions, *Orrick v. Bestway Trucking, Inc.*, 184 S.W.3d 211, 216 (Tenn. 2006); *Bohanan v. City of Knoxville*, 136 S.W.3d 621, 624 (Tenn. 2004), or to a trial court's conclusions of law, *Seiber v. Reeves Logging*, 284 S.W.3d 294, 298 (Tenn. 2009).

Analysis

Causation

Employer first contends that the trial court erred by finding that Employee sustained a work-related injury in 2008. In support of this position, Employer points to the records of Premier Medical, Employee's primary care provider. Notes from October 6 and 31 do not mention back pain at all. Notes from December 8 and 12 show that Employee complained of back pain, but contain no reference to a work injury. Indeed, Dr. Silkowski's "Disability Management Form" of December 12 affirmatively states that Employee's back pain was not work-related. Employer further relies on the testimony of Mr. Corbitt that Employee did not report a work injury to him on December 8, and Ms. Cole's testimony that he did not seek or receive medical treatment at the first aid center in October 2008.

Employee testified that he reported his October and December injuries to Mr. Corbitt and Ms. Cole. He also testified that, notwithstanding the medical records, he told his physicians at Premier Medical about his work injuries. Dr. Hopp opined that Employee did not injure his back at work. That opinion was largely based on those medical records and Dr. Hopp's accompanying conclusion that the history provided to him by Employee was not accurate. Dr. Gaw reviewed the same records, but chose to accept the history presented to him by Employee, and thus concluded that a work-related injury had occurred. In effect, each doctor's opinion is based on his assessment of Employee's credibility. The trial court concluded that Employee's account was credible. It could have found otherwise, but it did not. After personally observing Employee's testimony on direct and cross-examination, it accredited that testimony. That finding is entitled to considerable deference by this panel, which is limited to reviewing the transcript and other documents. *Tryon*, 254 S.W.3d at 327; *Whirlpool*, 69 S.W.3d at 167. In light of the trial court's credibility finding, the court appropriately accredited Dr. Gaw's opinion that Employee sustained a work injury as described.

Permanency

Employer also asserts that the trial court erred by finding that Employee sustained a permanent injury as a result of the October and December 2008 incidents. This argument is based on Dr. Gaw's explanation of the permanent impairment he assigned to Employee. The rating was based on radiculopathy of the L5-S1 nerve. Employer points to the testimony of Dr. Hopp, who testified that Employee's symptoms in late 2008 and early 2009 were caused by an injury to the L4-5 disc. According to Dr. Hopp, subsequent tests showed that injury had healed by the middle of 2009, and Employee's symptoms thereafter were caused by a protrusion at the L5-S1 level. That was, of course, the same level that had been injured in 2003 and had continued to cause pain for Employee over the following years.

It is clear from Dr. Gaw's report and testimony that he was aware of Employee's previous injury and its consequences. With that knowledge, he opined that "the incidents which he describes as occurring while working at A.O. Smith in October and December of 2008 are the most likely cause of his present condition in that these incidents aggravated and advanced the pre-existing degenerative disc disease." Dr. Gaw acknowledged that there were inconsistencies between the history given to him by Employee and the records of Premier Medical. Nevertheless, he did not recant, in whole or in part, his opinion that the work incidents had advanced Employee's pre-existing degenerative condition. Such advancement of a pre-existing degenerative condition is compensable under the workers' compensation law. *Trosper v. Armstrong Wood Products, Inc.*, 273 S.W.3d 598, 607 (Tenn. 2008). That a change occurred is clear. Anatomical change at L4-5 clearly shows that a new injury occurred even if it resolved later. Radiculopathy at L5-S1and the atrophy in Employee's leg are indicative of aggravation of an existing condition.

Employee's own testimony about the diminution of his physical capabilities after the work incident is consistent with Dr. Gaw's opinion. We therefore conclude that the evidence does not preponderate against the trial court's finding on this issue.

Conclusion

The judgment of the trial court is affirmed. Costs are taxed to A.O. Smith Corporation and its surety, for which execution may issue if necessary.

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J.B. COX, 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 A.O. Smith Corporation and its surety, for which execution may issue if necessary.

PER CURIAM