Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: February 28, 2014

CLAIM NO. 201189780

CON-WAY FREIGHT PETITIONER

VS. **APPEAL FROM HON. OTTO DANIEL WOLFF, IV, ADMINISTRATIVE LAW JUDGE**

AUGUST F. SCHROER
and HON. OTTO DANIEL WOLFF, IV,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

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

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

STIVERS, Member. Con-Way Freight ("Con-Way") seeks review of the September 17, 2013, opinion, order, and award of Hon. Otto Daniel Wolff, IV, Administrative Law Judge ("ALJ") finding August F. Schroer ("Schroer") sustained compensable cervical and psychological injuries and awarding permanent total disability ("PTD") benefits and

medical benefits. The ALJ reduced the income benefits by 15% pursuant to KRS 342.165(1) and granted Con-Way a credit for pre-existing partial disability. Con-Way also appeals from the October 16, 2013, order overruling its petition for reconsideration.

On April 27, 2011, Schroer was operating a forklift in the course of loading a trailer at Con-Way's loading dock. Con-Way determined that because of the failure to "chock" the wheels the tractor and trailer moved forward. As a result, when Schroer backed out of the trailer, the forklift fell approximately four to five feet to the ground. Schroer was taken to the University Hospital emergency room. Although Schroer did not remember much of what occurred, he apparently hit his head on the forklift. He alleged injuries to his back, neck, and head. The parties hotly contested the gravity and significance of the blow to the head.

Schroer testified at a November 28, 2012, deposition and at the July 24, 2013, hearing. Schroer testified he did not remember much after the forklift fell. He had been treated by Dr. John Kelly, who is board certified in neurology and psychiatry, for previous low back problems which necessitated two surgeries in 2002. Although Schroer asserted a workers' compensation claim for

a 1996 head injury, he denied having any residuals or undergoing further treatment after the event. He believes he missed approximately two or three days of work after the 1996 incident. Schroer testified he now has significant cognitive problems and experiences two to three migraines daily. The vision in his right eye has changed, and he has ringing in both ears. He experiences cramps in his legs, back, and arm. Schroer has lost grip strength in the left hand and experiences numbness in his left arm. He is unable to look at newspapers or a computer screen for more than five or ten minutes at a time. He has developed speech problems which include stuttering. Schroer cannot use the sleep apnea machine he had used prior to the work injury. He does not like to be in crowds and does not engage in the activities he enjoyed prior to the injury. He continues to be seen by Dr. Kelly for his back problems and problems stemming from the work injury.

Dr. Kelly referred Schroer to Dr. Robert Wells, a psychologist. Schroer sees Dr. Kelly approximately once every three months and Dr. Wells once a week. His wife manages his medication and medical appointments. He only drives short distances, and Dr. Kelly prohibited him from driving at night. He also has problems with his personal hygiene. He has developed severe anxiety. He denied

having any anxiety problems prior to the April 27, 2011, injury. Schroer testified he has extensive problems with long term memory. He has contemplated suicide on more than one occasion. Since the injury he primarily stays in the house. He takes short walks and with the help of his grandchild tends a small garden.

For the most part, Schroer's limited hearing testimony mirrored his deposition testimony.

Schroer's wife, Catherine, testified at a November 28, 2013, deposition and at the hearing. Catherine, a graduate of Purdue University, has been married to Schroer for over twenty-two years. She testified her husband has severe headaches and elevated anxiety and is unable to relay information to her. He no longer has an outgoing personality. At times he is unable to remember certain tasks she requested he perform. On one occasion, when she returned home from work, Schroer had a bowel movement on the floor. Catherine currently manages Schroer's medication and medical appointments. Schroer's adult daughter has moved in to help with the household chores and his care. Their granddaughter also helps when needed. Schroer's brothers and eighteen-year-old son take care of the lawn work. Their eighteen-year-old son was forced to change high schools because Schroer could no

longer participate in the car pool. Catherine listed ten different medications Schroer now takes. She indicated Schroer's 1996 work injury did not impact him at work or home. Schroer's current speech pattern has changed significantly since the April 2011 injury.

Dr. Wells is helping Schroer deal with this "whole change in his life." She believed Schroer may have attempted "to carbon monoxide himself" on one occasion and also contemplated hanging himself as she found a noose Schroer had made out of a rope located at their home. Schroer has indicated he wished he could take his life. As a result, Catherine has locked up his medications. She testified Cymbalta has "literally saved our lives" because it has calmed Schroer and stopped him from yelling and speaking erratically. She identified Schroer's biggest problem as severe headaches. Schroer will also get in a "zombie state" when he is nervous, anxious, or around unfamiliar people. Schroer's "neck issues" include cramps and an inability to sleep. Schroer is frustrated and experiences anxiety and depression which he did not experience before the work injury. She emphatically denied Schroer was faking or malingering.

The parties introduced voluminous medical evidence. Con-Way argued although Schroer may have

received a slight head injury, the medical evidence overwhelmingly establishes he did not sustain a permanent injury and was guilty of symptom magnification and malingering. Conversely, Schroer argued he has significant physical and psychological injuries which cause him to be totally occupationally disabled. Schroer stipulated he was only asserting a claim for cervical and psychological injuries and was not alleging the injury caused a worsening or exacerbation of his pre-existing low back condition.

The ALJ first determined Schroer sustained a compensable physical injury finding as follows:

> During Plaintiff's final Hearing it was indicated Plaintiff's pursuit of his physical injury claim was limited to an injury to his cervical spine. The persuasive evidence regarding Plaintiff's alleged work-related cervical spine injury comes from Plaintiff's treating neurologist, Dr. Kelly.
>
> Dr. Kelly's input is persuasive because prior to Plaintiff's April 27, 2011 work incident, he was already treating Plaintiff for lumbar spine problems. He treated Plaintiff on at least 60 separate office visits. Surely, Dr. Kelly was very familiar with Plaintiff's spine. Prior to the work injury, no other involved physician's qualifications, based upon hands-on experience, comes anywhere near Dr. Kelly's. Dr. Kelly opined Plaintiff had a 6% WPI to his cervical spine, 50% apportioned to a pre-existing cervical spine condition and 50% attributable to

> Plaintiff's work incident of 2011. Based upon Dr. Kelly's sound input, it is determined Plaintiff sustained a 3% WPI to his cervical spine as a result of his 2011 work incident.
>
> There is very little proof, if any, just how Plaintiff's cervical spine impairment impedes his physical capacity to return doing the work he was doing when injured. In light of this status of the evidence regarding Plaintiff's cervical spine, it cannot be determined whether Plaintiff retains the physical capacity to return doing the work he was doing when injured; consequently, Plaintiff will not receive a multiplier under KRS 342.730 because of his cervical spine injury.

The ALJ determined Schroer sustained a compensable psychological injury finding as follows:

> In KRS 342.0011 (33) the term "objective medical findings" is defined as "information gained through direct observation and testing of the patient, applying objective are standardized methods."
>
> In Gibbs v. Premier Scale Company, 50 S.W.3d 754 (Ky. 2001) the Kentucky Supreme Court held that a diagnosis of a harmful change may comply with the requirements of KRS 342.0011 (1) and (33) if it is based upon symptoms which are documented by means of direct observation and/or testing applying objective or standardized methods. As set forth in Staples v. Diana Konvelski, 50 S.W.3d 754 (Ky. 2001) standardized psychological tests are simply not necessary or appropriate in every case. (Also see: Continental General Tire v. Marvin McKinney, 2001 – CA – 002526 – WC July 12, 2002 (unpublished).

Obviously suddenly crashing down 6 feet, riding a 10,000 pound forklift is a work-related traumatic event. There can be no doubt that this event arose out of and in the course of Plaintiff's employment with Defendant.

The available medical evidence more than amply shows Plaintiff's crash was the proximate cause of a harmful change in Plaintiff's body. Not only is this causation relationship confirmed in Plaintiff's credible testimony, but Dr. Kelly, who was very familiar with Plaintiff for 10 years of spine-related medical treatment prior to the work incident, testified Plaintiff's cervical strain/sprain, anxiety, and depression were a direct result of Plaintiff's work injury. Likewise, Dr. David Roebker, Psychologist, opined Plaintiff's severe psychological problems were a result of the April 27, 2011 work incident.

Also, it can be sufficiently deciphered from Dr. Robert Wells', Plaintiff's treating psychotherapist from October 2012 through, at least, February 13, 2013, Form 107, that Plaintiff's diagnosis was based upon the classification system of DSM-IV, being 300.02 - General Anxiety Disorder, and, 296.23 - Major Depression Disorder, Single Episode Severe Without Psychosis, Chronic, and that Plaintiff's DSM – IV and that such diagnosis was the direct result of Plaintiff's physical work-related injury.

As determined in Wal-Mart Stores v. Smith, 277 S.W.3d 610 (Ky. 2008), if a psychological change is a direct result of a physically traumatic event, such as riding a 10,000 pound forklift as it suddenly and unexpectedly drops 6 feet to a hard surface, an injured worker has sustained a compensable injury. Plaintiff's subsequent psychological

injury is related to such a physically traumatic event.

Plaintiff's work-related psychological injury includes, but is certainly not limited to, concussion – type symptomatology, extreme agitation with severe anxiety, two or three migraine-type severe headaches a day, suicidal ideation, blurred vision, intermittent diplopia, nausea, vomiting, an inability to concentrate, confusion, telegraphic and stuttering speech, enhanced depression, long- and short-memory loss, compromised social interaction, cognitive problems, etc.

The crux of Defendant's defense is that Plaintiff is a malingerer and everything about Plaintiff's situation is a hoax, Plaintiff is a fake and malinger [sic]. Dr. Granacher based this opinion upon Plaintiff's standard psychological test results. Dr. Granacher testified one could not evaluate whether one was malingering, even if a physician had been treating a patient for more than 10 years. Dr. Granacher testified the only way a physician, even a well- credentialed psychiatrist like Dr. Granacher, could assess malingering was through the results of standard psychological tests. According to Dr. Granacher, these test results constitute medically incontrovertible evidence of malingering. Dr. Granacher said on the issue of malingering, there was no value to an established relationship, even one of 10 years, when attempting to gauge another's truthfulness, only hard core test results could determine one's veracity. If this position is valid, then there would be no need for the involvement of a psychologist or psychiatrist in most litigation, standard psychological tests could be administered and those test results,

> inconvertible evidence, would determine the truthfulness of one's input. The question has to be asked, it would seem a less-trained and less-expensive person could administer tests and read results. Who really then needs a psychiatrist or psychologist?
>
> There is other evidence in this claim and it has been thoroughly reviewed and considered, but as previously noted the input Dr. Kelly and Dr. Roebker is the persuasive proof. Plaintiff has a substantial psychological injury as a result of his physical traumatic event. Dr. Roebker opined Plaintiff's WPI for his work-related psychological injury was 20%.
>
> Plaintiff's work-related traumatic psychological injury has rendered him permanently totally occupationally disabled. This would seem obvious to most anyone who has spent time with Plaintiff. Despite the obvious, a quick run through of the factors - age, education, vocational skills, post-injury medical restrictions and limitations, and the likelihood Plaintiff can resume some type "work" under normal employment conditions - as set forth in Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 858 (Ky. 2000) is in order.

Conducting an analysis pursuant to Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000), the ALJ determined Schroer was totally occupationally disabled.

Con-Way filed a petition for reconsideration making substantially the same arguments it makes on appeal. The ALJ overruled the petition for reconsideration.

On appeal, Con-Way argues the ALJ's findings were not supported by objective medical evidence. Relying upon Gibbs v. Premier Scale Co./Indiana Scale Co., 50 S.W.3d 754 (Ky. 2001), it asserts Schroer's self-serving statements concerning his symptoms, his presentation at the final hearing, and the length of the treating physician's relationship do not constitute objective medical findings of a harmful change.

Concerning the ALJ's finding of a compensable physical injury, Con-Way posits the ALJ gave more weight to Dr. Kelly's opinions because he had treated Schroer's back problems for over ten years. However, the ALJ failed to identify any objective medical findings in support of his opinions. Further, it asserts the ALJ is not required to give greater weight to the treating physician's testimony.

Con-Way also argues Dr. Kelly's testimony establishes he was not very familiar with Schroer's history because he had to amend his impairment rating when he was made aware Schroer had "suffered from a significant pre-existing cervical condition." Dr. Kelly was also not aware of Schroer's previous treatment for a serious 1996 head injury. It argues a proper legal analysis would have resulted in a finding Schroer did not sustain a physical injury since Dr. Kelly was unable to identify and document

any significant objective findings. It notes its specialist confirmed a lack of objective medical findings and any neck impairment was attributable to a pre-existing active condition.

Concerning the ALJ's finding of a psychological injury, Con-Way posits the ALJ "ignored the unanimously documented normal objective findings, and scientific testing consistently documenting symptom magnification or malingering." It argues the ALJ cannot rely on Dr. Kelly's direct observation even though he had a long term treatment relationship with Schroer because his testimony demonstrated a "severe lack of familiarity with certain significant components" of his medical history. Con-Way asserts over the ten year period Dr. Kelly only had sixty-three visits with Schroer. Regardless of their relationship, Con-Way argues Dr. Kelly never observed anything that would suggest an objective change in Schroer's mental condition and Schroer's complaints of symptoms are not objective medical findings as defined by Gibbs v. Premier Scale Co./Indiana Scale Co., supra. It argues Dr. Kelly readily admitted Schroer exhibited no objective findings to support his subjective complaints. Therefore, his opinions cannot constitute substantial evidence.

Con-Way argues reliance upon the findings of Dr. David Roebker, a psychologist and vocational expert, is misplaced as his diagnosis of anxiety and depression was based upon Dr. Kelly's flawed opinions and not his own evaluation. Further, because Dr. Roebker acknowledged his lack of qualifications his opinions cannot be persuasive.

Con-Way argues Dr. Well's diagnosis of general anxiety disorder and major depression disorder is not based on objective medical findings.

Con-Way also argues the test results of Dr. Robert Granacher clearly reveal Schroer engaged in symptom magnification and is malingering. Dr. Granacher conducted standardized mental assessments using neuropsychological testing used to measure cognitive distortion and identified Schroer's tendency to "fake bad." Con-Way argues Dr. Granacher's findings are supported by the tests results of two other specialists; Dr. Christopher Allen, a clinical psychologist, and Dr. Daniel Gripshover, to whom Dr. Kelly referred Schroer. It posits five specialists who examined Schroer found no objective change to support his alleged complaints. It argues in the "absence of objective findings and empirical test data, malingering is all but reality."

Finally, Con-Way asserts the ALJ's finding the testimony of Schroer and Catherine is credible ignores the

lack of objective medical findings and invalid test data. Con-Way cites the inconsistencies in the testimony of Schroer and Catherine. It posits either Dr. Kelly is an unqualified or irresponsible physician, or Schroer is exaggerating his symptoms, and in light of the normal objective findings and invalid test data the latter is the logical conclusion.

A claimant in a workers' compensation claim bears the burden of proof and risk of non-persuasion before the ALJ, as fact-finder, with regard to each of the essential elements of his cause of action. Burton v. Foster Wheeler Corp., 72 S.W.3d 925, 928 (Ky. 2002). A finding that favors the party with the burden of proof on an issue in a workers' compensation proceeding must be based upon substantial evidence and, therefore, be reasonable to survive on appeal. Brown-Forman Corp. v. Upchurch, 127 S.W.3d 615 (Ky. 2004). Since Schroer was successful before the fact-finder, the question on appeal is whether there is substantial evidence of record to support the ALJ's decision. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). "Substantial evidence" is defined as evidence of relevant consequence having the fitness to induce conviction in the minds of reasonable persons. Smyzer v. B. F. Goodrich Chemical Co., 474 S.W.2d 367 (Ky.

1971). The function of the Board in reviewing the ALJ's decision is limited to a determination of whether the findings made are so unreasonable under the evidence that they must be overturned. Ira A. Watson Department Store v. Hamilton, supra.

In rendering a decision, KRS 342.275 and KRS 342.285 grants the ALJ as fact-finder the sole discretion to determine the quality, character, and substance of evidence. AK Steel Corp. v. Adkins, 253 S.W.3d 59 (Ky. 2008). The ALJ may draw reasonable inferences from the evidence, 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. Caudill v. Maloney's Discount Stores, 560 S.W.2d 15, 16 (Ky. 1977). Although a party may note evidence that would have supported a different outcome than that reached by the ALJ, such evidence 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 weight and credibility or by noting reasonable inferences that otherwise could have been drawn from the evidence. 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 this instance, we believe the outcome selected by the ALJ is both supported by the evidence and in conformity with the Act.

For purposes of workers' compensation, the term "injury" is defined in relevant part as any work-related traumatic event or series of traumatic events 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. *See* KRS 342.0011(1). Concerning the cervical injury, in Dr. Kelly's Form 107 completed on June 5, 2012, he set forth Schroer's complaints. Dr. Kelly provided the following medical findings which supported Schroer's complaints:

> CERVICAL SPINE: He is tight and tender in the cervical paraspinous musculature diffusely. He has diffuse paraspinous tenderness in the cervical thoracic and lumbar spine, and diffuse tenderness in his extremities.

He noted an April 27, 2011, CT scan of the cervical spine revealed severe disc space narrowing with fragmentation and calcification at C4-5. There was facet hypertrophy, left greater than right. He concluded those findings resulted

in severe left foraminal narrowing. Dr. Kelly diagnosed the following:

> 1. Cerebral concussion.
> 2. Cervical strain/sprain.
> 3. Thoracic sprain/strain.
> 4. Anxiety.
> 5. Depression.
> 6. Pre-existing and relatively severe multilevel lumbar disc disease and spondylosis.
> 7. Pre-existing cervical foraminal stenosis.

Dr. Kelly stated the first five diagnoses were the direct and sole result of the work injury.

As to the explanation of causal relationship, Dr. Kelly stated as follows:

> Mr. Schroer was involved in a significant trauma in which he fell a distance of about 4-6 ft. in a 10,000 lb. forklift. He suffered a severe cerebral concussion as well as sprain/strain injuries to the cervical and thoracic sprain. The injury aggravated pre-existing dormant left C4-5 foraminal stenosis into a symptomatic state. He also developed severe anxiety and depression, as a direct result of the cerebral concussion.

Pursuant to the 5th Edition of the American Medical Association, Guides to the Evaluation of Permanent Impairment ("AMA Guides"), Dr. Kelly assessed a 6% impairment for the cervical spine injury. The records of

Dr. Kelly introduced into evidence are consistent with the findings and opinions expressed in the Form 107.

During his April 29, 2013, deposition, Dr. Kelly testified he first saw Schroer on November 8, 2001, and had been treating him regularly for chronic lumbar pain. Concerning the cervical injury, Dr. Kelly testified Schroer's neck was tight and tender and the range of motion was very limited in all directions. His final diagnosis was in part, severe cerebral concussion and cervical sprain/strain.[1] Dr. Kelly testified his diagnosis of a cervical spine injury is based on his examinations conducted over time and the CT and MRI findings. He acknowledged the cervical range of motion on April 16, 2013, was little improved from the range of motion in March 2011 shortly before the injury. Dr. Kelly explained his notes reveal during Schroer's October 21, 2010, examination he expressed no cervical complaints. Similarly, he expressed no cervical complaints when seen on March 14, 2011. This was significant since his range of motion on that date was worse than revealed during his examination on April 14, 2013. However, he modified his impairment rating to reflect one-half of the impairment rating was

[1] Dr. Kelly also diagnosed a thoracic sprain/strain.

attributable to a pre-existing condition and one-half was due to the current injury. This was based on an abnormal MRI, his sporadic complaints, and some limitation of cervical range of motion.

We disagree with Con-Way's assertion Dr. Kelly's opinions do not rise to the level of substantial evidence supporting a finding of a cervical injury because they were not based on objective medical findings. KRS 342.0011(33) defines "objective medical findings" as "information gained through direct observation and testing of the patient applying objective or standardized methods." In Gibbs v. Premier Scale Co./Indiana Scale Co., supra, the Kentucky Supreme Court, in addressing this definition, recognized that in addition to objective diagnostic tools such as x-ray, CT scan, EMG/NCV or MRI, there is a wide array of standardized laboratory tests and standardized tests of physical and mental function available to the medical practitioner. The court further emphasized, "[w]e 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 demonstrate the existence of symptoms of such a change." Id. at 762. The Court explained the term "testing" does not require the use of

sophisticated diagnostic tools and the statute does not require both testing and observation. The Court also explained that subjective factors cannot be avoided when collecting and interpreting medical information, but that their effect is decreased by the use of standardized methods, and what results is a more accurate and objective assessment of the patient's condition. Id.; *c.f.* University of Kentucky Family Practice v. Leach, 237 S.W.3d 540, 544 (Ky. 2007). In Staples, Inc. v. Konvelski, 56 S.W.3d 412 (Ky. 2001), the Supreme Court further instructed that while objective medical findings must support a diagnosis in order to establish the presence of a harmful change, the cause of the harmful change need not be proven by objective medical findings.

In the course of treating Schroer, Dr. Kelly performed physical examinations during which he observed Schroer and conducted range of motion studies and reviewed imaging studies which he outlined in his report and deposition. Taking into account the medical information garnered from these various sources, Dr. Kelly determined Schroer had a 3% impairment due to the work-related cervical injury. The opinions expressed in the Form 107 and during his deposition plainly qualify as substantial evidence upon which the ALJ was free to rely, and any

argument his expert conclusions were not based upon objective medical findings is wholly without merit. Dr. Kelly's testimony complied sufficiently with the standard described in Gibbs v. Premier Scale Co./Indiana Scale Co., supra, to prove that the trauma of April 27, 2011, resulted in a cervical spine injury which is compensable under the Act.

With respect to Schroer's psychological injury, Dr. Kelly diagnosed a cerebral concussion, anxiety, and depression. His medical records spanning the period from May 5, 2011, through March 19, 2012, consistently denote psychological symptoms. On May 5, 2011, when Dr. Kelly first saw Schroer after the work injury, he noted he was exhibiting a great deal of anxiety and was dreaming he is in a coffin and cannot get out. His main concern was Schroer's mental status, noting there appeared to be a combination of concussion type symptomology with a great deal of superimposed anxiety which are often co-existent. On each of Schroer's subsequent visits Dr. Kelly notes Schroer appears anxious. Specifically, in his note of September 29, 2011, he states Schroer's main issue at this point is severe anxiety and depression, an observation he continued to make in his subsequent office notes.

During his deposition testimony, Dr. Kelly noted Schroer was anxious and his speech was slow with pauses and consisted of incomplete sentences. He explained Schroer had concussion type symptomology and had a manifestation of a cerebral concussion. Because of his mental status change, Dr. Kelly recommended an MRI of the brain. Dr. Kelly testified that in his previous ten years of treating Schroer he had never received similar complaints. He believed Schroer had a severe anxiety response which became the main problem. Thus, the main residual from the work injury was anxiety and depression which persists and incapacitates Schroer.

Dr. Kelly disagreed with Dr. Granacher's opinion that Schroer was a malingerer. He stated malingering would go against his experience with Schroer as he had a strong work ethic. He noted he had treated Schroer prior to the injury so he could continue to work. He did not believe Schroer was willingly deceptive. Dr. Kelly believed Schroer was suffering from a significant anxiety disorder "far exceeding the degree of trauma to the brain." He also believed Schroer's prior head injury had no role in his current condition. Dr. Kelly conceded he would defer to the other doctors regarding a diagnosis of anxiety and depression.

Dr. Kelly stated an MRI and a CT scan are not used to diagnose brain injuries. Rather, you use a full battery of neuropsychological tests. He observed Dr. Granacher performed his tests long after the concussion component had likely resolved and "the anxiety component had moved in and become overwhelming." Dr. Kelly believed the tests in this case were revealing to the extent they reflect Schroer was not showing an expected pattern of response. He explained there were several findings consistent with a traumatic brain injury. He identified those as follows:

> There were several findings that would be consistent with a traumatic brain injury. One of those was the abnormal speech, the telegraphic speech. One of the most significant findings was the marked impairment of finger-nose-finger testing. As I mentioned, the past pointing, the marked degree of slowing on rapid repetitive movement testing. Even the weakness, which involved the left upper and left lower extremities would raise the possibility of a brain injury. By itself those aren't necessarily diagnostic, but those are all things that point in that direction.[2]

Dr. Kelly did not attach any significance to the results of the examination performed at the University Hospital because he believed the staff conducted "virtually

[2] See page 39 of Dr. Kelly's deposition.

no neurological examination." He explained traumatic brain injuries do not get worse. Therefore, he believed the reason Schroer was getting worse or perceives to be getting worse is of a psychological nature. Dr. Kelly further explained the basis for his diagnosis as follows:

> Q: In arriving at your diagnosis of Butch, Doctor, is it safe for us to say that you did not rely solely on neurological findings, but actually based on your long history with Butch?
>
> A: Yes. That is a, that is definitely a major component of how and why I reached my conclusion as to the significance of the test results on his neuropsychological batteries, both by Dr. Gripshover and by Dr. Granacher.

In addition, Dr. Kelly testified he and Dr. Gripshover expressed concern about the possibility of Schroer being suicidal and both took steps to minimize the risk.

The December 28, 2012, report of Dr. Roebker indicates he reviewed various medical records, obtained a medical, educational, social, and employment history. Dr. Roebker also conducted a clinical interview and performed a mental status examination. As part of the mental status examination, Dr. Roebker administered at least four different tests. His diagnosis was "Major Depressive Disorder – recurrent with suicidal ideation, Anxiety Disorder – NOS, Postconcussional Disorder, Pain Disorder

associated with both psychological factors and general medical condition." Because of the concussion and his cognitive difficulties, Schroer is functioning at a much lower academic level. He believed Schroer has "multiple major limiting psychological problems." His post-concussional disorder results in numerous cognitive limitations which limit his ability to perform tasks at occupations requiring good memory, concentration, and to function well under duress. Schroer also has depression which limits him to the extent he would be easily fatigued and unable to make good decisions as well as interact with co-workers, supervisors, and the public. Dr. Roebker concluded Schroer is totally occupationally disabled due to the limitations resulting from the April 27, 2011, work injury. After two years of treatment, Schroer still has very serious multiple impairments which prevent him from being able to return to any previous occupations as well as any less physically or mentally demanding occupations. Similarly, his physical and mental problems prevent him from returning to work. Dr. Roebker assessed a 20% impairment based on the AMA Guides due to the mental impairments, which are the result of his subsequent disorder following the April 27, 2011, work injury.

During his March 15, 2013, deposition, Dr. Roebker testified he had reviewed the reports of Drs. Granacher and Allen prior to performing his evaluation. He noted Schroer's previous depression and anxiety had resolved as he was able to return to work. Therefore, it was not considered a disability. Similarly, the 1996 concussion had resolved. He noted there had been no mention of suicide in the previous records and now there is a much more profound level of depression. Dr. Roebker again emphasized he believed Schroer has a cognitive deficit which caused his reading impairment. As a result, he disagreed with Dr. Granacher as there was no basis for his conclusion Schroer was malingering. He believed Dr. Granacher's tests showed Schroer is not malingering and support the presence of a neuropsychological problem. He identified those as the TOMM and the VSVT tests.[3] He noted these two specific tests, designed to detect malingering, revealed Schroer was not malingering. He also noted Dr. Granacher's test revealed Schroer read on a 4th grade level and Dr. Granacher did not interview Schroer's wife. He concluded Schroer manifested all the signs of having a

[3] During his May 7, 2013, deposition, Dr. Granacher acknowledged those test results were within normal limits revealing Schroer had provided good cognitive effort.

neuropsychological problem. In addition, one test showed Schroer had significant speech problems. Thus, he believed Schroer's stuttering was legitimate. He also believed Dr. Granacher's report contained contradictory statements. Although he would defer as to neuropsychological and validity conclusions, Dr. Roebker stated he was inclined to rely upon the treating physician of over ten years as opposed to Con-Way's doctors. He concluded by noting the opinions expressed in his report have not changed.

The Form 107 of Dr. Robert Wells, Schroer's current treating psychologist, was introduced. As noted by the ALJ this report is almost illegible. However, it is apparent Dr. Wells diagnosed general anxiety disorder and major depressive disorder single episode. Because of its illegibility we will not endeavor to further discuss this report.

Because of the significance Con-Way and Dr. Granacher attach to the report of Dr. Gripshover, in arguing Schroer engaged in symptom magnification and malingering, we will address its contents. Dr. Gripshover's report reflects he performed assessments on October 2, and October 4, 2012. He conducted a clinical interview with Schroer and administered a battery of tests. Dr. Gripshover determined the test results were not valid

and set forth his reasoning. In his summary, he stated as follows:

> Results of neuropsychological testing were judged not valid. On self-report measures of symptoms, results indicated that he over-reported a range of cognitive, somatic and psychological symptoms that is uncommon even among individuals with genuine severe dysfunction. With cognitive testing, his mood symptoms appeared so extreme that his ability to give his best effort was limited and results were judged not valid or interpretable.

Dr. Gripshover noted the Cymbalta did not appear to adequately manage Schroer's mood symptoms. Dr. Gripshover highlighted the fact Schroer had serious thoughts of suicide and made one suicide attempt earlier this year and sometimes dreams about suicide, although he denied any imminent intent to harm himself. Until Schroer's mood symptoms had been adequately treated, he concluded further neuropsychological evaluation would be deferred. He referred Schroer for psychotherapy with Dr. Wells and requested his treating physician start him on anxiolytic medication, such as Ativan. If his mood did not improve with psychotherapy and this medication, Schroer may benefit from a psychiatric referral to explore other medication options. Dr. Gripshover believed Schroer has significant risk factors to again attempt and complete a suicide and

asked Schroer's wife to remove a gun and ammunition from the home as well as rope he previously fashioned in a hangman's noose. He requested Schroer's wife closely monitor him and to seek assistance from his healthcare providers if necessary. Once Schroer's mood improves and he is better able to tolerate neuropsychological testing, he will be scheduled for a follow-up appointment.

Dr. Gripshover did not express the opinion Schroer was a malingerer or faker. Rather, he stated Schroer's inability to provide his best efforts caused the results to be invalid and not interpretable. Clearly, Dr. Gripshover believes significant psychological problems existed and recommended certain steps be taken to deal with those problems including a referral to Dr. Wells for therapy. Thus, we believe the contents of Dr. Gripshover's report do not support a conclusion Schroer is malingering and engaging in symptom magnification.

In summary, the reports and testimony of Drs. Kelly and Roebker constitute substantial evidence supporting the ALJ's determination Schroer sustained a psychological injury. Further, both doctor's opinions as to the existence of psychological problems are supported by objective medical findings as both doctors identified throughout their deposition the objective findings upon

which they based their diagnosis and opinions. Significantly, Dr. Roebker believed the results of two tests administered during the course of Dr. Granacher's evaluation of Schroer supported his opinions.

Without question, the ALJ is the sole judge of the witnesses' credibility. Despite Con-Way's assertion to the contrary, we find nothing in the record mandating the ALJ discount the testimony of Schroer and his wife. Further, we do not believe the medical evidence mandates the ALJ determine their testimony is not credible. Succinctly stated, the ALJ was not required to accept the opinions of Con-Way's doctors as the gospel in this case.

Finally, we note Con-Way does not attack the ALJ's finding that based on the physical and psychological injuries Schroer is totally disabled or the ALJ's analysis pursuant to the criteria set out in Ira A. Watson Department Store v. Hamilton, supra, is deficient or erroneous. Therefore, in light of the above evidence and the ALJ's analysis, and despite any conflicting testimony which may have supported a different conclusion, we believe the ALJ could reasonably conclude Schroer sustained physical and psychological injuries as a result of the April 27, 2011, injury. Consequently, the medical evidence upon which the ALJ relied in determining Schroer sustained

a physical and psychological injury is based on objective medical findings, and that evidence constitutes substantial evidence in support of the ALJ's determination Schroer is totally occupationally disabled.

That said, the award of income benefits must be vacated. In paragraph one of the award, the ALJ awarded PTD benefits of $710.90 per week. In paragraph two, the ALJ ordered the award reduced by 15% pursuant to KRS 342.165(1). Without explanation, paragraph three of the award reads as follows:

> Until such time as Defendant is no longer obligated to pay Plaintiff a Permanent Partial Disability benefit of $13.86 ($710.90 X .03 = $21.33 X .65 = $13.86 X 1 = $13.86) Defendant shall take a credit for such payment against the weekly sum due Plaintiff as a Permanent Total Disability benefit.

Paragraph four pertains to the award of medical benefits and paragraph five pertains to the award of attorney fees.

Paragraph three and the award of income benefits must be vacated as there are absolutely no findings of fact providing the basis for this exclusion. The benefit review conference order and memorandum of September 18, 2013, identifies exclusion for pre-existing disability/ impairment as one of the contested issues. However, the ALJ provided no discussion explaining the basis for

exclusion contained in paragraph three of the opinion. Schroer did not file a petition for reconsideration and Con-Way did not raise the issue in its petition for reconsideration.

Without explanation, the ALJ computed a permanent partial disability award based on a 3% impairment and arrived at the sum of $13.86. The ALJ deducted from the award of PTD benefits the sum of $13.86. Presumably, paragraph three is based on Dr. Kelly's deposition testimony assessing a 3% impairment rating for a pre-existing condition. Dr. Kelly modified his impairment rating to the extent he assessed "50% due to a pre-existing condition and 50% due to the current work injury." However, Dr. Kelly did not testify this impairment rating was attributable to a work injury. Consequently, paragraph three which contains a permanent partial disability award for a previous work injury is clearly erroneous. Therefore, the matter must be remanded to the ALJ for entry of an award in conformity with the statute. Although neither party raised this issue, this Board is permitted to *sua sponte* reach issues even if unpreserved. KRS 342.285(2)(c); KRS 342.285(3); George Humfleet Mobile Homes v. Christman, 125 S.W.3d 288 (Ky. 2004).

In accordance with the directive in KRS 342.730(1), the ALJ determined the work-related cervical injury and psychological injury resulted in permanent total disability.[4] Once the ALJ determined the work-related cervical injury and psychological injury resulted in Schroer being totally occupationally disabled, then pursuant to Roberts Bros. Coal Co. v. Robinson, 113 S.W.3d 181 (Ky. 2003) he should have determined whether at the time of the injury on April 27, 2011, Schroer had a pre-existing disability. As the Supreme Court explained in Roberts Bros., supra, awards of total disability are based on a finding of disability as opposed to awards for permanent partial disability which are based on impairment ratings. The Supreme Court explained for purposes of determining whether there is to be an exclusion from a total disability award, impairment and disability are not synonymous stating as follows:

> In other words, KRS 342.730(1)(a) requires the ALJ to determine the worker's disability, while KRS 342.730(1)(b) requires the ALJ to determine the worker's impairment. Impairment and disability are not synonymous. We conclude, therefore, that an exclusion from a total disability award must be based upon pre-existing disability, while an exclusion from a partial disability

[4] See page 37 of the ALJ's opinion, order, and award.

> award must be based upon pre-existing impairment. For that reason, if an individual is working without restrictions at the time a work-related injury is sustained, a finding of pre-existing impairment does not compel a finding of pre-existing disability with regard to an award that is made under KRS 342.730(1)(a).

Id. at 183.

Regarding the pre-existing impairment, Dr. Kelly explained the MRI of October 10, 2003, revealed the following: "multilevel degenerative disc disease, C3-C4 through C7-T1 with moderate to severe foraminal narrowing right at C7-T1, disc bulges C5-C6, C6-C7, et cetera." He noted that prior to the work injury, Schroer voiced a cervical complaint on October 21, 2010. At that time his nurse practitioner discussed the possibility of obtaining a new cervical MRI. Dr. Kelly explained Schroer's last cervical complaint prior to the injury occurred on October 21, 2010. Dr. Kelly specifically referenced the January 14, 2011, note which revealed there was no complaint regarding Schroer's neck. However, in a report dated March 14, 2011, Dr. Kruer noted there were no cervical symptoms but Schroer's range of motion on that date was slightly

worse than those measured on April 16, 2013.[5] Dr. Kelly then stated:

> A: Yeah, I see what you're, I do see what you're saying. Range of motion in and of itself would not be evidence that he had a ratable impairment. If you have no symptoms, if you have no pain, no complaints, then you typically don't have a ratable impairment. We don't use MRI findings in and of themselves, for example, to do impairment ratings. We don't use range of motion findings in and of themselves to do impairment ratings.
>
> I will say this. I'm going to modify my impairment rating for the DRE cervical. It is six percent of the whole person. But as I look back, and as you've drawn my attention to those items, I'm going to modify this and say that that is 50 percent due to pre-existing condition and 50 percent due to the current work injury.
>
> And I'm saying that because I do see that there was some, there was an abnormal MRI. There were some complaints, although sporadic, and there was some limitation of cervical range of motion. So I'm going to, I am going to modify that and say that of that six percent impairment, three percent is due to the work injury.

The fact Dr. Kelly assessed a 3% impairment rating for a pre-existing condition does not necessarily mean Schroer had a pre-existing disability. Further, Dr. Kelly did not link the impairment rating to a work-related

[5] Apparently, Dr. Kruer was an associate in Dr. Kelly's office.

injury. This is highlighted by Dr. Kelly's testimony the last complaint of cervical symptoms received from Schroer was on October 21, 2010. Thus, even though Schroer may have had an impairment rating, he may not have had a pre-existing occupational disability since he had not complained of any cervical symptoms since October 21, 2010. Consequently, the ALJ must determine whether Schroer had a pre-existing occupational disability as explained in Roberts Bros., supra. On remand, should the ALJ determine Schroer has a pre-existing disability, he cannot formulate a fictitious award of permanent partial disability benefits. Rather, he must subtract from the award the extent of Schroer's pre-existing occupational disability. Conversely, if the ALJ determines there is no pre-existing disability, the award of income benefits is unaffected.

Accordingly, that portion of the September 17, 2013, opinion, order, and award and the October 16, 2013, order overruling the petition for reconsideration determining Schroer sustained work-related cervical and psychological injuries and he is totally occupationally disabled is **AFFIRMED**. However, the award of income benefits is **VACATED**. This matter is **REMANDED** to the ALJ for a determination of whether at the time of the April 27, 2011, injury, Schroer had a pre-existing disability and

entry of an amended opinion and award of permanent totally disability benefits in accordance with the views expressed herein.

ALL CONCUR.

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