Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: May 9, 2014

CLAIM NO. 201201514 & 201201510

AUSTIN POWDER COMPANY PETITIONER

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

BILLY KEITH STACY
and HON. R. SCOTT BORDERS,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION
AFFIRMING IN PART, VACATING IN PART,
AND REMANDING
* * * * * *

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

STIVERS, Member. Austin Powder Company ("Austin Powder") seeks review of the December 23, 2013, opinion, order, and award of Hon. R. Scott Borders, Administrative Law Judge ("ALJ") finding Billy Keith Stacy ("Stacy") sustained cumulative trauma injuries to his lumbar spine and both wrists which manifested on April 16, 2012, and awarding

permanent total disability ("PTD") benefits and medical benefits. The ALJ also determined Stacy sustained a work-related hearing loss, but only awarded medical benefits because he did not meet the impairment threshold contained in KRS 342.730(5)(2). Austin Powder also appeals from the January 7, 2014, order sustaining its petition for reconsideration regarding Stacy's average weekly wage ("AWW") and the impairment rating assessed by Dr. Arthur Hughes but overruling the remainder of the petition for reconsideration.

On November 1, 2012, Stacy filed a Form 103 alleging a work-related hearing loss while in the employ of Austin Powder occurring on April 16, 2012. On that same date, Stacy also filed a Form 101 alleging a cumulative trauma injury due to the repetitive use of his low back occurring on April 16, 2012. On December 4, 2012, the ALJ consolidated claims 201201510 (cumulative trauma injury) and 201201514 (hearing loss).[1] By order dated May 28, 2013, the ALJ sustained Stacy's motion to amend the claim to allege bilateral wrist injuries.

Stacy's Form 104 reflects he worked for Austin Powder as a drill operator from May 3, 2005, to April 16,

[1] Stacy also filed a claim for coal workers' pneumoconiosis ("CWP") but that claim was placed in abeyance.

2012. Prior to that he worked as a drill operator for BW Resources from 2004 to 2005, Miller Brothers Coal from 2003 to 2004, Star Fire Coal from 1998 to 2003, Hand Coal in 1997, and Nally & Hamilton Coal in 1997. Although Stacy primarily relied upon the Form 107 completed by Dr. Hughes, he also introduced the report from M & G Neurophysiology regarding a nerve conduction velocity study of both hands, the one page record of Dr. Ronald Belhasen with Baptist Southeast Orthopedics, the physical capacities evaluation of Dr. Michael Raichel, and the one page report of Dr. Dale Williams dated August 12, 2012, regarding Stacy's complaint of low back pain.

Austin Powder introduced three reports from Dr. Thomas Schiller, two of which were generated as a result of physical examinations, and one generated as a result of a medical records review in which he commented upon Dr. Williams' note of August 12, 2012, the release to work of Dr. Raichel, and the Form 107 prepared by Dr. Hughes. It also introduced the May 14, 2013, report of Dr. Thomas Gabriel and Dr. Belhasen's August 22, 2012, and July 25, 2012, records.

Stacy testified at a February 4, 2013, deposition and the October 22, 2013, hearing. During his deposition, Stacy testified he had been treated by Dr. Belhasen because

“big knots” developed on his hands. Dr. Belhasen told him he could not help him. Stacy believes he has arthritis in both hands. He has also been seen by Dr. Williams, a chiropractor, who x-rayed his back. Stacy has had problems with his back “for a while.” He denied having a specific injury.

Stacy explained a drill operator’s job involved marking the drilling pattern and then drilling at each marked spot. He sits in the cab of the drill and “flip[s] toggle switches and work levers” which require him to move his arms and elbows back and forth. Stacy explained the drill has a “nice cab” which is approximately five feet by five feet, however it is not pressurized. It contains a panel with approximately twenty-five to thirty toggle switches. Stacy also operates levers “for your jacks, your tram, and your boom up and down.” In the early 1970s, he operated the old manual drills while standing on the ground. The last twenty years he has been able to sit in a cab and operate the switches. The cab in which he works is enclosed which reduces the sound and dust to which he is exposed. He has always worn hearing protection.

Because of the problems with his hands, Stacy was not sure he would still be working even if he had not been laid off. He noticed a hearing problem approximately three

years ago. The last day he worked was April 16, 2012, when he was laid off due to cutbacks. Since a doctor never told him his "problems was work-related," somebody else gave notice to the company of his workers' compensation claim on October 30, 2012. Stacy admitted he continues to take medication for gout.

At the hearing, Stacy testified his job as a drill operator also involved cleaning the drill tracks, greasing the drill, and cleaning the cab. He also swept floors. He performed no hard physical work. Approximately five or six years ago, he began to experience low back problems just above the belt which did not prevent him from working. He estimated he began having wrist problems approximately six years ago. The pain in his wrist varied. His hands would become numb and hurt "real real bad" and would swell. Just using his hands caused swelling and numbness. The doctors told him nothing could be done for his hands. He has not received any treatment for his back condition. Since he stopped working, his back and hand pain have not been as severe. Stacy does not believe he can work because his hands swell with any type of work. He explained with any extensive use of his hands, he has to wait a couple of days before he uses his hands. He believes he first began treatment of his hand problems

approximately seven or eight years ago. He denied receiving treatment for back problems. He is able to sit for a couple of hours but cannot stand longer than fifteen minutes without experiencing back pain.

Concerning Stacy's hearing loss claim, the ALJ concluded as follows:

> Pursuant to KRS 342.315, the opinion of Dr. Jones carries with it presumptive weight. There has been no evidence submitted in this file to create any reason to disregard this opinion, and therefore the Administrative Law Judge finds that Plaintiff has met his burden of proving that he suffered noise induced hearing loss, being last exposed to occupational noise while employed at Austin Powder Company on April 16, 2012. There is simply no evidence in the record to indicate that Plaintiff was not last exposed to occupational noise while employed by the Defendant.

Since Dr. Jones assessed a 2% impairment rating, the ALJ found Stacy was only entitled to medical benefits.

In concluding Stacy sustained work-related cumulative trauma injuries to his back and wrists, the ALJ entered the following findings of fact and conclusions of law:

> In regards to the Plaintiff's claim that he suffered a cumulative trauma injury to his back and bilateral wrist that manifested on April 16, 2012, the Plaintiff submitted medical proof from Dr. Arthur Hughes, who is of

the opinion that Plaintiff did suffer cumulative trauma injuries to both his back and bilateral wrist, as a result of his working as a drill operator being last exposed to a series of mini traumas on April 16, 2012, while employed at Austin Powder Company. Dr. Hughes is of the opinion that Plaintiff retains an 18% function impairment rating, pursuant to the Fifth Edition of the AMA Guides, as a result of his cumulative trauma injuries to both his back and upper extremities.

The Defendant submitted proof from Dr. Schiller, who was of the opinion that cumulative trauma injuries do not exist. They submitted medical proof from Dr. Gabriel, who is of the opinion that Plaintiff did not suffer the cumulative trauma injury to his bilateral wrist as alleged by him.

In this specific instance, after careful review of the lay and medical testimony, the Administrative Law Judge finds persuasive the opinion of Dr. Arthur Hughes and finds that the Plaintiff has met his burden of proving that he suffered a cumulative trauma injury to his lumbar spine and bilateral wrist that manifested on April 16, 2012, while he was employed as a drill operator for the Defendant, Austin Powder Company. In so finding the Administrative Law Judge found the Plaintiff’s testimony to be credible and his complaints of pain to be credible. The Administrative Law Judge did not find Dr. Schiller’s opinions to be persuasive and specifically his opinion that cumulative trauma injuries do not occur. The Administrative Law Judge did not find Dr. Gabriel’s opinions to be persuasive either.

Noting this evidence was uncontradicted, the ALJ found Austin Powder had received timely notice of this claim and his claims had been timely filed.[2]

Concerning the impairment rating attributable to Stacy's cumulative trauma injuries, the existence of a prior active impairment, and whether Dr. Hughes' impairment rating was assessed pursuant to the 5th Edition of the American Medical Association, Guides to the Evaluation of Permanent Impairment ("AMA Guides"), the ALJ concluded as follows:

> The next issues for determination are entitlement to benefits to KRS 342.730, whether the Plaintiff suffers from any prior active impairment or disability, and whether Dr. Hughes properly assessed the Plaintiff of functional impairment rating pursuant to the Fifth Edition of the AMA Guides.
>
> There have been three physicians who testified in this claimant [sic] and have addressed whether or not Plaintiff is entitled to functional impairment rating as a result of his alleged work-related conditions. Dr. Schiller is of the opinion that Plaintiff did not suffer a work-related injury based upon his false assumption that there is no such thing as cumulative trauma injuries. Dr. Gabriel was of the opinion that Plaintiff did not retain a functional impairment rating as his bilateral wrist

[2] Although Austin Powder does not raise this on appeal, we find no testimony by Stacy that he was ever informed by Dr. Williams his bilateral carpal tunnel syndrome and lumbar spine condition were caused by his work on August 12, 2012.

> conditions, which in his opinion, were not causally related to his work. Dr. Hughes is of the opinion that Plaintiff retained in [sic] 18% functional impairment rating for both his lumbar spine condition and his bilateral wrist conditions pursuant to the Fifth Edition of the AMA Guides.
>
> The Defendant argues the [sic] Dr. Hughes did not properly apply the AMA Guides in this situation. The Kentucky Supreme Court has held that the assessment of an impairment rating pursuant to the AMA Guides is a medical determination which may only be performed by medical experts. *Kentucky River Enterprises v. Elkins*, 107 SW3d 206 (Ky. 2003).
>
> In this situation, we have a difference of opinion between medical experts on the use of the AMA Guides. The Administrative Law Judge, after having reviewed the medical evidence, find [sic] the opinions of Dr. Hughes persuasive and finds that he properly applied the AMA Guides in determining the Plaintiff retains an 18% functional impairment rating as a result of his lumbar and bilateral upper extremity conditions.
>
> The Plaintiff argues that as a result of his injuries that he is permanently and totally occupationally disabled. KRS 342.011(11)(c) defines permanent total disability as meaning, "the condition of an employee who, due to an injury, has a permanent disability rating and has a complete and permanent inability to perform any type of work as a result of an injury."

The ALJ determined Stacy is permanently totally disabled.

Austin Powder filed a petition for reconsideration requesting additional findings of fact to explain the finding Stacy sustained work-related compensable injuries and why Dr. Hughes' medical opinions qualified as "substantial evidence with regard to his impairment rating" and the finding of compensable injuries.[3] Concerning Stacy's hearing loss claim, it asked for additional findings of fact supporting the ALJ's finding Stacy was exposed to the hazardous occupational noise while operating a drill for Austin Powder; as the university evaluator testified he could not state Stacy's last injurious exposure was due to his employment with Austin Powder. Concerning Stacy's claims for cumulative trauma injuries to his back and wrists, it requested additional findings identifying the objective medical findings of a harmful change. Austin Powder also requested findings of fact as to the ALJ's finding of total disability. Finally, it requested a finding correcting Stacy's AWW.

Concluding he adequately detailed why he relied upon Dr. Hughes' opinions and did not rely on Dr. Schiller's opinions, except for correcting the impairment

[3] Austin Powder also pointed out Dr. Hughes did not assess an 18% impairment as found by the ALJ. Rather, he assessed a 16% functional impairment rating. It also requested the ALJ to state how Dr. Hughes' impairment rating was performed within the parameters of the AMA Guides.

rating Dr. Hughes assessed and Stacy's AWW, the ALJ overruled Austin Powder's petition for reconsideration.

On appeal, Austin Powder challenges the ALJ's opinion on four grounds; 1) the ALJ's decision is not supported by substantial evidence; 2) Dr. Hughes did not render his impairment ratings within the parameters of the AMA Guides; 3) there is no basis for an award of medical benefits for Stacy's hearing loss; and 4) there is no basis for a finding of total occupational disability.

Concerning its first argument, Austin Powder asserts Dr. Hughes did not render a diagnosis based upon objective medical evidence or even medical probability. It asserts Dr. Hughes' diagnosis was based on an inaccurate history consisting of Stacy's hearsay statement of an alleged diagnosis of arthritis and his own "fanciful imaginings" of Stacy's work duty and history neither of which constitutes objective medical evidence. Austin Powder contends Dr. Hughes obtained a brief history and his physical examination only revealed cysts on Stacy's hands which he considered to be of "unknown etiology." It insists the only other information Dr. Hughes could have relied upon was Dr. Williams' diagnosis of lumbar degeneration due to the physical stresses of working in the coal mining industry for forty-one years. Austin Powder

takes issue with Dr. Hughes' statement under the heading of "Explanation of Causation" in his Form 107. It notes Dr. Hughes' history of daily work activities does not describe repetitive injuries which could cause a harmful change. Austin Powder notes in reviewing Dr. Hughes' history there is no record of Stacy's physical work activities or the frequency his work activities were performed. It contends Dr. Hughes' diagnosis regarding Stacy's hand problems is based on Stacy's statement he had been told his hand problems were due to arthritis. Austin Powder argues this was not confirmed by physical examination, diagnostic testing, or any medical evidence reviewed by Dr. Hughes.

Austin Powder also asserts Dr. Hughes did not review the complete records of Dr. Raichel, Stacy's family doctor. If he had, he would have seen Stacy had been treated for over seven years for gout in his hands, hypertension, hyperglycemia, and anxiety none of which are work-related. Further, Dr. Hughes did not review any of the records of Dr. Belhasen, Stacy's treating orthopedic surgeon. It notes Dr. Belhasen's July 25, 2012, note reflects Stacy was known to have a history of gout with multiple flare ups in the past which had been debilitating. Dr. Belhasen noted Stacy's wrist problems had been progressively worsening over the past eight years and he

was complaining of swelling in both hands and at times he could not make a fist. The x-rays of both wrists Dr. Belhasen reviewed showed irregularity of the distal radial ulnar joint consistent with gouty arthritis. It asserts Dr. Belhasen's assessment was "a 60 year old male with gout involving both wrists and also both ankles...," and he did not relate Stacy's gout to his employment.

Austin Powder also cites to the following exchange it had with Dr. Hughes:

> Q: I think I asked you earlier if you could define repetitive. And is it your answer that you really can't?
>
> A: Yes. I think that's a fair statement.

Austin Powder posits Dr. Hughes must have knowledge of Stacy's actual job description and duties as well as the requisite level of exposure to repetitive activities which caused the claimed injury. He should also be able to predict the occurrence of a harmful change based upon the activity performed. However, Dr. Hughes admitted in his deposition he knew practically nothing of Stacy's job. Austin Powder also maintains Dr. Hughes acknowledged he was unfamiliar with the frequency and how Stacy used his hands in operating the drill.

Austin Powder espouses repetitive trauma is manifested by arthritis. Therefore, it is essential Dr. Hughes have a familiarity with this inflammatory process and its symptoms. Instead, Dr. Hughes acknowledged he was not an expert in arthritis or gout and the manifestations or implications of either.

Austin Powder notes Dr. Hughes testified he had done no studies regarding repetitive trauma. It contends the concept of repetitive trauma requires further examination by the legal and medical community to confirm its scientific foundation and reliability. Therefore, Dr. Hughes' methodology at deriving a diagnosis was deficient in comparison to those of other physicians who examined Stacy. Austin Powder submits if Dr. Hughes had utilized the same methodology as the other physicians involved in this case, he would have obtained similar findings and arrived at a similar diagnosis.

In an unpreserved argument which was not raised before the ALJ, Austin Powder argues Dr. Hughes does not satisfy the criteria of KRE Rule 702 in order to be qualified as an expert on the subject of repetitive trauma.

Concerning its argument that Dr. Hughes' impairment rating was not based upon the AMA Guides, Austin Powder notes his rating of the wrists was based upon range

of motion and loss of grip strength. It argued an impairment rating based on grip strength should not have been assessed. It maintains Dr. Hughes admitted on cross-examination he did not properly use the passive range of motion when confronted with less than a full arc of wrist motion. It cites in part to the following exchange during Dr. Hughes' deposition:

> Q: Okay. And technically speaking, you did not do your evaluation of the range of motion or develop your impairment rating of the range of motion based upon the Fifth Edition of the AMA Guides; is that correct?
>
> A: Based on the wording that they have, that is correct.
>
> . . .
>
> Q: Now, to what would you attribute his decreased strength? Or, let me ask you this. Did decreased strength result in part because of decreased motion or painful conditions?
>
> A: He had some pain and that of course causes guarding and that could result in a diminished ability to use a dynamometer, so in that respect, certainly the decreased strength would be a consequence of pain.
>
> Q: Now doesn't the AMA Guides say there under the section 16.8a that you're not to use grip strength if you've got the presence of decreased motion or of painful condition?
>
> A: It does. And I don't always agree with the way that the AMA Guides are phrased?

> Q: But if we just use the strict language of the AMA Guides, he would not get a rating for loss of grip strength; is that correct?
>
> A: Yes, sir, the way it's phrased there.

It argues without a proper measurement of range of motion and given the improper measurement of grip strength, "there is no AMA rating associated with Dr. Hughes' assessment of Mr. Stacy." Thus, there is no basis for an award of income benefits for injuries to the wrists.

The same also holds true regarding the impairment rating assessed for the low back condition. In support of this assertion Austin Powder cites to the following testimony of Dr. Hughes:

> Q: Why did you use DRE category II?
>
> A: Because he has complaints of pain without radiculopathy.
>
> Q: Doesn't that really fit though with DRE lumbar category I?
>
> A: I've never used it that way.
>
> Q: If you look at the specific ingredients that make up putting someone in category II, he doesn't have any of those, does he?
>
> A: No. Actually, note, And I would simply say in that regard that there are many people who have back pain with no objective abnormalities at all. And granted, the DRE category II is restrictive in that regard but I think it's unfairly restrictive because

> there's lots of folks who have functional limitations as a consequence of back pain, no radiculopathy, and I think by common agreement they have an impairment. And to deny them that impairment I think is wrong.
>
> Q: But if we are strictly going by the Fifth Edition of the AMA Guides, using table 15-3, he would fit though in lumbar category I; is that correct?
>
> A: He would if you went by the absolute strict wording of DRE 2.

It asserts this situation is almost identical to that presented in Jones v. Brasch-Barry General Contractors, 189 S.W.3d 149, 153 (Ky. App. 2006) wherein the doctor admitted his impairment rating was not in compliance with the AMA Guides. As in that case, Dr. Hughes' ratings do not constitute substantial evidence.

Regarding its third argument, Austin Powder notes Stacy was found to have a 2% impairment based on the AMA Guides. However, Dr. Jones was unable to state in "all medical probability" Stacy's hearing loss was due to his work. Therefore, there was no basis for an award of medical benefits.

Finally, Austin Powder argues there is no basis for a finding of total disability since substantial evidence establishes Stacy did not suffer a work-related

injury. It requests the matter be remanded to the ALJ with orders to dismiss the claim.

The Form 107 completed by Dr. Hughes on November 20, 2012, reveals he obtained a history that approximately five years ago Stacy began to experience a gradual onset of low back pain due to standing and walking. He noted Stacy had no pain when sitting but the pain occurs when he is changing drill bits, walking, or bending over. Stacy operated equipment for forty-one years while working in surface mining. Dr. Hughes noted Stacy is able to operate the drill while sitting, but is unable to lay out patterns which require walking and cannot operate rock trucks, graders, loaders, or dozers. He noted Stacy had a past history of hypertension and gout particularly affecting his right foot and as a result was unable to work when the gout was active. For the past seven years Stacy had pain in both hands, and when this occurs his hands swell and he is unable to grasp a hand rail or even use toggle switches on the drill. Stacy saw an orthopedic surgeon who informed him he had arthritis in his wrists, hands, and fingers. Surgery was not recommended. He noted when Stacy has severe hand pain he is unable to pick up objects and drive. The pain flares up when he tries to use his hands.

Dr. Hughes indicated he had reviewed the August 12, 2012, report of Dr. Williams and Dr. Raichel's physical restrictions. As noted by Austin Powder, there is no reference to Dr. Belhasen's report. There is a reference to the x-rays of the lumbar spine performed on September 15, 2012, which showed multilevel degenerative disc disease.

Because of Austin Powder's emphasis on Dr. Belhasen's history, we also set forth his history and conclusions. Dr. Belhasen's August 22, 2012, note reveals Stacy's chief complaint was a hand problem. He had seen Stacy three weeks ago and placed him on NSAIDS for significant swelling and pain in both hands. Stacy was mildly improved but still had swelling in both hands and wrists. His pain was about the same. Stacy had stopped all activities including around his home. Dr. Belhasen's diagnosis was localized primary osteoarthritis of the wrists and continued bilateral wrist pain. He discussed surgery but did not believe surgical treatment would allow a return to work.

Dr. Belhasen's July 25, 2012, report was also introduced. Dr. Belhasen stated Stacy presented with bilateral wrists complaints and bilateral ankle and foot complaints. He is known to have a history of gout and had

multiple flare-ups in the past which at times, had been debilitating. Stacy managed to continue walking and working and despite his discomfort had learned to control his gout to some extent through his diet. Stacy's wrist problems had been progressively worsening over the past eight years. He had worked as a heavy equipment operator for the majority of his life and his most recent employment had been as a drill operator. Stacy has a number of levers to operate and this makes his hand pain quite severe. At times, he complained of swelling in both hands to the extent he cannot make a fist. Dr. Belhasen noted he had large, what Stacy thinks are cysts over the dorsal aspect of his wrist.

In his assessment, Dr. Belhasen stated Stacy was a sixty year old male with gout involving both wrists and also both ankles in "the first MTP joints of both feet." Stacy had done what he could do to control this medically, and Dr. Belhasen did not think he had much more to add. Stacy's overall problem is that he is a heavy equipment operator and is required to use a number of levers which is certainly a source of increased hand and wrist pain and also bilateral ankle and foot pain. Dr. Belhasen discussed the possibility of surgical correction of the wrist, however he would not recommend it. Consequently, he

believed there was little he could offer Stacy as far as decreasing his pain.

In the Form 107, Dr. Hughes diagnosed low back pain, bilateral hand and wrist pain, and reduced range of motion and strength. With respect to causation, he stated as follows:

> Within reasonable medical probability, the plaintiff's long history of repetitive injuries as a consequence of his occupation as a heavy equipment operator for the past 41 years is the cause of his complaints.
>
> Mr. Stacy has lower back pain, which is a consequence of his occupation, and he has bilateral hand pain, which, as he understands it, had been attributed to arthritis, which also is a consequence of long term repetitive trauma as a consequence of his occupation.

Under the heading "Explanation of Causal Relationship," Dr. Hughes provided the following:

> Mr. Stacy's lower back pain has interfered with his ability to operate heavy equipment because he cannot stand, walk or lift. He is able to sit. This has interfered with his ability to do the ordinary tasks of daily living at home as well. He has developed bilateral hand pain attributed to arthritis, which also limits his ability to use his hands for ordinary tasks at home or in his job as a driller and heavy equipment operator.

Dr. Hughes assessed a 16% impairment rating broken down as follows:

> Lower back pain 5%
>
> Reduced range of motion of the left wrist 5%
>
> Restricted range of motion of the left wrist 1%
>
> Reduced grip strength $6%

For each impairment, Dr. Hughes referenced the portion of the AMA Guides upon which he relied. He also concluded Stacy did not have an active impairment prior to the injury. He stated Stacy had gradual worsening lower back pain and bilateral hand pain over many years and there was no specific single injury producing this as it was a "consequence of accumulating trauma as part of his job." Dr. Hughes opined Stacy had not reached maximum medical improvement ("MMI"). With respect to Stacy's restrictions, Dr. Hughes stated as follows:

> The physical requirements of Mr. Stacy's work include the ability to get on and off heavy equipment and to operate a drill from a seated position.
>
> This, however, requires using hand controls for the drill, which he is unable to do because of his bilateral hand dysfunction as described above. He also is unable to lay out patterns for drilling even though he is able to sit comfortably and operate a drill. He would have to be able to stand, walk, climb, reach, push, pull, lift, and bend and twist the lumbar spine in addition to stooping and crawling under equipment.

In a note dated December 19, 2012, Dr. Hughes indicated since Austin Powder had denied the claim and would provide no further medical treatment, Stacy was now at MMI and his impairment rating and restrictions remained the same.

During his February 6, 2013, deposition, Dr. Hughes acknowledged he was not an expert in gout or arthritis and agreed the nodules were of unknown etiology. He believed Stacy was completely honest and forthright. Regarding his evaluation of Stacy and the impairment he assessed for the hands and wrists, Dr. Hughes testified as follows:

> Q: How do you determine or why does he have a reduced motion from what you can tell?
>
> A: I would assume that it is the arthritis that he said that somebody said that he had. Now, I can't just that. All I can judge is that he does have a restrictive range of motion.
>
> Q: For whatever reason?
>
> A: For whatever reason.
>
> Q: And in terms of causation, you really don't have enough information to render a causal opinion, do you?
>
> A: Well, he's had the symptoms for seven years, his job involves repetitive use of the hands, and so I assumed that the hand issue was probably due to repetitive use as there

wasn’t any alternative explanation that made any sense.

Q: Did he describe pain?

A: He did. He had pain for seven years.

Q: Well, then let me ask you about your grip strength evaluation that you did. I’m looking here at the AMA Guides. And I’m looking particularly here at section 16.8a under Principles. And it’s talking about loss of strength and rating that. And you gave him how much impairment because of loss of strength?

A: Six percent.

Q: And it says that you are only to use that and combine it with other impairments if it is based upon unrelated etiologic or pathomechanical causes. I mean it is not based on unrelated causes, is it?

A: I don’t know. You know, he’s got the restricted range of motion, he’s got some pain and he’s got the weakness. And I could not be sure that the cause of the weakness was due to but, nonetheless, it was there. And of course it was more pronounced in his dominant hand than the non-dominant hand, which is just the reverse of what you would expect. So I thought that the weakness in the right hand was certainly pathological because that’s his dominant hand, but the origin of it I didn’t know.

Q: But it’s the same entity that you’re trying to quantify by use of the other sections of the AMA Guides for the upper extremity, that is for the wrist and for the reduced range of motion of both wrists; isn’t that correct?

A: Yeah. But I don’t know if the two of them are linked. He has the restricted range of motion, he’s got the weakness, but I don’t know that one caused the other or if they’re even associated. So far as I could tell from the evidence that I had, they were two independent phenomena.

Q: So he may not have decreased strength as a result of the problem with his wrist? You’re saying that may have another underlying cause?

A: It may have another cause. Yes, sir.

Q: Now, to what would you attribute his decreased strength? Or, let me as you this. Did decreased strength result in part because of decreased motion or painful conditions?

A: He had some pain and that of course causes guarding and that could result in a diminished ability to use a dynamometer, so in that respect, certainly the decreased strength would be a consequence of pain.

Q: Now doesn’t the AMA Guides say there under the section 16.8a that you’re not to use a grip strength if you’ve got the presence of decreased motion or if painful condition?

A: It does. And I don’t always agree with the way the AMA Guides are phrased.

Q: But if we just use the strict language of the AMA Guides, he would not get a rating for loss of grip strength; is that correct?

A: Yes, sir, the way it’s phrased there.

> Q: I've got a clean copy of that somewhere. Let me go ahead and attach a copy of that ad defendant exhibit in subsequent order.
>
> [text omitted]
>
> Q: So then if we review your report, strictly speaking, under the Fifth Edition of the AMA Guides, and I realize that you are not in complete agreement, but if we just strictly interpret the AMA Guides, he has zero impairment for the low back and he has just six percent for his wrist; is that correct?
>
> A: Adding the one and five, correct.

Although Dr. Hughes testified he could not define repetitive, earlier in his deposition, he provided the following testimony regarding the definition of repetitive:

> Q: Now, you were talking about people who did repetitive work. What is repetitive? What's your definition of repetitive?
>
> A: Does the same manual task over and over again.
>
> Q: How many times?
>
> A: I don't know.
>
> Q: I mean, so if you don't know, then you don't really know if what he did was repetitive?
>
> A: Well, he's been doing his kind of work 41 years. That is operating heavy equipment. And that would certainly fit the bill for heavy repetitive work I think from a common sense standpoint.
>
> Q: Well –

A: Do I know exactly what he does everyday? No.

Q: And you don’t know whether he’s pinching, grasping, twisting, pushing or pulling with his hands or the amount of that that he’s doing, do you?

A: No. He is doing it because he explained that to me, but –

Q: Well, what qualifies as repetitive? I mean if he twists knobs three times every minute, is that repetitive?

A: That would be repetitive.

Q: what about three times each hour?

A: What would probably be repetitive too. I know what you’re getting at and I don’t have a good answer for you.

Q: Okay.

A: But I think common sense would suggest that if you do this on a regular basis as an integral part of the job and you have to do it everyday –

Q: But the only evidence you have though is just your own anecdotal experience, isn’t it?

A: Well, and what he told me.

Q: Okay. He’s not the expert, is he?

A: Well, he’s an expert on his own body, his own job.

. . .

Q: Did you do any testing or review any medical documents showing that he had a work-related arthritis?

> A: I had the information that was provided and there was nothing in there regarding that.

Based on the Form 107 completed by Dr. Hughes and his testimony, we conclude Dr. Hughes' opinions are supported by objective medical findings.

In Gibbs v. Premier Scale Company/Indiana Scale Co., 50 S.W.3d 754 (Ky. 2001), the Supreme Court held:

> KRS 342.0011(1) makes it clear that not all work-related harmful changes are compensable. Therefore, we are constrained to conclude that although a worker may experience symptoms and although a physician may have diagnosed a work-related harmful change, the harmful change must be evidenced by objective medical findings as that term is defined by KRS 342.0011(33). Otherwise, it is not compensable as an "injury." KRS 342.0011(1).
>
> KRS 342.0011(33) limits "objective medical findings" to information gained by direct observation and testing applying objective or standardized methods. Thus, the plain language of KRS 342.0011(33) supports the view that a diagnosis is not an objective medical finding but rather that a diagnosis must be supported by objective medical findings in order to establish the presence of a compensable injury. The fact that a particular diagnosis is made in the standard manner will not render it an "objective medical finding." We recognize that a diagnosis of a harmful change which is based solely on complaints of symptoms may constitute a valid diagnosis for the purposes of medical treatment and that symptoms which are reported by a

patient may be viewed by the medical profession as evidence of a harmful change. However, KRS 342.0011(1) and (33) clearly require more, and the courts are bound by those requirements even in instances where they exclude what might seem to some to be a class of worthy claims. A patient's complaints of symptoms clearly are not objective medical findings as the term is defined by KRS 342.0011(33). Therefore, we must conclude that a diagnosis based upon a worker's complaints of symptoms but not supported by objective medical findings is insufficient to prove an "injury" for the purposes of Chapter 342.

In view of the evidence which was presented in this particular case, a question has arisen concerning whether a harmful change must be, or is capable of being, documented by means of sophisticated diagnostic tools such as the x-ray, CAT scan, EEG, or MRI in order to be compensable. Contrary to what some have asserted we are not persuaded that it must. Furthermore, at least to some extent, we view that question as being off the mark. Likewise, we are not persuaded that a harmful change must be both directly observed and apparent on testing in order to be compensable as an injury.

In the instant case, the claimant has focused upon the shortcomings of the sophisticated diagnostic tools. However, in addition to testing which utilizes the aforermentioned diagnostic tools, a wide array of standardized laboratory tests and standardized tests of physical and mental function is available to the medical practitioner. Although there may not be a standardized test which would apply to every conceivable symptom of which a

> patient might complain, or every symptom which cannot be directly observed, such tests are capable of confirming the existence and extent of a number of symptoms. We know of no reason why the existence of a harmful change could not be established, indirectly, through information gained by direct observation and/or testing applying objective or standardized methods that demonstrated the existence of symptoms of such a change. Furthermore, we know of no reason why a diagnosis which was derived from symptoms that were confirmed by direct objective and/or testing applying objective standardized methods would not comply with the requirements of KRS 342.0011(1).

Id. at 761-762.

Consistent with the above criteria, Dr. Hughes' report reflects he diagnosed a harmful change based on information gained through direct observation and testing applying objective or standardized methods which demonstrated the existence of symptoms of such a change.

We agree Dr. Hughes' history was limited and he did not reference Dr. Belhasen's report. However, Dr. Hughes' deposition testimony reveals he was more familiar with Stacy's work history and job description than was provided in his Form 107. In line with Gibbs, Dr. Hughes' medical examination revealed Stacy had reduced range of motion in both wrists and reduced grip strength. This does not appear to be in dispute. Clearly, Dr. Belhasen's

report establishes Stacy has significant wrist problems. This premise is reinforced by the report of M & G Neurophysiology which reveals Stacy had an abnormal nerve conduction velocity study of the bilateral upper extremities. There was electrodiagnostic evidence of bilateral carpal tunnel syndrome affecting both the motor and sensory portion of the nerve fiber.

Although Dr. Hughes did not review Dr. Belhasen's report, we do not believe that causes his findings and opinions to be less than substantial. Dr. Belhasen stated Stacy had gout involving both wrists, but he also noted Stacy had controlled his problem and his overall problem was that he was heavy equipment operator and was required to use a number of levers which was a source of increased hand and wrist pain. Although diagnosing gout of the wrist, Dr. Belhasen's report also attributes all or a portion of Stacy's wrist problems to his repetitive work as a drill operator. Thus, we do not believe the failure of Dr. Hughes to allude to Dr. Belhasen's report sufficiently negates his diagnosis, as portions of Dr. Belhasen's report actually support Dr. Hughes' diagnosis and conclusion that Stacy sustained work-related cumulative trauma injuries to both wrists. Although his report is not very specific as to causation, it is obvious that based on his examination

and the history he obtained as set forth in his report and deposition, Dr. Hughes concluded Stacy sustained cumulative trauma injuries to his wrists. The limited medical history and description of job duties contained in the Form 107 and the failure to review Dr. Belhasen's report merely goes to the weight to be afforded Dr. Hughes' opinions and not their admissibility.

Further, we observe Dr. Hughes' Form 107 and his testimony reveal his diagnosis and assessment of impairment was based upon a loss of range of motion. Clearly, the ALJ reviewed the Form 107 and the deposition testimony and was permitted to conclude Dr. Hughes' diagnosis was derived from symptoms which were confirmed by direct objective and or testing applying objective standardized methods. Gibbs at 672. We find Austin Powder's argument concerning the presence of arthritis to be a red herring as Dr. Hughes' Form 107 and testimony reflect he did not diagnose work-related arthritis nor did he offer an opinion as to the existence of the arthritis or gout. Similarly, he did not attempt to relate the arthritis or gout to Stacy's work. Rather, Dr. Hughes' Form 107 reflects his diagnosis was lower back pain, bilateral hand and wrist pain, and reduced range of motion and strength. From that the ALJ was free to conclude Dr. Hughes' diagnosis and his impairment rating

did not take into consideration the presence of arthritis or gout. Moreover, we note Austin Powder does not argue Dr. Hughes' diagnosis was based upon symptoms which were not confirmed by direct objective or testing applying objective standardized methods. Rather, it complains of Dr. Hughes' lack of knowledge of Stacy's work activities and the previous medical history discussed in Dr. Belhasen's report.

Moreover, the fact Dr. Hughes did not know how many times per minute Stacy grasped and released the levers or knobs, how he held his hands while doing these activities, and whether he did any pinching merely went to the weight to be afforded his opinions not their admissibility. Likewise, the fact Dr. Hughes had not seen the cab on the drill, was not familiar with the inside of the cab, and did not know how high the switches and levers were in relation to Stacy's chest and wrist went to the weight of his opinions and not their admissibility.

We find Austin Powder's assertion that pursuant to KRE 702, Dr. Hughes is not competent to testify on this issue to be without merit. On appeal, for the first time, Austin Powder attempts to raise a challenge pursuant to Daubert v. Merrell Dow Pharm., Inc., 509 U.S.579, 113 S.Ct. 2786, 125 L.Ed.2d 469 (1993) wherein the United States

Supreme Court held that under Federal Rules Evidence 702, "the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable." The Kentucky Supreme Court held the Daubert standard with respect to admissibility is applicable in workers' compensation proceedings. City of Owensboro v. Adams, 136 S.w.3d 446, 449-50 (Ky. 2004).

In the case *sub judice*, no such challenge was made to Dr. Hughes' testimony during the proceedings before the ALJ. Thus, Austin Powder is precluded from challenging Dr. Hughes' opinions and the admissibility of his report and deposition on this ground. Significantly, Austin Powder failed to raise the Daubert objection prior to submission of this case for a decision, nor did it raise the issue at the benefit review conference conducted by the ALJ during which the ALJ identified all of the contested issues and which he confirmed again during the final hearing. As a result, Stacy was not afforded an opportunity to present evidence on the reliability of Dr. Hughes' report under the Daubert standard. Accordingly, Austin Powder waived its Daubert objection. *See* 803 KAR 25:010 Section 13(14)("Only contested issues shall be the subject of further proceedings."). Thus, we will not

consider Austin Powder's argument on appeal as it is untimely and unpreserved for review.

As to Austin Powder's second argument regarding the impairment rating assessed by Dr. Hughes for the injuries to Stacy's wrists and back, we agree that a portion of the impairment rating assessed for cumulative trauma injuries to the wrists was not assessed pursuant to the AMA Guides. In Jones v. Brasch-Barry General Contractors, supra, the Supreme Court stated as follows:

> A claimant found to have a compensable, permanent partial disability receives workers' compensation benefits based on the percentage of the employee's disability assessed by the ALJ in accordance with the AMA Guides. [footnote omitted] Thus, the AMA Guides are an indispensable tool utilized by an ALJ to determine the nature and severity of any claimant's injuries. In the case at hand, two physicians found that Jones suffers from a "Category III" impairment under the AMA Guides; and only Dr. Reasor found that Jones suffered from a "Category IV" impairment. Thus, the ALJ's decision to find Jones twenty-six percent disabled rests solely upon Dr. Reasor's opinion.
>
> As noted by the Board, Dr. Reasor's impairment rating "is a reflection of a personal [sic] desired outcome for the numerical percentage rather than an expert medical application of the definitions reflected within the categories of impairment [found in the AMA Guides]." [footnote omitted] This inescapable conclusion is borne out by the fact that Dr. Reasor testified

repeatedly in his deposition that Jones's impairment properly fell within the “strict definition” of Category III of the AMA Guides, not Category IV. We will not belabor this opinion by reprinting the lengthy excerpt of Dr. Reasor's opinion on this topic, especially in light of the fact that the Board has already done so on pages 5–12 of its opinion. Category III calls for an impairment range of ten to sixteen percent. Accordingly, Dr. Reasor's assignment of a twenty-six percent impairment rating for Jones was not in accordance with the strictures of the AMA Guides.

We agree with Jones that the AMA Guides do not abrogate a physician's right to assess independently an individual's impairment rating. We also agree that if the physicians in a case genuinely express medically sound, but differing, opinions as to the severity of a claimant's injury, the ALJ has the discretion to choose which physician's opinion to believe. But an ALJ cannot choose to give credence to an opinion of a physician assigning an impairment rating that is not based upon the AMA Guides. In other words, a physician's latitude in the field of workers' compensation litigation extends only to the assessment of a disability rating percentage within that called for under the appropriate section of the AMA Guides. The fact-finder may not give credence to an impairment rating double that called for in the AMA Guides based upon the physician's disagreement with the disability percentages called for in the AMA Guides, ***154** which is precisely what Dr. Reasor did in the case at hand.

Under our law, the AMA Guides are an integral tool for assessing a

> claimant's disability rating and monetary award. So to be useful for the fact-finder, a physician's opinion must be grounded in the AMA Guides, meaning that a physician's personal antagonism toward the AMA Guides, such as that demonstrated by Dr. Reasor in this case, is legally irrelevant. And any assessment that disregards the express terms of the AMA Guides cannot constitute substantial evidence to support an award of workers' compensation benefits.
>
> Therefore, Dr. Reasor's opinion that Jones is twenty-six percent disabled is not competent, substantial evidence because such a finding is greatly in excess of the express terms of the AMA Guides for the Category III injury Dr. Reasor found Jones to have. Since the Board found that the ALJ's decision was not supported by substantial evidence, it neither "overlooked or misconstrued controlling statutes or precedent, or committed an error in assessing the evidence so flagrant as to cause gross injustice." [footnote omitted] Accordingly, the Board's decision to remand this case to the ALJ with instructions to select an impairment rating in accordance with Category III of the AMA Guides is affirmed.

Dr. Hughes' testimony reveals he assessed an impairment rating for both wrists due to reduced range of motion. For the right wrist, he assessed a 5% impairment rating and for the left, a 1% impairment rating. Dr. Hughes also assessed an impairment based on reduced grip strength. His testimony recited herein establishes upon examination Stacy had pain in both hands. During his

deposition, Dr. Hughes acknowledged Section 16.8a of the AMA Guides states grip strength is not to be used if there is a presence of decreased range of motion or painful condition. In this case, Stacy had both decreased range of motion and a painful condition. Dr. Hughes specifically acknowledged the AMA Guides prohibit an assessment of an impairment rating based on grip strength when there is decreased range of motion or pain. Chapter 16.8a, on Page 508 of the AMA Guides reads, in relevant part, as follows:

> In a rare case, if the examiner believes the individual's loss of strength represents an impairing factor that has not been considered adequately by other methods in the *Guides*, the loss of strength may be rated separately. An example of this situation would be loss of strength due to a severe muscle tear that healed leaving a palpable muscle defect. If the examiner judges that loss of strength should be rated separately in an extremity that presents other impairments, the impairment due to loss of strength *could be combined* with the other impairments, *only* if based on unrelated etiologic or pathomechanical causes. *Otherwise, the impairment ratings based on objective anatomic findings take precedence*. Decreased strength *cannot* be rated in the presence of decreased motion, painful conditions, deformities, or absence of parts (eg, thumb amputation) that prevent effective application of maximal force in the region being evaluated.

Clearly, the above provision of the AMA Guides prohibited Dr. Hughes from adding an impairment rating for reduced grip strength in the presence of decreased motion in both wrists. We acknowledge that at the end of his deposition, Dr. Hughes testified he thought his impairment rating was based on his interpretation of the AMA Guides. However, we believe Jones v. Brasch-Barry General Contractors, supra, is applicable in part to the impairment rating assessed for both wrists.

Although unpublished, we cannot ignore the recent holding of the Kentucky Supreme Court in Central Baptist Hospital v. Hayes, 2012-SC-000752-WC, rendered August 29, 2013, Designated Not To Be Published, noting as follows:

> Dr. Nicholls reviewed Hayes's condition and assigned her an impairment rating of 7% for gait derangement pursuant to Table 17-5 of the *Guides* and an impairment rating of 3% for arthritis pursuant to Table 17-31 of the *Guides*. Nicholls then added the two impairment ratings and assigned Hayes a combined impairment rating of 10%. However, Table 17-2 of the *Guides*, which sets forth how to calculate lower extremity injury impairment ratings, states that an impairment rating for gait derangement may not be combined with an impairment rating for arthritis. Further, Section 17.2c specifically provides that, "the lower limb impairment percents shown in Table 17-5 [gait impairment] stand alone and are not combined with any other impairment evaluation method."

Since the ALJ relied upon Dr. Nicholls' 10% impairment rating, the Supreme Court reversed the award holding the 10% impairment was not assessed pursuant to the AMA Guides stating as follows:

> In this matter, Central Baptist provided sufficient evidence to show that the combined 10% impairment rating assigned to Hayes was erroneous and not in compliance with the *Guides*. Table 17-2 and Section 17.2c of the *Guides*, state that an impairment rating for gait derangement may not be combined with an impairment rating for arthritis. NO medical analysis or expertise is necessary to come to this conclusion. Thus, Dr. Nicholls should not have combined the two different impairment ratings, and Hayes cannot be assigned the combined 10% impairment rating.

Slip Op. at 4.

We believe the holding in Central Baptist Hospital v. Hayes, supra, applies in the case *sub judice* and Dr. Hughes, by his own admission, could not properly increase the impairment for the wrists by adding 6% for reduced grip strength. Therefore, the ALJ's reliance upon Dr. Hughes' total impairment rating for the wrists must be vacated.

That said, we find no merit in Austin Powder's argument an impairment rating assessed pursuant to the AMA Guides for Stacy's bilateral wrist condition is lacking.

Austin Powder relies upon page 451 of the AMA Guides which reads as follows: "[i]n determining the range of motion of individual joints, the examiner must evaluate both the active and the passive motion." However, the full text of that paragraph on page 451 reads as follows:

> In assessing motion, the examiner should first observe what an individual can and cannot do by asking him or her to move each joint of the extremity, from the shoulder down, through its full range of motion. *Both extremities should be compared*. Individual joints are then evaluated separately. Similarly, movements of the digits are first evaluated as a unit by having the individual make a complete fist and then extent the digits fully over several repetitions. In determining the range of motion of individual joints, the examiner must evaluate both the active and the passive motion. *Active or voluntary motion* is that performed by the active contraction of the governing muscles and is evaluated first.

Regarding his testing to determine the range of motion of the wrists, Dr. Hughes testified as follows:

> Q: When you were doing range of motion of his wrists, did you do both active and passive?
>
> A: This was all active, not passive?
>
> Q: Okay. Do you recall what the AMA Guides says about evaluation of the upper extremity and the requirement to do both active and passive?
>
> A: I don't recall it. No, sir.

Q: Let me show you a document here. I'm looking here at page 451 of the Fifth Edition of the AMA Guides. And in this paragraph on the left side it says "In determining the range of motion of individual joints, the examiner must evaluate both the active and passive motion." Do you see that?

A: Yes, sir.

Q: Again strictly speaking, if we're using the Fifth Edition of the AMA Guides, you did not do your examination in accordance with that directive; is that correct?

A: Yes. But there's a reason for that. And the reason is particularly when you're looking at range of motion of the spine, that I do not want to overstretch some particular joint. And so by using the active range of motion, I let the person who's got the problem pretty much define what the range of motion is until pain becomes an issue.

Q: In his wrist, was he able to complete an active arc of motion or was that incomplete?

A: An active arc? Yeah. He was completing an active arc of motion.

Q: You said he had a restriction of 15 percent and only able to go up to 20 percent on one side?

A: Yes, sir.

Q: That's not a full range?

A: No. No. Not a full range of motion. But in terms of his ability on his own to flex and extend his wrist, he did that.

Q: Well, the AMA Guides continues here and says “when a person has full active joint excursion passive motion, values need not be taken because a joint that has full active excursion will have full passive range. However, if the active arc of motion is incomplete, assisted active and/or passive motion measurements are necessary to evaluate the joint motion.” So that would seem to mandate use of passive range of motion; is that correct?

A: I disagree with that. I mean, that’s --

Q: Well, I mean do you disagree that this is what that says?

A: You are running the potential of hurting the patient and you do not want to do it.

Q: I know. But isn’t that what this document says here in the AMA Guides?

A: It is what the document says.

Q: And isn’t that what AMA Guides, right or wrong, is directing you to do?

A: Yes, sir.

Q: Okay. And technically speaking, you did not do your evaluation of the range of motion or develop your impairment rating of the range of motion based upon the Fifth Edition of the AMA Guides; is that correct?

A: Based on the wording that they have, that is correct.

Q: Okay. And the wording they have is all that we have, isn’t it?

A: Well, the AMA Guides are a guide and they’re not the be all and end all.

We note the AMA Guides specifically state in assessing motion, the examiner should first observe what an individual can and cannot do by asking him or her to move each joint of the extremity, from the shoulder down, through its full range of motion. Given that language, we conclude the basis for Dr. Hughes' 6% impairment rating for reduced range of motion was in keeping with the mandates of the AMA Guides. It appears Dr. Hughes believed he had complied with the AMA Guides and his findings concerning the range of motion in each wrist was in keeping with the AMA Guides. Specifically because he could not obtain passive motion measurements without hurting Stacy, Dr. Hughes did not believe he was required to obtain these measurements.

The above discussion aside, the issue here is not the same as the previous issue where it was clear an impairment rating could not be assessed for reduced grip strength. Here, Austin Powder argues Dr. Hughes' calculation of the range of motion and diagnosis of a loss of range of motion was not based upon the mandates of the AMA Guides. The Supreme Court in Tokico v. Kelly, 281 S.W.3d 771 (Ky. 2009), held KRS 342 does not require a doctor to conform his diagnosis to criteria listed in the AMA Guides. The Supreme Court stated:

KRS 342.730(*l*)(b) bases partial disability benefits on a permanent impairment rating, which KRS 342.0011(35) defines as being the "percentage of whole-body impairment" that an injury causes "as determined by" the latest edition of the *Guides.* Neither statute refers to a physician's diagnosis. Chapter 1 of the Fifth Edition discusses the *Guides'* philosophy, purpose, and appropriate use. Page 11 acknowledges that "some medical syndromes are poorly understood," that physicians must use clinical judgment when assigning impairment ratings, and that "clinical judgment, combining both the 'art' and 'science' of medicine, constitutes the essence of medical practice." Diagnosing what causes impairment and assigning an impairment rating are different matters. Diagnostic criteria stated in the *Guides* clearly have relevance when judging the credibility of a diagnosis, but Chapter 342 does not require a diagnosis to conform to criteria listed in the *Guides*.

The employer relies on *Jones v. Brasch-Barry General Contractors*, 189 S.W.3d 149 (Ky. App. 2006), which concerned an ALJ's authority to rely on a physician who conceded that a worker's back condition fell within a particular impairment category but disagreed with the percentages called for in the *Guides. Jones* is instructive though distinguishable. The present case concerns an ALJ's authority to choose among the opinions of physicians who diagnose a condition differently and who interpret the *Guides* differently when rating impairment for the condition.

As noted in Tokico v. Kelly, supra, the ALJ could consider the diagnostic criteria contained in the AMA Guides in "judging the credibility of a diagnosis." Here, the ALJ obviously determined Dr. Hughes' diagnosis of a loss of range of motion in the wrist was based on appropriate criteria. We do not believe Austin Powder established Dr. Hughes did not comply with the procedure recommended by the AMA Guides in determining Stacy's range of motion in both wrists. Rather, it appears in keeping with the AMA Guides, Dr. Hughes determined Stacy's range of motion in both wrists in a manner which would not cause any pain or discomfort. Even if, in evaluating the range of motion and formulating a diagnosis, Dr. Hughes did not strictly comply with Table 16.4a, we believe his diagnosis and the impairment rating assessed for reduced range of motion for both wrists was appropriate. Significantly, Austin Powder does not challenge the impairment rating assessed for loss of range of motion; rather, it challenges the manner in which Dr. Hughes determined the loss of range of motion.

Turning to the issue of Dr. Hughes' impairment for the back, concerning this impairment rating, Dr. Hughes testified as follows:

> Q: Now, in looking at the AMA Guides, Fifth Edition, and I know you've got to be familiar with that, it says that you

are – or, let me ask you this. Why did you use DRE category?

A: I've gotten in the habit of using it ever since the DRE became available. And the reason I like it is that so often when you're examining a patient, the range of motion is not reliable. You can have bad pain on the day that you're examining the patient and maybe he doesn't have pain the day before, and if you had done the exam when he didn't have pain, you get a completely different impression. So the DRE system eliminates that kind of uncertainty and that's why I prefer it.

Q: Why did you use DRE category II?

A: Because he has complaints of pain without radiculopathy.

Q: Doesn't that really fit though with DRE lumbar category I?

A: I've never used it that way.

Q: If you look at the specific ingredients that make up putting someone in category II, he doesn't have any of those, does he?

A: No. Actually, not. And I would simply say in that regard that there are many people who have back pain with no objective abnormalities at all. And granted, the DRE category II is restrictive in that regard but I think it's unfairly restrictive because there's lots of folks who have functional limitations as a consequence of back pain, no radiculopathy, and I think by common agreement that have an impairment. And to deny them that impairment I think is wrong.

Q: But if we are strictly going by the Fifth Edition of the AMA Guides, using

> table 15-3, he would fit though in lumbar category I; is that correct?
>
> A: He would if you went by the absolute strict wording of DRE 2.
>
> . . .
>
> Q: So then if we review your report, strictly speaking, under the Fifth Edition of the AMA Guides, and I realize that you are not in complete agreement, but if we just strictly interpret the AMA Guides, he has zero impairment for the low back and he has just six percent impairment for his wrist; is that correct?
>
> A: Adding the one and five, correct.

Based on the above testimony, we believe Dr. Hughes' impairment rating for the low back injury based on his belief Stacy's condition fell within DRE Category II is not in compliance with the AMA Guides. DRE Lumbar Category II as set forth in Table 15-3 requires as follows:

> Clinical history and examination findings are compatible with a specific injury; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy.
>
> **or**
>
> individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be

> expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment
>
> **or**
>
> fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal.

Dr. Hughes' testimony firmly establishes Stacy did not fall within DRE Category II. Stacy did not have a specific injury, radiculopathy, or any fractures. Thus, the assessment of an impairment based upon DRE Category II was not made pursuant to the AMA Guides. Jones v. Brasch-Barry General Contractors, supra; Central Baptist Hospital v. Hayes, supra. Consequently, a valid impairment rating was not assessed pursuant to the AMA Guides for Stacy's lower back condition. Dr. Hughes is the only physician to assess an impairment rating for Stacy's low back condition. Thus, that portion of the ALJ's decision finding Stacy had a 5% impairment for a low back condition based on the opinion of Dr. Hughes must also be vacated.

We find no merit in Austin Powder's third argument that Stacy is not entitled to an award of medical benefits

for his work-related hearing loss. In his Form 108, Dr. Jones stated the audiograms and other testing establish a pattern of hearing loss compatible with that caused by hazardous noise exposure in the work place and based on the AMA Guides, Dr. Jones assessed a 2% impairment. He also concluded Stacy's hearing loss was related to a repetitive exposure to hazardous noise over an extended period of employment and his hearing loss was not due to a single incident of trauma.

During his deposition of August 16, 2013, Dr. Jones testified Stacy had occupationally related noise induced sensory hearing loss and had a 2% impairment. Stacy told him the drill was a "pretty noisy piece of equipment." He conceded he did not know the decibel level to which Stacy was exposed. Further, he acknowledged Stacy could have had a hearing loss with less than 85% decibel exposure. However, he conceded Stacy could have been exposed to a dangerous level of noise in the past and not during his last employment. Further, he could not state that the last injurious exposure to a dangerous level of noise was at Austin Powder. However, he was certain the hearing loss happened but he could not state how long ago it was.

KRS 342.7305 reads, in relevant part, as follows:

> (1) In all claims for occupational hearing loss caused by either a single incident of trauma or by repetitive exposure to hazardous noise over an extended period of employment, the extent of binaural hearing impairment shall be determined under the "Guides to the Evaluation of Permanent Impairment."
>
> . . .
>
> (4) When audiograms and other testing reveal a pattern of hearing loss compatible with that caused by hazardous noise exposure and the employee demonstrates repetitive exposure to hazardous noise in the workplace, there shall be a rebuttable presumption that the hearing impairment is an injury covered by this chapter, and the employer with whom the employee was last injuriously exposed to hazardous noise shall be exclusively liable for benefits.

As pointed out by Dr. Jones, Stacy told him the drill was a pretty noisy piece of equipment. Contrary to the testimony of Hirley Smith ("Smith"), Austin Powder's Blasting Coordinator Supervisor at the time Stacy worked there, Stacy testified his cabin was not pressurized. Thus, we believe the ALJ was not required to rely upon Smith's testimony and the literature attached to his deposition indicating the machine Stacy operated generated a decibel level of between 74.6 or 76. Further, the ALJ was not required to rely on Smith's testimony that with the use of ear plugs the decibel level would be 30. Likewise,

the ALJ was not required to accept Smith's testimony that to ensure the noise level is kept to a safe operating standard the cab is pressurized as Stacy refuted that assertion stating the cab merely contained a heater and an air conditioner. Thus, the ALJ was free to disregard Smith's testimony and the documents introduced regarding the decibel level generated by the drill in concluding Stacy demonstrated he was subject to repetitive exposure to hazardous noise while working for Austin Powder. The testimony of Stacy and Dr. Jones constitute substantial evidence supporting the ALJ's award of medical benefits for a work-related hearing loss.

In light of our holding herein, Austin Powder's fourth argument that the ALJ's decision of total disability is not supported by substantial evidence is moot.

That said, by virtue of KRS 342.285(2) this Board is permitted to reach issues which are not raised by either party on appeal. There is no question this case does not concern a specific injury to either the wrists or the back. The ALJ and the parties treated the claim as involving only cumulative trauma injuries. Stacy specifically stated he did not sustain a specific back and wrist injury. Dr. Hughes' opinions were all couched in terms of cumulative trauma injuries occurring over the life of Stacy's

employment in the coal industry. That being the case, the law of cumulative trauma injury is applicable.

A cumulative trauma injury must be distinguished from an acute trauma injury where a single traumatic event causes the injury. In Randall Co./Randall Div. of Textron, Inc. v. Pendland, 770 S.W.2d 687, 688 (Ky. App. 1989), the Kentucky Court of Appeals adopted a rule of discovery with regard to cumulative trauma injury holding the date of injury is "when the disabling reality of the injuries becomes manifest." (emphasis added). In Special Fund v. Clark, 998 S.W.2d 487, 490 (Ky. 1999), the Supreme Court of Kentucky defined "manifestation" in a cumulative trauma injury claim as follows:

> In view of the foregoing, we construed the meaning of the term 'manifestation of disability,' as it was used in Randall Co. v. Pendland, as referring to physically and/or occupationally disabling symptoms which lead the worker to discover that a work-related injury has been sustained.

In other words, a cumulative trauma injury manifests when "a worker discovers that a physically disabling injury has been sustained [and] knows it is caused by work." Alcan Foil Products v. Huff, 2 S.W.3d 96, 101 (Ky. 1999). A worker is not required to self-diagnose the cause of a harmful change as being a work-related

cumulative trauma injury. *See* American Printing House for the Blind v. Brown, 142 S.W.3d 145 (Ky. 2004). Rather, a physician must diagnose the condition and its work-relatedness.

In cumulative trauma claims, the date upon which the obligation to give notice is triggered by the date of manifestation. Special Fund v. Clark, supra. Pursuant to KRS 342.185(1), a claimant has two years "after the date of accident" or following the suspension of payment of income benefits to file a claim. The Court of Appeals, in the case of Randall Co./Randall Div. of Textron, Inc. v. Pendland, supra, stated as follows regarding the clocking of the statute of limitations in the case of a cumulative trauma claim:

> We therefore conclude that in cases where the injury is the result of many mini-traumas, the date for giving notice and the date for clocking a statute of limitations begins when the disabling reality of the injuries becomes manifest.

The ALJ erroneously found Stacy suffered a cumulative trauma injury to his lumbar spine and bilateral wrist manifesting on April 16, 2012. Stacy testified that on April 16, 2012, he was laid off for reason unrelated to the alleged injuries. Clearly, the date Stacy was laid off does not comprise a date of manifestation. Therefore, the

ALJ's determination Stacy sustained cumulative trauma injuries manifesting on April 16, 2012, must be vacated. On remand, should the ALJ determine Stacy sustained a cumulative trauma injury or injuries, he must determine the date of manifestation of Stacy's cumulative trauma injury or injuries. The ALJ must also review the applicable law pertaining to a cumulative trauma injury as set forth herein and make the necessary findings, based on the evidence in the record. It is the date of manifestation of disability that controls the starting date for liability in work-related cumulative trauma situations. American Printing House for the Blind v. Brown, supra. This is true for both the alleged injuries to his wrists and low back.

The ALJ also erred in another critical respect. While in claims for hearing loss, KRS 342.7305 causes liability to fall on the last employer, this is not the case with non-hearing loss cumulative trauma injury claims. In Southern Kentucky Concrete Contractors, Inc. v. Campbell, 662 S.W.2d 221, 222 (Ky. App. 1983), the claimant's pre-existing condition was found to be attributable to "his hard manual labor" with multiple employers over the years of his work life. It was determined that the last employer– Southern Kentucky Concrete – could not be held liable to the extent the

claimant's condition was work-related and pre-existed his employment at Southern Kentucky Concrete. Thus, the Court remanded the matter with the following directions:

> We are therefore of the opinion that this case should be remanded to the Workers' Compensation Board with directions to determine the percentage of Campbell's disability attributable to the work performed by him while employed by Southern, and Southern is to be liable to that extent. Absent evidence to the contrary, Southern shall be liable for that percentage of Campbell's disability which is equal to the percentage of Campbell's worklife spent with Southern. The remainder of his disability is the responsibility of the Special Fund.

Id. at 222-223.

In Southern Kentucky Concrete, supra, the fact-finder determined "Campbell suffered a permanent, total, occupational disability that occurred during his lifetime of employment as a manual laborer." In the case *sub judice*, the ALJ found based on Dr. Hughes' opinion that Stacy suffered "a cumulative trauma injury to his lumbar spine and bilateral wrist that manifested on April 16, 2012, while he was employed as a drill operator" for Austin Powder. The ALJ also relied upon Dr. Hoskins' impairment rating in calculating Stephens' PPD benefits. Clearly, Dr. Hughes attributed both injuries to Stacy's work "as a heavy equipment operator for the past 41 years."

In the December 23, 2013, opinion, order, and award the ALJ imposed liability for all of Stacy's disability on Austin Powder. However, this determination can only stand if the evidence indicates the period from May 3, 2005, through April 16, 2012, in and of itself, caused all of Stacy's occupational disability. Stacy's testimony on this issue may or may not be consistent with such a finding as he indicated he began experiencing problems with his hands and back approximately six years from the date of his testimony. Dr. Hughes' statement regarding causation is not sufficient to impose liability upon Austin Powder for all of Stacy's disability due any cumulative trauma injury the ALJ may find Stacy sustained.

Just as important, is the fact that in the December 23, 2013, opinion, order, and award or the January 7, 2014, order there is no finding Stacy had a pre-existing dormant condition aroused into disabling reality by the work he performed during the period he worked for Austin Powder. Significantly, there is no allegation by Stacy of any injurious event occurring during his employment with Austin Powder which ended on April 16, 2012, the date he was laid off. In the opinion, order, and award, the ALJ addressed the presence of a pre-existing active impairment finding the record was devoid of medical or vocational

proof that Stacy suffered from pre-existing occupational disability in existence on April 16, 2012. The ALJ stated he found the opinion of Dr. Hughes more persuasive regarding the work injury and concluded Stacy met his burden of proving he "suffered a cumulative trauma injury to his lumbar spine and bilateral wrist that manifested on April 16, 2012, while he was employed as a driller operator for the Defendant." This finding clearly negates a finding of a dormant condition being aroused into disabling reality. In fact, the ALJ has ruled out the arousal of a dormant non-disabling condition into disabling reality during Stacy's employment at Austin Powder. By finding Stacy sustained cumulative trauma over many years of work as a drill operator, the ALJ by implication specifically rejected the premise Stacy's work at Austin Powder resulted in arousal of a pre-existing dormant non-disabling condition into disabling reality. The ALJ is left, then, with analyzing this as a cumulative trauma claim with multiple employers, and Southern Kentucky Concrete, supra, is determinative.

Based on our decision, the ALJ is not required to perform this analysis regarding an impairment rating attributable to Stacy's alleged cumulative trauma back injury as no impairment rating was assessed pursuant to the

AMA Guides for the cumulative trauma back injury. That said, Dr. Hughes did assess an impairment rating of 6% pursuant to the AMA Guides for Stacy's right and left wrists. Therefore, as required by Southern Kentucky Concrete, supra, the ALJ must determine whether Stacy sustained cumulative trauma wrist injuries during his employment with Austin Powder, and if so, whether all, a portion, or none of the impairment rating assessed for the condition of each wrist, is directly attributable to Stacy's employment from May 3, 2005, through April 16, 2012, with Austin Powder. In doing so, the ALJ must cite, in his amended opinion and order, the medical proof that establishes Stacy's work at Austin Powder contributed to his overall cumulative trauma injury or injuries and then, with specificity, denote to what degree it contributed. Simply because Stacy was last employed by Austin Powder does not impose liability on Austin Powder for all of his alleged permanent impairment and resulting occupational disability. There must be evidence of record establishing that Stacy's work activities performed during the period of employment between May 3, 2005, and April 16, 2012, contributed to his overall permanent condition, producing some degree of harmful change to the human organism.

In addition, even though we have held Stacy is not entitled to income benefits for a cumulative trauma back injury, the ALJ still may award medical benefits if he finds Stacy has sustained a work-related cumulative trauma back injury. Specifically, the ALJ must determine whether Stacy sustained a cumulative trauma back injury during the course of his employment with Austin Powder from May 3, 2005, through April 16, 2012.

"Injury" is defined at KRS 342.0011(1) as:

> [A]ny work-related traumatic event or series of traumatic events, including cumulative trauma, arising out of and in the course of employment which is the proximate cause producing a harmful change in the human organism evidenced by objective medical findings. "Injury" does not include the effects of the natural aging process, and does not include any communicable disease unless the risk of contracting the disease is increased by the nature of the employment. "Injury" when used generally, unless the context indicates otherwise, shall include an occupational disease and damage to a prosthetic appliance, but shall not include a psychological, psychiatric, or stress-related change in the human organism, unless it is a direct result of a physical injury.

The above definition does not require a permanent injury to be compensable. "Permanent disability" is defined at KRS 342.0011(11)(c). For permanent disability, the

claimant must have a permanent impairment rating. Furthermore, workers suffering temporary injuries may be entitled to medical benefits pursuant to KRS 342.020. An injured worker is entitled to an award of medical benefits "at the time of injury and thereafter during disability" in the absence of a permanent injury or disability. KRS 342.020(1); Combs v. Kentucky River District Health Dept., 194 S.W.3d 823 (Ky. App. 2006). Subsequently, in FEI Installation, Inc. v. Williams, 214 S.W.3d 313 (Ky. 2007), the Supreme Court instructed that KRS 342.020(1) does not require proof of an impairment rating to obtain future medical benefits, and the absence of a functional impairment rating does not necessarily preclude such an award.

Consequently, in addition to determining whether Stacy sustained cumulative trauma injuries to his wrists during his employment with Austin Powder, the ALJ must also determine whether Stacy sustained a cumulative trauma back injury during the course of his employment with Austin Powder. Should the ALJ determine Stacy sustained a cumulative trauma back injury during the course of his employment with Austin Powder he must then determine whether Stacy is entitled to future medical benefits pursuant to FEI Installation, Inc. v. Williams, supra.

Finally, should the ALJ determine Stacy sustained a cumulative trauma injury to one or both wrists meriting an impairment rating he must then determine the extent of Stacy's occupational disability in accordance with the guidelines set forth in the statute and applicable case law.

Accordingly, those portions of the December 23, 2013, opinion, order, and award and the January 7, 2014, order ruling on the petition for reconsideration concerning the ALJ's determination Stacy sustained work-related cumulative trauma injuries to both wrists and his low back meriting an impairment rating pursuant to the AMA Guides and his determination Stacy is totally occupationally disabled are **VACATED**. That portion of the December 23, 2013, opinion, order, and award and the January 7, 2014, order determining Stacy sustained work-related hearing loss and is entitled to medical benefit is **AFFIRMED**. This claim is **REMANDED** to the ALJ for a determination of whether Stacy sustained work-related cumulative trauma injuries to his wrists and low back. Further, if the ALJ determines Stacy sustained a work-related cumulative trauma injury to one or both of his wrists, the ALJ shall determine the impairment rating attributable to each cumulative trauma injury occurring

during the course of Stacy's employment with Austin Powder. Similarly, if the ALJ determines Stacy sustained a work-related cumulative trauma back injury during the course of his employment with Austin Powder, the ALJ shall determine in accordance with FEI Installation, Inc. v. Williams, supra, whether Stacy is entitled to future medical benefits. Further, if the ALJ determines Stacy has sustained work-related cumulative trauma injury to his wrist or wrists meriting an impairment rating, the ALJ shall then determine the extent of Stacy's occupational disability as a result of the injury or injuries.

ALL CONCUR.

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