

Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: December 23, 2015

CLAIM NO. 201275710

ALEXIA WOODS

PETITIONER

VS.

APPEAL FROM HON. R. SCOTT BORDERS,
ADMINISTRATIVE LAW JUDGE

CORRECT CARE
HON. R. SCOTT BORDERS,
ADMINISTRATIVE LAW JUDGE
and DR. ROBERT W. LINKER

RESPONDENTS

AND

DR. ROBERT W. LINKER

PETITIONER

VS.

ALEXIA WOODS
CORRECT CARE
and HON. R. SCOTT BORDERS,
ADMINISTRATIVE LAW JUDGE

RESPONDENTS

OPINION
AFFIRMING

* * * * *

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

STIVERS, Member. Alexia Woods ("Woods") and Dr. Robert W. Linker ("Dr. Linker") seek review of the June 30, 2015, Opinion and Order of Hon. R. Scott Borders, Administrative Law Judge ("ALJ") resolving a post-award medical fee dispute in favor of Correct Care. Both parties also appeal from the July 28, 2015, Order overruling their petitions for reconsideration.

In an August 4, 2014, Supplemental Opinion, Award, and Order, relying upon the opinions of Dr. Jules Barefoot who assessed a 3% impairment rating for "persistent paresthesiae, left upper extremity," Hon. Steven Bolton, Administrative Law Judge ("ALJ Bolton") determined Woods sustained a compensable work-related injury. Based on the opinions of Drs. Barefoot and Huey Y. Tien, ALJ Bolton determined Woods was entitled to permanent partial disability ("PPD") benefits enhanced by the three multiplier pursuant to KRS 342.730(1)(c)1. ALJ Bolton also awarded medical benefits.¹ No appeal was taken from this decision.

¹ ALJ Bolton's August 4, 2014, decision was supplemental since on January 31, 2013, he entered an interlocutory award determining Woods had not reached maximum medical improvement and based on the opinions of three doctors referred her to Kleinert Kutz & Associates for an evaluation of whether she suffered from carpal tunnel syndrome. After receiving the reports of Dr. Tien and other medical evidence, ALJ Bolton subsequently entered the August 4, 2014, decision.

On January 20, 2015, Correct Care filed a motion to reopen and a Form 112 contesting Dr. Linker's request for pre-certification for surgery of the "left vat procedure with resection 1st rib." It also filed a motion to join Dr. Linker as a party. In its motion to reopen, Correct Care provided the litigation history, the decisions of ALJ Bolton, Dr. Tien's records, Dr. Linker's request for pre-certification, and the medical records review report of Dr. Richard Mortara.

Correct Care stated when Woods was seen by Dr. Tien on May 9, 2014, his notes reflect the additional EMG and NCS tests performed on May 5, 2014, were normal except for a new finding of mild C8 radiculopathy. Dr. Tien released Woods from his care and referred her to Dr. Linker who treats proximal nerve irritation conditions. Correct Care represented Dr. Tien's diagnosis was upper extremity peripheral neuropathy, myofascial pain. It stated that on December 19, 2014, Dr. Linker's office faxed to KEMI, the carrier for Correct Care, a request for pre-authorization of surgery to treat Woods for thoracic outlet syndrome. The procedure was described as "left vat procedure with resection first rib." Correct Care represented that as a result, KEMI obtained a medical records review from Dr. Mortara, an orthopedic surgeon, who questioned whether the

diagnosis of thoracic outlet syndrome was proper. Correct Care represented that assuming thoracic outlet syndrome was the proper diagnosis Dr. Mortara explained it was not causally related to the August 12, 2012, injury. Correct Care requested the ALJ resolve the dispute as to whether the proposed thoracic outlet syndrome surgery was causally related to the effects of the injury.

On February 12, 2015, Woods filed a response asserting Correct Care had no grounds to contest the treatment because the medical fee dispute was procedurally deficient. Woods raised the same issues regarding the deficiency of the motion that she raises on appeal. She also asserted Correct Care failed to meet its burden of proof to contest the proposed surgery. Woods asserted Correct Care's denial is not supported by any evidence of record demonstrating the recommended treatment is unreasonable or unnecessary. Woods notes Dr. Mortara did not address the reasonableness and necessity of the treatment. Instead, Correct Care's denial was based on Dr. Mortara's opinion that Woods' thoracic outlet syndrome is not related to the subject work injury. It contended this issue was decided by ALJ Bolton as he found Woods suffered a compensable work-related injury resulting in persistent paresthesiae in the left upper extremity for which she was

entitled to all reasonable and necessary medical treatment. Woods contended the opinions of Dr. Mortara do not rise to the level required by the case law in order for Correct Care to deny the medical treatment. In support of its response, Woods relied upon and designated the medical records of BaptistWorx, Dr. Paul Goodlett, Dr. Barefoot, and Dr. Tien previously filed in the underlying claim. Woods also designated the hearing transcript in the underlying claim.

In an Order dated February 17, 2015, the ALJ noted Correct Care had filed a medical fee dispute asserting the treatment was not reasonable or necessary for the cure and relief of the work-related condition and/or not causally related to the effects of the work-related condition. The ALJ noted Correct Care's motion was supported with the utilization review report from Dr. Mortara and Woods was given the opportunity to respond. The ALJ found Correct Care made a *prima facie* showing for reopening, sustained the motion to reopen, and joined Dr. Linker as a party. The ALJ also set a date for a telephonic conference.

In a March 10, 2015, Order, the ALJ noted a scheduling order following initial conference on medical dispute reopening was conducted and Woods, Correct Care,

and Dr. Linker were all represented. The challenged or unpaid procedure at issue was thoracic outlet syndrome surgery. The basis for the challenge was; reasonableness and necessity and causation/work-relatedness. Under "Other," the ALJ noted Woods' objection to the motion to reopen was overruled and Correct Care was granted twenty days to correct any deficiencies in the motion to reopen. In addition, Correct Care's motion to amend the medical fee dispute to challenge the reasonableness and necessity of the proposed surgery was sustained over Woods' objection.

Woods introduced a questionnaire completed by Dr. Linker on February 19, 2015. Dr. Linker stated his diagnosis was thoracic outlet syndrome, chronic pain syndrome. Dr. Linker opined the cause of Woods' diagnosed condition was her August 8, 2012, work-related injury and the left VAT procedure with resection of the first rib was reasonable and necessary treatment of that work-related injury. Dr. Linker provided the following explanation as to why the recommended surgery is reasonable and necessary:

Recommended that she have a left video thoracoscopy with transthoracic resection of left 1st rib to help with her problems with her left arm. She has tried multiple visits with physical therapy in which symptoms of left arm numbness and tingling persist. We could try more physical therapy and/or medications but feel would not

alleviate symptoms and surgery would be her best option.

On March 10, 2015, Correct Care filed a Supplement to Motion to Reopen to Resolve Medical Dispute in which it noted it had previously filed a motion based on the causation issue. KEMI represented it also obtained a utilization review to address the issue of whether the treatment proposed by Dr. Linker is reasonable and necessary. The initial utilization review was performed by Dr. Mortara resulting in a January 12, 2015, denial of notice. KEMI set forth Dr. Mortara's summary contained in that document and also attached a copy of the notice of denial. Significantly, KEMI noted Woods' counsel had requested a formal appeal of the utilization review notice of denial as evidenced by a copy of the letter from Woods' counsel which it attached. KEMI represented a final utilization review decision dated February 11, 2015, was obtained from Dr. Mithran S. Sukumar. KEMI set forth Dr. Sukumar's specific conclusions and attached a copy of the final utilization review decision which contained the same language.

The final utilization review decision signed by Dr. Sukumar reads as follows:

It is not clear that the claimant has left thoracic outlet syndrome as her

Nerve conduction studies do not reveal a significant abnormality. There is no documented evidence of an anatomical abnormality in the thoracic outlet or a venous or arterial compression. A trial of Botox injection of the outlet has not been tried to assess response to this treatment and to help determine if they may benefit from first rib resection. The request for left VAT with resection of 1st rib is not reasonable or necessary for the cure and/or relief of the work injury of 08/08/12.

KEMI represented it would provide to Woods' counsel a Form 106 and the medical chart from Dr. Linker both of which it had requested. It also stated it was attaching a copy of an affidavit that it had not filed in the previous motion to reopen. Finally, KEMI designated the following evidence: the IME report of Dr. Henry Tutt, the medical records from Dr. Bonnarens, the peer review and utilization review reports of Drs. Parker and Kirsh, the May 9, 2014, report from Dr. Tien accompanied by an EMG study report, and the medical records submitted by Woods with the Form 101 including the IME report of Dr. Barefoot.

Pursuant to the March 10, 2015, Order, on March 30, 2015, Correct Care filed an addendum to its motion to reopen to resolve the medical fee dispute. It asserted Woods had maintained the motion to reopen was deficient because it did not include a current Form 106, an affidavit

certifying no previous motion to reopen had been filed, a designation of the evidence from the original record, and the medical records of Dr. Linker. After setting forth the provisions of 803 KAR 25:010 Section 6(a), Correct Care stated a current Form 106 is a document within the control of Woods; therefore, Woods does not need a document in order to obtain her own medical records. However, it had obtained from Woods' counsel a current Form 106.

Correct Care asserted a motion to resolve a medical fee dispute did not require an affidavit stating a previous motion to reopen had not been filed within one year. It contended that was only necessary in dealing with the situation when a motion to reopen was filed pursuant to KRS 342.125(3). Correct Care stated even though Woods was aware no previous motion to reopen was filed and there was no requirement such an affidavit be filed, such an affidavit had been provided. Relative to its failure to include a designation of evidence from the original record, Correct Care noted its failure was not grounds for dismissal but at most would be grounds to request the ALJ to preclude it from introducing evidence which had not been properly designated. Correct Care noted in its supplement to the motion to reopen it designated the evidence from the original litigation to be considered by the ALJ.

Concerning its failure to include medical records from Dr. Linker, Correct Care indicated it had submitted with its motion all of the medical records obtained from Dr. Linker as of that date. Correct Care represented counsel for Dr. Linker has provided a copy of the medical records from Dr. Linker which were attached.

In addition, Correct Care attached Dr. Mortara's complete report from his December 29, 2014, review and Dr. Sukumar's report who conducted a review on reconsideration of the utilization review process on February 10, 2015.

On April 10, 2015, Dr. Linker filed his letter addressed to his counsel, Hon. Doug U'Sellis, in which he began by stating: "[t]his letter will serve to clarify and support my diagnosis and treatment plan of Woods."

On April 23, 2015, Correct Care introduced the April 2, 2015, report of Dr. Richard DuBou based on his examination of Woods.

The May 6, 2015, Benefit Review Conference ("BRC") Order reflects the parties agreed the contested issues were reasonableness and necessity and/or work-relatedness of thoracic outlet syndrome as well as mileage

reimbursement from the spring of 2014.² The BRC Order stated the parties waived a hearing and the matter would be submitted as of the date of the order. The proof time was extended for twenty days in order to obtain a supplemental report from Dr. Linker.

In the June 30, 2015, Opinion and Order after summarizing the medical evidence, regarding the surgery proposed by Dr. Linker, the ALJ entered the following:

The first issue for determination is the reasonableness, necessity, and/or work-relatedness of the proposed left VAT procedure with resection first rib. Dr. Linker opines that this procedure is reasonable and necessary for the treatment of Plaintiff's work-related injuries.

Dr. Linker feels Plaintiff has developed thoracic outlet syndrome as a result of the August 8, 2012, work-related accident and that this procedure should alleviate the Plaintiff symptoms and allow her to return to work. He feels that the Plaintiff's story is very typical for a patient with traumatic neurogenic thoracic outlet syndrome but concedes that there are no diagnostic tests available to confirm his theory and that he cannot prove it. His opinion is clinical in nature as is his belief that Plaintiff has developed thoracic outlet syndrome as a result of the work-related injury.

The Defendant/Employer has submitted proof from Dr. Mortara, Dr.

² On April 30, 2015, Woods filed a motion to supplement the medical fee dispute to include entitlement to reimbursement for mileage relating to her medical treatment which the ALJ sustained.

DuBou and Dr. Sukumar. All three have opined that they do not believe that the Plaintiff suffers from thoracic outlet syndrome and that the proposed surgery would therefore be unreasonable and unnecessary. Dr. DuBou had the opportunity of evaluating the Plaintiff performing a thorough and detailed physical examination. Dr. DuBou notes that the Plaintiff lacked evidence of osteoporosis or muscle atrophy in the left upper extremity which in his mind was an indication that she is using her arm more than she realizes. In fact, he felt that this evidenced that she was basically using it normally. He also does not believe that Plaintiff has clinical evidence of a thoracic outlet compression. Dr. DuBou states that the surgery proposed by Dr. Linker has a published success rate of 19% and it is not to be considered a minor procedure nor undertaken lightly.

In this specific instance after careful review of the medical evidence, the Administrative Law Judge was persuaded by the opinions of Dr. DuBou and Dr. Mortara and finds that the Plaintiff has not proven to the satisfaction of the undersigned Administrative Law Judge that she does in fact suffer from thoracic outlet compression therefore justifying the extensive surgery proposed by Dr. Linker. In so finding the Administrative Law Judges is persuaded by the opinions of Dr. DuBou who notes the Plaintiff lacks evidence of atrophy in her left upper extremity indicating normal use. In addition, Dr. Mortara does not believe that the patient has thoracic outlet compression. Lastly, even Dr. Linker admits he cannot prove the Plaintiff has thoracic outlet syndrome but feels that she does based on clinical examination.

Therefore, the Administrative Law Judge finds that the proposed thoracic outlet surgery as recommended by Dr. Linker is neither reasonable, necessary, nor related treatment for the Plaintiff's work-related injuries and is therefore found to be non-compensable.

The ALJ also determined Woods was not entitled to reimbursement for her mileage expenses. That issue is not before us.

Woods filed a petition for reconsideration raising the same arguments she raises on appeal. Dr. Linker's petition for reconsideration adopted the contents of Woods' petition for reconsideration.

In an Order dated July 28, 2015, the ALJ overruled both petitions for reconsideration.

On appeal, Woods argues the ALJ abused his discretion in reopening the claim since Correct Care's motion to reopen was procedurally deficient. Woods asserts Correct Care did not comply with specific provisions of 803 KAR 25:010 Section 4(6)(a). Woods contends Correct Care did not comply with Subsection 1 by failing to provide a current Form 106 medical release. She asserts Correct Care also failed to comply with Subsection 5 since it did not provide an affidavit certifying a previous motion to reopen had not been filed. Correct Care also failed to comply with Subsection 6 in that it did not provide a designation of

evidence from the original records specifying the relevant items of proof to be considered as part of the record during reopening. Woods notes she timely filed a response to the motion and the ALJ failed to consider that response. Thus, the ALJ erred in reopening the claim without actually considering her arguments and objections because the motion to reopen was procedurally defective. Woods requests the Board reverse the ALJ's order allowing the reopening.

Woods also contends the ALJ abused his discretion by allowing Correct Care an opportunity to supplement its motion to reopen and correct deficiencies in the original motion to reopen. She contends during the telephonic conference, Correct Care acknowledged the deficiencies and attempted to correct them by filing a supplement to its motion to reopen. Woods contends the ALJ's actions in allowing Correct Care a "second bite at the apple" is arbitrary, unreasonable, and unfair.

Woods also asserts the ALJ erred as a matter of law by placing the burden of proof on her to show the recommended treatment was causally related to the work injury. She relies upon the Kentucky Supreme Court's holding in C & T of Hazard v. Stollings, 2012-SC-000834-WC, rendered October 24, 2013, Designated Not To Be Published, wherein it held the employer not only has the burden of

proving the recommended treatment is unreasonable and unnecessary but also that it is not work-related. Woods requests the decision of the ALJ be reversed because his analysis is flawed as to which party bore the burden of proof on causation. Further, since the overwhelming evidence shows Correct Care failed to meet its burden of proof on causation, Woods requests remand with instructions to find Correct Care failed to meet its burden.

Dr. Linker joins in this argument asserting even if Woods had the burden of proving the medical expenses are causally related to her work injury, causation does not factor into the medical fee dispute. Dr. Linker asserts Woods is seeking medical treatment for the left upper extremity symptoms she has experienced since the work injury which the prior ALJ found compensable. Therefore, causation is not a question. Dr. Linker maintains the question to be resolved is the reasonableness and necessity of the treatment. Thus, the standard is whether Correct Care met its burden of proof of establishing the proposed surgery is not reasonable and necessary treatment for the cure and relief of Woods' injury. Dr. Linker asserts that did not occur. Instead, the ALJ shifted the burden to Woods and found she had not proven she had a specific diagnosis which the surgery was to address.

Dr. Linker asserts the opinions of Drs. Sukumar and Mortara are somewhat equivocal. Dr. Linker contends the bottom line is the ALJ shifted the burden of proof to Woods in this case under the incorrect assumption that the issue was one of causation. Dr. Linker requests remand to the ALJ with instructions to perform an analysis whether the treatment is reasonable and necessary.

Next, Woods asserts the ALJ abused his discretion and erred in finding she does not have thoracic outlet syndrome for which Dr. Linker recommended surgery. Woods also submits the ALJ erred in substituting his findings for those of ALJ Bolton who found Woods sustained a compensable work-related injury for which she was entitled to reasonable and necessary medical treatment. Woods contends the work injury, as found by ALJ Bolton is a Brachial Plexus Compression/Thoracic Outlet Compression resulting in persistent paresthesiae, left upper extremity. Woods maintains it is clear she has thoracic outlet compression as documented by the multiple treating physicians including Dr. Barefoot. She identifies the doctors in the proceedings before ALJ Bolton who found she has thoracic outlet syndrome. She contends Dr. Linker, to whom she was referred by Dr. Tien, examined her over a number of months and explained the development of her condition arising from her

work-related injury. Dr. Linker opined it was his clinical opinion she has thoracic outlet syndrome. Woods argues Dr. Mortara did not meet, interview or examine her. Further, he was not provided all of the medical records to review. She notes ALJ Bolton found the report of Dr. Barefoot to be the most compelling, complete, and persuasive evidence as to her medical condition. She contends Dr. Barefoot diagnosed thoracic outlet syndrome. Woods dismisses the opinions of Drs. DuBou and Mortara as not being credible since they are contrary to ALJ Bolton's findings.

Finally, Woods contends the ALJ erred in finding the surgery proposed by Dr. Linker not reasonable and necessary treatment since Correct Care failed to present medical evidence meeting its burden on this issue. Further, the ALJ failed to analyze this issue pursuant to the applicable precedent in determining whether Correct Care had met its burden of proof. Woods argues Dr. Linker recommended the surgery and issued numerous reports explaining why it is reasonable and necessary for the cure and relief of her work injury. On the other hand, Dr. DuBou disagreed in what Woods contends is a "solicited opinion." She concedes there is a disagreement among the physicians contending as follows: "However, such disagreement is not

sufficient, and does not meet the Employer's burden, to prevail in a post-opinion MFD."

We find no merit in Woods' first argument Correct Care's motion was deficient and the ALJ should have overruled it. 803 KAR 25:010 Section 4(6)(a) 1 through 6 reads as follows:

(6)(a) A motion to reopen shall be accompanied by **as many of the following items as may be applicable:** (emphasis added)

1. A current medical release Form 106 executed by the plaintiff;
2. An affidavit evidencing the grounds to support reopening;
3. A current medical report showing a change in disability established by objective medical findings;
4. A copy of the opinion and award, settlement, voluntary agreed order or agreed resolution sought to be reopened;
5. An affidavit certifying that a previous motion to reopen has not been made by the moving party, or if one (1) has previously been made, the date on which the previous motion was filed;
6. A designation of evidence from the original record specifically identifying the relevant items of proof which are to be considered as part of the record during reopening.

In the case *sub judice*, Correct Care was not required to attach a current Form 106 medical release

signed by Woods. The whole purpose behind supplying a medical release is to allow the opposing party to obtain the necessary medical records. Here, Woods had the ability to obtain her own medical records and did not require a medical release signed by her.

We agree with Correct Care, the affidavit certifying a previous motion had not been filed by the moving party does not pertain to medical fee disputes. Rather, Subsection 5 relates to KRS 342.125(3) which in part prohibits a party from filing a motion to reopen within one year of a previous motion to reopen by the same party. Thus, we believe Subsection 5 does not apply to medical fee disputes and an affidavit certifying a motion to reopen had not been made by the moving party is inapplicable.

Likewise, the failure to provide a designation of evidence would, at most, prevent Correct Care from relying upon evidence filed in the original record which it failed to designate. Our review of the record reveals Correct Care did not seek to introduce any documents introduced in the previous litigation which were not attached to its motion to reopen. The only documents it relied upon were documents attached to its pleadings none of which appear to have been introduced in the previous proceeding. Further,

we note Woods did not object to any evidence filed by Correct Care on the basis it had not been previously designated. That said, since the rules of civil procedure are applicable to workers' compensation proceedings, we believe Correct Care's failure to initially designate portions of the record would not prohibit it from later designating a portion of the previous record as part of the evidence on reopening after its motion to reopen was sustained. CR 15.01 states leave to amend "shall be freely given when justice so requires."

For the reasons previously stated, we find no merit in Woods' assertion the ALJ erred in granting Correct Care the opportunity to supplement its motion to reopen as we find no deficiencies in the original motion to reopen.

Similarly, we are unpersuaded by the argument which is a subpart to Woods' first argument that the ALJ erred in not considering her objections and arguments prior to issuing an order permitting a reopening. In considering a motion to reopen, the sole determination to be made by the ALJ is whether the movant has made a *prima facie* showing adequate to support the granting of the motion to reopen. The motion does not have to withstand a countervailing response filed by the opposing party. In

(Ky. 2010) the Kentucky Supreme Court instructed:

A *prima facie* showing adequate to support granting a motion to reopen need not be sufficient to support a finding for the movant on the merits in the event that the respondent fails to go forward with evidence to the contrary. [footnote omitted] The standard for deciding the motion is whether the movant has made a preliminary showing of the substantial possibility of proving one or more of the prescribed conditions sufficient to justify putting the adversary to the expense of re-litigation. [footnote omitted] The standard for review on appeal is whether or not the decision was an abuse of the ALJ's discretion because it was "arbitrary, unreasonable, unfair, or unsupported by sound legal principles." [footnote omitted]

Here, in light of the documents attached to the motion to reopen, we do not believe the ALJ's decision to grant Correct Care's motion to reopen was arbitrary, unreasonable, unfair, or unsupported by sound legal principles.

We will address Woods' third and fifth arguments and Dr. Linker's argument together. For purposes of this appeal, assuming Correct Care had the burden of proof as to causation in addition to the reasonableness and necessity of treatment, the ALJ's statement Woods had the burden of proof regarding causation is harmless error since the ALJ

stated he relied upon the opinions of Correct Care's doctors. By doing so, we believe the ALJ ultimately imposed the burden of proof regarding causation and the reasonableness and necessity of the treatment on Correct Care. In determining the reasonableness and necessity and work-relatedness of the surgery performed by Dr. Linker, the ALJ specifically stated he was persuaded by the opinions of Drs. DuBou and Mortara that the surgery was not reasonable and necessary nor work-related. The ALJ did not state he was unpersuaded by the evidence submitted by Dr. Linker. He affirmatively stated he was more persuaded by the opinions of Drs. DuBou and Mortara in resolving the reasonableness and necessity of the surgery as well as whether it was causally related to the work injury.

In his physician review report dated December 29, 2014, Dr. Mortara reviewed the various medical records including the records of Drs. Tien and Linker. Dr. Mortara specifically noted Dr. Goodlett, Woods' family physician, noted on February 11, 2013, she had shoulder pain and there was a possibility she had brachial plexus pathology. He also observed Dr. Goodlett noted Woods had an IME which reported nothing significantly wrong and that Woods was at MMI. Dr. Goodlett felt a second opinion was required and referred Woods to a hand surgeon, Dr. Tien, who saw her on

March 14, 2014. At that time, Dr. Tien did not feel brachial plexus pathology was present. As a result, Dr. Tien recommended further medication and a nerve conduction study. Woods was subsequently seen by Dr. Tien on April 11, 2013. A repeat EMG was performed on May 5, 2014, which revealed no denervation changes from C5-T1 and a slight C8 left radiculopathy of unknown significance.

Based on his review of the records, Dr. Mortara noted Woods' complaints had changed fairly significantly over a period of time from mid-back pain, cervical pain, and shoulder pain "which was thoroughly evaluated to complaints that include the left upper extremity." Dr. Mortara stated:

Unfortunately, the diagnosis of a thoracic outlet syndrome is difficult as noted by Dr. Linger [sic] to confirm and based on the nerve conduction study, the MRI, and it is difficult to confirm that this diagnosis is actually present on this patient in view of the injury that the patient sustained.

The information provided does not confirm a thoracic outlet compromise by EMG criteria or as noted by the test requested by Dr. Linger [sic]. In my opinion this is now based on a clinical diagnosis and it is not related to the described injury that the patient states on 8/8/2012. The initial pathology is related to the shoulder, mid-back, and the subsequent pathology developed somewhat later. Therefore, the diagnosis of thoracic outlet

syndrome is not medically related to the work injury of 08/08/2012.

In a utilization review notice of denial dated January 12, 2015, attached to the supplemental motion to reopen Dr. Mortara stated as follows regarding the clinical rationale for denial of the left vat with resection of the first ribs:

In my evaluation, the information does not confirm thoracic outlet syndrome by EMG or by MRI, and is based on the clinical diagnosis. Additionally, in the IME by Dr. Tutt he felt the patient did not have any organic pathology but felt that the complaints were functional in nature. Therefore, based on the information in the chart, the request for Left Vats with resection of 1st Rib is not medically reasonable and necessary for the cure and/or relief of the work injury of 8/8/2012.

Similarly, the report of Dr. DuBou reflects his opinion that Woods does not have a thoracic outlet syndrome and the surgery is not reasonable and necessary treatment of the work-related injury. Dr. DuBou stated Woods indicated she gradually stopped using her left hand for most anything. He noted this had been going on since August 2012 almost two and half years prior to his examination. Dr. DuBou noted that in spite of not using this arm except minimally over the past two and half years, there is no osteoporosis on x-rays. Dr. DuBou took

pictures of the x-rays which were included with his report. He observed osteoporosis, a loss of calcium, always occurs if an extremity is not being used and this will always occur within six weeks. Another objective finding which Dr. DuBou believed did not demonstrate a lack of use of the extremity is that there was no atrophy of the muscles. This was confirmed by the measurements he took. Thus, he concluded at the very least Woods is using her left arm for acts of daily living and most normal activities.

Dr. DuBou stated he had a very long discussion with Woods regarding the advisability of going through a first rib resection. He explained to her the published success rate of thoracic outlet compression surgery is 19%. Dr. DuBou pointed out a vacuum-assisted thoracoscopy with first rib resection is not a minor procedure and should not be undertaken light. Woods stated she was considering the procedure only because no one else has offered any other possibility. Dr. DuBou noted Woods' range of motion in the elbows, wrists, and digits were normal. The range of motion in her shoulder was normal with the exception of her left shoulder abduction which abducts to only 150 degrees without pain. Woods can go beyond that but did not because of the pain. All other motions of the shoulder, flexion,

extension, abduction, internal and external rotation were normal.

Dr. DuBou's diagnosis was a transient strain which would have resolved within two or three weeks. He believed Woods did not have thoracic outlet compression. Dr. DuBou noted all objective tests for thoracic outlet compression are negative. The only test that is positive is often positive in 20% of normal people. The findings of normal objective tests, i.e. lack of any osteoporosis and lack of any muscle atrophy belie the fact Woods states she is not using her left arm. Dr. DuBou was asked if Woods had thoracic outlet syndrome is it related to the subject work injury. He responded he did not believe it was causally related to her work injury. He opined the surgery proposed by Dr. Linker is not reasonable, since in all likelihood Woods does not have thoracic outlet compression on clinical grounds. In addition, since Woods uses her left upper extremity normally, the surgery is not necessary on the basis of objective findings. He did not believe Woods required additional treatment since she had a large amount of medical tests which were all negative. Upon reviewing Dr. Linker's December 16, 2014, note, Dr. DuBou stated "[i]n view of the negativity of all tests and

negativity of her history, I am unsure as to what Dr. Linker is truly referring to.”

Since Correct Care was successful before the ALJ and it had the burden of proof as to all issues, the question on appeal is whether the ALJ’s findings are supported by substantial evidence. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). Substantial evidence is defined as evidence of relevant consequence, having the fitness to induce conviction in the minds of reasonable persons. Smyzer v. B. F. Goodrich Chemical Co., 474 S.W.2d 367 (Ky. 1971). As fact-finder, the ALJ has the sole authority to determine the quality, character and substance of the evidence. Square D Company v. Tipton, 862 S.W.2d 308 (Ky. 1993). 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 order to reverse the decision of the ALJ it must be shown there is no evidence of substantial or probative value to support his decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986). Here, we believe the ALJ placed the burden to establish the proposed surgery is not reasonable and necessary or causally related to the injury upon Correct Care. Since the ALJ's decision is supported by substantial evidence, specifically the opinions of Drs. Mortara and DuBou, we find no merit in Dr. Linker's argument and Woods' third argument.

Even assuming *arguendo*, the ALJ incorrectly imposed the burden on Woods to prove the treatment is causally related to her work injury, the ALJ's decision still must be affirmed because he determined the surgery was not reasonable and necessary treatment of Woods' work injury. We agree with Woods that Dr. DuBou's characterization of the injury cannot be relied upon as ALJ Bolton has already determined she sustained a compensable injury as opposed to Dr. DuBou's diagnosis of a transient strain which would have resolved within two or three weeks. However, the ALJ was permitted to rely upon the opinions of Drs. Mortara, DuBou, and Sukumar as they all expressed the

opinion the surgery was not reasonable and necessary for the cure of the work-related injury. Each doctor provided specific reasons in support of their opinions the surgery was not reasonable and necessary. In expressing their opinions, the doctors unanimously cited to the clinical tests which did not support a diagnosis of thoracic outlet syndrome. Thus, the ALJ's decision must be affirmed solely on the basis of his decision the proposed surgery by Dr. Linker is not reasonable and necessary treatment of the work-related injury as that finding by the ALJ is clearly supported by substantial evidence.

Similarly, we find no merit in Woods' fifth argument the ALJ erred in finding the surgery proposed by Dr. Linker to be neither reasonable nor necessary. Regarding the proposed surgery by Dr. Linker, ample evidence supports the ALJ's decision that Woods does not have thoracic outlet compression, and the surgery is also not reasonable and necessary. Although the ALJ stated Woods had not proven to his satisfaction that she suffers from thoracic outlet compression justifying the proposed surgery by Dr. Linker, we believe in relying upon the opinions of Drs. DuBou and Mortara the ALJ concluded Correct Care had met its burden of establishing the surgery was both not reasonable and necessary. Drs. DuBou,

Mortara, and Sukumar noted none of the tests supported a diagnosis of thoracic outlet syndrome. In addition, Dr. DuBou concluded his physical examination of Woods did not support a diagnosis of thoracic outlet syndrome. Dr. DuBou set out in detail his reasons for so concluding. Since the ALJ's decision the proposed thoracic outlet surgery is not reasonable and necessary is supported by substantial evidence in the record, we are without authority to direct a different result. Special Fund v. Francis, supra.

That said, we believe it is important to cite to Dr. Linker's April 6, 2015, letter to his counsel. In the letter, Dr. Linker stated as follows:

Ms. Woods's story is very typical for a patient with traumatic neurogenic thoracic outlet syndrome. Currently there is no diagnostic test that will definitely diagnose thoracic outlet syndrome. All testing is aimed at ruling out other possible causes of the symptoms. It is important to recognize that consistently over this 2 year period of time the patient always had complaints of neck pain. Hyperextension-flexion injuries to the neck are a major cause of traumatic thoracic outlet syndrome. The neck pain causes spasm in the scalene muscles which then pulls the first rib upward. This elevates the brachial plexus and wedges it against the tendons of the muscles. This results in the compressive symptoms. The symptoms in turn result in more pain and thus more spasm in the scalene muscles. This results in more elevation of the

plexus. This sets up a vicious cycle that is hard to break. In Ms. Woods's case I believe that the work injury caused the neck pain which has resulted in the neck arm and hand pain and dysesthesias. **It is typical for the thoracic outlet symptoms to develop gradually and not appear immediately after injury.** Since there are no diagnostic tests available to confirm this theory I cannot prove this. It is my clinical opinion that this patient has thoracic outlet syndrome and would benefit from first rib resection. At the time of surgery the plexus would be assessed for the need of a possible neurolysis. The muscles would also be assessed for chronic inflammation or scarring which would indicate need for resection of the muscles. The expected outcome would be guarded due to the prolonged presence of the symptoms. However I do feel the patient's symptoms could be improved and she could return to work after the surgery. My goal for surgery would be at least 80% improvement in symptoms with return to full-time work. (emphasis added)

The above-language is hardly a ringing endorsement for the surgery Dr. Linker proposes since there are no diagnostic tests available to confirm this theory and "[Dr. Linker] cannot prove this." This statement confirms the opinions of Drs. DuBou, Mortara, and Sukumar who indicated the tests performed in an attempt to diagnose thoracic outlet syndrome are negative.

Finally, Woods' fourth argument that ALJ Bolton determined her injury is thoracic outlet compression is

unpersuasive as his August 4, 2014, decision does not support her argument. In his August 4, 2014, Supplemental Opinion, Award, and Order, ALJ Bolton concluded Dr. Barefoot diagnosed "persistent paresthesiae, left upper extremity" for which he assigned a 3% whole person impairment. ALJ Bolton found the medical testimony of Dr. Barefoot to be more compelling as to Woods' medical condition. ALJ Bolton believed Woods' myofascial pain in the left upper extremity persists thereby limiting her ability to function physically. ALJ Bolton found Woods did not reach MMI until May 14, 2013, the date upon which she was assigned an impairment rating by Dr. Barefoot. He noted Dr. Barefoot's only recommendation for further medical treatment was a referral to Kleinert Kutz for further examination which was negative for carpal tunnel syndrome. ALJ Bolton noted Dr. Barefoot recommended restrictions of using her left arm at or above the left shoulder level.

ALJ Bolton's analysis, findings of fact, and conclusions of law do not contain a finding Woods has thoracic outlet syndrome. We note in his summary of Dr. Barefoot's report, ALJ Bolton noted the MRI of the cervical spine and left shoulder were negative. Nerve conduction studies of the left upper extremity show no evidence of

peripheral nerve entrapment or radiculopathy. He noted Dr. Barefoot felt Woods had persistent complaints of chronic left shoulder pain with left arm paresthesiae since her work injury. She had seen multiple physicians for these complaints but no clear diagnosis had been established as of this date for ongoing complaints of left shoulder and left arm pain, numbness, and tingling. Dr. Barefoot agreed with Dr. Goodlett's recommendation for a referral to Kleinert/Kutz for evaluation. ALJ Bolton then set forth the limitations Dr. Barefoot imposed.

In summarizing Dr. Tien's report, ALJ Bolton noted the electrodiagnostic report from an EMG NCS performed by Dr. Vasudeva Iyer on May 5, 2014, included evaluation for cervical radiculopathy, brachial plexopathy, and upper limb neuropathy. The impression of the study was no denervation changes at C5-T1 distribution on the left side and the only abnormality was minimal decrease in the motor unit recruitment at C8 distribution on the left. Dr. Iyer noted in the absence of denervation changes that finding was of questionable significance. ALJ Bolton stated Dr. Tien reported the painful limitation of abduction of the left shoulder does not appear to be secondary to axillary nerve injury, as no denervation or reinnervation changes are seen in the deltoid.

ALJ Bolton did not find Woods suffered from thoracic outlet syndrome. Throughout his opinion, ALJ Bolton noted the test results do not establish a definitive condition. This is undeniably confirmed by all the medical studies and is consistent with the observations of Drs. Mortara, DuBou, and Sukumar that the medical tests performed to establish thoracic outlet syndrome were negative. Thus, Woods' assertion the ALJ erred as a matter of law in finding she did not have thoracic outlet syndrome has no merit. ALJ Bolton did not determine the specific nature of Woods' shoulder injury and did not define her shoulder injury as being thoracic outlet syndrome. Consequently, the ALJ's findings are not in contravention with any findings contained in ALJ Bolton's decision.

Since the ALJ's decision finding Woods does not have thoracic outlet compression and the surgery recommended by Dr. Linker is neither reasonable, necessary, nor related treatment of Woods' work injury is supported by substantial evidence, we are without authority to disturb the ALJ's decision.

Accordingly, the June 30, 2015, Opinion and Order and the July 28, 2015, Order overruling the petitions for reconsideration are **AFFIRMED**.

ALL CONCUR.

COUNSEL FOR PETITIONER:

HON CHRISTOPHER P EVENSEN
6011 BROWNSBORO PK BLVD #A
LOUISVILLE KY 40207

COUNSEL FOR RESPONDENT:

HON JAMES G FOGLE
333 GUTHRIE GREEN STE 203
LOUISVILLE KY 40202

COUNSEL FOR RESPONDENT:

HON DOUGLAS U'SELLIS
600 E MAIN ST STE 100
LOUISVILLE KY 40202

ADMINISTRATIVE LAW JUDGE:

HON R SCOTT BORDERS
8120 DREAM STREET
FLORENCE KY 41042