IN THE COMMONWEALTH COURT OF PENNSYLVANIA

Ronald Krnaich,	:	
Petitioner	:	
	:	
v.	:	No. 215 C.D. 2014
	:	Submitted: August 8, 2014
Workers' Compensation Appeal	:	
Board (Allegheny Ludlum Corp.),	:	
Respondent	:	

BEFORE: HONORABLE DAN PELLEGRINI, President Judge
HONORABLE PATRICIA A. McCULLOUGH, Judge
HONORABLE ROCHELLE S. FRIEDMAN, Senior Judge

OPINION NOT REPORTED

MEMORANDUM OPINION BY
PRESIDENT JUDGE PELLEGRINI FILED: September 3, 2014

Ronald Krnaich (Claimant) petitions for review of an order of the Workers' Compensation Appeal Board (Board) affirming the Workers' Compensation Judge's (WCJ's) decision granting Allegheny Ludlum Corporation's (Employer's) petition to terminate compensation benefits due to Claimant's full recovery. For the following reasons, we affirm.

I.

On June 7, 2007, Claimant, who worked as a production laborer, sustained a work injury to his cervical spine when a coil car he was pulling with a tow tractor slammed into the back of his tractor. He filed a claim petition, which

the WCJ granted by decision dated August 26, 2010, accepting the diagnosis of Claimant's medical expert, John Jefferson Moossy, M.D., a board-certified neurosurgeon, that Claimant sustained a whiplash injury which aggravated his pre-existing degenerative disc disease and resulted in muscle spasm and straightening of the normal cervical lordosis with accompanying neck pain, decreased range of motion, and headaches.

In September 2010, Employer's medical expert, William James Hennessey, M.D, a board-certified physician in physical medicine and rehabilitation, performed an independent medical evaluation (IME) of Claimant and determined that he had fully recovered from his "neck strain, headache, aggravation of degenerative change in the neck" injury. (Reproduced Record [R.R.] 369a.) Based upon Dr. Hennessey's IME and finding of full recovery, Employer filed a petition to terminate compensation benefits.[1]

[1] Section 413 of the Workers' Compensation Act (Act) provides that a claimant's benefits may be suspended, modified, or terminated based on a change in his disability:

> A workers' compensation judge designated by the department may, at any time, modify, reinstate, suspend, or terminate a notice of compensation payable, an original or supplemental agreement or an award of the department or its workers' compensation judge, upon petition filed by either party with the department, upon proof that the disability of an injured employe has increased, decreased, recurred, or has temporarily or finally ceased, or that the status of any dependent has changed….

Act of June 2, 1915, P.L. 736, *as amended*, 77 P.S. §772.

Employer also filed a petition to review medical treatment and/or billing and a subsequent petition to modify compensation benefits, but those adjudications are not the subject of the instant appeal.

II.

In support of Employer's petition to terminate, it presented the deposition testimony of Dr. Hennessey, who stated that on September 28, 2010, he physically examined Claimant, collected his history, and reviewed his medical records.[2] Dr. Hennessey testified that as of the date of his examination, there existed no evidence of physical impairment and that Claimant's complaints regarding his head and neck pain were not supported by objective findings. Specifically, he noted that Claimant's clinical exam revealed "normal muscle tone, normal muscle bulk, normal strength, normal sensation, normal muscle strength reflexes in both upper limbs," normal range of motion, and lack of muscle spasms, bruises, scrapes, abrasions, swelling, or any other objective abnormalities. (*Id.* at 388a–389a.) He explained that these findings indicated "that if there was an injury in the past, there is no evidence of one now because it's the way it's supposed to be." (*Id.* 389a.)

He further testified that in his medical opinion, degenerative disc disease cannot be aggravated by a whiplash-type injury such as the one Claimant sustained, despite the WCJ's prior ruling to the contrary. (*Id.* at 409a.) Nonetheless, when asked to assume that Claimant did sustain a neck injury on July 7, 2007, Dr. Hennessey still opined that Claimant made a full recovery because:

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[2] Dr. Hennessey reviewed Claimant's August 15, 2007 cervical spine magnetic resonance imaging (MRI) as well as an MRI of Claimant's cervical spine dated March 11, 2009. In a report issued after the IME, Dr. Hennessey further indicated that Claimant "had an excellent neuromuscular clinical examination and excellent imaging studies with excellent anatomy" and that as such, Claimant was fully recovered from his disability and could return to work without restriction. (R.R. at 367a.)

> He had a self-limited injury with no anatomic change by MRI and a normal neurologic examination, and under such an instance, time by itself will complete the healing process, and it has done so to the extent that his clinical examination findings and imaging findings are normal and, therefore, there is no residual injury.

(*Id.* at 390a–391a.) He explained that the passage of time heals injuries akin to whiplash and that treatment consisting of an anti-inflammatory prescription, formal physical therapy, and use of a home Transcutaneous Electrical Nerve Stimulation (TENS) unit were likely effective in treating any injury Claimant sustained.[3]

In opposition to Employer's termination petition, Claimant presented Dr. Moossy's deposition testimony. Although Dr. Moossy did not specifically recall his previous testimony in this matter, the record established that at a prior

[3] Employer also presented the testimony of Michael Nanney, who manages Employer's Human Resources Department and oversees its workers' compensation program. Mr. Nanney testified that upon receiving Dr. Hennessey's IME report, he advised Claimant to schedule a return-to-work physical as per company protocol. The physical revealed an elevated blood pressure, which prevented Claimant from returning to work until he sought treatment from his primary-care physician (PCP). Subsequently, Dr. Moossy submitted an updated restriction slip stating that Claimant was unable to wear a hardhat weighing approximately thirteen to fourteen ounces at work and needed to remain on light-duty pending further evaluation.

Paula Kinnamon, a registered nurse assigned to Employer's facility, further testified that Claimant contacted her to schedule his return-to-work physical, after which she learned Claimant suffered from hypertension. As a result, Ms. Kinnamon provided Claimant a form letter directed to his physician, advising him of the need to follow up with his PCP regarding his blood pressure and of the need to obtain from his PCP paperwork documenting his current blood pressure, treatment, ability to return to work, and any applicable restrictions. Although Ms. Kinnamon did receive documentation from Claimant's PCP, Thor Mathos, M.D., addressing some of these criteria, Dr. Mathos did not address whether Claimant could return to work with or without restriction.

deposition given in support of Claimant's claim petition, Dr. Moossy stated that he had last seen Claimant on January 20, 2010. Since that time, he examined Claimant again on July 28, 2010, when Claimant sought advice regarding an invasive procedure of percutaneous rhizotomies recommended by his pain-management doctor, Dr. Chen. At that time, Claimant provided Dr. Moossy an electric study of his arms, demonstrating mild bilateral carpal tunnel syndrome but no cervical radiculopathy. Two prior facet injections provided him with relief for seven days and two hours, respectively, and based on these results, Dr. Moossy recommended that the injections be repeated at least one more time before making a decision regarding the procedure. Dr. Moossy testified that his physical examination revealed a decreased range of motion in Claimant's neck and mild to moderate neck spasm with tenderness to palpitation.

Dr. Moossy stated that he next examined Claimant on October 27, 2010, and that Claimant advised that he had returned to work full-duty, resulting in a "complete recurrence of his symptoms of uncontrollable neck pain, spasms, and difficulty moving his head."[4] Dr. Moossy noted persistent muscle spasm, decreased range of motion, and increased discomfort as evidenced by the fact that Claimant was wearing a collar which he had not previously worn to the office. As such, Dr. Moossy recommended that Claimant return to light-duty and resume physical therapy, ultrasound treatment, and massage therapy because he experienced satisfactory symptomatic relief by limiting his activities and

[4] (R.R. at 196a–197a.) Claimant, however, denied telling Dr. Moossy that he had returned to work.

undergoing therapy in the past, while his attempt to resume his work regiment led to a worsening episode.

Dr. Moossy testified that he examined Claimant a number of times after his initial examination. On December 8, 2010, Claimant returned to Dr. Moossy's office with complaints of pain and spasms, worsening with range of motion. Dr. Moossy recommended an MRI and x-rays of the cervical spine and advised Claimant to wear his collar at night. When Claimant returned on February 2, 2011, Dr. Moossy reviewed the MRI and x-ray images which showed "increasingly severe degenerative change at the C4-5 level and what would appear to be an autofusion at C5-6." (R.R. at 200a.) Because arm discomfort prevented Claimant from obtaining the flexion/extension films, Dr. Moossy suggested facet blocks to alleviate the pain so that the films could be obtained to determine if Claimant was developing instability above his autofusion. In March 2011, the flexion/extension films were obtained and according to Dr. Moossy, they showed reversal of the normal lordosis, a radiographic sign of muscle spasm, as well as degenerative changes in osteophytes but no obvious instability.

Dr. Moossy diagnosed Claimant with "degenerative arthritis of the cervical spine," "symptomatic muscle spasm in the cervical musculature," and "irritation of the C3 nerve root, giving him head pain and occipital neuralgia" as a result of his work injury which exacerbated his preexisting condition of degenerative arthritis. (R.R. at 203a.) He further explained that the most recent set of imaging studies showed arthritic changes, indicative of progressive

degenerative-arthritic disorder of the spine.[5] It was his opinion that Claimant's work injury exacerbated his pre-existing degenerative arthritis.

Claimant also testified regarding his course of treatment. He stated that he maintained a notebook regarding his treatment, physical examinations, blood pressure, and physical activities over the past several years. Specifically, he testified that after his IME, he stopped taking his muscle relaxer and increased his physical activity pursuant to Dr. Hennessey's recommendation. He completed tasks such as cleaning out his garage, mopping the floor, and cleaning his basement, all while wearing a hardhat in an effort to prepare himself to return to work, but after doing so for twenty to thirty minutes, he experienced lightheadedness, increased pain, nausea, and headaches.

He testified that after the IME, he received a letter from Employer instructing him to return to work and that he attended a return-to-work physical, which revealed his high blood pressure. Subsequently, he consulted his PCP, Dr. Mathos, who monitored and treated his blood pressure by prescribing an increased dose of Atenolol. Claimant explained that Dr. Mathos completed Employer's blood-pressure form and that Claimant faxed the completed form to Employer's medical department.

[5] Dr. Hennessey challenged Dr. Moossy's findings because Dr. Moossy "doesn't have a diagnosis to explain [Claimant's] pain," "does not explain why [Claimant's] pain is worsening in the absence of any gainful employment," and does not note any "objective abnormal neurological findings." (R.R. at 392a.)

He further testified that he underwent physical therapy twice per week until April 2011, when he began aquatic therapy for neck strengthening. However, the aquatic therapy resulted in increased pain and tightness and therefore he terminated the therapy after eight to ten weeks and returned to ultrasound therapy. Although Dr. Chen subsequently provided an injection, it was ineffective, and Claimant continued to experience headaches, blurred vision, tightness, and pain in his neck. He usually sleeps only three to five hours per night, and upon waking up, does stretches and other physical activities prescribed by the therapist, such as walking, driving, and using the treadmill. Although he strives to do such activities for thirty minutes at least three days per week, his neck pain and tightness prevent him from realizing his goal. Regarding daily living activities, he folds clothes, unloads the dishwasher, and shops. Claimant continues to use his TENS unit because it helps to loosen his muscles, but he has decreased his use from six to eight times per day to three to four times per day.[6]

Based on the evidence presented, the WCJ found that Claimant fully recovered from his work injury as of the date of his IME and granted Employer's termination petition, in reliance on Dr. Hennessey's testimony, stating:

> Dr. Hennessey performed a thorough physical examination of the claimant on September 28, 2010, and

[6] Claimant also submitted the deposition transcript of Dr. Mathos, who examined and treated Claimant for his elevated blood pressure following his return-to-work physical by doubling Claimant's blood-pressure medication dosage from 50 to 100 milligrams per day. Dr. Mathos stated that he did not recall Claimant providing a form to fill out and return to Employer. He explained that his office generally retains copies of all such forms in patients' files and that no such copies existed in Claimant's file. Nonetheless, Dr. Mathos stated that Claimant's blood pressure was not high enough to prevent him from returning to work.

> noted no objective finding on examination that would substantiate the claimant's subjective complaints. He noted that the claimant had normal muscle tone and normal muscle bulk in his neck, full range of motion in all directions, normal strength, normal sensation and no muscle spasm in the neck. As part of his examination, Dr. Hennessey also reviewed the various diagnostic studies that the claimant had undergone and found them to be normal. As a result, it was his opinion that the claimant had fully recovered from his work-related injuries and could return to his time of injury job duties without restrictions.

(WCJ's March 29, 2012 decision at 8–9.)[7]

On the other hand, the WCJ found Dr. Moossy not credible, explaining that the treatment Dr. Moossy rendered was based upon Claimant's subjective complaints rather than clear, objective findings. Similarly, he explained that by Dr. Moossy's own admission, the restrictions regarding Claimant's use of a hardhat were not based upon any objective medical evidence but were based solely upon Claimant's subjective complaints. The WJC also noted Dr. Moossy's "erroneous understanding of the claimant's activities in October 2010, as he understood that the claimant had returned to full-duty work following his examination by Dr. Hennessey, when in fact, the claimant was not permitted to return to work because of problems with his blood pressure." (*Id.* at 9.) Likewise,

[7] The WCJ also credited Mr. Nanney's and Ms. Kinnamon's testimony that Claimant's blood pressure prevented him from returning to work at the time of his initial return-to-work physical, although the WCJ did not find his blood pressure problems to bear any relationship to his work injury.

the WCJ found Claimant's testimony regarding his ongoing symptoms and complaints unpersuasive, based upon his demeanor during the proceedings.

III.

Claimant appealed to the Board, arguing that the WCJ erred in allowing Dr. Hennessey's testimony to serve as the basis of his decision because the testimony was incompetent and barred by *res judicata* and collateral estoppel because it challenged the WCJ's prior adjudication regarding Claimant's work injury and failed to prove a change in Claimant's physical condition since that adjudication. Specifically, Claimant asserted that the WCJ erred in: (1) reaching a substantive decision on the merits of Employer's petition to terminate because the issues raised in it were barred by the doctrines of *res judicata* and collateral estoppel; and (2) finding that Dr. Hennessey's deposition testimony and IME report were sufficient to sustain Employer's burden of proof in the termination proceeding because they were not premised upon medical proof of a *change* in Claimant's condition.

Regarding Claimant's argument that Dr. Hennessey's testimony could not support a termination of benefits because he did not accept that an injury occurred, the Board explained, "Notwithstanding a medical expert's disbelief that a claimant sustained a particular injury at work, his testimony can support a termination of benefits if his examination reveals that the claimant is nonetheless fully recovered from any injury he may have sustained in the course of employment." (Board's January 28, 2014, decision at 2-3.) Noting that "Dr. Hennessey further opined that if Claimant had an injury in the past, there was no

evidence of an injury now," the Board found Claimant's argument without merit. (*Id.* at 3.)

With regard to Claimant's argument that a termination of benefits is barred by *res judicata*, the Board explained:

> Dr. Hennessey was asked to assume that Claimant did sustain an injury to his neck on July 7, 2007 as found by WCJ Bloom. (Dr. Hennessey at p. 16). He was then asked if he had an opinion within a reasonable degree of medical certainty as to whether Claimant had fully recovered from his injury as of September 28, 2010. Dr. Hennessey opined that Claimant had made a full recovery. (*Id.* at p. 17). He elaborated that Claimant's clinical examination findings and imaging findings were normal. (*Id.* at pp. 17–18).
>
> Upon review, we cannot agree that Defendant did not make the required showing of a change of condition since the preceding disability adjudication. Dr. Hennessy assumed that Claimant did sustain injuries as found by WCJ Bloom, and opined within a reasonable degree of medical certainty that Claimant had recovered from those injuries as of a later date. Thus, Defendant's evidence met the requirements of *Browne [Delaware County v. Workers' Compensation Appeal Board (Browne)*, 964 A.2d 29 (Pa. Cmwlth. 2008)] and is sufficient to meet the *Lewis* [*v. Workers' Compensation Appeal Board (Giles & Ransome, Inc.)*, 919 A.2d 922 (Pa. 2007)] standard. We determine no error.

(*Id.* at 5.) This appeal followed in which Claimant raises the same issues that he raised before the Board.[8]

[8] Our review of a decision of the Board is limited to determining whether errors of law were made, constitutional rights were violated, and whether necessary findings of fact are **(Footnote continued on next page…)**

IV.

A.

As to Claimant's argument that Employer's termination petition[9] was barred by the principles of *res judicata* or collateral estoppel[10] simply because Employer sought to terminate benefits established during the claim-petition proceedings, we agree with the Board that those doctrines do not apply because the purpose of claim-petition and termination-petition proceedings are entirely different. The former seeks to establish the existence of a work-related injury as of a specific date and the latter seeks to establish full recovery from that injury as of a subsequent date. Because Claimant's full recovery as of September 28, 2010, was not litigated at the claim-petition stage, neither *res judicata* nor collateral estoppel

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supported by substantial evidence. *Ward v. Workers' Compensation Appeal Board (City of Philadelphia)*, 966 A.2d 1159, 1162 n.4 (Pa. Cmwlth.), *appeal denied*, 982 A.2d 1229 (Pa. 2009).

[9] In a termination proceeding, an employer bears the burden of proving that a claimant's work injury has ceased. *Udvari v. Workmen's Compensation Appeal Board (USAir, Inc.)*, 705 A.2d 1290, 1293 (Pa. 1997). Where a claimant has continued complaints of pain, this burden may be satisfied by presenting unequivocal testimony from a medical expert that the claimant is fully recovered and can return to work without restriction, "and that there are no objective medical findings which either substantiate the claims of pain or connect them to the work injury. If the WCJ credits this testimony, the termination of benefits is proper." *Id.* (internal footnote omitted).

[10] Although Employer asserts that Claimant's *res judicata* and collateral estoppel arguments have been waived, we find that these arguments were presented in Claimant's proposed findings of fact and conclusions of law, submitted to the WCJ after the record was closed, and therefore were properly preserved for appellate review. *See* 34 Pa. Code §131.101(h)(3) (explaining that all legal arguments shall be set forth in legal briefs submitted to the WCJ after the record has been closed).

barred Employer's termination petition.[11] *See Henion v. Workers' Compensation Appeal Board (Firpo & Sons, Inc.)*, 776 A.2d 362, 365–66 (Pa. Cmwlth. 2001) (explaining that *res judicata* applies only when, among other requirements, "the subject matter and the ultimate issues are the same in both the old and the new proceedings"); *id.* at 365 ("Collateral estoppel acts to foreclose litigation in a later action of issues of law or fact that were actually litigated and necessary to a previous final judgment.").

Claimant also contends that *res judicata* and collateral estoppel bar Employer's termination petition because "Dr. Hennessey's opinion of Claimant's full recovery is predicated on his opinion that Claimant never actually sustained the injuries that were found by Judge Bloom." Generally, "a medical expert's opinion will not support a termination if that medical expert does not acknowledge the accepted work injuries and does not opine full recovery from those injuries" because an employer may not litigate the nature of the accepted work injury in a termination petition. *Hall v. Workers' Compensation Appeal Board (America*

[11] According to Claimant's brief, Employer's termination petition asserted that "Claimant had fully recovered from the work injury as of September 28, 2010, one month and two days after Judge Bloom ruled that it had occurred…." (Br. for Pet. at 10.) While the WCJ's opinion adjudicating the claim petition was dated September 28, 2010, the issue it addressed was whether Claimant established that a work injury occurred on July 7, 2007. Although an injury is presumed to continue until an employer establishes that it has ceased pursuant to Section 413 of the Act, *Pieper v. Ametek-Thermox Instruments Division*, 584 A.2d 301, 304 (Pa. 1990), the WCJ's decision did not expressly determine that Claimant's injury continued as of September 28, 2010. Even if the decision had so held, Employer would not be precluded from seeking a termination of benefits the following month, provided that it could satisfy the standard for doing so. *See Udvari v. Workmen's Compensation Appeal Board (USAir, Inc.)*, 705 A.2d 1290, 1293 (Pa. 1997).

Service Group), 3 A.3d 734, 740 (Pa. Cmwlth. 2010). However, even when a physician does not believe that the injury occurred or that it was work-related, his testimony will support the finding of a full recovery if he nonetheless opines that if the injury was in fact sustained, claimant has fully recovered from it. *See To v. Workers' Compensation Appeal Board (Insaco, Inc.)*, 819 A.2d 1222, 1225 (Pa. Cmwlth. 2003).

We addressed this precise issue in *Folmer v. Workers' Compensation Appeal Board (Swift Transportation)*, 958 A.2d 1137 (Pa. Cmwlth. 2008), *appeal denied*, 971 A.2d 493 (Pa. 2009). There, the claimant contended that the testimony of the employer's medical expert, Dr. Talbott, was incompetent when he testified during a termination proceeding that he disagreed with the WCJ's adjudication that the claimant sustained cranial nerve damage during his work injury. *Id.* at 1147. Relying on *To*, we explained:

> It is irrelevant whether Dr. Talbott actually believed Claimant ever damaged his eighth cranial nerve. A medical professional is not required to believe a condition existed; he is merely required to accept as true the adjudicated fact that a condition existed and opine as to whether the condition continues to exist at the time of the examination.

Finding that Dr. Talbott did not disregard the WCJ's prior determination of injury, but rather, made an independent finding of full recovery on a subsequent examination date, we found his testimony competent and not otherwise barred by collateral estoppel.

Similarly in this case, Dr. Hennessey disbelieved that Claimant's degenerative disc disease was aggravated by his whiplash-type injury, stating that no abnormalities were present on Claimant's MRIs, despite the WCJ's ruling to the contrary. Nonetheless, he assumed that the injury did occur and went on to state that regardless of whether Claimant's pre-existing degenerative disc disease was exacerbated by his work injury, as of September 28, 2010, Claimant had fully recovered from such exacerbation. He supported his opinion by citing to a lack of anatomical change in Claimant's clinical examination and imaging and by explaining that self-limited injuries caused by whiplash generally are healed by the passage of time and the types of treatment Claimant received, physical therapy, an anti-inflammatory prescription drug, and use of a TENS unit. Because Dr. Hennessey offered unequivocal medical testimony that Claimant was fully recovered and could return to work without restriction, and that no objective medical findings support Claimant's claim of pain or connected his complaints to his work injury, the testimony constituted competent and substantial evidence to support a termination of benefits.[12]

[12] To the extent Claimant argues that the WCJ's finding that Dr. Moossy was credible at the claim-petition stage bars a subsequent finding that he was not credible at the termination-petition stage, we disagree. As the WCJ duly noted, Dr. Moossy continued to treat Claimant based upon his subjective complaints of pain and went so far as to restrict Claimant from wearing a hardhat at work simply because Claimant advised that the hat irritated his condition. Moreover, Dr. Moossy clearly misunderstood the Claimant's activities in October 2010, as he believed Claimant had returned to work full-duty after his IME when he was precluded from doing so. These grounds constitute an adequate basis for rejecting Dr. Moossy's testimony, the assessment of which is within the sole discretion of the WCJ. *City of Philadelphia v. Workers' Compensation Appeal Board (Reed)*, 785 A.2d 1065, 1069 (Pa. Cmwlth. 2001), *appeal denied*, 820 A.2d 706 (Pa. 2003); *see also* Section 422 of the Act, 77 P.S. §834 (requiring a WCJ to identify and adequately explain the reasons for rejecting evidence). Although Claimant contends that the WCJ failed to specify whether he found Dr. Moossy's prior opinions rendered at the claim-petition stage or his opinions rendered at the termination-petition stage unpersuasive, it is

(Footnote continued on next page…)

B.

Relying on *Lewis v. Workers' Compensation Appeal Board (Giles & Ransome, Inc.)*, 919 A.2d 922 (Pa. 2007), Claimant also argues that Dr. Hennessey's medical opinions were legally insufficient to support a termination of benefits because they were not based on medical proof of a *change* in Claimant's condition. In *Lewis*, our Supreme Court held that in order to terminate compensation benefits on the basis of a decrease in physical disability, an employer "must show a change in physical condition since the preceding disability adjudication" and further defined "change of condition" as "any change in the claimant's physical well being that affects his ability to work." *Id.* at 926, 929. Claimant contends that Dr. Hennessey's testimony did not satisfy this standard because it was based on his finding that no objective evidence substantiated Claimant's complaints.

We addressed a similar claim in *Folmer*, a post-*Lewis* decision in which the claimant's work-related injury consisted primarily of pain and dizziness. After filing an initial termination petition which was denied, the employer filed a second termination petition alleging full recovery. *Id.* at 1140. In support of the petition, the employer's medical expert testified that there existed no objective findings to confirm the claimant's subjective complaints because claimant's range of motion in his neck, muscle composition, reflexes, strength, sensation, and MRI

(continued…)

obvious from the nature of the opinions discussed that the WCJ was referring to those rendered in the subsequent proceeding.

report all yielded normal results. *Id.* at 1140–41. Therefore, the expert opined that the claimant was fully recovered. *Id.* at 1140. The WCJ granted the termination petition, and the Board affirmed. *Id.* at 1141–42.

In reviewing the evidence presented, we determined that the employer's medical expert demonstrated a change in claimant's physical well-being, explaining that a battery of tests were performed on claimant but that none corroborated his complaints. *Id.* at 1144. We noted that the complaints were substantiated in the prior litigation through objective findings, including mild nystagmus and taut neck muscles, but found that a subsequent exam of claimant's neck revealed normal muscles and therefore, a change in the claimant's physical well-being that affected his ability to work.[13]

Similarly, in this case, Dr. Hennessey's testimony established a change in Claimant's physical condition. The WCJ previously found Claimant to be suffering from an exacerbation to his pre-existing degenerative disc disease from his whiplash-like injury, which resulted in neck pain, headaches, decreased range of motion, and muscle spasm. As did the physician in *Folmer*, Dr.

[13] We further rejected the claimant's contention that a change in his physical condition could be demonstrated only through cessation of his own complaints, his discontinuance of medical treatment, his physician's testimony that he recovered, or surveillance footage demonstrating his recovery, explaining that such a holding "would mean that an employer could never terminate benefits where, as here, the claimant's injuries consist primarily of subjective complaints." *Folmer*, 958 A.2d at 1144. We likewise rejected the contention that a change in physical condition can be shown only by diagnostic testing, noting that "it is for medical experts to determine what tests … are appropriate to demonstrate change" and that "no test is infallible." *Id.* at 1145 n.14.

Hennessey testified that there existed no objective findings to confirm Claimant's subjective complaints because Claimant's clinical examination revealed "normal muscle tone, normal muscle bulk, normal strength, normal sensation, normal muscle strength reflexes in both upper limbs," normal range of motion, and lack of muscle spasms, bruises, scrapes, abrasions, swelling, or any other objective abnormalities. (R.R. at 388a–389a.) Moreover, Dr. Hennessey explained "that if there was an injury in the past, there is no evidence of one now because it's the way it's supposed to be." (*Id.* at 389a.)

Finally, Claimant asserts that Dr. Hennessey's testimony failed to satisfy the *Lewis* standard because it was based, in part, on two MRI studies which pre-dated the WCJ's adjudication of his claim petition. Specifically, Claimant argues that in the WCJ's claim-petition decision, he credited Dr. Moossy's testimony regarding the proper interpretation of the cervical MRIs dated August 15, 2007, and March 11, 2009. As such, Claimant argues that Dr. Hennessey's opinion of full recovery, which is partially based upon a contradictory reading of the imagery, must be deemed incompetent under *Lewis* and its progeny.

However, this argument was rejected in *Folmer*, where the employer filed a petition to terminate benefits as of December 11, 2003, the date on which its expert, Dr. Senter, conducted a physical examination of the claimant revealing normal findings. *Folmer*, 958 A.2d at 1140. During his examination, Dr. Senter reviewed a prior MRI report which he interpreted as showing normal degenerative disc disease, even though the WCJ previously determined that the claimant suffered "cervical disc syndrome or cervical myalgia," among other injuries, and

credited testimony from the claimant's treating chiropractor that a 1996 MRI revealed a herniation at the C4-C5 level.[14] *Id.* at 1139–40, 1147. Nonetheless, we found this discrepancy immaterial, stating: "It does not matter because Dr. Senter specifically examined Claimant for a cervical disc problem and found none to exist. Employer was required to show a change from the last termination adjudication, and that proceeding established that Claimant did not have a disc herniation." *Id.* at 1147.

Likewise, whether Dr. Hennessey's opinion was based, in part, upon a contradictory reading of Claimant's prior MRIs is not dispositive. As in *Folmer*, here, Dr. Hennessey specifically examined Claimant for head and neck problems and found none to exist as of September 28, 2010. His testimony regarding his physical examination of Claimant, even absent his testimony regarding the MRIs, is a sufficient basis upon which to grant Employer's termination petition. *See Hoffmaster v. Workers' Compensation Appeal Board (Senco Products, Inc.)*, 721 A.2d 1152, 1155 (Pa. Cmwlth. 1998) (explaining that the critical inquiry in reviewing a decision is whether there exists substantial evidence to support the findings actually made).

Accordingly, we affirm the Board's order upholding the WCJ's grant of Employer's petition to terminate benefits.

DAN PELLEGRINI, President Judge

[14] It is unknown whether the MRI Dr. Senter reviewed was a 1996 or 1999 MRI.

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O R D E R

AND NOW, this 3rd day of September, 2014, the order of the Workers' Compensation Appeal Board dated January 28, 2014, at No. A12-0575 is affirmed.

DAN PELLEGRINI, President Judge