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STATE OF NORTH DAKOTA

IN THE SUPREME COURT

STATE OF NORTH DAKOTA

Pete Frazer, Appellant, vs. North Dakota Workforce Safety & Insurance, Appellee.	)	Supreme Court Case No. 20120189

BRIEF OF APPELLEE

On Appeal from the District Court Order dated February 13, 2012, Order for Judgment Dated March 16, 2012, and Judgment Entered March 16, 2012
Northwest Judicial District
Mountrail County, North Dakota
Mountrail County Civil No. 31-2011-CV-0014
The Honorable Gary H. Lee

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STATEMENT OF THE ISSUES

[1] WHETHER A REASONING MIND COULD FIND CLAIMANT DID NOT SUSTAIN A COMPENSABLE WORK INJURY.

STATEMENT OF THE CASE

[2] On September 3, 2009, WSI received a First Report of Injury from Frazer alleging a work related injury took place on July 11, 2009. (C.R. 1) On October 29, 2009, WSI issued a Notice of Decision Denying Benefits. (C.R. 15)

[3] Thereafter, on November 23, 2009, WSI received Frazer's request for reconsideration and extension. (C.R. 17) On November 25, 2009, WSI wrote to Frazer stating he would have 14 days within which to provide additional evidence he wanted WSI to consider. (C.R. 20)

[4] On December 14, 2009, WSI received a letter from Frazer via facsimile regarding the same. (C.R. 21) On January 13, 2010, WSI sent Frazer a letter stating it had reviewed the evidence submitted to reconsider its decision and that the evidence was insufficient to change WSI's decision. (C.R. 29)

[5] On February 4, 2010, WSI issued an Order denying Frazer's claim because he failed to prove his right shoulder condition was work related. (C.R. 30) On March 25, 2010, WSI received Frazer's request for hearing. (C.R. 39)

[6] Administrative Law Judge Susan Bailey ("ALJ Bailey") was assigned to this claim. On May 10, 2010, ALJ Bailey issued a Notice of Hearing and Prehearing Order setting the hearing for July 23, 2010. (C.R. 40) There were a couple continuances; however, a hearing date was eventually set for December 16, 2010, which took place as scheduled. (C.R. 43a) The record was kept open to take the deposition of Dr. Richard

Ganzhorn, which took place on February 8, 2011. (C.R. 118)

[7] On January 26, 2011, ALJ Bailey issued an Order for Post Hearing Briefing. (C.R. 161) Frazer submitted his brief on March 2, 2011. (C.R. 164) WSI and the employer submitted their briefs on March 18, 2011. (C.R. 173 and 187) Frazer replied to these briefs on March 23, 2011. (C.R. 225)

[8] On April 27, 2011, ALJ Bailey issued her Findings of Fact, Conclusions of Law and Order. (C.R. 231)

[9] On May 24, 2011, Frazer petitioned the Court to reconsider its previous Order. (C.R. 255) On June 7, 2011, ALJ Bailey issued an Order granting the petition for reconsideration and set a briefing schedule regarding the same. (C.R. 263) On June 9, 2011, the employer responded to Frazer's Petition for Reconsideration. (C.R. 266) On June 10, 2010, WSI answered Frazer's Petition for Reconsideration. (C.R. 270) Frazer submitted his reply brief to these pleadings on June 13, 2011. (C.R. 276) ALJ Bailey issued an Order on July 28, 2011, rejecting Frazer's arguments and affirming her previously issued April 27, 2011, Order without amendment. (C.R. 279)

[10] On August 12, 2011, Frazer served a Notice of Appeal and Specification of Error. Thereafter, the District Court issued two Orders which set the deadline for Frazer's Brief as November 11, 2011, and the deadline for WSI's Brief as December 6, 2011.

[11] On February 13, 2012, the Honorable Gary Lee ("Judge Lee") filed an opinion affirming ALJ Bailey's Order. (App. 142) Judge Lee issued a formal Order for Judgment on March 16, 2012. (App.148) Judgment was entered the same day and Notice of Entry of Judgment was served April 4, 2012. (App. 149).

[12] On April 10, 2012, Frazer served his Notice of Appeal to this Court. (App. 152)

STATEMENT OF THE FACTS

[13] The objective medical evidence in this case tells a compelling story of Frazer's ongoing, degenerative shoulder condition, leading up to surgical repair of those degenerative issues. That objective evidence, including clinical testing, an x-ray, and an MRI arthrogram, is all consistent in revealing that Frazer did not suffer an injury or a substantial worsening of his rotator cuff pathology. Because the medical evidence and Frazer's treatment history are critical to the analysis, WSI provides that information in chronological order below, including the explanatory testimony of Frazer's expert, Dr. Richard W. Ganzhorn.

A. Frazer had a long history of bone spurs and radiating pain from his neck.

[14] Frazer has a long history of neck and radiating arm pain, beginning in approximately 1967. (C.R. 45 H.T. 44:14-19) Frazer was born with a congenital condition of narrowing of the openings at the C4, C5 and C6 areas of his spinal cord. (C.R. 127) Frazer has stenosis in that area, meaning that the hole in his spine for his spinal cord is too tight. (C.R. 127) In addition, over time, Frazer developed degenerative changes on his spine in that area, which his expert, Dr. Ganzhorn, explains are bone spurs. (C.R. 127) Importantly, the CS and C6 nerves extend to the dermatomes in the thumb and finger, and the C6 muscular innervation is the lateral hand and thumb area. According to Dr. Ganzhorn, spurs and congenital narrowing of the spine may have caused the radiating pain down into his hand. (C.R. 128)

[15] More than 40 years after this problem had started in 1966, Frazer had surgery on his spine in 2008 for "multilevel degenerative changes with significant spondylosis at the 5/6 level and bilateral foraminal stenosis." (C.R. 45-46) In other words, he had surgery

for multilevel degenerative changes and multiple bone spurs. (C.R. 128) The surgeon removed a large bone spur that overlaid the disc at C5-C6. Then the surgeon removed additional bone spurs on the joints in that area. Finally, the surgeon fused the bones in Frazer's neck, at the C5-C6 level of the spine. (C.R. 49 and C.R. 128 and 129)

B. Frazer's first treating doctor after July 11, 2009, Dr. Mehta, diagnosed impingement syndrome based on clinical testing and x-ray results.

[16] On July 16, 2009, Frazer saw Dr. Mehta in Minot, North Dakota. (C.R. 70) He complained of right shoulder pain that radiated to his right hand, which he attributed to an incident at work on July 11, 2009. (C.R. 70) As Dr. Ganzhorn testified, this pain could have been a nerve issue originating from C6. (C.R. 129 Transcript 38:6-10) At that time, Frazer also had a positive Tinnel sign, which may also indicate a nerve-related issue, such as carpal tunnel syndrome. (C.R. 70 and C.R. 129 Transcript 3 8:22 — 39:22)

[17] Frazer was able to abduct his arm for his full range of motion, but he experienced pain after about 75-80°. (C.R. 7 and C.R. 130 Transcript 40:4 — 41:7) Abduction is when the patient lifts his extended arm straight out to the side and up above the head. The normal range of motion for abduction is about 160-170°. (C.R. 124) Notably, the issue with Frazer was not his power to lift his arm, but rather pain beginning in the mid arc area of the movement.

[18] Dr. Mehta diagnosed Frazer with "possibility of tendonitis and also possibility of osteoarthritis." (C.R. 70) Dr. Mehta offered Frazer a steroid injection and therapy, but Frazer refused the treatment. Id.

[19] Frazer saw Dr. Mehta again on July 28, 2009. (C.R. 71) He reported he felt a little better but still had a lot of pain and discomfort, and was unable to sleep on his right side.

Dr. Mehta ordered an x-ray of Frazer's shoulder, and again offered a steroid injection and therapy. (C.R. 71) Frazer again refused the treatment, explaining he might go back to see a doctor in Wisconsin. (C.R. 71)

[20] Frazer's third appointment with Dr. Mehta was on August 3, 2009. Frazer had an x-ray earlier that day, which indicated Frazer had impingement syndrome. (C.R. 72)

[21] According to Frazer's expert, Dr. Ganzhorn, an impingement syndrome or impingement in the shoulder usually refers to the acromioclavicular joint; basically when the two bones are very close or actually touching each other. It is a mechanical compression on the supraspinatus tendon, the subacromial bursa and the long head of the biceps tendon. Basically, the compression causes an impingement because of the decreased space for the soft tissue and the bones potentially rubbing together. (C.R. 123)

[22] Dr. Ganzhorn also testified that an impingement syndrome can create a cycle of worsening of the shoulder condition, where the impingement causes inflammation, the inflammation increases the impingement issues, which then causes more fraying and damage to the rotator cuff tendons, and the cycle keeps repeating. (C.R. 123 Transcript 13:21 — 14:15)

[23] Dr. Mehta again offered Frazer physical therapy or a trigger point injection at the August 3, 2009, appointment, but Frazer refused the treatment. (C.R. 72) Dr. Mehta noted that x-ray had suggested that Frazer might have an MRI, but Frazer refused that as well, wanting to wait and see. Id. The doctor showed Frazer some exercises, which Frazer was able to do within pain tolerance, and recommended follow-up the next week. (C.R. 72)

[24] The x-ray of August 3, 2009, provides objective information about Frazer's

shoulder issues at that time. The findings were as follows:

> Moderate scattered degenerative changes present, greatest involving the AC joint, to lesser extent the greater tuberosity, and to the least extent the glenohumeral joint space. Equivocal narrowing of the humeral acromion space on the external rotation view could reflect impingement syndrome, and if clinically indicated, follow up MRI could be considered here.
> No evidence of a fracture, subluxation, or other significant shoulder finding. Incidental note made of a lower cervical spine anterior fusion plate. (C.R. 74)

[25] In his deposition, Dr. Ganzhorn, explained the x-ray findings. The "scattered degenerative changes" are bone spurs, also known as osteophytes. (C.R. 131) These bone spurs are acquired over time. (C.R. 131 Transcript 46:5-7) The greatest of those bone spurs involved the AC joint. (C.R. 131 Transcript 45:13-15)

[26] Having reviewed the x-ray results, Dr. Mehta concluded that Frazer had impingement syndrome in his shoulder. Based on the x-ray and the clinical testing at that time, Dr. Ganzhorn opined in his deposition that he agrees with this diagnosis. (C.R. 131 Transcript 46:19 — 47:1)

[27] Frazer returned to see Dr. Mehta on September 14, 2009. (C.R. 73) This time, he complained about pain in his neck and right upper extremity. He also complained about pain in his left upper extremity. He informed Dr. Mehta he was filing a workers compensation claim. He had talked to someone at WSI and now wanted to have an MRI done "or something like that" but he was going to wait to have approval from WSI. When Dr. Mehta offered an injection, Frazer refused. The doctor stated he would request authorization for NCV-EMG testing of the Frazer's upper extremities when it was approved. (C.R. 73) In notes the following day, Dr. Mehta stated that if the NCV-EMG was positive, he would then advise an MRI. (C.R. 73)

[28] Dr. Ganzhorn explained the nerve conduction and EMG study would check on the condition of the nerves in Frazer's upper body, indicating Dr. Mehta was concerned about a nerve issue. (C.R. 132 Transcript 48:24-50:4) Dr. Ganzhorn agreed with that because Frazer was complaining about neck pain and pain in both extremities; it could be a nerve issue (unless there were rotator cuff issues in both shoulders). (C.R. 132 Transcript 48:10 — 49:2) Frazer did not return to see Dr. Mehta again.

[29] An MRI done on September 22, 2009, showed that Frazer had radiating pain in his right arm and bone spurs were returning to his spine at C5 and C6.

[30] On September 22, 2009, Frazer had an MRI done at Marquette General Hospital in Michigan, ordered by the same doctor who had conducted Frazer's spinal surgery a year before, Dr. Craig Coccia. (C.R. 56). The diagnosis was neck pain with right arm radiculpathy, which means that Frazer had reported neck pain with radiating pain and tingling down his right arm. (C.R. 132 Transcript 50:25 — 5 1:7)

[31] The MRI showed that "mild to moderate spur-disc is again noted at C5-C6, with moderate narrowing of the right neural foramina." In other words, in the one year since his cervical surgery, the bone spurs had returned to Frazer's spine. (C.R. 132 Transcript 51:25 — 51:11) Dr. Coccia then referred Frazer to a doctor specializing in rehabilitation, Dr. Richard E. Vermeulen. (C.R. 58)

C. <u>Frazer's second treating doctor, Dr. Vermeulen, diagnosed impingement syndrome caused by degenerative changes associated with aging</u>.

[32] Frazer first saw Dr. Vermeulen on October 1, 2009. (C.R. 58) He brought pictures of a truck caked with mud at a rig site and told the doctor that soil collects on hoods and other parts of automobiles in North Dakota. Frazer also reported to Dr. Vermeulen he

moves his arm above his head to open a hood on the truck every time he gets into his vehicle to drive it. (C.R. 59)

[33] Frazer told the doctor he was taking, among other things, prescribed pain killers ordered by Dr. Richard Ganzhorn. (C.R. 58) When asked what increases his pain, Frazer voluntarily demonstrated by moving his right arm in an arc of abduction, noting that he had pain at about 140°. The doctor's notes make a point of stating that Frazer did this on his own, prior to the examination. (C.R. 59)

[34] Dr. Vermeulen then did a clinical exam. He found that Frazer had pain between 120° and 140° when he abducted his right arm. However, the most painful exam maneuver for Frazer was the Hawkins impingement maneuver, which is a test for shoulder impingement. (C.R. 59)

[35] Dr. Vermeulen also reviewed the x-ray from September 22, 2009. He noted that the AC joint degenerative changes and tuberosity changes typically come from rotator cuff pathology at the insertion of the supraspinatus. (C.R. 59) Dr. Ganzhorn agrees this statement as a matter of medical probability. (C.R. 134 Transcript 58:18 — 59:1)

[36] The Hawkins-Kennedy test is where the patient has the arm flexed forward at 90° (parallel to the ground) and then the patient bends the elbow across himself so that it is bent toward the other shoulder. The therapist then rotates the arm internally. Where there is pain in that rotation, the test indicates an impingement in the shoulder. (CR. 125 Transcript 22:14 — 23:16)

[37] Importantly, Dr. Vermeulen explained Frazer's good power in abducting his arm made it improbable his shoulder issue was a large rotator cuff tear. (C.R. 59) In other words, at this time, Frazer did not likely have a full-thickness rotator cuff tear.

[38] While Dr. Ganzhorn said this is not an absolute rule, he agrees with Dr. Vermeulen's clinical diagnosis as a matter of probability. (C.R. 134-135 Transcript 59:2 — 60:20) In other words, based on objective clinical evidence, all of the medical testimony in this case is in accord as of this date: As a matter of medical probability, the clinical testing shows Frazer did not have a full thickness tear in his rotator cuff in October of 2009.

[39] Dr. Vermeulen saw Frazer again on November 3, 2009. (C.R. 61) At that time, Frazer's "mid arcs of humeral abduction [were] pain free." Frazer was able to "abduct his arm to 160° with lesser end range right humeral abduction pain." Frazer noted that at times he had neck pain but "that is not really the problem since things began." (C.R. 61)

[40] Dr. Vermeulen's impression was "right rotator cuff syndrome." (C.R. 61) Dr. Vermeulen noted the age-acquired spur near the AC joint, which could be seen on the September 22, 2009, x-ray. Dr. Vermeulen indicated that a spur like this, and the syndrome that is resulting from it, is principally a result of aging. He explained this to Frazer. (C.R. 61)

[41] Dr. Ganzhorn testified rotator cuff syndrome includes degenerative issues in the shoulder. It also includes tendinopathy. (C.R. 136 Transcript 65:15-18) Tendinopathy is basically pain irritation and discomfort, in early pathology. The cuff is somewhat damaged, somewhat strained, and somewhat torn. This can be a chronic degenerative change in the shoulder. And the patient can have some tearing and fraying of the rotator cuff tendons with the tendinopathy. (C.R. 126 Transcript 25:15 — 26:3)

[42] Frazer had one more office visit with Dr. Vermeulen on December 3, 2009. (C.R. 64) At that time, according to the doctor's notes, Frazer reported that he "has

substantially improved since I last saw him November 3, 2009." Id. Frazer also reported to Dr. Vermeulen he had changed a tire few days earlier and that hurt a little bit, but the doctor noted he would not have been able to do that early on in the treatment. Frazer was also abducting his arm to 165°, **which was the full shoulder range of motion**. Frazer had no pain with the Hawkins' impingement maneuvers on that date, which Dr. Ganzhorn acknowledged in his deposition was a major improvement. (Id. and C.R. 137 Transcript 70:19-23)

[43] Dr. Ganzhorn testified that the improvement of Frazer's condition from November 3, 2009 to December 3, 2009 was the result of the therapy and the steroid injection. Further, when asked whether, in light of the improvement after receiving an injection, there's a good likelihood that some of Frazer's pain was caused by the impingement, Dr. Ganzhorn said that was correct. (C.R. 137 Transcript 68:17-25)

[44] Dr. Ganzhorn stated that partial tears of the tendons in the rotator cuff are common in older populations, and there is a good possibility that the person with a partial rotator cuff tear is completely asymptomatic. (C.R. 136 Transcript 66:2 1 — 67:23) "[T]earing and fraying of the rotator cuff muscles, particularly the supraspinatus and infraspinatus, is common in older people." (C.R. 136 Transcript 67:17-2 1) Further, bone spurs are also common in older people. (C.R. 136 Transcript 67:22-24)

[45] Frazer agreed to a second injection on December 3, 2009, which was again given to deal with his impingement syndrome. (C.R. 138 Transcript 72:13-19) At the end of his December 3, 2009, notes, Dr. Vermeulen stated:

> [I]f Pete claims he cannot do any kind of work and he is therefore disabled through another administrative entity, then he has raised in medical probability reason to suspect fictitious amplification of symptoms to gain secondary financial wage benefit. (C.R. 65)

D. <u>Frazer's third treating doctor, Dr. Santino, confirmed the impingement syndrome diagnosis, with an MRI</u>.

[46] After his December 3, 2009, appointment with Dr. Vermeulen, when his condition had substantially improved, **Frazer did not see another doctor for any shoulder issues until almost four months later**, on March 26, 2010. On that date, Frazer saw another rehabilitation specialist, Dr. Steven Santino. (C.R. 91) Contrary to his prior reports to doctors, Frazer told Dr. Santino he had no history of neck pain. <u>Compare</u> (C.R. 56 & 72 with C.R. 91) He also told Dr. Santino that Dr. Vermeulen had treated him and told him the pain was age related, but Frazer disputed that. (C.R. 91)

[47] Dr. Santino's assessment was that Frazer had possible degenerative changes in his shoulder. (C.R. 94) The clinical testing Dr. Santino conducted also showed some evidence of tendinopathy of the rotator cuff. The doctor noted: "He does continue to have fairly good strength and I would not suspect a full thickness tear but again a partial tear may be underlying his pain." (C.R. 94) This analysis is consistent with Dr. Vermeulen's analysis and Dr. Ganzhorn's agreement that power and strength in abduction make improbable a full thickness tear in the shoulder. <u>See</u> (C.R. 59 and C.R. 134-135 Transcript 59:2 — 60:20)

[48] Dr. Santino ordered an MRI arthrogram of Frazer's right shoulder for further evaluation. (C.R. 94) This MRI indicates degenerative and genetic issues, and Frazer did not have a full thickness tear. (C.R. 88) In this regard, on April 8, 2010, an MRI arthrogram was performed on Frazer's right shoulder. (C.R.88) Overall, the results of the MRI were consistent with the x-ray that had been taken on September 22, 2009, some six months before, as well as the clinical testing and analysis of the doctors in the meantime.

The MRI showed chronic changes in the AC joint, with some osteophytes (bone spurs). (C.R. 88) As Dr. Ganzhorn explains, the bone spurs indicate Frazer has some arthritis in his shoulder. (C.R. 139 Transcript 77:17 — 78:1) The MRI also showed Frazer's acromion is curved. (C.R. 88) The curved acromion has special significance. The acromion is a piece of the scapula that articulates with the clavicle (collar bone). (C.R. 123 Transcript 14:22 — 15:1) Indeed, the most common cause of impingement is an anatomical variation in the shoulder. (C.R. 123 Transcript 15:2-5) Curving of the acromion can cause fraying of the supraspinatus tendon. Individuals who have a curved or hooked-shape acromion are more likely to have problems with impingement in the AC joint. This impingement causes inflammation and a mechanical wear of the rotator cuff tendon (specifically the supraspinatus tendon). (C.R. 123 Transcript 15:6-14) Dr. Ganzhorn agreed impingement syndrome occurs over time and may be genetic in Frazer's case, because of the shape of his acromion. (C.R. 123 and 140-141 Transcript 14:9-20; 83:18 — 84:2) Moreover, when this pathology exists in the shoulder, the individual often will develop an increased number of acromial osteophytes (bone spurs). (C.R. 123 Transcript 15:15-20)

[49] As Dr. Ganzhorn explained, this process becomes a negative cycle. When the inflammation occurs, the shoulder becomes painful and because of the pain, there is inhibition. The muscles don't want to work to full capacity, even though they technically could work. In other words, the muscles do not perform properly because it is painful. (C.R. 123 Transcript 13:21-14:8) Where the muscles aren't doing exactly what they are supposed to do, more inflammation occurs, which in turn causes more pain, and which

then circles around and causes the muscles to be more inhibitive. (C.R. 123 Transcript 14:9-15).

[50] The MRI showed Frazer's labrum (which is a cushion in the joint) was not torn. (C.R. 88) There were subchondral cystic changes at the greater tuberosity. (C.R. 88) The MRI also found "[n]o evidence of a full-thickness tear of the rotator cuff, but the attachment points are somewhat thin." (C.R. 88) According to Dr. Ganzhorn, the reference to their attachment points means that the rotator cuff had been worn down and was fraying enough that it was thin. (C.R. 139 Transcript 79:6-13) As Dr. Ganzhorn explains, an MRI arthrogram such as was done here involves the injection of dye into the shoulder. The dye helps show whether a patient has a full thickness tear. (C.R. 138 Transcript 75:14-24)

[51] Dr. Gregory Peterson, who reviewed both the MRI images and the MRI report, explains an arthrogram in more detail. He says:

> **It is very important to note that the study that Mr. Frazer had on 4/8/10 was performed with intra-articular gadolinium injection. Most joints, in this case the shoulder, are enclosed by a water tight joint capsule. In the case of the shoulder, the rotator cuff tendons form part of the shoulder joint capsule. Fluid injected into a joint with a tear will "leak" out through a tear in the rotator cuff, allowing the radiologist to find tears that might be missed by an MRI without contrast. It is very unlikely to miss a full thickness tear on a shoulder MRI with intra-articular contrast. One might picture looking at a bag to find a tear, then filling up with water to see if there is a leak. You might miss a tear even with a very good exam of the bag, but you are not at all likely to miss a tear by adding water to the bag and looking for a leak. (C.R. 28a)**

[52] Dr. Peterson points out four doctors, including himself, reviewed the MRI image and report. Neither the radiologist, Dr. Santino, nor Dr. Ganzhorn found any evidence on the MRI of a full thickness rotator cuff tear. Dr. Peterson saw no evidence of such a tear

either. Id.

[53] This MRI result is also consistent with the clinical assessment of both Dr. Vermeulen and Dr. Santino that Frazer's power to abduct his arm indicated he did not have a full thickness tear at the time. (C.R. 59 and 94)

[54] The final impression of the MRI from radiology was "AC joint arthropathy, bursitis, and some tears of the supraspinatus and infraspinatus tendons." (C.R. 88) When asked about joint arthropathy, Dr. Ganzhorn explained: "[This s]imply means wear and tear. The joint's wearing out, AC joint's wearing out — or has arthritis. That's bone spurs." (C.R. 139 Transcript 79:14-19)

[55] Dr. Ganzhorn testified, when a person has arthropathy, the joint space narrows. (C.R. 140) With the narrowing, the two bones are rubbing against one another, causing spur formation and pain and weakness. This happens over time, and can be a degenerative issue. (Id.) The MRI also showed an inflammation of the bursa, which can be caused by other inflammatory conditions. (Id.)

[56] Overall, Dr. Ganzhorn testified in agreement with Dr. Peterson and the other treating doctors that the objective medical record in this case shows Frazer had degenerative changes, as well as tendinopathy in his shoulder. (C.R. 140 Transcript 81:3-8) Frazer had a curved acromium (a genetic issue), and a curved acromium can cause wear and tear and impingement in the shoulder. That issue pre-existed any alleged incident in the summer of 2009. (C.R. 140 Transcript 81:17 — 82:1) Further, Dr. Ganzhorn acknowledged rotator cuff tears can occur over time and are common in the older population. (C.R. 40 Transcript 82:2-5)

E. Frazer's symptoms significantly worsened by August 31, 2010, and on October 22, 2010, he had surgery conducted by Dr. Richard Ganzhorn.

[57] Dr. Ganzhorn wrote a letter on June 7, 2009, indicating he had been treating Frazer since May 17, 2010, for his right shoulder and stating for the record that Frazer was unable to perform the duties of a trucker at the time. (C.R. 78) Although Frazer was fully abducting his arm to 165° in December, by June he could only abduct it to 90°. Thus, in the time between December 3, 2009, and when Dr. Ganzhorn wrote a letter some six months later, Frazer's condition had worsened.

[58] Dr. Ganzhorn wrote another "To Whom It May Concern" letter on August 31, 2009. (C.R. 95) He stated Frazer sustained a significant rotator cuff tear of his right shoulder and could only abduct his arm up to 90°. Dr. Ganzhorn stated that "[w]ithout surgical correction of his rotator cuff tear and anterior acromial impingement syndrome, he will not . . . return to gainful employment." (C.R. 95) Remarkably, despite the objective evidence, and in direct contrast to his testimony in his deposition, Dr. Ganzhorn stated that Frazer's injuries "were the result of a work-related injury on 07/11/08 and not the result of any pre-existing conditions." (C.R. 95)

[59] Dr. Ganzhorn conducted surgery on Frazer on October 22, 2010. (C.R. 95a-95b) He found extensive synovitis, which he testified is a painful condition, and he removed the synovium. (C.R. 95a and C.R. 141 Transcript 85:13 — 86:8) He also found the labrum (a "rubber washer" in the shoulder joint) had some tearing, and he smoothed out that part of the joint. (C.R. 95a and C.R. 141 Transcript 86:9-21) Labrum tearing can also cause a dull, throbbing ache in the joint. (C.R. 141 Transcript 86:25 — 87:6)

[60] Then Dr. Ganzhorn did a Neer-Mumford procedure. (C.R. 95a) Essentially, this procedure involved drilling off part of Frazer's acromium and then also doing the same to part of Frazer's clavicle, so that the two bones would no longer touch each other and rub up against each other. (C.R. 141 Transcript 87:12-23) This procedure was done to relieve the impingement problem Frazer had in his shoulder. (C.R. 141) Dr. Ganzhorn testified this could be considered both a degenerative and a genetic issue that he resolved. (C.R. 142 Transcript 88:2-5)

[61] Dr. Ganzhorn then completely removed Frazer's bursa, because it too, was inflamed. (C.R. 95a and 142 Transcript 88:6-18) Dr. Ganzhorn explained that the impingement around that area caused the bursitis. (C.R. 142 Transcript 88:19-25)

[62] Then, Dr. Ganzhorn found a 3-centimeter (more than one inch) full-thickness tear. Dr. Ganzhorn testified regarding the tear as follows:

> Q. Okay. Could the various chronic and degenerative issues that Mr. Frazer had, you know, the tendinopathy, the impingement, the acromion spur, the curved acromion, could they have contributed to the fraying and tearing of the muscle over time?
> A. Yes.
> Q. Okay. And could the shoulder have been painful because of the impingement and the chronic and degenerative issues?
> A. You mean after his accident or --
> Q. At any time.
> A. Right.
> Q. Okay. And, in fact, you know, he might have been walking around with some of these issues and not had any pain for a while because sometimes people have these issues and they're asymptomatic; correct?
> A. Correct.
> Q. Something triggered and he ended up with pain after that accident, right?
> A. Well, the accident triggered his condition. Correct.
> Q. Okay. So as a clinical matter, could [Frazer] have developed from a partial tear to a complete tear in the 12 months prior to the time you did surgery?
> A. Oh, anything's possible.

(C.R. 142 Transcript 89:6 — 90:8)

[63] At the end of his deposition, after the attorneys had completed their questioning, and without any explanation based on objective medical evidence or any explanation of how his conclusion could be accorded with his prior testimony, Dr. Ganzhorn stated he believes "it's pretty clear cut that [Frazer] had an accident and he got a cuff tear." (C.R. 143)

F. <u>Dr. Gregory Peterson concludes, based on the objective evidence Frazer's condition was not substantially worsened</u>.

[64] Dr. Gregory Peterson, a specialist in physical medicine and rehabilitation, reviewed the medical records in this case. (H.T. 118:19-20). Dr. Peterson completed his residency in this area of specialty at Mayo in 1986, and he has been practicing medicine in that area for 23 years. (H.T. 119:4-17). Dr. Peterson's initial opinion, dated January 9, 2010, based on records medical records through that date (H.T. 137:12-16), was as follows:

> 1. The objective findings are primarily those of right shoulder impingement associated with AC joint and glenohumeral joint degenerative arthritis.
> 2. Based on the records, it appears likely that Mr. Frazer's pre-existing cervical spine condition contributes to his symptoms to at least some degree.
> 3. The contemporaneous notes indicate no clear causal relationship between Mr. Frazer's shoulder condition and an alleged work injury.
> 4. There are no objective findings specifically attributed to a work incident on or about 7/11/09.
> 5. Dr. Vermeulen's 11/3/09 report clearly outlines the relationship of Mr. Frazer's condition to age related changes and outlines reasons for the unclear relationship of Mr. Frazer's condition to a work injury. (C.R. 28)

[65] Dr. Peterson explained his opinion at the hearing. "I thinks it's kind of broadly understood as a degenerative condition of [Frazer's] rotator cuff, or the structures that

surround the rotator cuff, and that the degenerative condition caused the irritation of his rotator cuff (H.T. 120:9-13) He further explained an impingement is a result of irritation of the rotator cuff, "[a]nd an incident, unless fairly significant, would not substantially change that." (H.T. 121:21-25) The degenerative changes were evidenced on the x-rays and in subsequent evaluations. (H.T. 122:12-14) Dr. Peterson explained these changes are what you would see as a result of "long-term, gradually-developing degenerative process" in the rotator cuff and its surrounding structures. (H.T. 122:14-17) The nature of these conditions are rarely substantially aggravated by a specific incident, and it would take "a pretty good-sized work incident, with more significant objective findings at the outset. . . and findings or symptoms that persist as a result of the work injury." (H.T. 122:18-25) Here, as shown above, that objective evidence was lacking.

[66] When asked about what the pre-existing condition was, Dr. Peterson highlighted three aspects of Frazer's condition. (H.T. 123:5-125:5) First, Dr. Peterson explained Frazer had "degenerative rotator cuff disease," which involves the rotator cuff wearing out. Essentially, the tendons in the rotator cuff develop microscopic tears over time. Second, Dr. Peterson explained Frazer had impingement syndrome, which describes a collection of symptoms that result from the irritation or pinching of the rotator cuff. Dr. Peterson explained that Frazer has pre-existing conditions that could increase the likelihood of developing this impingement syndrome, including arthritis in the AC Joint and a down-sloping acromion, which was a genetic issue that can worsen with age. Third, besides his arthritis in the AC joint, Frazer had arthritis around the glenohumeral joint. All of these conditions pre-existed the alleged work injury. (H.T. 123:5 — 125:5)

[67] Dr. Peterson also concluded that if we assume Frazer was injured at work, that injury did not substantially accelerate or worsen Frazer's condition. (H.T. 126:1-11) He explained degenerative tears of the rotator cuff are common conditions in people of Frazer's age, and many of those people have no complaints of shoulder pain. In regard, people who have a rotator cuff issue on one shoulder have a 35% likelihood of having an asymptomatic rotator cuff issue on the other shoulder. (H.T. 126:13 — 127:2) Further, the primary factors causing the development of impingement syndrome and degenerative changes, including a rotator cuff tear, are independent of any injury. This condition involves a gradual process. (H.T. 127:3-10)

[68] Notably, in reaching his opinion, Dr. Peterson gave Frazer the benefit of the doubt as to the mechanism of injury. (H.T. 138:7-23) Even accepting Frazer's rendition of what happened, Dr. Peterson concluded that because Frazer's symptoms seemed to improve in the fall of 2009, and then Frazer went a long time with no medical attention, the evidence did not support his claim. Further, Dr. Peterson noted that if a person sustained an acute one-inch rotator cuff tear, he would not be **capable** of continuing to work. (H.T. 140:17-22; 141:17-21) With that sort of injury, the person would not do "pretty well for a while and then not so well and pretty well and not so well." (H.T. 140:24-141:2)

[69] Dr. Peterson essentially found that while the alleged incident might have triggered pain, the condition itself was not caused or substantially worsened by the alleged incident. (H.T. 127:11-25; C.R. 28; and C.R 28b).

[70] Dr. Peterson also testified in reference to a report regarding the findings of the April 8, 2009, MRI. (H.T. 155:13-18) Dr. Peterson explained the report. He noted chronic changes of the AC joint with some osteophyes (bone spurs) and curving of the acromium

(which is a factor causing impingement and tearing). (H.T. 146:3-17) He also explained that there was no labral tear noted. (H.T. 146:19-147:1) Dr. Peterson further explained the subchondral cystic changes noted on the MRI at the greater tuberosity indicated changes inside of Frazer's bone, a result of degeneration. Such changes are "a sign of a long-standing gradually-developing degenerative condition." (H.T. 147:17-18)

[71] Dr. Peterson then noted the MRI indicated "no evidence of a full thickness tear of the rotator cuff, but the attachment points are somewhat thin." When asked to explain the significance of the "somewhat thin" attachment points, he stated: "It's a process of attenuation or wearing away of the rotator cuff as a result of the degeneration of the — of the tendonous structure as well as the impingement on that structure." (H.T. 147:25-148:3)

[72] Dr. Peterson also noted the MRI showed Frazer had bursitis (a result of impingement), which can be painful. Finally, Dr. Peterson explained the note regarding tears of the supraspinatus and infraspinatus tendons. He said this tearing typically means there is some wearing of the surface of those tendons, without a complete tear through them. (Hearing Tr. 148:25 — 148:8) Importantly, he explained: "[T]hose kinds of changes are not going to occur as a result of acute trauma, because it's a gradual process. And a gradual process does not allow for thinning of the tendon or attenuation of the tendon. Trauma results in, you know, acute tear." (H.T. 149:9-16)

[73] When asked to explain the difference in an acute tear and a degenerative tear, he further explained: "A tear would cause — to a relative healthy tendon, could cause some changes around the edges of the tear. If it was through the entire tendon, then that would cause bone structures to migrate and cause accelerated degenerative tears. But that's not

the kind of situation we have based on the physical examinations or the MRI report. (H.T. 150:25 — 15 1:6)

[74] Based on his review of the medical notes regarding the MRI and what Dr. Ganzhorn found almost six months later when he performed surgery on Frazer's rotator cuff, Dr. Peterson concluded something happened with Frazer's shoulder between the time of the MRI (April 8, 2010) and the surgery (October 22, 2009). (H.T. 155:9-12)

[75] Sometime after the hearing, Dr. Peterson had an opportunity to review the actual MRI image, as well as the radiologist's report regarding the MRI. He noted findings of impingement, AC joint osteoarthritis, a curved acromion, and partial thickness disruption of the rotator cuff "There was no clear evidence of a full thickness rotator cuff tear in this study performed with intra-articular gadolinium injection." (C.R. 28). Based on the full record of medical evidence, Dr. Peterson stated, "[T]he medical evidence strongly indicates that the full thickness tear of the rotator cuff occurred long after Mr. Frazer's 7/11/09 work injury." Id. (response to question 1). He further explained, "The fact that Dr. Ganzhorn identified a 'large rotator cuff tear,' 'full thickness in nature' at the time of Mr. Frazer's 10/22/10 shoulder surgery strongly demonstrates that the full thickness tear occurred between [the] 4/8/10 shoulder MRI and the time of Mr. Frazer's 10/22/10 surgery." (C.R. 28a) The pain in Mr. Frazer's shoulder was caused by 'impingement syndrome," a general term for describing shoulder pain caused by pinching or irritation of an inflamed part of a rotator cuff tendon. (C.R. 28b) "Impingement syndrome is also multifactorial and related to the factors that increase the likelihood of rotator cuff tears." Id. Impingement syndrome can be present with or without the presence of a rotator cuff tear." Id.

[76] Dr. Peterson concluded: "I believe that Mr. Frazer's alleged 7/11/09 work injury triggered symptoms in his shoulder without substantially accelerating or worsening his pre-existing impingement syndrome and degenerative changes. My reasoning is outlined in my initial 1/9/10 medical review on page 28 of the hearing exhibits. The additional materials I have reviewed since the hearing (see above) provide clear evidence that any significant rotator cuff tear took place long after the work injury. Mr. Frazer's objective medical evidence demonstrates that his 7/11/09 work injury triggered symptoms in his pre-existing shoulder condition. His symptoms improved and he continued to experience variable shoulder symptoms associated with his pre-existing condition. There is no objective medical evidence that the 7/11/09 [incident] resulted in lasting significant change in his pre-existing shoulder condition." Id.

LAW AND ARGUMENT

I. BURDEN OF PROOF AND SCOPE OF REVIEW ON APPEAL

[77] Frazer bears the burden of establishing his right to benefits from the Workers Compensation Fund. Unser v. North Dakota Workers Compensation Bureau, 1999 ND 129 ¶ 22, 598 N.W.2d 89; N.D.C.C. § 65-01-11. This burden requires proof by a preponderance of the evidence that Frazer is entitled to benefits. Reynolds v. North Dakota Workmen's Compensation Bureau, 328 N.W.2d 247 (N.D. 1982); Howes v. North Dakota Workers Compensation Bureau, 429 N.W.2d 730 (N.D. Ct. App. 1988). To carry this burden, Frazer must prove that the medical condition for which benefits are sought is causally related to a work injury. Manske v. Workforce Safety & Ins., 2008 ND 79, ¶ 9, 748 N.W.2d 394.

[78] When an administrative agency requests designation of an administrative law judge from the Office of Administrative Hearings to issue a final decision, judicial review of the ALJ's factual findings is the same as used for agency decisions. Workforce Safety & Insurance v. Auck, 2010 ND 126, ¶ 9, 785 N.W.2d 186; North Dakota Securities Commissioner v. Juran and Moody, Inc., 2000 ND 136 ¶ 27, 613 N.W.2d 503. This is a limited, deferential standard of review. Auck, 2010 ND 126, ¶ 9, 785 N.W.2d 186; Bruder v. Workforce Safety and Insurance, 2009 ND 23, ¶ 6, 761 N.W.2d 588. WSI's decision must be affirmed unless its "findings of fact are not supported by a preponderance of the evidence, its conclusions of law are not supported by its findings of fact, its decision is not supported by its conclusions of law, or its decision is not in accordance with the law." Feist v. North Dakota Workers Compensation Bureau, 1997 ND 177 ¶ 8, 569 N.W.2d 1, 3-4 (N.D. 1997).

[79] The Court must also exercise restraint in determining whether WSI's decision is supported by a preponderance of the evidence and should not make independent findings of fact or substitute its judgment for that of the agency. Bruder, 2009 ND 23, ¶ 7, 671 N.W.2d at 790; Hopfauf v. North Dakota Workers Compensation Bureau, 1998 ND 40, 575 N.W.2d 436 (N.D. 1988); Lucier v. North Dakota Workers Compensation Bureau, 556 N.W.2d 56, 69 (N.D. 1996). In fact, the Court need determine "only whether or not a reasoning mind could have decided the agency's findings were proven by the weight of the evidence from the entire record." Barnes v. Workforce Safety and Insurance, 2003 ND 141, ¶ 9, 668 N.W.2d 290.

[80] In the case of conflicting medical opinions, a factfinder may rely upon either party's expert witness. Swenson v. Workforce Safety and Insurance, 2007 ND 149 ¶ 26,

738 N.W.2d 892. However, the reason for disregarding evidence favorable to the claimant in denying benefits must be explained. Hein v. North Dakota Workers Compensation Bureau, 1999 ND 200 ¶ 14, 601 N.W.2d 576, 578. The explanation for rejecting medical evidence favorable to the claimant may consist of the analysis of why contrary evidence was accepted. Id. ¶ 15. In reviewing the resolution of conflicting medical opinions, this Court must not make independent findings or substitute its judgment for that of the decisionmaker. Id. Although the decision of the ALJ is reviewed by the Court, the District Court's decision is entitled to respect if its reasoning is sound. Lange v. North Dakota Department of Transportation, 2010 ND 201 ¶ 5, 790 N.W.2d 28; Toso v. Workforce Safety and Insurance, 2006 ND 70 ¶ 7, 712 N.W.2d 312.

II. A REASONING MIND COULD DETERMINE THAT FRAZER DID NOT SUSTAIN A COMPENSABLE WORK INJURY.

[81] The dispositive issue on appeal is whether a reasoning mind reasonably could have found that Frazer did not prove by the weight of the evidence that he suffered a compensable injury to his shoulder while lifting a truck hood at work.

[82] Under North Dakota Workers Compensation law, a "[c]ompensable injury" is defined as "an injury by accident arising out of and in the course of hazardous employment which must be established by medical evidence supported by objective medical findings." N.D.C.C. § 65-01-02(10).

[83] However, the term "compensable injury" does not include "[i]njuries attributable to preexisting injury, disease, or other condition, including when the employment acts as a trigger to produce symptoms in the preexisting injury, disease, or other condition unless

the employment substantially accelerates its progress or substantially worsens its severity." N.D.C.C. § 65-01-02(10)(b)(7).

[84] Therefore, under this statute, unless a claimant's employment "substantially accelerates' the progression of, or 'substantially worsens' the severity of, a preexisting injury, disease, or other condition, it is not a 'compensable injury' when the claimant's employment merely acts to trigger symptoms in the preexisting injury, disease, or other condition." Bergum v. N.D. Workforce Safety and Insurance,, 2009 ND 52, ¶ 12, 764 N.W.2d 178.

[85] The legislative history to N.D.C.C. § 65-01-02(10)(b)(7) is also instructive when reviewing this statute. This legislative history states: "A workplace incident that is only "the straw that broke the camel's back" is not considered a work injury. For example, if a worker has a degenerative condition that is getting progressively worse, and it so happens that the condition takes a turn for the worse at work, that will not be compensable…" See Hearing on H.B. 1269 Before House Industry, Business and Labor Committee, 55th N.D. Legis. Sess. (February 5, 1997)(prepared testimony of Reagan Pufall).

[86] In this case ALJ Bailey found the work incident was not a substantial contributing factor to Frazer's right shoulder condition. (App. 124) ALJ Bailey explained the greater weight of the evidence does not establish Frazer's employment substantially accelerated the progression or substantially worsened the severity of his pre-existing right shoulder condition. Id. In this regard, ALJ Bailey stated: "At most, the work incident of July 11, 2009, acted as a trigger to produce irritation and symptoms of pain and discomfort in Frazer's pre-existing right shoulder condition." Id.

[87] When taking into consideration the law cited above and the facts of this case, it is clear ALJ Bailey could reasonably have found as she did. In fact, the record is replete with evidence that: A) Frazer had a pre-existing condition; and B) Frazer's pre-existing condition was not substantially accelerated or substantially worsened by a work injury.

[88] In regard to whether there was a pre-existing condition, several treating doctors, based on objective clinical testing, diagnosed Frazer's shoulder as involving a pre-existing degenerative condition, encompassing rotator cuff pathology, impingement syndrome, and arthritic conditions. (C.R. 70-71) (Dr. Mehta diagnosing tendonitis and osteoarthritis on July 16, 2009, based on clinical testing and impingement syndrome on August 2, 2009, based on x-ray) (C.R. 59, 61, 64) (Dr. Vermeulen diagnosing rotator cuff syndrome involving age-acquired bone spur near the AC joint, based on x-ray and clinical testing) (C.R. 89) (Dr. Santino diagnosing degenerative arthritis, based on clinical testing and MRI). In other words, several treating doctors found a pre-existing condition that was progressing because of impingement and bone spurs.

[89] These are just a few examples evidencing a pre-existing condition. For a more complete and detailed explanation the Court can look to ALJ Bailey's Findings. (App. 108-114) Perhaps it was best stated by ALJ Bailey when she said: "There is considerable evidence of record establishing that Frazer had pre-existing right shoulder conditions including right shoulder impingement associated with acromioclavicular (AC) joint and glenohumeral joint degenerative arthritis. Either Frazer does not understand the objective medical findings of the pre-existing degenerative changes in his right shoulder, or ignores those findings." (App. 108) Simply put, there is no question Frazer had a pre-existing condition.

[90] In regard to whether there was a "substantial acceleration" or a "substantial worsening" of Frazer's condition, the record is as rife. In this regard, the objective medical evidence not only shows that Frazer didn't have a full thickness rotator cuff tear at the time of the work incident, it shows he improved at nearly every doctor's appointment he had until December 3, 2009!

[91] Two treating doctors, both physical medicine and rehabilitation specialists, found the clinical testing indicated Claimant did not have a full thickness tear in his rotator cuff at the time they saw him. These treating doctors both noted Claimant's strength and power to abduct his arm was inconsistent with a full thickness rotator cuff tear. (CR 58 – Dr. Vermeulen and 94 –Dr. Santino) Although Dr. Ganzhorn believes this is not an absolute rule, as a matter of medical probability, he agrees that if a patient has good power in abduction and external rotation, the patient does not wholly have a full-thickness tear. (CR 134-135) (Agreeing with Dr. Vermeulen that Frazer did not likely have a full-thickness tear on 10/1/09, because of his ability to abduct his arm). Thus, even Claimant's own expert agrees with this clinical analysis.

[92] Further, the two objective diagnostic images, an x-ray done on 9/22/09 and an MRI arthrogram done on 4/8/10, both indicate Frazer's ailment involved degenerative and congenital issues, including bone spurs, a curved acromium with a significant bone spur on it, impingement of the AC joint, degenerative arthritic changes in the AC joint, and arthritic changes in the glenohumeral joint. Neither the x-ray nor the MRI provided any evidence Frazer had a full thickness tear of his rotator cuff. Indeed, the MRI, which was conducted with a dye injection that would reveal a full thickness tear, specifically ruled out this possibility.

[93] In addition, as Dr. Peterson explained, Frazer's significant improvement in the autumn of 2009 shows Claimant did not have an acute rotator cuff tear. Frazer's improvement in by 12/3/09 as to the Hawkins-Kennedy test and his ability to fully abduct his shoulder are two examples of this improvement. The fact he was able to change a tire in early December and never sought medical care again until almost four months later also supports this conclusion.

[94] As Dr. Ganzhorn acknowledged, an impingement syndrome is a factor that contributes to rotator cuff pathology –the tearing and fraying and inflammation of the bursa joint. (C.R. 126) Hence the thin attachment points noted on the MRI (H.T. 147:19-148:3). Furthermore, according to Dr. Ganzhorn, if that tearing and fraying goes untreated, the patient can eventually develop a full-thickness tear. (C.R. 127) Specifically, the tearing generally and most commonly begins with the supraspinatus and progresses to eventually involve the infraspinatus. (C.R. 127) It was these exact tendons that were found to be frayed and torn in Frazer's shoulder during his surgery in October 2010. (C.R. 142)

[95] Moreover, in the older population, tears to the tendons can result from the accumulation of micro trauma over a lifetime. (C.R. 126) Indeed, Dr. Ganzhorn testified a rotator cuff problem can get worse over time, and Frazer's injury could have changed or developed in the 15 months between the alleged date of injury and when Dr. Ganzhorn did his surgery on Frazer. (C.R. 130)

[96] Frazer makes much of the fact he did not have symptoms prior to July 11, 2009. As Dr. Ganzhorn and Dr. Peterson both explained, however, an impingement syndrome and fraying of the rotator cuff tendons or muscles can be, and actually frequently are

asymptomatic in many people. In fact, a good portion of older individuals unknowingly have rotator cuff conditions, including the fraying of the rotator cuff tendons, and they do not have any symptoms. At some point, as happened here, a trigger causes the symptoms.

[97] Notably, the surgery Dr. Ganzhorn did was a full seven months after the MRI arthrogram, and approximately 15 months after the work place incident. Frazer's condition had degenerated in the last months prior the surgery. For example, while Frazer was able to abduct his arm in the autumn of 2009 and was able to do that without pain by December of 2009, he was not able to abduct his arm beyond 90 degrees by the summer of 2010. (C.R. 64 and 95) Additionally, by the time he had surgery in October, Frazer had developed a one-inch full thickness tear, and Claimant's labrum had developed tearing. Compare (CR 88 with 95a) These were new developments in the time between April and October 2010. They were not caused by any alleged work incident some 15 months earlier.

[98] Furthermore, even if we were to assume Frazer was symptom free prior to the work incident, there is nothing in the plain language of the statute which would indicate that when an asymptomatic condition because symptomatic it satisfies compensability. Indeed, the plain language of the statute reflects that if the employment "acts as a trigger to produce symptoms in the preexisting injury, disease, or other condition" there is no compensable injury. An additional finding is required – that of substantial worsening of the severity or substantial acceleration of that preexisting condition.

[99] There is simply no basis, in case law or statute, for Frazer's argument. When a statute is clear and unambiguous it is improper for the courts to attempt to construe the

provision so as to legislate that which the words of the statute do not themselves provide. Haggard v. Meier, 368 N.W.2d 539 (N.D.1985); Haider v. Montgomery, 423 N.W.2d 494, 495 (N.D. 1988) (emphasis supplied). Accord: State v. Grenz, 437 N.W.2d 851, 853 (N.D. 1989).

[100] Frazer also appears to argue that because WSI did not point out one specific intervening cause for Frazer's medical decline after April of 2010, the full thickness-rotator cuff tear found in October of 2010 must be from the July 2009 work incident. Such reasoning is flawed on at least two different levels. First, a full thickness tear in October of 2010 does not, ipso facto, mean there was a full thickness tear in July of 2009. In fact, the objective medical evidence absolutely refutes it! Second, the record shows Frazer's decline was because of his degenerative condition long after the alleged work incident. As such, even if WSI needed to prove a specific "intervening cause," which is adamantly denied, there was one provided within the record –progression of a pre-existing severe degenerative condition.

[101] Simply put, the overwhelming majority of the medical evidence establishes Frazer had a pre-existing right shoulder condition. While he may have had pain triggered for a while after July 11, 2009, his condition was not substantially accelerated or substantially worsened on that date. Indeed, his ability to do the clinical tests improved each time he saw the doctor throughout the fall of 2009, until he was doing quite well on December 3, 2009. There is simply no causal relationship between his degenerative condition and the work incident –period.

[102] Frazer also argues Dr. Ganzhorn's opinion that "this is a work injury" must be given greater weight than the copious medical evidence, including medical records and testimony, cited above. This argument is flawed on several levels.

[103] First of all, when confronted with a classic "battle of the experts" the ALJ, as fact-finder, may rely upon either party's witness. So long as the ALJ considered the entire record, clarified inconsistencies and adequately explained her reasoning, this Court must accept the ALJ's decision. Stated another way, this Court cannot re-weigh the evidence, but must simply determine whether ALJ Bailey could reasonably conclude as she did. Curran v. Workforce Safety and Insurance, 2010 ND 227, 791 N.W.2d 622 (reversing District Court decision where ALJ considered and explained reasons for rejecting medical evidence favorable to claimant and reasoning mind could reasonably conclude from weight of entire record the ALJ's decision). ALJ Bailey's decision meets this standard and therefore it should be affirmed. Id.

[104] In this regard, she considered and explained the medical record in meticulous detail. In a summary, ALJ Bailey stated: "However to accept Dr. Ganzhorn's opinion carte blanche, then one must ignore the other treating physicians' opinions and other substantial medical evidence based on objective medical findings. Dr. Mehta, the physician who treated immediately following the incident, based on clinical examination, assessed possible tendinitis and osteoarthritis at the outset, and impingement syndrome once the x-rays were reviewed. The next treating physician, Dr. Vermeulen, based on thorough clinical examinations, x-ray report, and MRI, was unequivocal in his opinion that [Claimant] had age related, degenerative processes resulting in rotator cuff syndrome, also referred to as right shoulder impingement associated with AC Joint

degenerative arthritis. Dr. Santino, based on clinical examination, review of other records, and a dye enhanced MRI diagnosed chronic degenerative arthritis. A close review of Dr. Ganzhorn's deposition testimony shows he does not have a major disagreement with the opinions of any of the other treating physicians. Dr. Ganzhorn agrees that Frazer's right shoulder condition 'could be' fully attributable to preexisting conditions; nonetheless, he consistently opines that Frazer's right shoulder condition is fully attributable to the work incident of July 11, 2009." (App. 122)

[105] In addition, ALJ Bailey adequately explained her decision to give Dr. Peterson's opinion more weight. For example, she stated: "Dr. Peterson convincingly integrates and explains the course of Frazer's treatment and the progression of Frazer's condition based on the specific clinical findings and radiologic images and reports." These considerations alone are enough under the law.

[106] This said, ALJ Bailey went on to explain Dr. Ganzhorn's inconsistencies deterred her from giving his opinion more weight. As this Court has stated: "[i]nconsistencies in a medical expert's opinions may be considered by [the ALJ] in assessing the credibility of medical evidence." Swenson v. Workforce Safety and Insurance, 2009 ND 97 ¶ 13, 775 N.W.2d 700; Reynolds v. North Dakota Workmen's Compensation Bureau, 328 N.W.2d 247, 251 (N.D. 1982)(giving deference to WSI ability to weigh credibility of testimony and evidence in light of inconsistencies and affirming WSI decision).

[107] ALJ Bailey noted Dr. Ganzhorn inconsistently stated Frazer's injuries to his right shoulder were unrelated to any pre-existing condition, yet, acknowledged that "it is more likely than not that Frazer's work activities as described were a substantial (not trivial)

contributing factor to any pre-existing condition." As a result, ALJ Bailey felt his testimony was less credible.

[108] Simply put, ALJ Bailey's findings go above and beyond what is required by the law and therefore, her decision must be affirmed.

[109] This said, even if we were to assume this appeal is a de novo review, which is adamantly denied, Frazer would still lose under North Dakota Century Code 65-05-08.3.

[110] As can be seen by this statute, a treating doctor's opinion is not per se accepted as the "controlling" opinion. And, rightfully so. North Dakota Century Code Section 65-05-08.3 imports certain factors to make sure WSI can use the most credible and medically acceptable opinions. If such "safe guards" were not in place, a person such as Frazer could simply keep moving from doctor to doctor until he found a favorable opinion and then proclaim to the Court: "This opinion must be given controlling weight!"

[111] In the case at hand, several of the above-cited factors precluded ALJ Bailey from giving Dr. Ganzhorn's opinion controlling weight. For example, his opinion basically contradicts every other doctor's opinion and the medical evidence cited above. As such, under factor "c" it is easy to say there is little to no evidence supporting his opinion. Furthermore, it is clear, based on his unsupported statements, Dr. Ganzhorn was engaging in patient advocacy. Indeed, ALJ Bailey noted such blind and inexplicable advocacy hurt Dr. Ganzhorn's credibility. (App. 123 Dr. Ganzhorn's resistance to specifically acknowledge the preexistence of Claimant's right shoulder impingement and degenerative arthritis made his opinion "come out as primarily patient advocacy.").

[112] Medical opinions have been disregarded in similar situations in the past. For example, in Bruder, the North Dakota Supreme Court reinstated WSI's denial of benefits

where "neither opinion [of the two medical providers] discloses or addresses the underlying facts or data supporting the opinion." Bruder v. North Dakota Workforce Safety & Ins., 761 N.W.2d at 593. The medical providers' opinions were not credited by WSI because one medical provider "did not address the relationship between [the claimant's] degenerative disc disease and his work activities." Id. at 592. Similarly, the opinion of the other medical provider was determined to be "not helpful" because it was "based on [the claimant's] complaints and [the medical provider] offers no explanation or foundation for his opinion." Id. at 592. This Court determined denial of benefits was appropriate. Id. at 593.

[113] Like in Bruder, Dr. Ganzhorn did not address or explain the relationship between the pre-existing condition and his work injury. ALJ Bailey addressed this in another portion of her Order as well: "his failure or inability to adequately address (a) other provider's earlier clinical observations and radiologic images, and (b) the fact that [Frazer's] condition improved and then worsened again subsequent to the date of the work injury, makes his opinion even less persuasive." (App. 123)

[114] Contrary to the plain language of the statute, Frazer also appears to argue WSI has a "presumption" to overcome under this statute. This is simply wrong. Indeed, North Dakota Century Code Section 65-05-08.3 does **not** create a "presumption," but rather codifies prior case law which refused to establish a presumption that a treating physician's opinion is entitled to greater weight. See House Bill No. 1562; see also Swenson v. Workforce Safety and Insurance, 2007 ND 149, ¶ 27; Symington v. North Dakota Workers Compensation Bureau, 545 N.W.2d 806, 809-10 (N.D. 1996); Myhre v. North Dakota Workers Compensation Bureau, 2002 ND 186 ¶ 24, 653 N.W.2d 705;

Boger v. North Dakota Workers Compensation Bureau, 1999 ND 192 ¶ 16, 600 N.W.2d 877. As such, Frazer's argument must be disregarded.

[115] Overall, it is clear ALJ Bailey could have reasonably concluded as she did.

CONCLUSION

[116] For the foregoing reasons, Appellee respectfully requests that this Court *affirm* the District Court's Order dated February 13, 2012, Order for Judgment Dated March 16, 2012, and Judgment Entered March 16, 2012.

Respectfully submitted this 14th day of June, 2012.

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CERTIFICATE OF COMPLIANCE

The undersigned, as the attorney representing Appellee, North Dakota Workforce Safety & Insurance, and the author the Brief of Appellee, hereby certifies that said brief complies with Rule 32(a)(7)(A) of the North Dakota Rules of Appellate Procedure, in that it contains 10,096 words from the portion of the brief entitled "Statement of the Case" through the signature block. This word count was done with the assistance of the undersigned's computer system, which also counts abbreviations as words.

Dated this 14th day of June, 2012.

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