

Commonwealth of Kentucky  
Workers' Compensation Board

OPINION ENTERED: December 21, 2015

CLAIM NO. 201297740

AIG AS WORKERS' COMPENSATION OBLIGOR  
FOR CORRECTIONS CORPORATION OF AMERICA PETITIONER

VS. APPEAL FROM HON. JOHN B. COLEMAN,  
ADMINISTRATIVE LAW JUDGE

AMY HUGHES  
DR. JAMES BIDDLE  
and HON. JOHN B. COLEMAN,  
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION  
AFFIRMING  
\* \* \* \* \*

BEFORE: ALVEY, Chairman, STIVERS and RECHTER, Members.

**STIVERS, Member.** Corrections Corporation of America ("CCA") seeks review of the July 13, 2015, Opinion and Order of Hon. John B. Coleman, Administrative Law Judge ("ALJ") resolving a medical fee dispute filed by CCA in favor of Amy Hughes ("Hughes"). The ALJ found the treatment Hughes receives from Dr. James Biddle is reasonable and necessary

and therefore compensable. CCA also appeals from the August 19, 2015, Order on Reconsideration denying its petition for reconsideration.

The Form 110 settlement agreement approved by Hon. R. Scott Borders, Administrative Law Judge ("ALJ Borders") on November 13, 2013, states Hughes alleged she was injured on January 19, 2012, as a result of an insect bite at the base of her skull. It notes Hughes alleged problems with Lyme disease, the lumbar and cervical spine, and a psychological injury. The agreement sets out the impairment ratings assessed by various physicians. CCA paid medical expenses in the amount of \$13,678.58 and there were no contested or unpaid medical expenses. Hughes received a lump sum payment of \$35,000.00 which was broken down as follows:

Waiver or buyout of income benefits	\$29,325.30
Waiver or buyout of past and future Medical benefits for cervical spine and psychological complaints	\$3,000.00
Waiver of vocational rehabilitation	\$674.70
Waiver of right to reopen	\$2,000.00

Hughes did not waive her right to "past and future medical benefits for Lyme disease and lumbar spine."

Under "Other Information," is the following:

Upon approval of this agreement, Plaintiff shall retain only the right to past, outstanding, and future medical benefits for treatment of her Lyme disease and lumbar spine, pursuant to KRS 342.020.

On July 29, 2014, CCA filed a motion to reopen and Form 112 medical fee dispute. In the motion, CCA represented it has continued to pay all medical bills and Hughes has continued to treat with Dr. James Biddle in Asheville, North Carolina for Lyme disease. It noted Dr. Biddle's treatment included Diflucan, weekly penicillin shots, Flagyl, Zithromax, Magnesium, Magnesium & Melatonin, and Vitamin B complex.

CCA represented Hughes' treatment with Dr. Biddle was submitted to Dr. Daniel Wolens for utilization review. CCA cited to the opinions of Dr. Wolens expressed within his July 10, 2014, report and a supplemental report of July 14, 2014, which were attached. Pursuant to Dr. Wolens' opinions, CCA contested the compensability of all treatment provided by Dr. Biddle. It represented Dr. Wolens stated Dr. Biddle's practice does not conform to standard medical practice. CCA asserted Dr. Biddle's treatment is unnecessary and sought to be relieved from liability for the contested treatment and all similar future treatment.

In the Form 112, CCA again cited to the opinions of Dr. Wolens expressed in his July 2014 reports.

In his July 10, 2014, report, Dr. Wolens set forth the medical records he had reviewed in forming his opinions. In his discussion, Dr. Wolens noted Hughes alleged she was bitten by an insect and as a result she developed a multitude of complaints. Dr. Wolens noted that throughout these records there were references to a positive Lyme test. However, he noted all Lyme studies were unremarkable. He concluded that at most, Lyme antibodies, when initially tested, were at equivocal levels, being neither negative nor positive. Dr. Wolens noted when Lyme studies are either equivocal or positive, confirmatory testing in the form of Western Blot was required which was negative. Dr. Wolens noted the "polymerase chain reaction (PCR)" was also negative. Therefore, "any reference to Hughes having Lyme disease was frankly incorrect." Dr. Wolens opined there was no laboratory abnormality identifiable which can explain Hughes' condition. He observed Hughes' care was now being provided predominantly by Dr. Biddle who appropriately noted his practice does not conform to standard medical practice. Dr. Biddle's treatments consisted of prolonged high-dose antibiotics of multiple classes to include those

that are antibacterial and antifungal. Dr. Wolens stated there was no scientific support for such an approach. In addition, antibiotic administration in the absence of a validated infection is contraindicated.

In response to the question whether it was medically probable the current findings and subsequent treatment was related to the January 19, 2012, work injury, Dr. Wolens stated: "[u]nfortunately, from a scientific perspective, it is not possible to answer this question with certainty." First, he noted it was unknown what had occurred to Hughes as no insect was ever identified. In addition, she has wide-ranging complaints for which there is no medical explanation. Dr. Wolens posited that in order to determine whether there is a cause-and-effect relationship between an exposure and disease, one must be able to define the exposure and the disease. In this case, there is no ability to define either, other than knowing Hughes had hives which results from immune system disturbance. Therefore, nothing else can be said about her condition as wide-ranging tests for infectious disease, immunological disease, autoimmune disease, and neurological disease were all ruled out. Thus, in the absence of a defined exposure and defined disease, one must then look toward probabilities of an occurrence, and the plausibility

of there being an insect bite. Dr. Wolens set out his reasons for believing it was not plausible Hughes was bitten on the neck by a tick primarily because of her environment and the time of year the bite supposedly occurred. Dr. Wolens also determined it was not likely Hughes was bitten by an insect.

Dr. Wolens stated another issue was if there had been an insect bite of one kind or another, what was the probability the bite would explain Hughes' condition? He concluded Hughes' condition defies explanation since a very extensive multi-disciplinary evaluation was conducted which reveals not only the absence of insect-related disease, but disease of any definable kind. Therefore, had there been an insect bite, there was no identification of a disease associated with it. Therefore, it was highly implausible Hughes had a disease that would be associated with an insect bite.

With respect to whether the treatment was medically reasonable and necessary, Dr. Wolens stated as follows:

As stated above by Dr. Biddle himself, the methods he utilizes have no scientific merit and are considered an alternative to medical practice. The indiscriminate use of multiple classes of antibiotics provided over prolonged periods of time is contraindicated for

many reasons to include destruction of normal flora, emergence of Clostridia difficile colitis, adverse reaction to the antibiotics themselves, and the development of resistance. Therefore, the continuing methods, being inconsistent with standard scientific methods, I would not consider to be appropriate.

In his July 14, 2014, letter, Dr. Wolens stated it was his understanding there was an agreement for CCA to pay for treatment of Lyme disease. Consequently, two questions were posed to him; what medications are reasonable and necessary for the treatment of Lyme disease and whether or not the continuing treatment with Dr. Biddle is reasonable and necessary. Dr. Wolens stated there was a "logical error" in attempting to answer the first question since he stated in his previous report Hughes does not have Lyme disease. Thus, for purposes of responding to the question, he would address generally the appropriate treatment for a patient with Lyme disease which is the administration of antibiotics to which Borrelia spirochete is known to respond. This would include Doxycycline and Rocephin. He noted that other than a course of antibiotics for early diagnosis of Lyme disease or a more prolonged course or repeat course of antibiotics when later diagnosed, there was no specific treatment for patients who claimed to have chronic symptoms after developing Lyme

disease. Therefore, any chronic symptoms should be treated symptomatically, i.e., anti-inflammatory drugs for musculoskeletal pain, anxiolytics for anxiety, and "antidepressant for depression, etc."

Dr. Wolens opined there need not be ongoing treatment with Dr. Biddle as he was employing primarily the administration of multiple courses of antibiotics of various families to include antibacterials and antifungals. He opined there is no scientific support for the provision of antibiotics in an individual with chronic symptoms following infection with the *Borrelia* spirochete. He noted Dr. Biddle also admitted his care deviates from scientific standards. Dr. Wolens observed the scientific literature shows an increase in morbidity and mortality for post-Lyme syndrome individuals receiving chronic antibiotic administration. He stated that "per the National Institute of Allergy and Infectious Disease, chronic antibiotic administration is not indicated for post-Lyme disease syndrome." Dr. Wolens believed treatment could be provided in the local community as specialty care is not required.

By Order dated September 3, 2014, the ALJ found CCA made a *prima facie* showing for reopening, sustained the motion to reopen, joined Dr. Biddle as a party, and set a telephonic conference.

CCA filed the Form 114 Requests for Reimbursement which had been submitted by Hughes for the treatment currently at issue.

CCA introduced the July 8, 2013, report of Dr. Richard Snepar previously introduced during the litigation of Hughes' claim. Significantly, the September 25, 2014, Scheduling Order and the November 19, 2014, Benefit Review Conference ("BRC") Order identify the contested issue as Lyme disease treatment. The BRC order further illuminates the contested issue is reasonableness, necessity, and work-relatedness of the treatment.

On January 9, 2015, the ALJ conducted a hearing at which only Hughes testified. Hughes testified her first visit to Dr. Biddle was in January 2013. She settled her claim after the formal hearing conducted by ALJ Borders. At the time of settlement, Hughes was taking the same medications Dr. Biddle is currently recommending for her treatment. Consistent with the settlement agreement, CCA reimbursed Hughes for her vitamins and other items she was taking at Dr. Biddle's direction. Hughes testified Dr. Biddle preferred she pay him and then she be reimbursed. Hughes sees Dr. Biddle once a year in Asheville, North

Carolina.<sup>1</sup> Approximately every three months, she and Dr. Biddle have a phone conversation. Hughes testified one of the main reasons she settled her claim was to keep her past and present medical benefits. She provided the following regarding her treatment by Dr. Biddle:

A: Every three months we do a phone call and we do like refills and everything at that time. And I was doing blood work every six weeks but since it will be good for a whole year we discontinued doing that until yearly and then if something is wrong then we'll go back to that. So right now mainly we just like go over it and make sure the symptoms, you know, is not bothersome to where I can't handle it and then he'll order blood work as needed now? [sic]

Hughes listed the medication she was currently taking for Lyme disease. CCA also pays for Lortab prescribed by another doctor for her lumbar back condition.<sup>2</sup> Regarding the difference in the treatment she is now receiving versus her treatment at the time she testified at the hearing before ALJ Borders, Hughes explained:

A: As often as I take Dioflucan has changed and the Flagyl. Everything has stayed the same. It's just kinda- I know when I need it and I don't have to take it as often. And I don't take the

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<sup>1</sup> Dr. Biddle's Curriculum Vitae relates his office is in Asheville, North Carolina. He is a Diplomate, American Board of Internal Medicine, and Certified in Clinical Metal Toxicology and Advanced Proficiency in Chelation Therapy.

<sup>2</sup> This treatment is not being contested.

Vandale (sic) Sulfate anymore and I don't take the Ryclampin (sic) which is misspelled in the report. It was spelled R-s-a-n-t-h-a-n which that was suppose to have been called Ryclampin. I'm not on it anymore. I'm not on the arthomycin anymore. And they did add the Cholestyem for the diarrhea and the Vicillin Shots.

Hughes testified there was improvement in her CD 57 which she explained, "is blood work that tests how [her] immune system is responding to the medication." The lower the number the worse the immune system is responding. She testified hers jumped from 42 to 98. Hughes explained the difference in her symptoms since she started seeing Dr. Biddle:

Q: Tell us about your symptoms, From [sic] the time you started seeing Dr. Biddle tell us how they were immediately seeing Dr. - before you saw Dr. Biddle and how they have improved if they have since you've seen him.

A: Before I went to Dr. Biddle I couldn't shower myself. I couldn't drive. I couldn't take care of my child. We were living with my mom who had to help cook because my husband worked. I was in a wheelchair. I couldn't go up and down steps. I had to take my hand and physically move my legs. I couldn't hardly remember anything. I was very sick. My hands would draw up. I couldn't open a can of pop. I couldn't wash my own hair. I couldn't do anything really.

Q: And now that you've seen him and he's giving you these various

medications it appears you're doing much better.

A: Now that I'm taking all this medicine I can drive. I can bathe my child. I can cook for my husband most of the time. I'm not saying I'm a hundred percent better by no means but I would rather feel the way I do today than what I did without my medicine. I still have to have help. I still have bad days. I still have days that I lay in the bed most of the day but I have more good days than I do bad days where I was having a lot of bad days and hardly ever any good days before the medicine.

Hughes testified she takes no narcotics for the Lyme disease.

Hughes explained she has blood work is at Pikeville Medical Center and the results are forwarded to Dr. Biddle. She was having blood work every six weeks but Dr. Biddle discontinued this because her condition remained fairly normal. Hughes anticipated she would undergo yearly blood work before she saw Dr. Biddle in March.

Hughes converses with Dr. Biddle by phone every three months. Hughes estimated her phone calls with Dr. Biddle ranged between fifteen and thirty minutes. She explained that since the August 2013 final hearing, Dr. Biddle has added Cholestyrem and Penicillin which is known as "Vicillin LA Shots." Hughes sees Dr. Biddle because there is no "Lyme Leader (sic) doctors in the area."

Hughes testified she checked the Lyme Leader website and Dr. Biddle was the closest Lyme Leader doctor accepting new patients. She acknowledged there was another physician in Virginia which is approximately the same distance. Hughes recounted how the medication is prescribed and received:

Q: Now in terms of your treatment with Dr. Nadar and Dr. Biddle are those completely separate? Do they speak to each other about what they're prescribing?

A: Not that I know of. Which, of course, Dr. Nadar has as [sic] list that I give him of the medicine that I'm on.

Q: And how often is it that you go to fill your prescriptions?

A: What do you mean? For both of them or just Dr. Biddle?

Q: Just for Dr. Biddle.

A: I go once a month.

Q: So just briefly how does it work? Do you speak to him every three months and then he writes three refills and then you'll go once a month to get that refilled?

A: Yes.

At the conclusion of the hearing, Hughes introduced office notes of Dr. Biddle dated January 28, 2013, March 27, 2013, June 25, 2013, and March 24, 2014. In his initial report of January 28, 2013, Dr. Biddle noted Hughes stated she did not know whether she had Lyme disease

but she was still sick and unable to work. Hughes had not been released by her physicians to return to work. He noted Hughes and her husband had investigated Lyme Leader physicians hoping he could help her improve. Under the heading "Assessment," Dr. Biddle stated as follows:

We have discussed the Two 'Standards of Care' around Lyme disease, so please understand that we do not treat Lyme in the same way as conventionally-oriented physicians. In the general medical community, it is thought that Lyme disease is a rare and acute condition that is resolved with one short round of antibiotics. We believe that Lyme can become chronic, may not be curable, and instead may need to be suppressed, as in conditions like TB or herpes. We have a consent form to read and sign, indicating understanding of the difference.

Dr. Biddle indicated he focused on the overall health of the patient's body and immune system. Dr. Biddle set forth the course of treatment he recommended for Hughes. His reports dated March 27, 2013, June 25, 2013, and March 24, 2014, set out Hughes' problems, his treatment recommendations, and the progress she made.

The transcript of the August 21, 2013, hearing before ALJ Borders reflects Hughes testified she has Lyme disease and had been treating with Dr. Biddle, who she characterized as a "Lyme Leader doctor." At the time of the hearing, Hughes had been to Dr. Biddle's office one

time and had four phone conversations. She explained lab work is performed at the Pikeville Medical Center and forwarded to Dr. Biddle. Hughes provided a list of all the medications she was taking at that time. She stated she provides every doctor she sees with a list of her medications. Hughes acknowledged much of what has been provided by Dr. Biddle is vitamins, herbs, and antibiotics to help with Lyme disease. Hughes was on none of these medications before her injury. At the time she was also seeing Dr. Fogg at Pikeville Medical Center every two months for pain management who prescribes Lortab.<sup>3</sup>

The March 2, 2015, Agreed Order reflects that after the hearing the parties discussed the fact Hughes' next scheduled appointment was March 2015, at which point some or all of the treatment may be discontinued. The parties agreed the claim would be removed from submission and Dr. Biddle's treatment would continue until Hughes attends her next office visit and a determination is made as to what, if any, ongoing treatment Dr. Biddle recommended.

On April 8, 2015, CCA filed the April 6, 2015, report of Dr. Wolens. In his report, Dr. Wolens again

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<sup>3</sup> Hughes did not provide Dr. Fogg's first name.

stated "[u]nfortunately, this case has somewhat taken a life of its own, Ms. Hughes now being diagnosed and having her claim accepted for Lyme disease." Dr. Wolens stated there is no evidence of a tick bite, no clinical evidence of a tick-borne infection, no response to therapeutic antibiotic management of Lyme disease, and the diagnostic testing was all negative. He stated: "[t]herefore, as absolute as one can get, there is absolute evidence that this individual has not and does not have Lyme disease."

Dr. Wolens stated the hearing testimony of Hughes and Dr. Biddle's March 23, 2015, record did not alter his prior opinions. Dr. Wolens opined Hughes has been provided a myriad of treatment regimens which have been disproven by medical research. He stated the CD57 counts have no basis in detecting the presence of Lyme disease nor determining the results of therapeutic management. He concluded with the following:

At the risk of sounding like a broken record, I once again cannot emphasize enough that this individual does not have and has never had Lyme disease, the effects thereof, or any other tick or insect borne illness. What this individual does have is completely unknown. As I have noted previously, the indiscriminate use of antibiotics, and in particular multiple antibiotics representing a broad spectrum of activity against multiple classes of bacteria and fungus, is fraught with

risks. Ms. Hughes already reports experiencing diarrhea from the use of antibiotics. I had cautioned previously that indiscriminate antibiotic use, and even discriminate antibiotic use, can result in *Clostridium difficile* intestinal infection with the risk of death. There is also the risk of development of bacterial resistance to antibiotics due to chronic exposure, which itself can present a significant risk to the individual and society. There is lastly the iatrogenic injury of leading this individual to believe that she has a disease process that is not present, with the disabling effects thereof. Ms. Hughes [sic] dependence upon Dr. Biddle's care is already an effect of that iatrogenic injury.

In my last report of 7/14/2014, I had included a reference list in support of my opinions. I have added two references to this report as well, the first cited above by Marques in 2009. I have also added a citation by Wormser in 2006, representing a publication in 2006, discussing the assessment, treatment, and prevention of Lyme disease. This article from the journal *Clinical Infectious Diseases* also underlies the Centers of Disease Control recommendations for the identification and management of Lyme disease. It is of interest to note that this document does not support the use of CD57 counts, nor the provision of chronic antibiotic administration for individuals believed to have chronic Lyme disease or chronic Lyme syndrome, which in this case, Ms. Hughes does not.

Hughes introduced Dr. Biddle's March 23, 2015, office note. That report reflects Hughes had lost weight

since her last visit and probably would have lost more if she had improved her diet. Dr. Biddle noted Hughes had some good progress and has been doing the German Protocol for Lyme disease for approximately a year. He went on to list the medications Hughes was currently taking and scheduled to take. Dr. Biddle noted Hughes continued to have the same symptoms when she was initially seen by him but they are much shorter in duration and not anywhere near as severe as they initially had been. Hughes had a lot more good days than bad, but even on the good days she still needed a nap in the afternoon. Hughes has had improvement in most of her symptoms with the latest being an improvement in walking. She still has a little bit of foot drag, but can go up and down steps. Dr. Biddle noted Hughes reminded him that when they first met she was unable to use the steps in his office.

After setting out her current symptoms and course of treatment, under "Assessment," Dr. Biddle noted Hughes' CD57 was down from 98 to 55. He observed Hughes was afraid of big changes because she is still continuing to improve and did not want to rock the boat. Dr. Biddle believed Hughes "seems like she has come more to a plateau with not any big jumps; just the slow gradual improvement." Hughes is reluctant to go off the antibiotics as her symptoms have

not completely resolved and she would like to keep addressing them. Dr. Biddle decided to keep Hughes on approximately the same antibiotics but with a little stronger dose. In addition, Rifampin would again be prescribed because the best CD57 result occurred while Hughes was taking this medication. Dr. Biddle set out the recommended changes in her diet. He also discussed the effects of certain medications she was taking.

On April 10, 2015, CCA filed the July 5, 2013, report of Dr. Brian Greenlee introduced during the initial proceedings regarding the results of his psychological evaluation.

The ALJ conducted another hearing on May 20, 2015. At that hearing, the ALJ noted the reopening pertained to the reasonableness and necessity of the treatment rendered by Dr. Biddle. He also noted the report from Dr. Snepar filed during the initial litigation had recently been introduced.

Hughes testified at the hearing she continues to see Dr. Biddle on an annual basis. Her blood work is performed at the Pikeville Medical Center and faxed to Dr. Biddle, and he either changes or modifies the medication or talks to her. Because her CD57 level had dropped from 98 to 55, Hughes had resumed taking Rifampin. She also

discussed the changes in her medication including the addition of Rifampin. Hughes testified the medications she is taking are helping:

Q14: In what ways do they help that you've noticed that you can tell?

A: I've got more energy. I can walk. I can speak. I can function. I can - I can do things that people take for granted like showering, you know, just everyday living activities. I couldn't function without help before and now I can. I can drive. I don't have to type GPSA in my system to get to my mom and dad's house. Just simple things that you take for granted I can do as long as I have my medicine.

Hughes continues to receive treatment from Dr. Nadar for her spinal pain. He prescribes Lortab 5 on an as needed basis. She sees Dr. Nadar approximately every four or five months. Hughes gets her herbs and supplements from an herbal store known as "Nutrients, Etc," located in the building where Dr. Biddle's office is located.

After reviewing the evidence, the ALJ provided the following:

The plaintiff testified at formal hearings held herein on January 9, 2015 and May 20, 2015. She currently sees Dr. Biddle on a yearly basis and speaks with him by phone every three months as well as has blood work periodically at Pikeville Medical Center. She reviewed her current medication regimen and explained that her condition has significantly improved with his

treatment. She described being unable to perform such activities as showering, driving, climbing stairs or taking care of her son prior to beginning treatment with Dr. Biddle. She testified that she was wheelchair bound prior to beginning treatment with Dr. Biddle. While she acknowledged that she continues to have bad days at times, she is now able to bathe her son and cook dinner. She described having increased energy and is better able to function. At the formal hearing, she testified that at the time of her most recent visit of March 23, 2015, medications were adjusted as her CD-57 level had fallen from 98 to 55. She testified that she is very satisfied with the treatment regimen prescribed by Dr. Biddle. On cross examination, the plaintiff testified that she found Dr. Biddle through an internet search and he was the closest physician who treats Lyme disease that was accepting new patients. She testified that she is currently taking two herbal anti-depressants. She obtains her medication from a pharmacy, but gets the herbal supplements at Dr. Biddle's location in Asheville, North Carolina.

It is the employer's responsibility to pay for the cure and relief from the effects of an injury or occupational disease, all medical, surgical, hospital treatment, including nursing, medical and surgical supplies and appliances as may be reasonably be required at the time of the injury and thereafter during disability... K.R.S.342.020. However, treatment which is shown to be unproductive or outside the type of treatment generally accepted by the medical profession is unreasonable and non-compensable. This finding is made by the Administrative Law Judge based upon the facts and

circumstances surrounding each case. *Square D Company v. Tipton* 862 SW2d 308 (Ky. 1993). In a post-award medical fee dispute, the employer has the burden of proving that contested medical treatment is not reasonable or necessary for the cure and relief of a work injury. *National Pizza Company v. Curry*, 802 SW2d 949 (Ky. App., 1991). However, the burden of proving work relatedness and causation remains with the claimant. *R.J. Corman R.R. Construction Company v. Haddix, Ky.*, 864 SW2d 915 (1993). 803 KAR 25:096 Section 7(1) provides that prior to the resolution of a workers compensation claim by opinion or order of an arbitrator or administrative law judge, the medical payment obligor shall notify the medical provider and employee of its denial of a specific statement for services, or payment for future services from the same provider, in writing within 30 days following receipt of a completed statement for services.

This is a very unusual case involving the compensability of treatment for Lyme disease. The defendant moved to reopen the claim and initiate a medical dispute on July 29, 2014, eight months after the claim was settled on November 25, 2013. While statements contained in a settlement agreement shall not be considered by the Administrative Law Judge as an admission against interest in a reopened claim, the parties are bound by the terms agreed to in the settlement. In this particular settlement, the parties had gone through a final hearing wherein the plaintiff's treatment with Dr. Biddle for Lyme disease was thoroughly examined. Thereafter, the parties agreed to settle the claim which was

approved on November 25, 2013. As part of that agreement, the defendant and the plaintiff agreed to waive the claim for past and future medical benefits for cervical spine and psychological complaints. However, there was no waiver or buyout of past or future medical benefits for Lyme disease in the lumbar spine.

The plaintiff argues in this case the defendant should be "equitably estopped" from now contesting those medical benefits for treatment of Lyme disease as the initiation of the medical dispute occurred in such a short time after the settlement agreement. This does give the appearance the settlement was entered into with the intention of contesting said treatment immediately after obtaining a binding agreement on the other issues. This would clearly be a misrepresentation of intention for entering into an agreement. A thorough review of the regulations seems to indicate this type of situation has been contemplated. As noted above, Section 7 of 803 KAR 25:096 provides for the medical payment obligor to notify a medical provider and the employee of intent to deny future services prior to the resolution of a claim. It seems to the undersigned, this regulation covers such an instance as this as the plaintiff's treatment for Lyme disease, which was agreed to be paid for in November of 2013 has not changed but nevertheless, the defendant has now decided to contest the treatment on the grounds of relatedness and reasonableness and necessity. If the settlement agreement is going to stand for anything and be binding, the defendant has to be responsible for payment of reasonable and necessary treatment of Lyme disease as the terms

of the agreement indicate the parties agreed to a waiver of past and future medical benefits for cervical spine and psychological complaints but not in regards to Lyme disease and the lumbar spine condition.

The defendant now asserts the plaintiff should look for a psychological reason for continuing treatment. While the evidence presented did indicate there may have been some pre-existing depression issues, this does not take away from the fact the defendant agreed to pay for Lyme disease treatment only to contest that treatment when she continued. Dr. Wolens did summarize much of the medical treatment which documents the difficulties in diagnosing the plaintiff's problems after the insect bites. The plaintiff has testified that treatment with Dr. Biddle has helped her condition. Dr. Biddle indicates that his treatment has been somewhat successful and is aimed at bridging the gap with integrative medicine between conventional and alternative healthcare. He explained the plaintiff's condition is a chronic condition, oftentimes without a cure but only continuing treatment for management. While his treatment may be different than that recommended by Dr. Wolens, it seems to have given the plaintiff some relief from the effects of her condition following the work related insect bite. While the treatment protocols may be subject to future review, I have simply not been convinced at the current time the defendant has proven the treatment, which was initiated prior to the settlement and continued thereafter, is unreasonable or unnecessary. Given the fact the defendant agreed to pay for treatment of Lyme disease, I must find

the current treatment with Dr. Biddle to remain compensable under KRS 342.020.

CCA filed a petition for reconsideration raising the same arguments it now raises on appeal. CCA requested additional findings of fact regarding the compensability of Dr. Biddle's treatment.

In his August 19, 2015, Order denying the petition for reconsideration, the ALJ noted CCA's argument he had mischaracterized the issue. However, he noted a review of the file indicated Hughes was treating for Lyme disease with Dr. Biddle at the time of the original litigation. Hughes testified regarding her treatment at the hearing conducted by ALJ Borders and the matter was settled thereafter allowing medical benefits for the continued treatment of Lyme disease. He noted Hughes continued her treatment only to have it contested shortly after settlement. The ALJ concluded the proceedings in the medical dispute clearly documented the issue to be treatment of Lyme disease based on work-relatedness as well as the reasonableness and necessity. The ALJ noted he found the contested treatment to be compensable based, in part, on the fact the treatment is the same type of treatment which Hughes was undergoing at the time of her original settlement and CCA did not notify the medical

provider of its intent to challenge future services at that time as required by the regulations. The ALJ found CCA failed to prove the treatment is unreasonable and unnecessary. Therefore, CCA was bound to pay for reasonable and necessary treatment of Lyme disease as required by the settlement agreement.

On appeal, CCA argues the ALJ failed to accurately analyze the issue before him. It asserts it did not file the medical fee dispute to contest the compensability of all treatment for Lyme disease. Rather, the medical fee dispute contested the treatment provided by Dr. Biddle. CCA insists it has never requested to be relieved of liability for the treatment of Lyme disease. However, it seeks to be relieved of liability for the controversial and unscientific treatment offered by Dr. Biddle.

CCA notes KRS 342.020(7) does not require it to pay for medical treatment when the medical expenses are incurred without reasonable benefit to the employee. It relies primarily upon the Court's holding in Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993) arguing the treatment of Dr. Biddle is only marginally effective and therefore unproductive. CCA maintains case law demonstrates the question of whether ongoing treatment offered by Dr. Biddle

is compensable depends on the following: 1) whether it is unproductive or outside the type of treatment generally accepted by the medical profession; 2) whether it is reasonably required; and 3) whether it provides reasonable benefit to the patient. CCA contends the answers to the questions are clear and the contested treatment offered by Dr. Biddle is not compensable. It also relies upon the records of Dr. Biddle from which Dr. Wolens quoted the following excerpt:

Please be advised that Asheville Integrative Medicine is an integrative medicine consulting practice and not designed to be a primary care provider ... *It has been our experience that we cannot provide appropriate documentation to withstand scrutiny in disability/workers' compensation cases, which could cause us to be accused of fraud if challenged.* Therefore, we regret that Dr. Biddle will not complete physical assessment-type forms for insurance or disability claims. Id. at 15. (emphasis added)

Based on the above-language, CCA contends Dr. Biddle is cognizant of the fact his treatment is outside the type of treatment generally accepted by the medical profession as reasonable. It cites to the July 8, 2013, report of Dr. Richard Snepar introduced during the initial litigation of the claim in which he noted Hughes did not

require long-term antibiotic therapy for Lyme disease or any other infectious disease.

CCA cites the opinion of Dr. Wolens that there is no scientific support for Dr. Biddle's approach. Therefore, Dr. Biddle admittedly deviated from the scientific standards. CCA also cites Dr. Wolens' statement that pursuant to the National Institute of Allergy and Infectious Disease, chronic antibiotic administration is not indicated for post Lyme disease syndrome. It notes Dr. Wolens opined the treatment of Hughes' condition can be provided in her local community at her primary care level. Thus, the specialty care of Dr. Biddle is not required. CCA maintains:

Dr. Biddle's claim that the discontinuation of Rifampin caused the decreased CD57 count cannot be scientifically supported. *Id.* at 4. Dr. Wolen's [sic] noted that, "Current treatment recommendations for patients with suspected chronic Lyme syndrome do not include chronic antibiotic administration. (*Wormser 2006 - CDC*)."  
*Id.* All studies of patients with chronic Lyme syndrome have shown no improvement with chronic antibiotic administration. *Id.* This is unrebutted evidence.

CCA contends Dr. Biddle's treatment is not reasonable or necessary to treat Hughes' condition because it is unproductive, outside the type of treatment generally

accepted by the medical profession as reasonable, and is not of reasonable benefit to Hughes.

In a post-award medical fee dispute, the burden of proof and risk of non-persuasion with respect to the reasonableness and necessity of medical treatment falls on the employer. National Pizza Company vs. Curry, 802 S.W.2d 949 (Ky. App. 1991).

At the May 20, 2015, hearing, the ALJ identified the issue as whether the treatment offered by Dr. Biddle was reasonable and necessary. In its brief on appeal, CCA has argued the medical evidence clearly reveals Hughes' treatment is not reasonable and necessary. Thus, CCA bore the burden of proof in this claim.

Since CCA was unsuccessful before the ALJ regarding the reasonableness and necessity of Dr. Biddle's treatment, the sole issue in this appeal is whether the evidence compels a different conclusion. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984).

The claimant bears the burden of proof and risk of persuasion before the board. If he succeeds in his burden and an adverse party appeals to the circuit court, the question before the court is whether the decision of the board is supported by substantial evidence. On the other hand, if the claimant is unsuccessful before the board, and he himself appeals to the circuit court, the question before the court is

whether the evidence was so overwhelming, upon consideration of the entire record, as to have compelled a finding in his favor.

Compelling evidence is defined as evidence that is so overwhelming no reasonable person could reach the same conclusion as the ALJ. REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985). In other words, an unsuccessful litigant on appeal must prove that the ALJ's findings are unreasonable and, thus, clearly erroneous, in light of the evidence in the record. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986). There, the Supreme Court said:

If the fact-finder finds against the person with the burden of proof, his burden on appeal is infinitely greater. It is of no avail in such a case to show that there was some evidence of substance which would have justified a finding in his favor. He must show that the evidence was such that the finding against him was unreasonable because the finding cannot be labeled "clearly erroneous" if it reasonably could have been made. Thus, we have simply defined the term "clearly erroneous" in cases where the finding is against the person with the burden of proof. We hold that a finding which can reasonably be made is, perforce, not clearly erroneous. A finding which is unreasonable under the evidence presented is "clearly erroneous" and, perforce, would "compel" a different finding.

Id. at 643.

As fact-finder, the ALJ has the sole authority to determine the quality, character and substance of the evidence. Square D Co. v. Tipton, supra. Similarly, the ALJ has the sole authority to judge the weight to be accorded the evidence and the inferences to be drawn therefrom. Miller v. East Kentucky Beverage/Pepsico, Inc., 951 S.W.2d 329 (Ky. 1997); Luttrell v. Cardinal Aluminum Co., 909 S.W.2d 334 (Ky. App. 1995). The fact-finder may reject any testimony and believe or disbelieve various parts of the evidence, regardless of whether it comes from the same witness or the same adversary parties' total proof. Magic Coal Co. v. Fox, 19 S.W.3d 88 (Ky. 2000); Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999); Halls Hardwood Floor Co. v. Stapleton, 16 S.W.3d 327 (Ky. App. 2000).

In the case *sub judice*, we believe the evidence does not compel a contrary result and substantial evidence, consisting of Hughes' testimony and Dr. Biddle's March 23, 2015, note, supports the ALJ's decision.

We reject CCA's assertion the ALJ failed to accurately analyze the issue. The issue, as defined in the November 19, 2014, BRC Order and by the ALJ at the May 20, 2015, hearing, was the reasonableness and necessity of the treatment. Clearly, the only treatment being offered for

the Lyme disease was that offered by Dr. Biddle. The ALJ specifically stated he was not convinced CCA had proven the treatment by Dr. Biddle initiated prior to the settlement was unreasonable or unnecessary. Thus, we believe the ALJ clearly understood the issue was whether the treatment for Lyme disease offered by Dr. Biddle was reasonable and necessary.

Hughes' testimony at the hearings held on January 9, 2015, and May 20, 2015, establishes she has received substantial relief from her symptoms as a result of Dr. Biddle's treatment regimen. Dr. Biddle's report of March 23, 2015, confirms Hughes' testimony as he notes the specific improvement in Hughes' symptoms.

As noted by the ALJ, CCA was well aware Hughes was seeing Dr. Biddle during the pendency of the claim. In fact, Hughes' first three visits to Dr. Biddle's office in Asheville, North Carolina pre-date the date of settlement. Hughes' testimony at the hearing before ALJ Borders clearly outlines the medications prescribed by Dr. Biddle for Lyme disease. After the hearing, the parties reached an agreement resulting in CCA specifically agreeing to be responsible for the treatment of Hughes' Lyme disease. The report of Dr. Snepar introduced during the original proceeding, upon which CCA partially relies, merely attacks

Hughes' assertion she has Lyme disease. Even though Dr. Snepar opined no further treatment is necessary, his opinion is based on his belief Hughes does not have Lyme disease. It does not in any way address Dr. Biddle's treatment of Hughes' Lyme disease. Thus, we find it has no probative value.

On the other hand, a substantial portion of Dr. Wolens' reports is devoted to establishing Hughes does not have Lyme disease. Dr. Wolens' opinion Lyme disease is not present rings hollow in light of the terms of the settlement agreement in which CCA agreed to be responsible for the treatment of her Lyme disease. In the case *sub judice*, there does not appear to be any dispute that Dr. Biddle's treatment, as he noted, is not the same as that offered by "conventionally-oriented physicians." That fact aside, we believe the issue is whether Dr. Biddle's treatment provides a reasonable benefit to Hughes.

In Square D Co. v. Tipton, supra, discussing KRS 342.020(1), the Supreme Court held:

We believe, however, that this section relieves an employer of the obligation to pay for treatments or procedures that, regardless of the competence of the treating physician, are shown to be unproductive or outside the type of treatment generally accepted by the medical profession as reasonable in the injured worker's particular case. We

also believe that such decisions should be made by the ALJs based on the particular facts and circumstances of each case, so long as there is substantial evidence to support the decision.

Id. at 310.

Hughes' testimony and Dr. Biddle's March 23, 2015, report establish the treatment he is providing is far from unproductive.

As to whether Dr. Biddle's treatment is outside the type of treatment generally accepted by the medical profession as reasonable, only Dr. Wolens has offered that opinion. We do not believe the evidence compels such a finding based solely upon the opinions of Dr. Wolens. In Square D Co. v. Tipton, supra, the Supreme Court noted all of the physicians who testified, including Dr. Atasoy, agreed the procedure was controversial within the medical community. Here, the evidence is far from compelling that the treatment offered by Dr. Biddle is outside the type of treatment generally accepted by the medical community. In reviewing Dr. Biddle's records, we note Dr. Biddle indicated his office did not treat Lyme disease in the same way as "conventionally-oriented physicians." By making that statement, Dr. Biddle did not concede his treatment is outside the type of treatment generally accepted by the

medical profession. In his July 10, 2014, report, Dr. Wolens cites to the following:

Letter to whom it may concern from June Levine, office manager, for Asheville Integrative Medicine. 'Please be advised that Asheville Integrative Medicine is an integrative medicine consulting practice and not designed to be a primary care provider. We focus on bridging the gap between conventional and alternative healthcare. The patient's medical record at AIM is tailored to help us improve patient outcomes, not to document levels of disability. It has been our experience that we cannot provide appropriate documentation to withstand scrutiny in disability/workers' compensation cases, which could cause us to be accused of fraud if challenged. Therefore, we regret that Dr. Biddle will not complete physical assessment-type forms for insurance or disability claims.'

We find no such statement in Dr. Biddle's records introduced in these proceedings.

We conclude the above notation and the opinions of Dr. Wolens do not establish Dr. Biddle's treatment was outside the type of treatment generally accepted by the medical profession. Unlike in Square D Co. v. Tipton, supra, there is not a unanimous agreement Dr. Biddle's treatment is outside the type of treatment generally accepted by the medical profession. Unconventional medical treatment is not *per se* unacceptable treatment within the medical community. In Square D Co. v. Tipton, supra, the

Supreme Court directed the decision as to what is reasonable and necessary should be made by the ALJ based on a particular facts and circumstances in each case. In the case *sub judice*, there is no basis for setting aside the ALJ's decision.

In summary, KRS 342.020 provides the employer must pay for medical benefits that are reasonable and necessary for the cure and relief of an employee's work-related injury. National Pizza Co. v. Curry, *supra*. A medical procedure will not be considered reasonably necessary for the cure and relief of an injury if it is unproductive or outside the type of treatment accepted by the medical profession as reasonable. Square D Co. v. Tipton, *supra*. Temporary relief may be sufficient to justify payment for treatment depending on the circumstances of a given case. However, a demonstration of "relief" alone is not the standard for compensability. KRS 342.020. The treatment provided must also be reasonable and necessary, providing a "reasonable benefit" to the injured worker. Id. The issue of what is a "reasonable benefit" is a medical question of fact that must be decided by the ALJ on a case-by-case basis. Where the medical proof regarding the issue is conflicting, the ALJ may pick and choose what evidence is most credible.

Relying upon Hughes' testimony and the records from Dr. Biddle, the ALJ concluded Dr. Biddle's treatment provided relief to Hughes and was not unreasonable and unnecessary treatment of her condition. As previously noted, since Hughes' testimony and the March 23, 2015, record of Dr. Biddle constitute substantial evidence supporting the ALJ's decision and the evidence does not compel a contrary result, we have no authority to disturb the ALJ's decision.

With respect to the dissent, even though the ALJ did not explicitly address whether Dr. Biddle's treatment is outside the type of treatment generally accepted by the medical profession, we believe he tacitly confronted the issue and rejected CCA's argument. The ALJ addressed CCA's objection to Dr. Biddle's treatment modality and rejected CCA's argument with the following:

The plaintiff has testified that treatment with Dr. Biddle has helped her condition. Dr. Biddle indicates that his treatment has been somewhat successful and is aimed at bridging the gap with integrative medicine between conventional and alternative healthcare. He explained the plaintiff's condition is a chronic condition, oftentimes without a cure but only continuing treatment for management. While his treatment may be different than that recommended by Dr. Wolens, it seems to have given the plaintiff some relief from the effects

of her condition following the work related insect bite.

Additionally, had the ALJ agreed with Dr. Wolens that Dr. Biddle's treatment is outside the type of treatment generally accepted by the medical treatment he would have so found and resolved the dispute in favor of CCA. We believe the ALJ clearly understood CCA's objection to Dr. Biddle's treatment regimen and concluded it was without merit.

Accordingly, the July 13, 2015, Opinion and Order and the August 19, 2015, Order ruling on the petition for reconsideration are **AFFIRMED**.

ALVEY, CHAIRMAN, CONCURS.

RECHTER, MEMBER, CONCURS IN PART, DISSENTS IN PART, AND FILES A SEPARATE OPINION.

**RECHTER, MEMBER.** I respectfully dissent in part because the ALJ did not adequately address whether the treatment Hughes is receiving from Dr. Biddle conforms to standard medical practice. This issue was raised by the employer via Dr. Wolens' medical opinion. In Square D v. Tipton, our Supreme Court made clear that the employer is not responsible for treatment that is "outside the type of treatment generally accepted by the medical profession as reasonable." 862 S.W.2d at 310. While the ALJ is not required to accept Dr.

Wolens' opinion on this matter, given the evidentiary circumstances of this case, I believe he was required to squarely address this issue in his opinion.

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