OPINION ENTERED: MAY 3, 2012

CLAIM NO. 201100365

DEBORAH SPALDING PETITIONER

VS. **APPEAL FROM HON. HOWARD E. FRASIER, ADMINISTRATIVE LAW JUDGE**

LORETTO MOTHERHOUSE
and HON. HOWARD E. FRASIER, JR.
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION AFFIRMING

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

SMITH, Member. Deborah Spalding ("Spalding") appeals from the Opinion and Award rendered October 27, 2011, by Hon. Howard E. Frasier, Jr., Administrative Law Judge ("ALJ"), awarding permanent partial disability ("PPD") benefits and medical benefits against Loretto Motherhouse ("Loretto"). The ALJ awarded Spalding benefits based upon a 4% whole person impairment, of which he found 2% due to non-

compensable pre-existing active conditions. Spalding also appeals from the November 30, 2011, order denying her petition for reconsideration. On appeal, Spalding argues the ALJ's finding of a pre-existing active impairment was not supported by substantial evidence and the ALJ erred in the methodology used to calculate pre-existing active impairment.

Spalding testified by deposition on June 1, 2011, and at the formal hearing held September 13, 2011. Spalding was employed by Loretto as a dietary aide working in the kitchen cooking, cleaning and serving meals. She stated the job involved sitting, squatting, lifting and being on her feet a majority of her shift. Spalding injured her knee on September 22, 2009, when taking a cart out of the walk-in refrigerator. As she was backing out, she tripped on a rug and caught herself on the table behind her, but twisted her leg in the process. She felt a burning sensation and pain in her right knee, but was able to finish her shift.

The next day, she sought treatment at Bardstown Ambulatory Care where she was given pain medications and directed to follow-up with Dr. Michael Sewell, an orthopedic surgeon. Dr. Sewell obtained an MRI and performed surgery in November 2009. Following her recovery from surgery, Spalding returned to light duty data entry

work for several weeks. She noted that after standing for 15 minutes, she began to have swelling and throbbing pain in her knee. Although the surgery reduced her pain level, Spalding was unable to bend her knees, squat, or climb stairs.

Spalding acknowledged a prior injury to her knee while she worked for Barber Cabinet from 1999 to 2007. In 2000, she injured her right leg and in 2001, she injured her right knee when she tripped pushing a dolly. She was off work for several days and did not seek further treatment for her knee. In 2006, she injured her right knee again when trying to lift a cabinet. She treated at the Springview Hospital emergency room and also saw Dr. Sewell.

Dr. Sewell performed surgery on her knee in 2006. Spalding testified she did not have further problems with her knee following that surgery. She received workers' compensation for her right knee as a result of the 2006 injury.

Spalding also acknowledged Dr. Sewell performed surgery on her right knee in July, 2009 prior to this latest work injury. She was taken off work for approximately two months following the surgery. Thereafter, she had no restrictions and required no medications prior to the work injury in September 2009.

Prior to the July 2009 surgery, Spalding had some pain and swelling in her knee. Following recuperation from that surgery, she returned back to her normal condition with no swelling or pain and normal range of motion. Dr. Sewell then released her to return to work with no restrictions. Her last treatment with Dr. Sewell with regard to the September 2009 injury was on December 7, 2009, when he released her to return to full duty work.

Spalding filed Dr. Sewell's records documenting treatment from June 5, 2006 through December 7, 2009. A June 5, 2006 MRI of the right knee revealed bone marrow edema and probable cartilage and meniscal injury. On June 16, 2006, Dr. Sewell diagnosed a questionable partial ACL tear and a questionable meniscal tear. A July 7, 2006 MRI report revealed evidence of lateral meniscal contusion and probable tears of the anterior meniscotibial ligament and transverse inner meniscal ligament with a small amount of fluid collecting within the anterior cruciate synovial sleeve. There was no evidence of a cruciate ligament disruption.

A July 25, 2006 operative report documented a partial meniscectomy and chondroplasty. On December 4, 2006, Dr. Sewell noted Spalding was still having symptoms in her knee. He noted an MRI showed essentially degenerative

changes. He noted her symptoms were stiffness in the morning and cracking and crepitus if she exercised too much. Dr. Sewell planned to administer a Synvisc injection and continued her on light duty work.

On March 28, 2007, Dr. Sewell indicated he would arrange to have a disability rating assessed in Louisville. He indicated Spalding was to return on an as needed basis.

Spalding was next seen on May 6, 2009. She reported she still had persistent symptoms in her right knee. X-rays revealed some loss of joint height. Dr. Sewell noted she had prepatellar bursitis and symptomatic crepitus. There was no obvious instability. Dr. Sewell's impressions were right knee pre-patellar bursa and questionable recurrent meniscal tear. On May 13, 2009, Dr. Sewell noted Spalding had recurrent pain in her knee. An MRI showed degenerative changes but no meniscal tear. Dr. Sewell administered Synvisc injections on June 1, 8, and 15, 2009. On July 13, 2009, Dr. Sewell noted the Synvisc had not been helpful. Spalding inquired about the possibility of arthroscopy. On July 22, 2009, Dr. Sewell saw Spalding for follow-up of her surgery and noted she was doing well. On August 26, 2009, Dr. Sewell noted Spalding released to return to work on September 9, 2009. Spalding was to return for treatment on an as needed basis.

Dr. Sewell examined Spalding once again on November 5, 2009, when she reported a work-related injury on September 22, 2009. Dr. Sewell found tenderness over the medial joint space. Spalding had no obvious instability or joint line tenderness. She had functional range of motion and a small amount of fluid in her knee. Collateral ligaments were stable and anterior and posterior drawer were negative. Dr. Sewell's impression was knee strain versus repeat medial meniscal tear. Spalding was to return after having an MRI. On October 21, 2009, Dr. Sewell noted the MRI showed a tear of the lateral meniscus within the middle third of the anterior horn extending into the transverse ligament and loss of meniscal tissue within the body and anterior horn of the medial meniscus. He planned to schedule arthroscopy and partial meniscectomy.

Dr. Sewell's records included an operative report from Flaget Memorial Hospital dated November 20, 2009. A partial lateral and discectomy for a right lateral meniscal tear along with multiple loose bodies was performed.

The final note from Dr. Sewell on December 7, 2009, indicated Spalding was walking without any type of limp. Spalding had no obvious atrophy, and had increasing strength. Spalding had pain and appeared to have an effusion to her knee. Dr. Sewell aspirated the fluid and

she received an injection. Spalding was to return in four weeks.

Spalding submitted reports of Dr. Jules Barefoot who performed an independent medical examination ("IME") on May 23, 2011 surveying Spalding's non-work-related chronic obstructive pulmonary disease ("COPD") and her complaints of chronic right knee pain. Spalding told Dr. Barefoot that she had undergone surgeries to her right knee once in 2006 and twice in 2009. At the time of this examination, she complained of intermittent swelling in the right knee with pain made worse with cold and rainy weather.

We do not address Dr. Barefoot's conclusions relating to Spalding's COPD. With respect to her knee, Dr. Barefoot diagnosed degenerative joint disease/-osteoarthritis of the right knee, for which he assigned a 6% whole person impairment pursuant to the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th Edition ("AMA Guides"), for the right knee. The 6% consisted of 4% whole person impairment under the diagnosis based estimate methodology and 2% for arthritis. Upon reviewing Spalding's medical records, Dr. Barefoot stated she had a pre-existing right knee problem.

In an addendum to his original report, Dr. Barefoot stated:

> Therefore in reviewing the Spalding's medical records, it is clear that she had pre-existing right knee problems. She had undergone a partial medial meniscectomy in July 2006. She then underwent another partial medial meniscectomy in July 2009. After a fall in September 2009 she then underwent a partial lateral mastectomy as well as a partial medial meniscectomy. She was noted to have arthritic changes noted in her knee with grade II and III changes to the medial plateau as well as the medial femoral condyle.
>
> Therefore, in apportioning her impairment rating due to her fall that occurred in September 2009, referring to page 546, table 17-33, discectomy lateral, partial equals a 1% whole person impairment. She has undergone two previous knee arthroscopies for partial meniscectomy. She did have underlying degenerative osteoarthritis as noted on her arthroscopy done in July 2009.
>
> Therefore I would apportion a 1% whole person impairment for work readiness in regard to her September 2009 fall.

Loretto filed the report of Dr. David Muffly, an orthopedic surgeon, who performed an IME on June 2, 2011. Dr. Muffly’s assessments stated:

> Active pre-existing right knee arthritis and medial as well as lateral meniscus tear prior to the 9-22-09 work injury. There are no new findings on her MRI test after the 9-22-09 injury. She has advanced osteoarthritis which, in my opinion, remains symptomatic and is not related to her 9-22-09 work injury. I do not think that she had a

> harmful change caused by the 9-22-09 work injury.

Dr. Muffly determined that Spalding had a 10% whole person impairment rating pursuant to the AMA Guides, fifth edition related to her osteoarthritis. In his opinion, "all of her impairment was pre-existing active impairment." Dr. Muffly concluded Spalding could return to her previous job without restrictions.

Loretto filed the report of Dr. Gregory Snider, a family medicine physician, who performed an IME on June 23, 2011. Dr. Snider diagnosed status post multiple right knee arthroscopies and chronic right knee pain. He stated Spalding had a pre-existing active knee condition. Dr. Snider indicated Spalding's reported work injury was a sprain/strain requiring additional meniscectomies and debridements. He assessed a 4% whole person impairment for partial medial and lateral meniscectomies according to Table 17–33 of the AMA Guides. He assessed an additional 8% impairment for range of motion according to Table 17–10. Thus, he concluded Spalding's impairment was 12%. Dr. Snider apportioned the 12% impairment in equal parts to her three bouts of medical problems. He indicated a 4% whole person impairment was related to the most recent work-related injury.

Dr. Snider testified by deposition on July 27, 2007. He noted Spalding had returned to full duty work following the 2006 injury and he agreed there was no documentation of any treatment for symptoms after December 2006 or perhaps March 2007. However, he acknowledged the medical records showed Spalding was still having stiffness, cracking, and crepitus. Dr. Snider observed "people will put up with a certain level of symptoms before they seek treatment, so it may not be a surprise that she wasn't actually in active treatment."

Dr. Snider reaffirmed his assessment of a total impairment rating of 12% for the knee. He noted the AMA Guides provide for a 4% impairment for a partial medial and partial lateral meniscectomy. He explained the rating as follows:

> Q. Is that four percent, is that--that me double check something. Is that from the last surgery, the four percent where he did the medial and lateral meniscectomy? Because we have three surgeries were dealing with.
>
> A. That's right. And the AMA Guides and as perfect as we all know it is, does not give us guidance. Basically what they say is, if you do a partial meniscectomy on one side, it's one percent --
>
> Q. Whole person impairment?

> A. Whole person impairment. If you go back, and say you trim away a little bit more at a later procedure, they don't say that it's another one percent.
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> Q. They still call it a one percent
>
> A. It's one percent. So if you had one percent from an old procedure, and you have another little trimming, is it another additional percent, or is it you already had your one percent? They don't make that very clear. I think traditionally, probably people get the percent. If you do a partial on both sides, medial and lateral that is, to different meniscus, they assigned for. Again, they don't make it clear whether the prior one percent – or the prior one percent and another one percent, they don't make that entirely clear. We know that she hasn't had a total meniscectomy on either side, so as she presented, she had partial meniscectomy done in three phases on one of the meniscus, and then a partial meniscus, as far as I know, from only the last procedure on the other side. But she pretty clearly fits into the partial medial and lateral category at four percent.

Dr. Snider stated Spalding only qualified for a 4% impairment rating after the third surgery. He indicated an 8% impairment rating was related to range of motion. Dr. Snider stated there was no documentation regarding range of motion prior to the third surgery. Spalding had a loss of range of motion following the third surgery. Dr. Snider admitted he did not have a good explanation for why

Spalding had poor range of motion based on the pathology. Dr. Snider stated:

> It's been my experience that in people who have had multiple procedures done on the knee, that they have sort of stepwise loss of range of motion over, and I've had several patients that I've actually had the opportunity to see, I see this. I won't say it's universal, but I'll save more often than not, when the orthopedist documents just a wonderful looking examination, it's not. Dr. Sewell takes it even a step further, or maybe he takes it a step back. He doesn't bother to document whether it was good or bad; he just doesn't document anything.

Dr. Snider stated, assuming Spalding was having no symptoms or loss of range of motion prior to the last episode, the 12% impairment would be attributed to the injury. Dr. Snider noted Dr. Sewell's records after the 2006 injury indicated months of struggling and the last note indicated she still had stiffness, cracking and popping. Although there were no records beyond that, Dr. Snider indicated, within a reasonable degree of medical certainty, the complaints did not vanish.

On cross-examination, Dr. Snider indicated some patients can have a meniscectomy and, within two or three weeks, actually feel completely normal. However, he stated people with prolonged periods of complaints such as

Spalding, may have been predisposed to additional episodes of problems with or without macro trauma. He indicated the incident in September 2009 possibly was an idiopathic aggravation of her prior conditions. He stated "It was going to happen whether Spalding was at work, whether getting out of bed, whether she was walking along, whether she was doing anything." Dr. Snider stated he would not expect someone who stumbled over a rug to tear a meniscus, "chip a chunk of cartilage off her knee" and lose range of motion.

Dr. Snider stated Spalding had a ratable condition from the standpoint of the prior surgeries alone. He indicated the AMA Guides did not clearly instruct whether 1% should be assessed for each of the prior surgeries for a total of 2% or only 1% impairment.

Loretto filed the utilization review notice of denial of Dr. Peter Kirsch dated November 9, 2009. Dr. Kirsch opined Spalding's condition was long-standing and recommended denial of the arthroscopy and partial meniscectomy as unrelated to the injury of September 22, 2009.

After reviewing the evidence, the ALJ determined Spalding sustained a harmful change as a result of the September 22, 2009 injury "at least to the extent of a

permanent arousal or worsening of a pre-existing active condition." The ALJ then made the following findings relevant to this appeal:

> The issue of impairment is much more problematic because of the preexisting injury, preexisting right knee condition, two prior right knee surgeries, and the divergent opinions of the medical professionals.
>
> The Kentucky Supreme Court has explained the requirements for proving a preexisting active impairment as follows:
>
>> [3][4][5][6][7][8] It is well-established that the work-related arousal of a pre-existing dormant condition into disabling reality is compensable. McNutt Construction/First General Services v. Scott, 40 S.W.3d 854 (Ky. 2001). In its opinion, the Board correctly and succinctly set forth the law upon compensability of a pre-existing dormant condition:
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>> What then is necessary to sustain a determination that a pre-existing condition is dormant or active, or that the arousal of an underlying pre-existing disease or condition is temporary or permanent? To be characterized as active, an underlying pre-existing condition must be symptomatic and impairment ratable pursuant to the AMA Guidelines immediately prior

to the occurrence of the work-related injury. Moreover, the burden of proving the existence of a pre-existing condition falls upon the employer. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984).

Alternatively, where the underlying pre-existing disease or condition is shown to have been asymptomatic immediately prior to the work-related traumatic event and all of the employee's permanent impairment is medically determined to have arisen after that event—due either to the effects of the trauma directly or secondary to medical treatment necessary to address previously nonexistent symptoms attributable to an underlying condition exacerbated by the event—then as a matter of law the underlying condition must be viewed as previously dormant and aroused into disabling reality by the injury. Under such circumstances, the injured employee must be compensated not just for the immediate physical harm acutely produced by the work-related trauma, but also for all proximate chronic effects corresponding to any contributing pre-existing condition, including any previously dormant problem strictly attributable solely to congenital or natural aging processes, as it relates to the whole of her functional impairment and

subsequent disability rating, including medical care that is reasonable and necessary pursuant to KRS 342.020.

The arousal of a pre-existing dormant condition into disabling reality may be considered temporary when, upon attaining maximum medical improvement, the employee post injury fully recovers and reverts to her pre-injury state of health. However, where the trauma or the underlying pre-existing defect exacerbated by the trauma results in a permanent impairment rating post injury, even though secondary to surgery or other medical treatment, the totality of the effects of the employee's condition must be judged compensable as a matter of law.

[9][10][11] To summarize, a pre-existing condition that is both asymptomatic and produces no impairment prior to the work-related injury constitutes a pre-existing dormant condition. When a pre-existing dormant condition is aroused into disabling reality by a work-related injury, any impairment or medical expense related solely to the pre-existing condition is compensable. A pre-existing condition may be temporarily or permanently aroused. If the pre-existing condition does not completely revert to its pre-injury dormant state,

> the arousal is considered permanent, rather than temporary. With these legal principles in mind, we shall undertake a review of the ALJ's award.

Finley v. DBM Technologies, 217 S.W.3d 261, 265 (2007).

The employer bears the burden of establishing a preexisting active condition which requires both preexisting symptoms and preexisting impairment. Otherwise, a preexisting dormant condition exists.

Considering the circumstances of the work injury, getting a foot hung up in a carpet, the existence of two prior surgical alterations of the right knee, including one surgery only two months prior to the work injury, it is simply not believable that the claimant does not have preexisting active impairment. Whether or not she was released to full duty, or testified that she did not have any symptoms after the recent prior surgery and before the work injury, it is not believable that her prior knee condition was completely dormant immediately before the work injury. To that extent, the testimony of Dr. Snider is more credible that despite the absence of a prior record of range of motion testing, the Plaintiff would be expected to have "step-wise" progression of a reduction in range of motion with subsequent surgeries. (footnote omitted)

In a perfect world, range of motion measurements would have been taken by the treating physician at the time of release from surgery in order to obtain an accurate picture if there is a worsening of symptoms at a later

point. However, since a second surgery was not a result of a work-related condition, and the Plaintiff was not even working for the Defendant and calculation of an impairment rating was not a consideration at that time, we do not have hard numbers to compare.

Although the Plaintiff is correct that the Defendant has the burden of showing pre-existing active impairment, the Plaintiff still has the burden of proof for determining work-related impairment. The undersigned finds that because of the doubts of Dr. Snider about whether the 8% impairment for range of motion was due to the work injury, the plaintiff has not met her burden that the range of motion testing should be included in the total impairment rating, even before any apportionment for pre-existing active is considered.

The undersigned finds the remaining 4% impairment opined by Dr. Snider is the more credible total impairment rating of the Plaintiff after reaching MMI from her September 22, 2009, work injury. This is also supported by the fact Plaintiff had greater range of motion when tested by Dr. Barefoot. As a result, the use of the range of motion calculations in the total impairment is not reliable here.

In regard to pre-existing active impairment, the undersigned finds the 2% impairment relied upon by Dr. Snider to be more credible, resulting in remaining whole body impairment to the right knee of 2%. The 0% by Dr. Muffly and the 1% by Dr. Barefoot are less credible because they did not do a credible analysis of the permanent impairment after the two prior surgeries. The undersigned finds that

> the defendant has met its burden on pre-existing active impairment to the extent of 2%.

Spalding filed a petition for reconsideration arguing the ALJ violated the directives the Supreme Court set out in Finley vs. DBM Technologies, 217 SW3d, 261 (Ky., 2007). Spalding insisted no substantial evidence existed to support the ALJ's conclusion that she had a pre-existing active condition. According to Spalding there was no evidence of record, other than Dr. Snider’s speculations, to indicate Spalding had any symptoms prior to her work injury.

Spalding also took exception with the ALJ's calculation of the extent of the pre-existing active condition. She urged that the ALJ misconstrued Dr. Snider's opinions relating to the pre-existing active condition and impermissibly doubled the pre-existing impairment. Finally, Spalding requested the ALJ reconsider his rejection of the two multiplier. Spalding argued that after the work injury occurred she continued working at her regular employment, and regular wages, but on light duty.

By order dated November 30, 2011, the ALJ denied Spalding’s petition for reconsideration stating:

> (1) The undersigned finds that the Plaintiff has failed to identify

any patent errors in the Opinion and Award of October 27, 2011;

(2) The undersigned finds the substantial evidence, especially after consideration of surgery only two months before the injury, to support the burden of the employer in showing preexisting active impairment prior to the work injury, and the first objection is OVERRULED;

(3) The undersigned finds that the Plaintiff has not tipped the scales for any application of the range of motion method by showing that it accurately reflects the impairment rating for the work injury, especially since her own evaluating expert, Dr. Barefoot did not utilize such a method for the calculation of the impairment rating, and the second objection is OVERRULED;

(4) The undersigned finds that substantial evidence supports the total impairment rating of four percent with a two percent carve out for preexisting active impairment, and the Plaintiff has not met her burden of proof under the existing facts for higher total impairment rating or the use of the higher range of motion calculations for the work injury, and the third objection is OVERRULED;

(5) The undersigned also finds that the party seeking to apply the two multiplier has not met its burden of showing that any cessation of employment at lighter duty was due to the disabling injury, and despite the agreement of the Defendant that the two multiplier analysis be applied and the prior finding of the application of the three multiplier be set aside, no patent error in this prior finding

> (which is actually in favor of the Plaintiff by using the three multiplier) had been shown and the fourth objection is OVERRULED;

On appeal, Spalding argued the ALJ did not have substantial evidence to support his findings of a pre-existing active condition. Spalding argued the ALJ erroneously determined Spalding had a pre-existing active condition solely due to the fact she had undergone surgery two months before the work injury. Spalding argued that Finley v. DBM Technologies, *supra*, directs that a condition must be symptomatic and impairment ratable immediately prior to the occurrence of the work injury in order to be an ongoing active condition. Thus, the ALJ's reasoning was erroneous because it failed to take into account that Spalding had recovered from her medical problem and the surgery and her condition was no longer symptomatic.

Spalding also argues that in choosing to rely upon the impairment rating and apportionment assigned by Dr. Snider, the ALJ completely misconstrued Dr. Snider’s testimony and failed to consider significant evidence elicited from Dr. Snyder on cross examination. Spalding argues Dr. Snider conceded his 4% impairment rating for pre-existing active condition was not accurate in that the pre-existing active impairment can only be 1%, or 2%. Dr. Snider acknowledged

physicians have differing opinions when calculating impairments or there is more than one meniscectomy and is symptom-free. After conceding that any pre-injury impairment would only be 1% or 2%, he then conceded the remaining 10% of his impairment rating would be attributable to the work injury. Therefore, since ALJ based his findings on Dr. Snider's opinions, he should have concluded Spalding had a 10% impairment rating.

As the claimant in a workers' compensation proceeding, Spalding had the burden of proving each of the essential elements of her cause of action. Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Since Spalding was unsuccessful in meeting her burden of establishing a greater functional impairment caused by her injury, 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 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 an 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).

Loretto had the burden of proving the existence of a pre-existing condition. See Wolf Creek Collieries v. Crum, supra, and Finley v. DBM Technologies, 217 S.W.3d 361 (Ky. App. 2007). Since Loretto was successful in that burden, the question on appeal is whether there was substantial evidence of record to support the ALJ's decision. Wolf Creek Collieries v. Crum, *supra*. 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 ALJ was well within the authority granted him by law in determining Spalding had a 4% impairment as a result of the September 2009, injury. Dr. Snider clearly stated he assessed a 4% impairment based upon the diagnosis based estimate methodology for the knee condition. He assessed additional impairment based upon loss of range of motion and stated this impairment could be combined with the DBE impairment. However, the ALJ was not convinced Spalding met her burden of proving she was entitled to additional impairment based on loss of range of motion. As we so often

note, the ALJ has discretion to accept a portion of the opinion of a physician. Dr. Snider's opinions constitute substantial evidence supporting the ALJ's finding of a 4% impairment for the knee condition.

In the case *sub judice*, Dr. Snider and Dr. Barefoot each concluded Spalding had a pre-existing active condition and impairment. Dr. Barefoot, Spalding's examining physician apportioned a 1% impairment to the work injury and the remaining 5% to a pre-existing condition. Dr. Snider also determined Spalding had "pre-existing and active knee condition status post partial meniscectomy's and debridements." In addition, Dr. Muffly also found Spalding had advanced osteoarthritis which remained symptomatic and was not related to the September 22, 2009 work injury. We believe the ALJ could properly rely on the opinions of these physicians in finding Spalding had a pre-existing active impairment. We therefore conclude the ALJ's finding is supported by substantial evidence and must be affirmed.

We also find no error in the ALJ's apportionment of a 2% pre-existing active impairment. Dr. Snider indicated Spalding had a ratable impairment pursuant to the AMA Guides based upon undergoing prior surgeries. He opined Spalding could be given 1% impairment for each of the prior knee

surgeries. Thus, his opinion supports the ALJ's conclusion that Spalding had a 2% pre-existing active impairment.

The ALJ, in his Opinion and Award, set forth the proper standard for determining prior active impairment pursuant to Finley v. DBM Technologies, *supra*. Substantial evidence supported the ALJ's conclusions and he applied the appropriate methodology. Thus, we must affirm the ALJ's finding that Spalding had a 2% active pre-existing impairment and had a 2% impairment as a result of the September 2009 injury.

Accordingly, the October 27, 2011 Opinion and Award and the November 30, 2011 order on petition for reconsideration, rendered by Hon. Howard E. Frasier, Jr., Administrative Law Judge, are hereby **AFFIRMED**.

ALL CONCUR.

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