STATE OF RHODE ISLAND

PROVIDENCE, SC. WORKERS' COMPENSATION COURT
APPELLATE DIVISION

ROBERT HAYES	)	
	)	
VS.	)	W.C.C. 2016-07301
	)	
R.T. NUNES & SONS, INC.	)	

FINAL DECREE OF THE APPELLATE DIVISION

This matter came to be heard by the Appellate Division upon the claim of appeal of the petitioner/employee and upon consideration thereof, the employee's claim of appeal is denied and dismissed, and it is

ORDERED, ADJUDGED, AND DECREED:

That the findings of fact and the orders contained in a decree of this Court entered on July 15, 2018 be, and they hereby are, affirmed.

Entered as the final decree of this Court this 13th day of June, 2023.

PER ORDER:

/s/ *Nicholas DiFilippo*
Administrator

ENTER:

/s/ *Olsson, J.*

/s/ *Minicucci, J.*

/s/ *Pepin Fay, J.*

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DECISION OF THE APPELLATE DIVISION

OLSSON, J. This matter is before the Appellate Division on the employee's appeal from the trial judge's decision and decree denying the employee's petition for workers' compensation benefits. The employee alleged that he developed a heart condition, specifically atrial fibrillation, caused by physical labor he performed at work on August 26, 2016 resulting in partial incapacity commencing August 27, 2016 and continuing. After a thorough review of the record, and following consideration of the parties' respective arguments, we deny and dismiss the employee's appeal and affirm the trial judge's decision and decree.

Robert Hayes (the employee) worked for R.T. Nunes & Sons, Inc. (the employer), a commercial excavation company, for seven (7) years. His duties were split so that he spent thirty percent (30%) of his time as a machine operator and seventy percent (70%) of his work hours as a laborer. As a laborer, he was required to use shovels, bars, hammers, and picks to subgrade dig, when the excavating machines could not remove impacted items. On August 26, 2016, while the outside temperature hovered around ninety (90) degrees, the employee used a shovel to remove collapsing sand so that support footings could be properly placed in the ground for a

building that was under construction. The employee testified that he felt fine until approximately an hour and a half after lunch when he experienced dizziness, profuse sweating, and a rapid heartbeat. After taking a break to have a drink, he continued to suffer from some of these symptoms. He was able to complete his workday activities at approximately 6:00 p.m. When he arrived home about 7:00 p.m., the employee was exhausted and sweaty, and he sensed that his heart was still racing.

The following morning the employee did not go to work, but instead went to Rhode Island Hospital as he continued to have a rapid heartbeat. In addition, he explained that he fell to his knees at home when he attempted to stand. The employee testified that he told the Rhode Island Hospital physicians and medical personnel that his symptoms began while working the preceding day. He was admitted to the hospital and was diagnosed with "afib" or atrial fibrillation. After his release from the hospital, the employee continued to treat with Dr. Aaron Weisbord, his cardiologist, and Dr. Karen Smigel, his primary care physician. He also treats with Dr. Peter Shorter for his blood pressure and kidney issues and with Dr. Rita Gonzalez, an endocrinologist. The employee stated that his symptoms failed to improve and for this reason on February 15, 2017 he underwent an ablation procedure performed by Dr. Bruce Koplan. Since his surgery, the employee's condition has improved; however, he reported experiencing additional occurrences of atrial fibrillation type symptoms on approximately thirteen (13) occasions. The employee stated that, as a result of his heart condition, he has not returned to work either for the employer or for any other business.

Initially, the employee denied any blood pressure difficulties prior to August 26, 2016. He did describe one incident of high blood pressure that he believed was caused by his taking cough medicine and Sudafed. He saw Dr. Smigel, who did not put him on any medication for

his high blood pressure or recommend any further treatment for this problem. He also denied that some attempts to donate blood were refused due to high blood pressure, although he agreed that he had been told that he could not donate blood if his blood pressure was elevated. The employee claimed that he kept a blood pressure monitor in his bag at work only out of a concern that he may sustain a bee sting, which could lower his blood pressure.

Upon questioning from the Court, the employee first stated that he never experienced symptoms or treatment for rapid heartbeats or dizziness prior to his August 26, 2016 episode. The employee then described an experience of lightheadedness and shortness of breath occurring in the Fall of 2015, which he related to the inhalation of asphalt and concrete dust at work. He sought treatment at South County Hospital and was referred to Dr. Weisbord, who did a stress test.

On cross-examination, the employee was asked if on November 17, 2014 he told Dr. Vanasse-Passas that he had suffered from shortness of breath on exertion for three-and-a-half weeks. He asserted that this complaint was from a respiratory condition he believed was caused by inhaling substances at work. He denied telling Dr. Vanasse-Passas on March 24, 2015 that on two (2) occasions he was refused the opportunity to give blood, due to his blood pressure being too high. He also denied being advised on that date that he should monitor his blood pressure. The employee attributed complaints of dyspnea (shortness of breath) and heart palpations made to Dr. Smigel in December of 2015 to another occasion when he inhaled dusty substances at work. In addition, he claimed that a history given to Dr. Weisbord of sudden shortness of breath and a pale appearance after lifting an eighty (80) pound bag at home was due to the chest congestion he experienced from inhaling concrete dust during that period as well. He did agree that in January of 2016 Dr. Weisbord advised him to check his blood pressure three (3) times a

day. The employee did not monitor his blood pressure as recommended, insisting that the purpose of the blood pressure monitoring order was due to fear of a bee sting and not due to a concern about high blood pressure. The employee also denied telling Dr. Weisbord that in the weeks leading up to August 26, 2016 he experienced intermittent chest palpations, shortness of breath, and unusual fatigue.

The voluminous medical evidence introduced at trial included the deposition and records of Dr. Weisbord and medical records from Dr. Bruce Koplan, Dr. Karen Smigel, Dr. Rebecca Vanasse-Passas, Dr. Peter Shorter, Dr. Rita Gonzalez, South County Hospital, Rhode Island Hospital, and the Rhode Island Blood Center. The medical records that are potentially relevant to the employee's current complaints and diagnoses begin with Dr. Vanasse-Passas, a hematologist, who treated the employee for lupus anticoagulant. Dr. Vanasse-Passas' November 17, 2014 record indicates that in the prior month the employee complained of dyspnea on exertion that lasted approximately three-and-a-half weeks. The office note from March 24, 2015 specifies that the employee reported that during the last four (4) weeks he was unable to donate blood on two (2) occasions due to high blood pressure. She indicated that the employee would be tracking his blood pressure and discussing the results with his primary care physician as he may need to start antihypertensives.

Records received from Dr. Smigel include an office progress note from March 18, 2015 listing hypertension as a chief complaint. The employee related that he had noted blood pressures as high as 192/44 and a repeat pressure of 180/76. Routinely he reported values of 140-150/74-84. The doctor's assessment included the diagnosis of elevated blood pressure. Also contained within Dr. Smigel's records is a report from the South County Hospital indicating that on December 23, 2015 the employee was treated in the emergency department for dyspnea.

The report indicates that the employee was instructed by the hospital personnel to follow up the next day with Dr. Laura Henseler, who was covering for Dr. Smigel.

The medical report from December 24, 2015 reveals that the employee told Dr. Henseler that his dyspnea symptoms commenced approximately six (6) weeks earlier. Additional complaints included occasional episodes of heart racing. The doctor's assessment included elevated blood pressure and palpitations. She instructed the employee to monitor his blood pressure and record the values, to undergo a stress echocardiogram, and to have a cardiology consult with Dr. Weisbord. The employee was advised to go directly to the emergency department if he suffered acute chest pain or shortness of breath. The report contains no mention of any history that the employee had inhaled construction dust from his work environment.

Dr. Weisbord's records indicate that his first office visit with the employee occurred on January 29, 2016 during which he reviewed with the employee the results of the stress echocardiogram the doctor performed on January 7, 2016, which was interpreted to be essentially normal. The employee advised the doctor that beginning in the late fall of 2015 he began to experience unusual shortness of breath with activity. While at home in November 2015, the employee lifted an eighty (80) pound bag and suddenly felt short of breath and appeared pale. At that time, he was seen at South County Hospital, but no clear etiology for the dyspnea was found. Due to continued intermittent shortness of breath with exertion, the employee returned to the emergency department on December 23, 2015, which occasioned the referral to Dr. Weisbord. The employee reported no dyspnea for the previous three (3) weeks but had felt a brief fluttering in his chest on rare occasions. The etiology of the transient dyspnea was unclear to the doctor. On that date the employee's diagnoses were hypertension and premature ventricular contractions. Dr. Weisbord requested that the employee check his blood

pressure at home three (3) times per week and return in a few weeks with his blood pressure log due to a concern that he may be suffering from masked hypertension. This report also lacks any mention of the employee inhaling dust during his work activities.

The medical record from the emergency department at Rhode Island Hospital for the admission of August 27, 2016 states that the employee went to the hospital for hypotension, rapid heart rate, and a pre-syncopal episode. He advised the hospital staff that "he has felt SOB, fatigue and 'heart racing' for the past few days." Ee's Ex. 11, Rhode Island Hospital records *17. The History of Present Illness section of the hospital Discharge Summary shows that the employee complained of rapid heart palpitations since 8:00 p.m. the night before admission and that this symptom continued into the morning along with dizziness and low blood pressure. The employee advised the hospital personnel that he had experienced episodes of low blood pressure occurring over the last two (2) to three (3) months without any palpitations.

A cardiology consult conducted during this admission includes a history that the employee "works a very strenuous job and has never developed chest pain with exertion although over the last few months, he fatigues easily." Ee's Ex. 11 at *46. Absent from the hospital record is any history of the employee suffering any cardiac symptoms while working in the heat on August 26, 2016. An echocardiogram revealed mild heart failure with weakening of the heart with a forty-five percent (45%) ejection fraction and a CAT scan demonstrated a mild enlargement of the heart chamber. The employee was diagnosed with rapid atrial fibrillation and cardiomyopathy and discharged from the hospital on August 29, 2016. The consult report indicates that the cause of the employee's atrial fibrillation and his reduced ejection fraction was unclear.

On September 1, 2016, two (2) days after his discharge from Rhode Island Hospital, the employee was seen again by Dr. Weisbord, who initially reviewed information regarding the recent hospital admission. The employee reported that, since his release from the hospital, he had episodes of shortness of breath with exertion and some palpitations. The report of that date also indicates that the employee was having unusual fatigue and perhaps some shortness of breath and intermittent palpitations in the weeks prior to the hospitalization. At his deposition, Dr. Weisbord indicated that the employee's reduced ejection fraction was not present at the previous examination in January 2016. Dr. Weisbord diagnosed the employee with new onset atrial fibrillation, defined as an irregular and rapid beating of the heart, as well as cardiomyopathy, which is a weakening of the heart muscle.

Dr. Weisbord's subsequent records note that the employee continued to complain of frequent episodes of intermittent palpitations, dyspnea on exertion with no clear etiology, and labile blood pressure. Dr. Weisbord referred the employee to Dr. Koplan, an ablation specialist, to determine if this procedure would assist in treating his arrhythmia. On January 17, 2017, the employee reported that he experienced more frequent and longer-lasting atrial fibrillation episodes, which appeared to be triggered by physical activity such as exercise. The doctor's assessment includes the comment that the atrial fibrillation episodes "clearly seems related to physical activity which is consistent with his original episode which occurred during a vigorous day of work in the hot weather." Ee's Ex. 15, Dr. Weisbord report dated 1/17/2017. When seen on April 18, 2017, the doctor noted that, since the February ablation procedure, the employee stated he experienced approximately ten (10) episodes of atrial fibrillation often with associated fatigue, chest pressure, and dyspnea, but that he had been unable to identify any clear trigger. Dr. Weisbord's October 19, 2017 record indicates that the employee complained of minimal

atrial fibrillation episodes over the last six (6) months; however, the etiology of the employee's intermittent dyspnea on exertion and labile blood pressure remained uncertain.

Dr. Weisbord was asked whether the employee's atrial fibrillation was causally related to the work activities of August 26, 2016. In response the doctor stated that he thought the atrial fibrillation symptoms were triggered by the employee's activities of that morning. When prompted to elaborate on his opinion, Dr. Weisbord stated:

> So one of the other things that can cause atrial fibrillation is dehydration and accompanying electrolyte disturbances, like low magnesium and low potassium that occur when you sweat and vigorously exert yourself. The pattern of his presentation was consistent with an onset of his symptoms during physical activity.

Ee's Ex. 5, Dep. of Aaron K. Weisbord, M.D., at 24:12-18. Furthermore, the doctor stated that while a left atrial abnormality and high blood pressure are associated with atrial fibrillation, neither is directly causal.

On cross-examination, Dr. Weisbord initially affirmed his opinion that the employee's "afib was triggered by his activity of that day." Ee's Ex. 5, at 28:18-29:3. When asked what caused the employee's atrial fibrillation after August 2016, when he had stopped working, the doctor responded that he could not answer that question. He then indicated that the employee said that physical activities seemed to precede his symptoms.

Dr. Weisbord also agreed that both his diagnosis of atrial fibrillation and his diagnosis of cardiomyopathy have many causes. He acknowledged that the medical records indicate that the employee was experiencing symptoms of dyspnea, intermittent palpitations, heart racing, and elevated blood pressure as far back as November 2015 and again in the weeks prior to any work activities that may have occurred on August 26, 2016.

After reviewing the history provided by the employee at Rhode Island Hospital during his admission on August 27, 2016, Dr. Weisbord conceded that the circumstances described within that record are different than the facts the employee relayed to him. The hospital record did not contain any history that the employee began to experience palpitations or dizziness or shortness of breath while performing any physical activities in the heat on August 26, 2016. The doctor also agreed that the medical providers at Rhode Island Hospital believed the cause of the employee's heart failure with reduced ejection fraction was unclear and likely idiopathic or uncertain until proven otherwise.

Dr. Weisbord then admitted that his own medical reports also indicate that the etiology of the employee's symptoms and complaints was unclear. As an example, his statement on a form to support the employee's application for benefits pursuant to the federal Family Medical Leave Act on September 15, 2016 denotes that the employee's two diagnoses were of "uncertain etiology." Ee's Ex. 5, Er's Ex. D, attached. When asked if his opinion has changed, the doctor replied, "If you are asking me what caused these, I don't know what caused those specifically." Ee's Ex. 5 at 44:6-7.

On redirect examination, Dr. Weisbord was again asked the causal question as to whether the employee's heart conditions were related to the work he performed on August 26, 2016. The doctor stated that his previously stated opinion was based upon the history communicated to him by the employee. He again acknowledged that the history contained in the Rhode Island Hospital records is different than the information provided to him by the employee. The doctor then agreed that, if the employee's symptoms commenced while working on August 26, 2016 prior to reporting to the hospital, it seemed "more likely than not" that the employee's atrial fibrillation was caused by his work activities. Ee's Ex. 5 at 48:20. On further cross-

examination, Dr. Weisbord acknowledged that his own medical report of September 1, 2016 contains no mention that the employee experienced any cardiac symptoms while working in late August of 2016. When prompted again regarding the causal relationship, the doctor agreed that he had first indicated that the atrial fibrillation was triggered by the employee performing physical labor at work, but he concluded by stating that he could not answer the "causal question." Ee's Ex. 5 at 51:8.

Additional relevant medical records from Dr. Smigel include her office record of September 8, 2016. The office note reflects that on this occasion, just slightly more than a week following the alleged work incident, the employee did not tell his primary care physician that his cardiac symptoms commenced while at work on August 26, 2016. The doctor's report of that date contains the comment that the employee already consulted with his cardiologist, stating that "Dr. Weisbord feels that cardiomyopathy is secondary to underlying and likely previously unrecognized afib." Ee's Ex. 8, Dr. Smigel report dated 9/8/2016 at 149. The only other document suggesting a possible cause of the employee's atrial fibrillation is correspondence from Dr. Smigel to employee's counsel on February 6, 2017. The letter includes in relevant part:

> On 8/26/2016, while working as a laborer, heavy machine operator in 90 degree weather and digging holes, Mr. Hayes felt his heart racing. He felt overheated and dehydrated. Certainly dehydration and the resultant electrolyte abnormalities can cause cardiac arrhythmias/ atrial fibrillation.

Ee's Ex. 9, South County Hospital Records and Reports at 11. This is the only mention by Dr. Smigel of information regarding the employee's work activities on August 26, 2016. None of the information as to the weather, the employee's job, and the employee's alleged symptoms while working is contained in any of Dr. Smigel's office notes. The conclusion of the doctor's

letter stated that all statements of fact and opinions contained herein were made within a reasonable degree of medical certainty.

Rhode Island Hospital records disclose that on October 5, 2016 the employee came into the Foster, Rhode Island police station complaining of shortness of breath. He was taken by rescue to Rhode Island Hospital where he reported that upon waking that morning, he had a sudden onset of heart palpitations and dyspnea. Symptoms also included mild chest discomfort, dizziness, and lightheadedness. After examination in the emergency department, he was released to follow up with Dr. Weisbord.

Dr. Koplan, a cardiologist associated with the Cardiac Arrhythmia Clinic at Brigham and Women's Hospital, first saw the employee on October 31, 2016, to assist in the management of his cardiac symptoms and to consider an ablation procedure. The doctor's report indicates that the employee told him that in the week leading up to August 26, 2016 he reported low blood pressure and that he did not feel well – symptoms the employee attributed to the heat. The report further states that his heart palpitations first began on August 26, 2016 at work during lunch after drinking a cold beverage. Dr. Koplan postponed the employee's ablation procedure in order to continue further drug therapy and to refer the employee for additional diagnostic testing. On January 19, 2017, the employee again met with Dr. Koplan and a decision was made to go forward with the ablation procedure, which was performed on February 15, 2017.

In his written decision, the trial judge carefully summarized the testimony given by the employee at trial as well as the deposition testimony of Dr. Weisbord. The judge also reviewed the voluminous medical records submitted by the parties. He then concluded that the employee failed to meet his burden to establish the probability that his heart condition was caused by his work activities on August 26, 2016.

The judge explained that the employee's testimony regarding the onset of his symptoms on the alleged date of injury was not supported by the history he provided to either the Rhode Island Hospital emergency department on that date or initially to Dr. Weisbord as documented in his office note of September 1, 2016. This fact was acknowledged by Dr. Weisbord during his deposition. In addition, the totality of the medical evidence demonstrated that the employee's heart condition was of longstanding duration, as he had been reporting similar symptoms of dyspnea, fatigue, and heart palpitations for at least ten (10) months before August 26, 2016. The trial judge noted Dr. Weisbord's concession at the conclusion of his deposition that he could not answer the question regarding the causal relationship between the employee's work and his cardiac condition. Moreover, the doctor's office record and the FLMA form both indicate that the etiology of the employee's condition was uncertain. Due to the lack of credible medical evidence to support a compensable injury, the petition was denied and dismissed. The employee filed a timely claim of appeal.

Our Appellate Division standard of review is highly deferential. "The findings of the trial judge on factual matters shall be final unless an appellate panel finds them to be clearly erroneous." R.I. Gen. Laws § 28-35-28(b). Accordingly, our panel is prohibited from engaging in a *de novo* review without first determining that the trial judge was clearly wrong or overlooked or misconceived material evidence. *Diocese of Providence v. Vaz*, 679 A.2d 879, 881 (R.I. 1996). After a review of the record, we affirm the trial judge's decision denying the employee's original petition for failure to establish a causal nexus between his heart condition and his employment.

The employee has presented five (5) reasons of appeal. Initially he contests the trial judge's finding that the causal relationship between his heart condition and his employment was

not sufficiently established. The employee asserts that the record contains "uncontroverted expert testimony" that the work performed on August 26, 2016 was the probable cause of his injury. Ee's Reasons of Appeal *1. The employee has not directed this appellate panel to the exact testimony he believes rises to the level of demonstrating the necessary causal link by a fair preponderance of the evidence. On the contrary, even when viewed in the light most favorable to the employee, the testimony of Dr. Weisbord was anything but uncontroverted and was at best equivocal.

At the end of his deposition, Dr. Weisbord admitted that he was unable to answer the question posed to him regarding causal relationship. His records contain statements that the etiology of the employee's cardiac symptoms is unclear. The trial judge was clearly not erroneous when he determined that these factors outweighed any response by the doctor earlier in his deposition that the employee's symptoms were "likely triggered" by physical activity at work. Ee's Ex. 5 at 24:8-10.

Furthermore, even uncontroverted expert testimony may be disregarded by the trial judge when, as here, that testimony is based upon an employee history that is lacking in necessary credibility. *Mazzarella v. ITT Royal Elec. Div.,* 120 R.I. 333, 338 A.2d 4 (1978). As outlined in the trial court decision, the causal opinion of Dr. Weisbord was based upon a statement by the employee that his symptoms of atrial fibrillation such as shortness of breath, palpitations, and the like began on the afternoon of August 26, 2016 while performing his work duties for the employer in hot weather. Yet, as the doctor himself recognized, his own record from September 1, 2016 and the record from the emergency department of Rhode Island Hospital from August 27, 2016 contain a different history. For these reasons it was appropriate for the trial judge to determine that the employee's cardiac condition was not precipitated by the work activities.

The employee's second reason of appeal asserts that the trial judge was clearly erroneous in his determination that the totality of the medical evidence demonstrates the employee's heart condition was of longstanding duration. The employee argues that this finding is unsupported by competent evidence as the "record contains no diagnosis of any cardiac condition prior to the petitioner's date of injury of August 26, 2016." Ee's Reasons of Appeal *1. While there may have been no explicit diagnosis of atrial fibrillation, the court exhibits are replete with similar cardiac symptomology going back at least to the report of Dr. Vanasse-Passas of November 17, 2014. The record of an office visit on that date indicated the employee told her that in the prior month he had suffered from dyspnea on exertion that lasted about three and a half weeks. In March of 2015 the medical records of both Dr. Vanasse-Passas and Dr. Smigel express their concern about the employee's hypertension. The reports of South County Hospital, Dr. Laura Henseler, and Dr. Weisbord all document the fact that, commencing in the Fall of 2015, the employee complained of unusual shortness of breath and/or heart racing with activity sufficient to necessitate two emergency department visits as well as the cardiology referral. Furthermore, Dr. Weisbord expressed an opinion to Dr. Smigel that the employee's cardiomyopathy is due to underlying and previously unrecognized afib. A trial judge is permitted to draw inferences from the record which are "reasonable, logical, and flow from the evidence of established facts." *Tanzi v. Fiberglass Swimming Pools, Inc.*, 414 A.2d 484, 487 (R.I. 1980). On appeal, such findings are valid despite the fact that other reasonable inferences could also be drawn from the evidence. *Id.* (citations omitted). The comment by the trial judge regarding the duration of the employee's medical condition is well supported by the medical documentation.

The employee's third and fourth reasons of appeal allege that the findings of the trial judge were erroneous or mistaken in that the testimony of Dr. Weisbord and the medical

evidence establish the causal connection between the employee's work activities and his cardiac condition to a reasonable degree of medical certainty. To a large extent these arguments have already been addressed by our response to the employee's first reason of appeal. In addition, we note that an expert opinion must be stated with reasonable medical certainty. *Morra v. Harrop,* 791 A.2d 472, 477 (R.I. 2002) (citing *State v. Lima,* 546 A.2d 770, 773 (R.I. 1988)). Medical evidence to establish the necessary causal relationship between certain activities and a physical injury "must speak in terms of 'probabilities' rather than 'possibilities.'" *Sweet v. Hemingway Transport, Inc.,* 114 R.I. 348, 355, 333 A.2d. 411, 415 (1975). The most positive statements of causation by Dr. Weisbord at his deposition are that the "symptoms were triggered, likely triggered by his activity that morning" and that, assuming that the employee began to experience symptoms of atrial fibrillation at work on August 26, 2016, it "would seem more likely than not" that the afib was caused by the work activities. Ee's Ex. 5 at 24:8-10 and 48:20.

Even if we were to assume *arguendo* that either statement meets the required level of probability, the employee has not demonstrated that the trial judge was clearly erroneous or that he overlooked or misconceived this testimony. As detailed above, when weighed against the other causation statements by Dr. Weisbord at his deposition and in his medical records the trial judge's determination that the employee failed to prove the requisite causal relationship is well founded. This is especially true when considering the fact that the historical foundation that forms the basis of the doctor's causation opinion was found to be of questionable credibility and/or accuracy.

Dr. Smigel's letter of February 6, 2017 suffers from similar defects. The statement that "dehydration and resultant electrolyte abnormalities can cause cardiac arrhythmias/atrial fibrillation" does not meet the probability requirement for the admission of expert opinion

testimony. Nor is this deficiency cured by the comment that the statements in the letter are made to a reasonable degree of medical certainty.

The final reason of appeal claims that the trial judge misconceived or overlooked medical evidence that the employee is disabled due to his heart condition. In that the employee failed to sufficiently establish the prerequisite causal nexus between his work activities and his alleged work injury, there was no need for the trial judge or for this appellate panel to address the issue of disability.

In conclusion, based on the foregoing discussion, we deny and dismiss the employee's appeal and affirm the decision and decree of the trial judge denying the employee's original petition seeking compensation benefits. In accordance with Rule 2.20 of the Rules of Practice of the Workers' Compensation Court, a final decree, a proposed version of which is enclosed, shall be entered on June 13, 2023.

Minicucci, J. and Pepin Fay, J., concur.

ENTER:

/s/ *Olsson, J.*

/s/ *Minicucci, J.*

/s/ *Pepin Fay, J.*