IN THE SUPREME COURT OF TENNESSEE
SPECIAL WORKERS' COMPENSATION APPEALS PANEL
AT NASHVILLE
November 28, 2011 Session

**TAMMY L. LEE v. DURA OPERATING CORP., ET AL.**

**Appeal from the Circuit Court for Lawrence County**
**No. CC-2240-08 Stella L. Hargrove, Judge**

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**No. M2011-00358-WC-R3-WC - Mailed - December 28, 2011**
**January 30, 2012**

Pursuant to Tennessee Supreme Court Rule 51, this workers' compensation 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. Tammy L. Lee ("Employee") alleges that she suffered an injury to her cervical spine while she was employed as a factory worker by Dura Operating Corporation ("Employer")[1]. Employer denies that Employee's cervical spine injury was caused by her employment with Employer. The trial court determined that Employee's cervical spine condition was a work-related aggravation of her pre-existing degenerative disc disease. The trial court awarded Employee temporary total benefits from November 8, 2007, to February 8, 2008. Finding that Employee had not been able to return to work, the trial court refused to apply the statutory cap and awarded Employee permanent partial disability benefits of 69% to the body as a whole, three times her anatomical impairment rating of 23% to the body as a whole. Finding that the evidence preponderates against the trial court's determination of causation, we reverse the trial court's judgment.

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

D. J. ALISSANDRATOS, SP. J., delivered the opinion of the court, in which CORNELIA A. CLARK, C. J. and WALTER C. KURTZ, SR. J., joined.

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[1]It appears that Employee was originally employed by defendant Excel whose name had been changed to Dura by the time of the alleged injury. It is unclear whether Employee was employed by defendant Dura Automotive Systems, Inc. or defendant Dura Operating Corp. at the time of the alleged injury as the parties simply refer to Employer as "Dura."

Ben Boston and Ryan P. Durham, Lawrenceburg, Tennessee, for the appellants Dura Operating Corporation, et al.

Richard T. Mathews, Columbia, Tennessee; Wayne Hairrell, Lawrenceburg, Tennessee (trial) for the appellee, Tammy L. Lee.

## MEMORANDUM OPINION

### Factual and Procedural Background

At the time of the trial in this case, Employee was forty-one years old, married, and had two children. Employee had a twelfth-grade education. Following high school, she worked briefly as a cashier before beginning work for Employer in 1990 as a production employee.

In August 2006, Employee had been working for approximately thirty days in a position which required that each day she lift, pick up, flip, and box 150 to 200 windows weighing twenty-five-to-thirty pounds each. In her pre-trial deposition and at trial, Employee testified that on August 6, 2006, she felt what she described as a crick and pain in her neck. Although Employee had previously experienced neck pain, she testified that the pain on this date was different, though she did not elaborate. According to Employee, she assumed that this pain was caused by repetitive motion at work, and she treated it herself with heat and over-the-counter pain medication. Despite this treatment, Employee testified that the pain continued without improvement, so she reported her condition to Employer approximately one week later.[2]

Employee was furnished a panel of physicians and selected Dr. Couch in Mount Pleasant, Tennessee. According to Employee,[3] she gave Dr. Couch her history. Employee testified in her deposition and at trial that she never told any of her treating physicians, presumably including Dr. Couch, that she had suffered a specific incident or work-related injury, but rather simply reported that she had begun to experience more pain than she had previously experienced. Employee testified in her deposition that she had not suffered neck

[2]Certain of Employee's medical records reflect that she first reported her condition on August 21, 2006. However, the Tennessee Department of Labor Employee Choice of Physician form that Employee signed on August 16, 2006, indicates the date of injury as August 14, 2006.

[3]Dr. Couch's records are not in the record on appeal; nor does the record contain any deposition or trial testimony from him.

pain for six months to a year before she saw Dr. Couch for the pain which began in August 2006.

Dr. Couch returned Employee to light duty work and treated her conservatively between August and October 2006, prescribing physical therapy, steroids, pain medication, and muscle relaxants. Dr. Couch ordered an MRI of Employee's cervical spine in October 2006, which was reported as a negative examination of the cervical spinal cord and negative for intervertebral herniations or nerve root compressions.

However, Dr. Couch referred Employee to an orthopaedist, and she was provided a panel from which she selected Dr. Daniel S. Burrus in Nashville. Employee saw Dr. Burrus on one occasion, on October 25, 2006. According to Dr. Burrus' office note from this visit, Employee explained that over the previous year or so she had difficulty with back and neck pain; that in August 2006, the pain worsened to the point that she reported it to her employer; that her symptoms tended to wax and wane to a certain extent; that she had no significant long-term neck or back problems prior to the last year or so; and that she had not described a specific work event or injury that resulted in the onset of her symptoms. Again, Employee likewise testified in both her deposition and at trial that she never told any of her treating physicians, including Dr. Burrus, that she had suffered a specific incident or injury at work. Dr. Burrus described Employee's symptoms as "somewhat vague," and noted the lack of objective findings on her MRI, on x-rays of her cervical spine, which he had ordered and reviewed, and on physical examination. According to his note, Dr. Burrus discussed with Employee that her condition appeared to be more myofascial-type symptoms and that he saw nothing which would cause him to recommend surgical intervention.[4] Dr. Burrus returned Employee to full duty with no restrictions.

Dissatisfied with Dr. Burrus, Employee requested a second opinion. Employee selected Dr. Thomas J. O'Brien and saw him for the first time on November 29, 2006. On the patient intake form Employee described the purpose of her visit as an August 21, 2006 on-the-job injury. However, on the patient history portion of the form, Employee described her symptoms as neck pain running through her shoulders, recurrent "catches" in her neck, and lower back pain running down her legs and "catches." Employee wrote "Years," in response to the question "When/how did your symptoms start?"

Dr. O'Brien testified by deposition that Employee gave no history of a specific work event or injury precipitating her symptoms. Again, this is consistent with Employee's deposition and trial testimony. Dr. O'Brien performed an examination and, except for some

[4] "Myofascial pain syndrome is a chronic form of muscle pain." http://www.mayoclinic.com/health/myofascial-pain-syndrome/DS01042 (last visited December 12, 2011).

subjective tenderness, the results were normal for Employee's neck and back. Her neurological examination also was normal. Dr. O'Brien reviewed Employee's previous x-rays and MRI films and determined that these too were normal, except for some mild, age-related degenerative changes in her cervical spine. He observed no herniated disc or nerve compression. Dr. O'Brien concluded that Employee was suffering from mechanical back and neck pain and that her neck pain was the result of age-related degenerative disc disease. According to Dr. O'Brien's note from this visit:

> I went over the natural history of degenerative disc disease. I also discussed work[-]related issues. I told her that this is a degenerative condition as opposed to being a workers' compensation issue and due to a combination of factors including genetics and daily "wear and tear."

Dr. O'Brien also reviewed Employee's films with her and explained that her condition was due to wear and tear and a loss of water content in her cervical disc, resulting in pain. He attributed the pain to a degenerative process and opined that Employee was not a surgical candidate. Dr. O'Brien agreed with Dr. Burrus that surgery was not warranted and that Employee was under no restrictions and could undertake any activities, including work, without risk of injury to her cervical spine. Like Dr. Burrus, Dr. O'Brien released Employee with no restrictions, directing her to follow up on an as-needed basis. Employee testified consistently at trial regarding her discussion with Dr. O'Brien.

Employee returned to Dr. O'Brien on April 18, 2007, with ongoing complaints of back and neck pain. Dr. O'Brien performed an examination from which he concluded that Employee's condition was unchanged from November 2006. He again reviewed his diagnosis of degenerative disc disease with Employee. As he explained in his deposition testimony, Dr. O'Brien concluded that Employee's condition was not work-related; rather, it was a degenerative condition. Employee suffered from very mild degenerative disc disease in her neck and likely in her back. Her symptoms represented a manifestation of progressive degenerative disease not caused by her work activities. Her work did not aggravate her pre-existing condition. Dr. O'Brien discussed with Employee the natural history of her condition, gave her a trial cortisone injection, and again returned her to full duty work with instructions to follow-up on an as needed basis.

Employee disagreed with Dr. O'Brien, so she went to her family physician, who referred Employee to a neurosurgeon, Dr. Scott Standard. Dr. Standard saw Employee for the first time on May 9, 2007. On her "New Patient Medical Questionnaire," Employee listed her chief complaint as neck pain and numbness, lower back pain, and numbness in her legs. In response to the question of whether she had experienced this problem before,

Employee responded "yes," and in response to the question of how long, she responded "(10 years)." Employee further indicated that she had been injured at work, and answered a question about the date of her injury with "reported 8-21-06."

Under a section for patient history, Dr. Standard's office note for the May 9, 2007 visit states: "This is a work injury which she reported . . . . This was on 8/21/06." Similarly, Dr. Standard testified in his deposition that Employee had reported to him that she had a specific injury on August 21, 2006, which she had reported to Employer. According to Dr. Standard, Employee reported this on the initial intake form, and she also mentioned having a ten-year history of this same type of problem. Dr. Standard had no other information about the specific injury. As previously noted, however, Employee testified both in her deposition and at trial that she never described to any of her treating physicians a specific work incident or injury. She testified unequivocally in her deposition that if any of her physicians had recorded the contrary in his notes, he was simply wrong in what he had recorded.

Dr. Standard reviewed Employee's October 2006 MRI on May 9, 2007, and observed no acute disc bulge or rupture. His impression at that time was symptomatic cervical radiculopathy. He ordered a series of epidural injections and physical therapy, with Employee to follow up in four-to-six weeks.

Employee continued to follow up with Dr. Standard's office approximately every four weeks. During this time, Dr. Standard placed work restrictions on Employee and she received epidural injections and physical therapy. Dr. Standard saw Employee on September 12, 2007, at which time he noted that epidural injections had not been successful and that she was experiencing a good deal of low back pain and right extremity radiculopathy, but that she was still working. Dr. Standard also noted: "She continues to claim that this is a worker's comp injury but really no specific anatomical abnormality has been identified." Nonetheless, Dr. Standard ordered an MRI of Employee's cervical and lumbar spine, which was performed on September 18, 2007, and which revealed a moderate disc at C4-5 with kyphosis.[5] According to Dr. Standard, this condition was eccentric to the left and probably accounted for Employee's symptoms. He planned to offer her an anterior cervical discectomy and fusion at C4-5. Dr. Standard opined that Employee's lumbar MRI was not impressive, demonstrating only mild disc degeneration at L4-5.

[5]"'Kyphosis'" is a curving of the spine that causes a bowing or rounding of the back, which leads to a hunchback or slouching posture." http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002220/ (last visited December 12, 2011).

Dr. Standard saw Employee on October 17, 2007, and discussed surgery with her. He noted at this time that "[s]he continues to complain of this as a work-related injury which occurred ten years ago when she reported to worker's comp. Due to the remote nature of this injury it is difficult to relate this entirely but she does consistently report that this was the initial onset of her pain and symptoms." The surgery was scheduled for November 8, 2007, and Dr. Standard took Employee off work for the three weeks leading up to her surgery.

On November 8, 2007, Dr. Standard performed an anterior cervical discectomy and fusion on Employee. Employee remained off work and continued to follow up with Dr. Standard's office through February 8, 2008. At that time, Dr. Standard indicated that Employee's x-rays looked good and that the surgery had been successful. He released her to return to work the following Monday with no restrictions, with directions to return to him on a symptomatic basis.

In February 2008, Employee returned to her prior position at Employer with no restrictions and at her same wage. Employee testified in her deposition that she was able to perform her job, was a good employee, and met the job requirements. According to Employee's deposition testimony, after the surgery and her return to work for Employer, her pain was less than before the surgery; the surgery made most of the pain go away. However, at trial, Employee testified that, although she performed her job when she returned to work for Employer after surgery, she had continued to experience pain, which she treated with heat and over-the-counter pain medication. Employee did not seek medical treatment from Dr. Standard or any other physician or take any prescription medications for her neck pain during this time.

On November 13, 2008, Employee was temporarily laid off by Employer as part of a facility-wide layoff. Approximately one month later, in December 2008, Employee went to work full time as a receptionist for a physician in Pulaski, Tennessee at a lower wage. Employee had no difficulty performing her duties as a receptionist.

Employer subsequently called Employee to return to work following the temporary layoff, with April 7, 2009, the expected date of return. However, Employee felt that she could not return to her former job with Employer or to factory work. She therefore did not return to work for Employer at that time and scheduled an appointment with Dr. Standard for May 6, 2009. Employee had not seen or called Dr. Standard prior to this time since her February 2008 release and return to work. At her May 4, 2009 deposition, Employee testified that she did not believe that she could perform factory work any longer, regardless of what Dr. Standard might say at her appointment two days later.

Dr. Standard's office note for Employee's May 6, 2009 visit indicates that Employee returned for followup and states that Employee "is not able to return to factory work, secondary to lifting restriction and no overhead work. She is getting along pretty well as a secretary. I will see her back as needed." While Dr. Standard initially testified that restrictions on lifting and overhead work were placed on Employee at the May 6, 2009 visit, he later testified that the restrictions possibly had been placed on Employee at an earlier time, between her February 2008 release and her May 6, 2009 visit. However, nothing concerning restrictions appeared in her chart, and Dr. Standard could recall no specific conversations with Employee about restrictions.[6] Dr. Standard acknowledged that he could not recall whether Employee was under any restrictions when she came to see him on May 6, 2009. Further, according to Dr. Standard, at the May 6, 2009 visit, he was under the impression that Employee had not gone back to her job at Employer and that she had been working another job. Dr. Standard simply discussed with Employee what he thought would be proper activities for her based on her symptoms. He did not know when or why those symptoms arose. Dr. Standard acknowledged that if Employee had returned to her former job in February 2008 without restrictions and had performed that job for more than six months, her doing so would indicate that she was under no restrictions during that time.

In June 2010, Employee lost her receptionist job when the physician for whom she had begun working in December 2008 moved. Employee attempted to work for another physician but, according to Employee, she was unable to perform the job because it required her to lift files overhead. Employee last worked in October 2010 and was not employed at the time of trial.

At the time of her May 4, 2009 deposition, Employee rated her pain as a level three on a scale of zero-to-ten, with zero being no pain and ten being the most severe pain. Employee testified that prior to her surgery, she would have rated her pain as a level ten, and shortly after surgery, a level seven. Employee testified that her neck pain had improved after her November 2008 layoff and during her employment as a receptionist for the Pulaski physician, but that it had not gone away completely. Her condition had not changed her social life, activities or the things she did with her family. Employee testified that she was at 70% as far as doing what she wanted to do.

At trial in November 2010, Employee rated her pain at a level six, rather than a level three, and she estimated that she was at 50% as far as doing what she wanted to do. Specifically, Employee testified that she had difficulty completing certain household chores.

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[6] And, as noted, Employee testified that she neither spoke with nor saw Dr. Standard between her February 2008 release and this May 6, 2009 visit.

The trial court found Employee to be "a very credible witness." The trial court then summarized Employee's testimony regarding the commencement of her condition as follows: "Plaintiff testified that her injury occurred in August of 2006 when she was repetitively lifting and manipulating windows. She testified that she felt a crick and a different pain in her neck than she had ever experienced." The trial court gave greater weight to the expert medical opinions of Dr. Standard than to those of Dr. O'Brien. The trial court summarized Dr. Standard's opinion as to causation as follows: "Neurosurgeon, Dr. Scott Standard, testified that Plaintiff's cervical condition was an aggravation of her pre-existing degenerative disease and that it was work related." The trial court found that there was a sufficient causal relationship between Employee's work activities and her injury. The trial court awarded Employee temporary total disability benefits for the period three weeks prior to her November 8, 2007 surgery until her February 8, 2008 release by Dr. Standard. The trial court also determined that Employee was not able to return to work for Employer and that the statutory cap, see Tenn. Code Ann. § 50-6-241(d)(1)(A) (2008), therefore, did not apply. The trial court awarded Employee permanent partial disability of 69% to the body as a whole, three times the anatomical impairment rating of 23% assigned by Dr. Standard.

## Standard of Review

The standard of review of issues of fact is *de novo* upon the record of the trial court accompanied by a presumption of correctness of the findings, unless the preponderance of the evidence is otherwise. See Tenn. Code Ann. § 50-6-225(e)(2) (2008). When credibility and weight to be given testimony are involved, considerable deference is given the trial court's factual findings when the trial judge had the opportunity to observe the witness' demeanor and to hear in-court testimony. Madden v. Holland Grp. of Tenn., 277 S.W.3d 896, 900 (Tenn. 2009). When the issues involve expert medical testimony included in the record by deposition, a determination of the weight and credibility of the evidence necessarily must be drawn from the contents of the depositions, and the reviewing court may draw its own conclusions with regard to those issues. Foreman v. Automatic Sys., Inc., 272 S.W.3d 560, 571 (Tenn. 2008). A trial court's conclusions of law are reviewed *de novo* upon the record with no presumption of correctness. Seiber v. Reeves Logging, 284 S.W.3d 294, 298 (Tenn. 2009).

## Analysis

### *Causation*

An employee bears the burden of proving each element of her cause of action in a workers' compensation case. Elmore v. Travelers Ins. Co., 824 S.W.2d 541, 543 (Tenn. 1992). Thus, an employee seeking to recover workers' compensation benefits must prove

both that her injury arose out of and occurred in the course of her employment. Trosper v. Armstrong Wood Products, Inc., 273 S.W.3d 598, 604 (Tenn. 2008). "The phrase 'arising out of' refers to the cause or origin of the injury." Id. "An injury arises out of employment when there is a causal connection between the conditions under which the work is required to be performed and the resulting injury." Id.

Other than in the most obvious cases, causation must be established by expert medical testimony. Id. "'Although absolute certainty is not required for proof of causation, medical proof that the injury was caused in the course of the employee's work must not be speculative or so uncertain regarding the cause of the injury that attributing it to the [employee's] employment would be an arbitrary determination or a mere possibility.'" Foreman, 272 S.W.3d at 572 (quoting Tindall v. Waring Park Ass'n, 725 S.W.2d 935, 937 (Tenn. 1987)). "'If, upon undisputed proof, it is conjectural whether disability resulted from a cause operating within [the employee's] employment, or a cause operating without [her] employment, there can be no award.'" Id. (quoting Tibbals Flooring Co., v. Stanfill, 410 S.W.2d 892, 897 (Tenn. 1967)).

"Although workers' compensation law must be construed liberally in favor of an injured employee, it is the employee's burden to prove causation by a preponderance of the evidence." Crew v. First Source Furniture Grp., 259 S.W.3d 656, 664 (Tenn. 2008). Case law requires a trial court to resolve "reasonable doubt" as to causation in favor of the employee. See, e.g., Phillips v. A&H Constr. Co., 134 S.W.3d 145, 150 (Tenn. 2004). The trial court, however, is not required to ignore discrepancies in the testimony of the employee or other evidence which tends to disprove the employee's claim. In the instant case, even crediting Employee's testimony and that of Dr. Standard, the preponderance of the evidence is contrary to the trial court's finding of causation.

Employee testified repeatedly and consistently that she did not experience a specific incident or injury in August 2006 while working for Employer. She further testified repeatedly, consistently, and unequivocally that she never informed any of her treating physicians, including Dr. Standard, that she had experienced a specific incident or injury at work. Employee's "New Patient Medical Questionnaire," completed at the time of her first visit with Dr. Standard, indicated a ten-year history of neck pain. Under date of injury, Employee listed the date on which she believed that she had first reported her condition to Employer—August 21, 2006.[7] It is apparent from Dr. Standard's records and deposition testimony that he misinterpreted this entry on Employee's form, reading it to mean that Employee had suffered a specific incident or injury on August 21, 2006. Employee had not.

[7] As noted, it appears from the Tennessee Department of Labor Employee Choice of Physician form signed by Employee that she actually reported her condition to Employer on an earlier date in August 2006.

It is equally apparent that this error on Dr. Standard's part was critical to his opinion on causation.

Dr. Standard's note of his July 16, 2008 meeting with Employee's attorney states:

> It is my opinion that the patient has a work-related injury referable to a lifting injury that she sustained lifting automobile windshields. This caused her previously asymptomatic cervical disc to become symptomatic. She did well after surgery corrected this and retains a 23% impairment to the body as a whole.

Dr. Standard initially completed a form C-32 on July 30, 2008, shortly after this meeting, in which he recorded a work-related injury of August 21, 2006, attainment of MMI on February 8, 2008, and a 23% anatomical impairment to the body as a whole. However, Dr. Standard failed to answer the question regarding the cause of Employee's condition. At the request of Employee's attorney, Dr. Standard subsequently amended this C-32, on or about September 29, 2009, answering in the affirmative the question regarding whether Employee's injury was work-related.

Dr. Standard testified in his deposition, however, that he based his opinion that Employee's cervical spine condition was work-related on his understanding that Employee had suffered a specific work incident and injury. Dr. Standard testified that Employee's findings were due to degenerative changes within the disc, but that her activities at work were very stressful on the neck. However, Dr. Standard further explained:

> [I]t was my understanding from the patient that there was a specific work injury occurring on the date of 8-21-06, which was pivotal, in terms of changing the patient's symptoms from being tolerable or minor, to being intolerable. And that that was the precipitating event that eventually led to her coming to see me and eventually having surgery.
>
> So, yes, I believe that the work-related activities did aggravate her symptoms, to the point where she eventually required treatment. And that work-related injury occurred on 8-21-06.

Dr. Standard acknowledged that his opinion of causation was based strictly on the history Employee provided. According to Dr. Standard, he relies very heavily on the patient intake form as an unbiased view of what happened to the patient. He understood from Employee's

history as reflected on that form that Employee had suffered a specific injury on August 21, 2006. Dr. Standard agreed that if the history were incorrect as to a specific work-related incident and injury on that date, and if, instead, Employee had been doing her job for thirty days and her condition gradually became worse, his opinion as to whether the condition was work-related would be different. Dr. Standard explained:

> My answer would be different, because I do not think that a cervical disc problem is a repetitive use injury. One can have a specific injury that can cause a previously minimally symptomatic condition to be symptomatic and require treatment. And that can occur as a result of a work-related event. But as I mentioned, there was nothing on her scan, where she ruptured a disc or had some big anatomical change. That we have to rely on the patient's history to identify what aggravated or caused her symptoms to become intolerable. If that history is incorrect or [un]reliable, that would, obviously, change my opinion.

Dr. Standard further explained, in response to questioning from Employee's counsel, as follows:

> Q. Would it be fair to say that repetitive heavy lifting, as described by Ms. Lee, could have precipitated the onset of the condition you found when you did the surgery in her neck?
>
> ...
>
> THE WITNESS: Well, repetitive lifting, it could have increased stress on the neck and caused something like this. But my understanding was that she had a specific injury that caused her previously minimally symptomatic neck condition to become more symptomatic, to the point where she required treatment, and ultimately needed the surgery. I do not think that just gradually worsening pain, doing heavy work, means that the neck is symptomatic because of the work-related injury. This is not a repetitive use injury type of scenario.
>
> ...
>
> Either there is a specific injury that causes an underlying condition to become symptomatic or not. If she gradually gets worse over time and was doing heavy work at the same time, it

> is impossible to tell how much of a role that work played in her worsening. So that is what is difficult about this case.
>
> ...
>
> Q. Okay. So is it your testimony that absent a specific traumatic event occurring around this time, as she reported to you, around August of '06 – absent a specific traumatic event about that time, that the condition in her neck is or is not work-related?
>
> A. Yes. It is my opinion that, absent a specific work-related event, causing worsening of her symptoms, that I cannot directly relate it to the work activity.

Employee has never claimed that she experienced a specific incident or injury at work involving her neck on August 21, 2006 or any other date. Rather, her testimony indicates that she experienced an increase or change in her level of pre-existing symptoms, specifically pain. Similarly, Dr. Standard's testimony, even putting aside his erroneous belief that Employee experienced a specific incident or injury at work on August 21, 2006, was that Employee suffered from a pre-existing degenerative disc condition and that the pain became intolerable, as opposed to tolerable or minor. Such an occurrence is not compensable, however.

In Trosper, the Supreme Court "resolved to provide some clarity for the trial courts" in cases such as this. 273 S.W.3d at 607. The Court then provided a framework for cases in which an employee seeks compensation on the grounds that a work injury has aggravated a pre-existing injury or condition:

> We reiterate that the employee does not suffer a compensable injury where the work activity aggravates the pre-existing condition merely by increasing the pain. However, if the work injury advances the severity of the pre-existing condition, or if, as a result of the pre-existing condition, the employee suffers a new, distinct injury other than increased pain, then the work injury is compensable.

Id. In this case, Employee's testimony and that of Dr. Standard at best support that Employee's work in August 2006 increased the pain Employee suffered from her pre-

existing degenerative cervical disc condition. Employee is not entitled to workers' compensation benefits on this basis.[8]

**Conclusion**

The judgment of the trial court is reversed. Costs of this appeal are taxed to Tammy L. Lee, for which execution may issue if necessary.

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D. J. ALISSANDRATOS, SPECIAL JUDGE

[8]The resolution of this issue pretermits the need to address Employer's challenge to the trial court's determination regarding the applicability of the statutory cap, Tenn. Code Ann. § 50-6-241(d)(1)(A), and its determination of the extent of Employee's permanent partial disability.

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SPECIAL WORKERS' COMPENSATION APPEALS PANEL
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**Circuit Court for Lawrence County**
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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 Tammy L. Lee, for which execution may issue if necessary.

PER CURIAM