

Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: September 9, 2016

CLAIM NO. 201501480 & 201501479

CHRISTOPHER CUNNINGHAM

PETITIONER

VS.

APPEAL FROM HON. CHRIS DAVIS,
ADMINISTRATIVE LAW JUDGE

QUAD/GRAPHICS, INC.
and HON. CHRIS DAVIS,
ADMINISTRATIVE LAW JUDGE

RESPONDENTS

OPINION
AFFIRMING
* * * * *

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

STIVERS, Member. Christopher Cunningham ("Cunningham") seeks review of the April 20, 2016, Opinion, Award, and Order of Hon. Chris Davis, Administrative Law Judge ("ALJ") awarding temporary total disability ("TTD") benefits, permanent partial disability ("PPD") benefits, and medical benefits for a right shoulder work injury sustained on April 13, 2014. The ALJ also awarded TTD benefits and

medical benefits for a left elbow work injury sustained on November 19, 2012. Cunningham also appeals from the May 23, 2016, Order ruling on his petition for reconsideration.

On appeal, Cunningham challenges the ALJ's reliance upon Dr. Stacie L. Grossfeld's 8% impairment rating for the right shoulder injury asserting it is not in conformity with the 5th Edition of the American Medical Association, Guides to the Evaluation of Permanent Impairment ("AMA Guides").

On September 16, 2015, Cunningham filed a Form 101 alleging a work-related injury to his left elbow on November 19, 2012. Cunningham was picking up pallets when he felt sharp pain in his left elbow. On that same date, Cunningham also filed a Form 101 alleging an injury occurring on April 13, 2014, when he was carrying a bundle and felt something tear in his right arm.

In separate Forms 111, Quad/Graphics, Inc. ("Quad/Graphics") accepted both injuries as compensable but indicated a dispute arose as to the amount of compensation due. The ALJ subsequently consolidated the claims.

As a result of the left elbow injury, Cunningham underwent surgery on June 3, 2013, performed by Dr. Martin Favetto consisting of a repair of the distal biceps. On June 11, 2014, Dr. Favetto performed surgery on the right

shoulder consisting of right shoulder arthroscopy, biceps tenodesis, subacromial decompression, and acromioclavicular joint resection.

Quad/Graphics introduced the report and deposition of Dr. Grossfeld who assessed 0% impairment for the left elbow injury and an 8% impairment rating for the right shoulder injury pursuant to the AMA Guides.

Cunningham relied upon the January 6, 2015, report of Dr. Gary Bray who assessed a 4% impairment rating pursuant to the AMA Guides for the left elbow injury and the August 13, 2015, report of Dr. Frank Burke who assessed, pursuant to the AMA Guides, a 1% impairment rating for the left elbow injury and a 17% impairment rating for the right shoulder injury yielding an 18% whole person impairment rating.

Cunningham's December 2, 2015, deposition was introduced, and he testified at the February 24, 2016, hearing.

Relative to the applicable impairment rating for each injury, the ALJ provided the following findings of facts and conclusions of law:

Dr. Burke has assigned an impairment rating of 18%, 1% for the left elbow and 17% for the right shoulder. He accepted the Plaintiff's complaints without question and his

performance on examination, including range of motion testing.

Dr. Grossfeld however testified that in her eighteen years of experience as an orthopedic surgeon specializing in shoulder surgeries and treatment she is qualified to determine when a patient is giving full effort on active range of motion testing. She determined that the Plaintiff was not giving full effort on active range of motion and despite the fact that his active range of motion testing would have resulted in a 14% impairment rating that this is inaccurate.

She did not, as the Plaintiff argues, agree she made up a rating. She based it on active [sic] range of motion testing. The Plaintiff has characterized the rating from Dr. Grossfeld unusable as an incorrect use of the AMA Guides inasmuch as the Guides require the use of active range of motion.

However it is a proper use of the AMA Guides if the treating physician can provide a cogent reason within their expertise from deviating somewhat from the narrow specifics of the Guides. Dr. Grossfeld has done this by explaining that based on her experience and expertise the Plaintiff's active range of motion was invalid.

Additionally, when addressing many types of conditions and injuries, but especially with extremity joints, range of motion testing is the preferred method to rate claimants under the AMA Guides. The Plaintiff's argument, if accurate, would create a rule that in most, if not all, claims involving an extremity joint the only rating would be based on active range of motion. In other words, "Plaintiff says, Plaintiff

gets." I do not believe either the General Assembly or the Supreme Court ever contemplated or intended such a result.

Having demonstrated why the rating from Dr. Grossfeld is in conformity with the AMA Guides it is evident that I intend to rely on said rating.

The rating assigned by Dr. Bray is not usable. He assigned in January, 2015 and the Plaintiff received additional medical treatment after that date. As a matter of course, the Plaintiff not being at MMI when the rating was assigned the rating from Dr. Bray is not in conformity with the AMA Guides.

The rating from Burke is based on his own examination findings and the Plaintiff's active range of motion on examination. It mirrors the Plaintiff's testimony and subjective complaints.

However I am more persuaded by the report and opinions of Dr. Grossfeld. Dr. Grossfeld carefully explained her rejection of the Plaintiff's active range of motion testing for the right shoulder. She carefully explained why the Plaintiff did not have a ratable condition for his left elbow. She is an expert in the treatment and evaluation of shoulder injuries. The Plaintiff retains a 2% impairment rating for his right shoulder.

The ALJ calculated the award as follows:

. . .

The Plaintiff's permanent partial disability award shall be 880.81 (AWW) x 2/3 (workers' compensation rate subject to statutory maximum) x .02 (impairment rating) x .65 (grid factor)

x 3.2 (KRS 342.730(1)(c)1.) = \$23.99 a week, for 425 weeks, from April 13, 2014, excluding any periods of TTD, with 12% interest on any past due portions and with the Defendant taking credit for any benefits paid.

He is also entitled to all future, work-related and reasonable and necessary medical expense, for the injuries to the left elbow and the right shoulder.

The ALJ awarded \$23.99 per week from April 13, 2014, for 425 weeks. He also awarded TTD benefits for the periods extending from April 24, 2013, through October 28, 2013; February 26, 2014, through March 20, 2014; April 15, 2014, through July 23, 2014; and August 1, 2014, through August 20, 2015.

Cunningham filed a petition for reconsideration asserting the ALJ awarded benefits for the right shoulder injury based upon a 2% impairment rating assessed by Dr. Grossfeld. He noted Dr. Grossfeld's lowest impairment rating for the right shoulder is 8%. Cunningham asserted Dr. Grossfeld's original report contained a typographical error assigning a 2% impairment rating for the right shoulder. However, in her deposition, Dr. Grossfeld stated 2% was a typographical error and Cunningham had an 8% whole person impairment rating due to the right shoulder injury.

Cunningham asserted an 8% impairment rating would amount to weekly benefits of \$125.51 for 425 weeks.

Citing to Jones v. Brasch-Barry General Contractors, 189 S.W.3d 149 (Ky. App. 2006), Cunningham contended Dr. Grossfeld's 8% impairment rating was based on a passive range of motion and not in accordance with the AMA Guides. Cunningham argued Dr. Grossfeld should have based her impairment rating upon the active range of motion measurements she obtained, which she testified merited a 14% whole person impairment.

Cunningham also asserted an argument concerning the left elbow injury.

The ALJ's May 23, 2016, Order ruling on the petition for reconsideration reads as follows:

1. On reconsideration, the ALJ amends the Opinion and adopts an impairment rating of 8% regarding the right shoulder. This shall result in weekly benefits of \$125.81 paid over 425 weeks effective of the date of injury.
2. On reconsideration, the ALJ amends the Opinion and adopts an impairment rating of 0 regarding the left elbow injury. This shall result in weekly benefits of \$0 paid over 425 weeks effective the date of injury.

On appeal, Cunningham argues, as he did in his petition for reconsideration, Dr. Grossfeld's impairment rating for the right shoulder condition is not in

accordance with the AMA Guides and therefore should have been rejected by the ALJ. Citing to Jones v. Brasch-Barry General Contractors, supra, Cunningham asserts when an evaluating doctor admits she did not follow the AMA Guides, the resulting impairment rating cannot constitute substantial evidence. Nonetheless, the ALJ adopted the impairment rating of Dr. Grossfeld even though she admitted it was not calculated in accordance with the AMA Guides. Cunningham notes Dr. Grossfeld assigned an 8% impairment rating for the right shoulder condition based on passive range of motion measurements obtained during her evaluation. However, during her January 11, 2016, deposition, Dr. Grossfeld agreed a correct application of the AMA Guides required the use of active range of motion measurements obtained during the examination. Cunningham notes that utilization of the active range of motion measurements Dr. Grossfeld obtained resulted in a 14% impairment rating.

Cunningham observes Dr. Grossfeld acknowledged she relied upon the passive range of motion measurements because Cunningham gave a poor effort when she obtained active range of motion measurements. Thus, Cunningham argues her decision to rely upon her measurements for passive rather than active range of motion measurements

represented Dr. Grossfeld's "personal approach." Cunningham maintains use of passive range of motion measurements is not an option permitted by the AMA Guides nor does it represent Dr. Grossfeld's interpretation of the AMA Guides. Cunningham notes the ALJ recognized Dr. Grossfeld deviated from the AMA Guides, but determined the rating was reliable because it is a proper use of the AMA Guides if the treating physician can provide a cogent reason within their expertise for deviating from the narrow specifics of the AMA Guides.

Cunningham concludes by arguing as follows:

In the instant case, Dr. Grossfeld had no issue interpreting and following the directions in the AMA Guides to calculate a 14% whole person rating based on active range of motion. While the doctor felt her approach of using passive range of motion findings would provide more accurate information, her role in these situations is to apply the Guides, not re-write or tweak the Guides.

Whether Dr. Grossfeld's deviation from the Guides was justified therefore, is not the issue. The issue is whether a rating that was admittedly not calculated in accordance with the Guides can constitute substantial evidence. Controlling case law indicates that it cannot. The case therefore, should be remanded to the ALJ with instructions to adopt an impairment rating for the right shoulder that was calculated in accordance with the AMA Guides.

As the claimant in a workers' compensation proceeding, Cunningham had the burden of proving each of the essential elements of his cause of action including the impairment rating attributable to his injury. Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Since Cunningham was unsuccessful in proving the applicable impairment rating for the shoulder injury is 17%, the question on appeal is whether the evidence compels a different result. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). "Compelling evidence" is defined as evidence that is so overwhelming no reasonable person could reach the same conclusion as the ALJ. REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985). The function of the Board in reviewing the ALJ's decision is limited to a determination of whether the findings made by the ALJ are so unreasonable under the evidence that they must be reversed as a matter of law. Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000).

As fact-finder, the ALJ has the sole authority to determine the weight, credibility and substance of the evidence. Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993). Similarly, the ALJ has the discretion to determine all reasonable inferences to be drawn from the evidence. Miller v. East Kentucky Beverage/Pepsico, Inc., 951 S.W.2d

329 (Ky. 1997); Jackson v. General Refractories Co., 581 S.W.2d 10 (Ky. 1979). The ALJ 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 party's total proof. Magic Coal Co. v. Fox, 19 S.W.3d 88 (Ky. 2000). Although a party may note evidence that would have supported a different outcome than that reached by an ALJ, such proof is not an adequate basis to reverse on appeal. McCloud v. Beth-Elkhorn Corp., 514 S.W.2d 46 (Ky. 1974).

The Board, as an appellate tribunal, may not usurp the ALJ's role as fact-finder by superimposing its own appraisals as to the weight and credibility to be afforded the evidence or by noting reasonable inferences that otherwise could have been drawn from the record. Whittaker v. Rowland, 998 S.W.2d 479, 481 (Ky. 1999). So long as the ALJ's ruling with regard to an issue is supported by substantial evidence, it may not be disturbed on appeal. Special Fund v. Francis, 708 S.W.2d 641, 643 (Ky. 1986).

In her January 6, 2016, report, Dr. Grossfeld provided the history she obtained from Cunningham and the results of her examination. Dr. Grossfeld believed Cunningham attained maximum medical improvement for his

shoulder and elbow conditions on August 20, 2015. She stated for the right shoulder, Cunningham had a 14% impairment rating for the upper extremity which equated to a 2% whole body impairment rating. Cunningham had 0% impairment for the left elbow condition. Dr. Grossfeld disagreed with the 17% impairment rating Dr. Burke assessed for the right shoulder condition and the impairment ratings assessed by Drs. Burke and Bray for the left elbow. Dr. Grossfeld attached a sheet delineating how she determined the permanent partial impairment rating for the right shoulder condition based on the AMA Guides, which reads as follows:

	ROM%	%	Page#	Figure/Table
Forward Flexion	160	1	476	16-40
Extension			476	16-40
Abduction	145	1	477	16-43
External Rotation	60	0	479	16-46
Internal Rotation	60	2	479	16-46
Motor Strength If > 12 months from surgery			510	16-35
AC Excision	n/a	10%	506	16-27

Dr. Grossfeld's sheet indicates Cunningham has a 14% upper extremity rating and an 8% total body permanent impairment rating for the shoulder injury, calculated pursuant to Table 16-3, Page 439, of the AMA Guides.

During her January 11, 2016, deposition, Dr. Grossfeld testified her report contained a typographical error. She stated the rating for the right shoulder condition merited a 14% upper extremity rating but the 2% impairment rating for the whole body was a typographical error. The impairment rating should be 8% for the right shoulder injury. Dr. Grossfeld testified she would dictate an addendum to that effect. Indeed, attached to her deposition is a January 11, 2015 letter in which she states the impairment rating for the right shoulder is 14% upper extremity and 8% total body based on Table 16-3, Page 439, of the AMA Guides. Also attached is the worksheet, referred to herein, showing how she arrived at the 8% impairment rating. Handwritten on this worksheet was "[p]assive ROM; poor effort in active ROM; therefore defaulted to passive ROM #S." Dr. Grossfeld attached another worksheet calculated pursuant to the AMA Guides based on active range of motion which yielded a 14% impairment rating upon which she handwrote the following:

"Active ROM [p]oor effort on patient's part therefore used passive ROM in report."

Dr. Grossfeld provided the following explanation as to how she arrived at the 8% impairment rating:

Q: Okay. Doctor, did you believe as though - or did you feel as though Mr. Cunningham warranted a permanent impairment rating per the Fifth Edition of the AMA Guides to the Evaluation of Permanent Impairment?

A: I did. I determined his PPI rating for his right shoulder based on range of motion loss and also the fact that he underwent acromioclavicular joint excision, which gave him a 14 percent rating for the upper extremity, converting over the eight percent for the total body.

In reference to his left elbow, he had full range of motion, normal strength, normal sensation, and that warranted a zero percent PPI rating.

Q: Okay, And just to clarify, Doctor, looking at the permanent partial impairment rating which is attached to your nine-page impairment report, I do see where a 10 percent upper extremity impairment was attributable to just the AC excision alone per the AMA Guides; is that correct?

A: Correct.

Q: And then there is an additional four percent of impairment relative to the right shoulder due to decreased range of motion; is that correct?

A: Correct.

Q: And thereby arriving at a 14 percent upper extremity impairment rating, which ultimately under the AMA Guides converts to eight percent whole person impairment rating?

A: Correct.

On cross-examination, Dr. Grossfeld was asked to calculate the impairment rating based on an active range of motion and provided the following testimony:

Q: Are you able to do a quick calculation to give the judge what the impairment rating would be if it was based on the active range of motion findings?

A: I can.

Q: Okay. And we'll give you as long as you need to do that and hang on for just a second.

THE WITNESS: On Mr. Cunningham's physical examination, I felt that he put forth fairly poor effort when doing active range of motion.

So when I examine a patient, if I feel that they're not giving me their full effort, I will go by my passive range of motion and not the active range of motion because I feel that that is not - that's inaccurate information.

But his active range of motion, he could forward flex 90 degrees, which would give him a six percent impairment; abduction was 75 degrees; external rotation, 55, existing. So that would be 14 percent for the range of motion.

And then you add that to the AC joint excision. That would give him a total upper extremity of 24 percent, which would then convert over to 14 percent for the total body.

But, again, the reason why I didn't use the active range of motion, I felt these were inaccurate in his ability to show me how far he was moving his arm.

Yeah. And I've actually put this on a calculation sheet. If you want to use that as an exhibit, you may.

. . .

Q: All right. Doctor, typically when you evaluate claimants, if you feel like there is some degree of self-limiting or symptom magnification, you certainly have no problem listing that in your report, correct?

A: I do sometimes; sometimes, I don't. Typically, I will know if I - if the patient - if I end up using passive - typically, when I measure range of motion in the shoulder, it's done actively.

If I feel like the patient is not exhibiting good effect, then I will do a passive range of motion, and I'll use that in my calculation. That's kind of my little way of knowing that he or she was not putting forth full effort. Yeah.

Now, if I see, like, Waddell's - pardon?

Q: I'm sorry, Doctor. Go ahead, please.

A: When I'm doing, like, a back exam, and I can really document Waddell's symptoms - which are physical findings

that have been written in a book - then I will list those.

For the shoulder, there's really not, like, Waddell's symptoms for the - for the shoulder. It comes with doing this for 18 plus years and specializing in shoulder surgery. You kind of get a sense when someone's putting forth effort and when they're not.

And then when there's such a difference between the passive and active, then there is - typically, there's some sort effort issues going on with the patient.

And to be clear, I should have put that in my notes, that there was limited effort on his behalf.

Dr. Grossfeld acknowledged that when she examined Cunningham, the passive range of motion caused him significant discomfort, and her report reflects that fact. She also acknowledged the AMA Guides call for the active range of motion measurements to be utilized in arriving at an impairment:

Q: Thank you, Doctor.

And, Doctor, you would agree the examples in the AMA Guides on the shoulder range of motion - and I'm looking at the examples given on page 475 and 476.

Certainly the basic instructions call for range of motion of the shoulder ratings to be based on active range of motion measurements, correct?

A: Correct. Correct.

However, Dr. Grossfeld provided a more thorough explanation as to why she could utilize the passive range of motion in calculating an impairment rating pursuant to the AMA Guides.

Q: Doctor, I have a few quick follow-up questions for you. I say "quick." Hopefully, I'm right about that.

First off, can you just tell the judge again why you felt it necessary to go with Mr. Cunningham's passive range of motion measurements as opposed to his active relative range of motion relative to the right shoulder?

A: I am fairly well versed in the Fifth Edition Guides to Permanent Impairment, and I know that you are supposed to list active range of motion.

However, when I have a patient who puts forth what I would consider poor effort, I will use passive range of motion. So that is why I did that with this particular patient -

Q: Okay.

A: -- because you can have any patient come in and not give effort.

I mean, I have many patients - even my own patients - that won't put forth any effort, and they have extremely poor range of motion. For whatever reason, they have limited effort.

So you have to kind of get a sense as to who is giving you good effort and who is not, and that's something a bit of the art and not the science of medicine.

But he was not putting forth full effort, and he was putting forth what I would consider not full effort; therefore, I went with the passive range of motion.

Q: Okay. Ultimately, Doctor, based upon your education, your training, your experience, your familiarity with the AMA Guides, did you feel as though Mr. Cunningham's active range of motions [sic] were an accurate reflection of his true level of impairment and disability?

A: I did not. The - I did not.

Q: Okay. According, do you feel as though the 14 percent whole body impairment rating - which you quickly calculated for us based upon those active range of motion measurements - is an accurate and reliable reflection of Mr. Cunningham's true level of impairment and disability.

A: I do not.

Q: Ultimately, what is the rating that you feel best reflects Mr. Cunningham's true level of impairment and disability here?

A: 14 percent for the upper extremity, and eight percent for the total body.

Cunningham relies, in part, upon the following response by Dr. Grossfeld:

Q: Doctor, I'm just going to try to wrap up with a few more questions here.

So the kind of rule that you cited a little bit earlier - if I think they're giving poor effort on active range of motion, I'll give a rating using the passive range - that's, for

lack of a better word, really your personal approach -

A: Yes.

Q: -- to these situations?

Would that be fair?

A: Yes.

Q: Okay. And so whether we agree with the technicalities or the letters of the AMA Guides, that's irrelevant.

If you want to follow the guides strictly, the 14 percent total body number that you cited to me based on active range of motion is the impairment rating that is done in accordance with the guidebook, correct?

A: Correct.

The following exchange between Quad/Graphics' counsel and Dr. Grossfeld then occurred:

Q: I get to follow up on that last set of questions, Doctor.

Are you aware of anything in the Fifth Edition of the AMA Guides that would insist upon you using range of motion measurements, active or passive, that you did not find to be accurate and reliable based on your training, your education, your experience?

A: I'm sorry. Can you repeat the question?

Q: Sure. Are you aware of anything in the AMA Guides that says you as an evaluator have to use range of motion measurements that you believe are inaccurate -

A: No.

Q: -- and not reliable -

A: Right.

Q: -- based upon your training, your education, and your experience?

A: No. I'm not aware of where it says that in the Guides. If the patient -

Q: Okay.

A: -- is not giving -

Q: I'm sorry, Doctor. It sounds like you were cut off. I heard, "If the patient is not giving," and that's the last I heard.

A: If the - and I just want to make sure that I'm understanding the question appropriately.

My opinion is if the patient is not giving me effort, then I can't give you an accurate PPI rating, so I can assist in getting a better PPI rating if I use a passive range of motion.

And based on the experience and et cetera, I don't know where anywhere in the guidebook it says that you can't - you can't use that.

It says that you should use the active range of motion, but if I have ab [sic] unreliable - what I would consider unreliable examination, that would give me an unreliable PPI rating, which is incorrect, which would be misinformation.

Q: And if I'm not mistaken, Doctor - and correct me if I'm wrong - the Guides do stress in scenarios like that you use the most accurate measurements

available to the evaluator in order to arrive at the most accurate and correct impairment rating. Am I correct about that?

A: Correct.

Q: Okay. And from what I'm hearing from you, is that what you attempted to do here - again, based upon your training, your education, your experience, and your familiarity with the Guides - take those range of motion measurements that you thought best reflected Mr. Cunningham's ability and thereby arrive at a permanent impairment rating?

A: Correct.

We disagree with Cunningham's assertion Dr. Grossfeld's testimony demonstrates she deviated from the AMA Guides in assessing the 8% impairment rating for the right shoulder injury. Because she believed Cunningham was not giving a full effort during the course of her evaluation, Dr. Grossfeld concluded she could not utilize his active range of motion measurements in calculating the right shoulder impairment rating. Without question, in conducting any evaluation a doctor must assess the credibility of the individual whom she is examining and evaluating. That includes determining whether the individual has accurately recounted his or her medical history, the nature of his or her symptoms, and has provided a true and accurate example of his or her physical capabilities. Here, Dr. Grossfeld concluded that

Cunningham was deliberately not providing a true example of his range of motion; thus, she discounted it and relied upon the passive range of motion measurements in arriving at an impairment rating. This is clearly the doctor's prerogative. A doctor is not required to assess an impairment rating based upon examination results the doctor believes were falsified. To follow Cunningham's logic, the doctor is required to rely upon the claimant's purported capabilities, however falsified. Acceptance of Cunningham's position would lead to absurd results.

The following is contained on page 19 of the AMA Guides and is extremely germane to this issue.

2.5c Consistency

Consistency tests are designed to ensure reproducibility and greater accuracy. These measurements, such as one that checks the individual's lumbosacral spine range of motion (Section 15.9) are good but imperfect indicators of people's efforts. The physician must use the entire range of clinical skill and judgment when assessing whether or not the measurements or tests results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.

The above provision contained within the AMA Guides permitted Dr. Grossfeld to discount the active range of motion measurements she obtained because she believed they were not as severe as Cunningham would have her believe. In that case, Dr. Grossfeld was permitted to modify the impairment rating in accordance with what she believed to be accurate range of motion measurements. In doing so, Dr. Grossfeld was required to describe and explain the reason for the modification. The record reveals Dr. Grossfeld adequately described and explained her reasons for using the passive range of motion measurements instead of the active range of motion measurements in obtaining an accurate impairment rating. Consequently, we believe Dr. Grossfeld's 8% impairment rating is in accordance with the AMA Guides. In referencing the AMA Guides in support of her opinions, Dr. Grossfeld explained why she believed Cunningham did not have a 14% impairment rating based upon the active range of motion measurements and the reasons why the 14% impairment rating was not an accurate reflection of Cunningham's physical capabilities. Thus, we find no error in the ALJ's reliance upon Dr. Grossfeld's 8% impairment rating for the shoulder injury.

Unlike the physician in Jones v. Brasch-Barry General Contractors, supra, Dr. Grossfeld did not opine the 8% impairment rating she assessed for the right shoulder injury was not in accordance with the AMA Guides. Rather, she steadfastly contended the 8% impairment rating was in accordance with the AMA Guides.

Concerning the ALJ's determination Cunningham has an 8% impairment rating as a result of the shoulder injury, this Board has repeatedly held that the ALJ, as fact-finder, has the authority to pick and choose whom and what to believe. The AMA Guides is clear that its purpose is to provide objective standards for the "estimating" of permanent impairment ratings by physicians. Because Dr. Grossfeld is a licensed medical doctor, the ALJ could appropriately assume her expertise in utilizing the AMA Guides was comparable or superior to any other expert medical witnesses of record. The ALJ is not required to look behind an impairment rating and meticulously sift through the AMA Guides to determine whether an impairment assessment harmonizes with that treatise's underlying criteria. Except under compelling circumstances, where it is obvious even to a lay person that a gross misapplication of the AMA Guides has occurred, the issue of which physician's AMA rating is most credible is a matter of

discretion for the ALJ. REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985). Hence, we find no error in the ALJ's reliance upon Dr. Grossfeld's opinion or the ALJ's ultimate determination that Cunningham has an 8% impairment rating as a result of the right shoulder injury. Because the ALJ's determination Cunningham has an 8% impairment rating due to the right shoulder injury is supported by substantial evidence and the record does not compel a different result, we are without authority to disturb his decision on appeal.

Accordingly, the April 20, 2016, Opinion, Award, and Order and the May 23, 2016, Order ruling on the petition for reconsideration and amending the award for the right shoulder injury are **AFFIRMED**.

ALL CONCUR.

COUNSEL FOR PETITIONER:

HON BRADLY SLUTSKIN
131 MORGAN ST
VERSAILLES KY 40383

COUNSEL FOR RESPONDENT:

HON JO ALICE VAN NAGELL
300 E MAIN ST STE 400
LEXINGTON KY 40507

ADMINISTRATIVE LAW JUDGE:

HON CHRIS DAVIS
657 CHAMBERLIN AVE
FRANKFORT KY 40601