OPINION ENTERED: MAY 21, 2012

CLAIM NO. 2011-00079 & 2010-98942

DEREK KINDLE — PETITIONER/ CROSS-RESPONDENT

VS. **APPEAL FROM HON. JOSEPH W. JUSTICE, ADMINISTRATIVE LAW JUDGE**

MEUTH CONCRETE — RESPONDENT/ CROSS-PETITIONER

and HON. JOSEPH W. JUSTICE, ADMINISTRATIVE LAW JUDGE — RESPONDENT

OPINION VACATING AND REMANDING

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

SMITH, Member. Derek R. Kindle ("Kindle"), appeals and Meuth Concrete ("Meuth") cross-appeals from the Opinion and Order rendered August 12, 2011 by Hon. Joseph W. Justice, Administrative Law Judge ("ALJ") dismissing Kindle's workers' compensation claim upon concluding Kindle's pulmonary emboli was not caused by the injury of November

23, 2009. Kindle also appeals from the ALJ's order on September 23, 2011 denying his petition for reconsideration. Kindle argues on appeal the ALJ erred in rejecting the opinions of the university evaluator appointed by the Department of Workers' Claims pursuant to KRS 342.315.

Meuth appeals the ALJ's finding Kindle provided timely notice of his occupational disease claim despite the fact it was dismissed. Meuth also appeals from the ALJ's separate order on reconsideration denying its motion for a determination Kindle failed to comply with the notice requirements for occupational diseases contained in KRS 342.316(2).

Kindle filed a Form 101, Application for Resolution of Injury Claim, on January 19, 2011 asserting he injured his right leg on November 23, 2009 when he fell from a flatbed truck and was trapped between a septic tank and the truck. Kindle also filed a Form 102, Application for Resolution of Occupational Disease Claim, on the same day alleging an occupational disease of "chronic thromboembolic pulmonary hypertension; pulmonary embolism; multiple chronic anticoagulation". His Form 102 further indicated Kindle developed complications from the physical injury and he did not learn of the pulmonary embolism until February 22,

2010. Kindle later amended his claim to also assert an injury to his left leg in the fall from the truck on November 23, 2009. He further alleged it was the injury to his left leg that caused most of his clotting which resulted in chronic thromboembolic pulmonary hypertension, pulmonary embolism and chronic anti-coagulation issues.

Kindle testified by deposition on April 13, 2011, and again at the formal hearing. Kindle stated he was operating a flatbed truck on November 23, 2009, at a job site. As he was climbing over the truck, Kindle fell backwards approximately nine (9) feet injuring his right knee when his leg was pinned between the septic tank and truck frame. He was taken to St. Camillus Urgent Care Center where he was treated by Dr. William Martin. Dr. Martin also prescribed physical therapy. Kindle returned to work several weeks later after he was released by Dr. Martin.

At the formal hearing, Kindle indicated he first had symptoms in his left leg approximately one week after the accident. He stated his leg “started getting real numb”. He spoke with his cardiologist about the problem one or two weeks after he fell.

Kindle testified he initially thought he had asthma since he was continually short of breath. He learned from

his physicians he had blood clots in his lungs. He first received medical treatment in Nashville, Tennessee. He was later hospitalized for five weeks in San Diego, California, where he underwent surgery for placement of a filter in his hip and placement of a pump in his heart area.

Meuth introduced medical records and reports from St. Camillus Urgent Care showing Kindle was treated on November 23, 2009, November 30, 2009, December 29, 2009 and February 22, 2010. The records for November 23, 2009 and November 30, 2009 show Kindle presented with injuries to his right knee and ankle due to a fall from a truck. The office note of December 29, 2009 shows the clinical impression to be "a lumbar strain." The February 22, 2010 report indicates Kindle was to be admitted to the hospital.

Kindle submitted the medical records and reports of Dr. Robert K. Mathew, his treating cardiologist. Dr. Mathew first saw Kindle on March 5, 2010, and took a history of moderate to severe pulmonary hypertension and bilateral pulmonary emboli with complaints of shortness of breath. An ultrasound of the lower extremities was performed which showed "left popliteal venous aneurysm suspected as source of emboli." Dr. Mathew performed placement of an inferior vena cava (IVC) filter on March

24, 2010 in anticipation of further surgical procedures in San Diego or Philadelphia.

Rafael Perez, M.D., a professor of medicine at the University of Louisville Medical School, conducted a university evaluation on February 25, 2011, pursuant to KRS 342.315. Because of the issues presented in this appeal, the "Plaintiff History" portion of Dr. Perez' report is quoted in its entirety:

> Plaintiff related history of complaints allegedly due to an occupational disease as follows:
>
> Note: If the occupational disease is lung or hear-related, [sic] include plaintiff's smoking history. Mr. Derek Kindle is a 30 year old never-smoker (did chew tobacco) who presents with a diagnosis of and is on therapy for chronic pulmonary thromboembolism. He has been a very healthy and active individual all of his life. He did not have any pulmonary problems including asthma, emphysema or recurrent infections. When asked when was the first time he noticed anything wrong with his breathing, Mr. Kindle replied that it was sometime in 2008 that he began [to] notice difficulty breathing with exertion. Mr. Kindle was working as a cement truck driver during this time. He describes his typical work day as driving for around a total 5 hours delivering cement on local jobs. He did not do any long distance driving requiring hours behind the wheel.
>
> On November 23, 2009, he fell off a flatbed truck at work injuring his knee tendons and breaking a kneecap. He did

not require surgery, but underwent physical therapy. He tried to return to work in December of 2009, but says that his dyspnea was too severe to perform the work he could do prior to the fall in November. The dyspnea did not resolve and worsened to the point that he sought medical attention and was found to have bilateral lower lobe pulmonary arterial filling defects consistent with pulmonary embolism. He was admitted the same day to Owensboro Hospital on February 22, 2010. He was treated appropriately with anticoagulation. He underwent an echo cardiogram on February 23, 2010 that showed moderate right ventricular dilation and dysfunction with an estimated right ventricular systolic pressure of 70 mm Hg consistent with severe pulmonary hypertension. He was sent home on anticoagulation. He says that his dyspnea did not improve despite this treatment. He had a series of medical encounters that included placement of an inferior vena cava filter on March 24, 2010 and the initiation of therapy with continuous i.v. Flolan on July 11, 2010. Management culminated with a pulmonary thromboendarterectomy in San Diego on September 3, 2010.

Mr. Kindle is now on the anticoagulant, warfarin, 5 mg daily and ambrisentan 10 mg daily. Despite all of these interventions, he still experiences debilitaiing dyspnea on exertion.

His current symptoms include shortness of breath most pronounced on exertion, fatigue, and he has episodes of rapid heart rate.

Mr. Kindle was asked and replied that not working for another employer during the period around the incident of

November 23, 2009.

Dr. Perez reviewed records supplied to him related to Kindle's prior treatment. He noted:

> Mr. Kindle was seen at Methodist Hospital in Henderson, KY on 3/22/07 with a chief complaint [of] fever and hemoptysis (coughing up blood). He had recently worked in Northfield Minnesota where he was hospitalized 3/16/07 to 3/17/07 with a diagnosis of "mono" (mononucleosis). He was discharged, but apparently remained with cough, fever, and sore throat. On or around 3/20/07 developed "...sputum with blood in it..." This was accompanied by abdominal pain. He was not placed on antibiotics in Minnesota. In addition to the presenting illness, a review of systems indicated complaints of headache and chest tightness.

Dr. Perez also reviewed a CT scan performed on March 22, 2007 and noted:

> CT scan of the chest with contrast findings on 3/22/07 for "hemoptysis": I reviewed the imaging provided on CD and concur with the radiologist's report of no abnormalities found in the lungs or mediastinum. In particular, pulmonary vascular structures appear normal and there are no gross vascular filling defects. However, the study was not done using a pulmonary embolism protocol and cannot be used to exclude pulmonary embolism.
>
> I have available the initial clinic visit note about Mr. Kindle’s visit to Vanderbilt written by Dr. Anna Hemnes dated 6/10/10. The presenting illness

> mentions a remote ("years ago") hospital admission with fever and shortness of breath following a long car ride. I cannot tell if this statement refers to the hospitalization on 3/22/07 in Henderson, KY or to another hospitalization. The incident in November of 2009 is mentioned in Dr. Hemnes' record. Dr. Hemnes reviewed in detail the studies done in between February and May 2010 confirming severe pulmonary hypertension. A striking finding was the presence of a popliteal venous aneurysm with thrombus seen by ultrasound Doppler imaging on 3/16/10. Popliteal venous aneurysms are rare venous malformations that under conditions that promote clot formation, can propagate severe thromboembolic disease. Recommendations were made [sic] Dr. Hemnes including referral to UCSD for thromboendarterectomy that was performed in September, 2010.

Dr. Perez diagnosed chronic thromboembolism with associated pulmonary hypertension. Within reasonable medical probability, Dr. Perez concluded Kindle's condition was causally related to his work environment. He concluded:

> On the basis of my interview, examination, and review of outside records and studies, my conclusion is that Mr. Kindle had chronic thromboembolic disease developing before the event of November 23, 2009. The disease burden was low and impairment was minimal allowing him to continue his occupational and other physical activities satisfactorily. Following the event of November 23, 2009, Mr. Kindle had a dramatic

> decrease in his abilities to perform any physical activity as demonstrated by his symptoms and the objective studies noted above. I conclude that the injury sustained on November 23, 2009 increased the amount of thrombus, or blood clots, in the injured extremities in an individual predisposed to this problem due to his popliteal venous aneurysm. A series of thromboembolic events to the lungs was sufficient to produce the severe pulmonary hypertension found after the injury.

Dr. Perez stated several factors led to his conclusion the chronic thromboembolism was present before the injury of November 23, 2009. They included 1) Kindle's admission he first noticed shortness of breath on exertion in 2008; 2) the presence of a left popliteal venous aneurysm as a strong predisposing factor for chronic thromboembolic disease; 3) echocardiographic, ventilation-perfusion scanning, and right heart catheterization studies consistent with the long-term process; and 4) photograph of "a large organized thrombotic burden removed at arterectomy indicating a long-term process.…".

Dr. Perez then set out the factors leading to his conclusion the chronic thromboembolic process was accelerated by the injury on November 23, 2009. They were 1) the debilitating symptoms and high pulmonary arterial pressures occurred only after the injury; and 2)

demonstration of a popliteal venous aneurysm with thrombus supporting clot burden after the date of injury. Using the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition ("AMA Guides"), Dr. Perez determined Kindle had a 51 to 100% whole person impairment and was in Class IV with 90% loss of pulmonary function. He also concluded Kindle had a 5% prior active condition "on the basis of only very mild dyspnea on exertion as admitted by Mr. Kindle in 2008". Dr. Perez noted Kindle may participate in sedentary work, but does not have the respiratory capacity to perform work requiring physical activity.

Meuth introduced the medical report and deposition testimony of Dr. Bruce Broudy who conducted an independent medical examination on April 29, 2011. The history Kindle provided to Dr. Broudy included in part:

> According to his history, he fell off a truck and fractured his right kneecap around Thanksgiving in 2009. He was injured on the job and the injury resulted in him being on crutches. He did have some physical therapy but was on no medications. He says later that he developed difficulty breathing and saw his doctor who diagnosed blood clots in his lungs. He was referred to a specialist in Philadelphia who recommended he see someone at Vanderbilt University. He was eventually referred to San Diego where he underwent a thoracic surgical procedure to remove thrombi from his

> pulmonary circulation. He says that at Vanderbilt he was found to have pulmonary hypertension and is on Letairis 20 mg for pulmonary hypertension, as well as Coumadin 5 mg daily. He states that he has had pulmonary hypertension due to the blood clots in his lungs.

Dr. Broudy reviewed Kindle's past medical history and noted:

> Past medical history reveals that he did receive some blood transfusions with surgery and had pneumonia as a complication of surgery. There is no history of any other surgery except for inferior vena cava filter placed in 2009 in Owensboro, KY. The records actually indicate that the procedure was done in March of 2010. The patient remembers being hospitalized in Minnesota 10 or 11 years ago for what he calls strep throat, although records indicate that he had hemoptysis at the time. He also was hospitalized overnight for motor vehicular accidents in 1997 and 2001. There is no history of any other surgery, serious injury or hospitalization. The patient has no history of tuberculosis, cancer, asthma, stroke, heart attack, peptic ulcer disease, kidney stones, diabetes or systemic arterial hypertension.

Dr. Broudy conducted a physical examination and reviewed medical records. He noted a report of a CT scan with pulmonary embolism protocol on February 22, 2010 revealed evidence of lower lobe pulmonary embolism bilaterally. Dr. Brody reviewed the notes of the

orthopedist who treated Kindle for his knee injury and noted Kindle was released to return to work on January 14, 2010, but was admitted to the Owensboro Medical Health System Hospital on February 22, 2010 with the diagnosis of pulmonary embolism. A CT venogram of the lower extremities done on March 5, 2010, revealed changes felt to represent a thrombosed left popliteal venous aneurysm. This was felt to be the source of the pulmonary embolism. An inferior vena cava filter was inserted on March 10, 2010. A March 8, 2011 echocardiogram showed pulmonary hypertension with a pressure of 55 mmHg and enlarged right ventricle. Kindle saw a pulmonologist and underwent the pulmonary thromboendarterectomy on September 3, 2010 at the University of California San Diego. He spent approximately three weeks in San Diego and was again hospitalized with hemoptysis a few days after he returned to Owensboro.

Dr. Broudy arrived at the following assessment:

> ASSESSMENT: Clearly this patient has had chronic thromboembolic pulmonary disease with pulmonary hypertension requiring pulmonary thrombectomy. The source of the emboli seems to [be] the crux of the case here. Whereas the patient did have a right knee injury prior to the onset of symptoms, he never had documented deep venous thrombosis of the right lower extremity. He did have documented left popliteal aneurysm with thrombosis.

> This aneurysm, in my opinion, predates the right knee injury and was probably the source of the emboli. Certainly the clinicians involved in the case seemed to think that the thrombosed left popliteal aneurysm was indeed the source of pulmonary emboli. Therefore the inferior vena cava filter was placed. I do not believe that the aneurysm was caused by the injury that this gentleman sustained on the job when he fell off the truck. Therefore it does not appear that the pulmonary embolism and its sequelae are a result of a work-related injury.

Dr. Broudy then opined there were some circumstances suggesting Kindle had previously experienced pulmonary embolism, "such as the time when he presented to hospital in Minnesota with hemoptysis" although Kindle stated he was diagnosed with strep. In Dr. Broudy's opinion, hemoptysis is inconsistent with a pharyngeal infection and certainly could easily have been due to undiagnosed pulmonary embolism.

Dr. Broudy testified by deposition on May 20, 2011. He addressed the issue of the popliteal aneurysm and the pulmonary emboli as follows:

> Q. Now, in your opinion, is the left popliteal aneurysm and the pulmonary emboli that resulted from that, do you have an opinion as to whether those were related to the work-related injury of November 23, 2009.
>
> A. Yes, I do.

> Q. And what is your opinion?
>
> A. That there is no relationship between the two.
>
> Q. And why do you think there's no relationship between the two?
>
> A. Well I don't think the injury caused the aneurysm and it appears that the aneurysm was indeed the source of the emboli which required subsequent surgery. So there is no relationship between the injury and what ultimately caused the pulmonary emboli.

Dr. Broudy further opined:

> [I]njuries to the lower extremities can cause damage to the vessels and result in clot formation. In this case there was injury to the right lower extremity but no reported injury or evidence of injury to the left lower extremity, yet the venogram showed that the clot was in the left lower extremity and the right lower extremity did not have a clot. Therefore it appeared that there was no relationship between the injury and subsequent clot formation.

Dr. Broudy concluded Dr. Perez' reasoning was flawed. Although Dr. Perez acknowledged the aneurysm was long-standing, he based his opinions on symptoms and diagnostic testing that occurred after the injury. Dr. Broudy stated:

> Therefore, I don't believe that there is a causal relationship between the injury and the subsequent thrombus and embolism. Therefore, the symptoms that develop [sic] were due to the popliteal aneurysm with thrombus and subsequent

> embolization that occurred after the injury but doesn't necessarily imply that the injury caused the symptoms. The symptoms were due to the popliteal aneurysm which, in my opinion, was not related to the injury. Just the fact that symptoms occurred after the injury doesn't mean--does not mean the symptoms were due to the injury. If one had this blood clot in the leg and developed pulmonary embolism one would expect the symptoms that he developed and the high pulmonary artery pressures, but just because it occurred after the injury doesn't mean they were due to the injury.

Rather than undertake the task of independently reviewing the relevant medical evidence, the ALJ stated:

> The ALJ will not attempt to summarize the extensive medical evidence herein. Much of this evidence is not relevant to the issue herein, but for this claim the consensus seems to be that the emboli emanated from the pre-existing aneurysm. The more discrete issue is whether the fall precipitated the thrombosis from the aneurysm in the left leg. The two physicians that weighed in on this issue are Drs. Perez and Broudy. Their reports will be discussed in the Analysis.

The ALJ provided the following analysis and findings relevant to this appeal:

> The ALJ was not satisfied with either of the reports by the two physicians who examined Plaintiff for medical causation and impairment. The ALJ finds it interesting that of all the physicians that treated Plaintiff,

none of them indicated Plaintiff's trauma in the fall was a precipitating cause of the pulmonary emboli. There is no indication that Plaintiff or Defendant called on them to give an opinion on the matter, and certainly, they were only interested in treating his condition rather expressing opinions on causation for legal matters.

In the history given by Dr. Perez, he states: "[h]e tried to return to work in December of 2009, but says that his dyspnea was too severe to perform the work he could do prior to the fall in November. The dyspnea did not resolve and worsened to the point that he sought medical attention and was found to have bilateral lower lobe pulmonary arterial filling defects consistent with pulmonary embolism." This is critical misinformation given to the physician. At another place under "Causation," Dr. Perez states: "[f]ollowing the event of November 23, 2009, Mr. Kindle had a dramatic decrease in his abilities to perform any physical activity as demonstrated by his symptoms and the objective studies noted above. I conclude that the injury sustained on November 23, 2009 increased the amount of thrombus, or blood clots, in the injured extremities in an individual predisposed to this problem due to his popliteal venous aneurysm." There was nothing in the medical records that Dr. Perez reviewed to refute Plaintiff's statement to him that in December he had dyspnea to the point he was having trouble doing his work. This inaccurate history may have led Dr. Perez to conclude: "Mr. Kindle had a **dramatic** decrease in his abilities to perform any physical activity as demonstrated

by his symptoms….” (Emphasis supplied). In sorting through Plaintiff's testimony, the ALJ concludes that the testimony given by Plaintiff in his deposition on April 13, 2011 was that when he started experiencing dyspnea as he was walking across the yard. He said, “I thought I had asthma. I was walking across the yard and I couldn’t breathe. It was like I was running.” That afternoon he went to Al Ward, who sent him to the Springs, a radiology department, who found the blood clots. (Dep.P.48). This visit was on February 22. He confirmed this testimony at the hearing. (Tr. P. 19-20). Plaintiff also gave Dr. Kawut at Penn Presbyterian Medical Center a history of doing the physical therapy without being dyspneic. He first noticed dyspnea two months after the injury. Although Plaintiff amended his claim to include a left leg injury in the incident of November 23, there is no record that Plaintiff complained to the treating orthopedist of a left leg injury. In fairness to Plaintiff, he did later give a history to one of his treating physicians that he had hurt his left leg in the fall. It was not significant enough for him to mention or seek treatment for. Dr. Kawut also had a history of the PE in March 2007 in Minnesota. He said Plaintiff had what sounded like a history of untreated PE, “which could account for this.” Interestingly, he did not say the fall could account for the bilateral emboli. Dr. Kawut opined that the “left popliteal aneurysm may indeed be the source of his pulmonary emboli.” Dr. Perez also elicited some history that the ALJ has not found anywhere else. He said sometime in 2008 Plaintiff began to notice difficulty breathing with exercise.

In reviewing the treatment history of Plaintiff, the ALJ was puzzled why Dr. Perez did not place more emphasis on the March 16, 2007 hospitalization in Minnesota. He said Plaintiff had a history of coughing up blood with a diagnosis of mononucleosis. Then on March 20 developed "…sputum with blood in it…." This was accompanied with abdominal pain. Under the "Causation" section of his report, in listing the factors that lead to his conclusion that Plaintiff had a pre-existing chronic thromboembolism, he listed:

1) Mr. Kindle's admission that he first noted shortness of breath on exertion in 2008.

2) The presence of a left popliteal venous aneurysm as a strong predisposing factor for chronic thromboembolic disease.

3) Echocardiographic, ventilation-perfusion scanning, and right heart catheterization studies consistent with a long term process.

Then he listed factors that lead to his conclusion that the chronic thromboembolic process was accelerated by the injury sustained on November 23, 2009:

1) The debilitating symptoms and high pulmonary arterial pressures occurred only after the injury;

2) Demonstration of a popliteal venous aneurysm with thrombus supporting clot burden after the date of injury.

Defendant referred Plaintiff to Dr. Bruce Broudy, who did an IME on April 29, 2011. In his assessment, he said the "source of the emboli seems to [be] the crux of the case here. Whereas the patient did have a right knee injury prior to the onset of symptoms, he never had documented deep venous thrombosis of the right lower extremity. He did have documented left popliteal aneurysm with thrombosis." He thought the aneurysm predated the right knee injury and was probably the source of the emboli. He then said, "I do not believe the aneurysm was caused by the injury…. Therefore it does not appear that the pulmonary embolism and its sequelae are a result of the work-related injury." In his deposition and in criticism of Dr. Perez's report, Dr. Broudy said that Dr. Perez "implies that the popliteal venous aneurysm with thrombosis was due to the injury, which I do not believe to be the case…" (Dep. P. 16). This is not what Dr. Perez said. He believed the aneurysm predated the injury. He said chronic thromboembolism was present before the injury. He gives four factors supporting this position. He said the process was accelerated by the injury. He said "the debilitating symptoms and high pulmonary arterial pressures occurred only **after** the injury." (Emphasis, supplied). On cross-examination, he did not think that Plaintiff's theory of Plaintiff landing on his left leg in the fall was sufficient to have caused the aneurysm. The proper inquiry would have been to see if the doctor would concede that if Plaintiff landed on his left leg, from which there was not a reportable injury, whether that would accelerate the thrombosis.

The ALJ has considered this claim and the reports of Drs. Perez and Broudy with the idea that Dr. Perez is the more independent of the two, even though the ALJ does not feel bound to give his report presumptive weight. It is obvious that Dr. Broudy did not consider the fall as a precipitating factor in the emboli ultimately going to the lungs. Although the many treating physicians did not mention the fall as a precipitating factor, the ALJ is aware that their attention was directed to treatment rather than the mechanics of the emboli getting into the lungs. The ALJ is convinced that Dr. Perez's opinion and assessment was mostly influenced by the incorrect history given him by Plaintiff. The history given him was that Plaintiff was experiencing severe dyspnea in December, 2009, the exact date not being mentioned. If Plaintiff sustained an injury in a fall and almost immediately began experiencing symptoms of pulmonary emboli from a pre-existing aneurysm, the ALJ probably could infer causation from the fall. The number one factor mentioned by Dr. Perez in his assessment of causation that Plaintiff's dyspnea symptoms "occurred only after the injury." The evidence seems clear that it was February 22, when he began experiencing breathing symptoms, two months following the injury.

It being the consensus that the emboli came from the pre-existing aneurysm in the left knee, Plaintiff then moved to amend his claim to allege an injury to the left lower extremity, even though there was no history given to any treating physician of any injury to the left leg. Dr. Perez stated Plaintiff had a pre-existing chronic

> thromboembolic process in March 2007 and sometime in 2008. Dr. Perez's report and conclusion of causation was flawed by the inaccurate history of when the dyspnea began following the fall. Dr. Broudy never addressed this issue, and the ALJ was not persuaded by his report. The ALJ was not persuaded by either physician as to causation of the pulmonary emboli emanating from the aneurysm.
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> Plaintiff having failed to persuade the ALJ on the issue of causation, his claim must be dismissed.

Meuth filed a petition for reconsideration noting, although the ALJ dismissed claim number 2010–98942, he inadvertently failed to dismiss claim number 2011–00079, the occupational disease claim. Meuth further argued the ALJ was required to provide a legal basis for finding notice made immediately after the injury constituted notice for the emboli.

Kindle filed a petition for reconsideration arguing the report of Dr. Perez was entitled to presumptive weight. Kindle argued the ALJ did not make adequate findings when stating he was not satisfied with either of the reports of the two physicians regarding medical causation and impairment. Kindle noted the ALJ indicated he was confused by Dr. Perez' report regarding pre-existing emboli. However, Kindle contended the ALJ's statements left the

parties with an insufficient understanding of the ALJ's requirements for “sufficiency” of evidence and standards of proof. Kindle also took issue with the ALJ's statement that an inaccurate history was given to Dr. Perez about dyspnea and those statements misled Dr. Perez. Kindle noted Dr. Mathew’s records stated Kindle had a four-month history of shortness of breath and Dr. Uragoda stated in March 2010 Kindle reported shortness of breath over the last “four months or so.”

The ALJ issued separate orders on September 23, 2011 ruling on the petitions for reconsideration. Kindle’s petition was denied without additional findings. The ALJ granted Meuth’s petition to the extent the opinion and order was modified to dismiss the occupational disease claim. In all other respects the petition was denied.

On appeal, Kindle argues the ALJ was bound to give presumptive weight to the university evaluator’s report. Kindle notes the Department of Workers’ Claims scheduled the university evaluation before the claim had been assigned to the ALJ. Kindle notes Meuth never objected to the scheduled university evaluation and never attempted to have the evaluation canceled. Further, Meuth never objected to the admissibility of the university evaluator’s

report. Kindle notes the issue of presumptive weight was never listed as a contested issue in the claim. Kindle notes KRS 342.315 provides any medical question can be decided by a university evaluator. Kindle asserts it is obvious there were several medical questions at stake including extent and duration, extent and duration of pre-existing conditions and medical causation. Kindle notes his claim involved a complicated pulmonary medical malady, seldom encountered in the workers' compensation system and this was a perfect case for a university evaluation to be helpful.

Kindle argues the ALJ erred as a matter of law in dismissing Dr. Perez' opinion regarding causation. Kindle states that, in order to reject Dr. Perez' opinion on causation, the ALJ speculated an inaccurate history may have led Dr. Perez to conclude the work injury caused the pulmonary embolism. Kindle contends the ALJ's speculation is not based on medical evidence of record. Kindle notes the ALJ thought it was "key" in his opinion that the pulmonary embolism symptoms should have appeared "almost immediately" after the fall. Kindle notes there is no medical evidence or opinion in the case supporting the ALJ's opinion that symptoms of pulmonary emboli must

manifest “almost immediately” after a traumatic event. Kindle contends the ALJ did not state a reasonable basis for rejecting the university evaluator’s opinion. He contends the ALJ essentially substituted his own medical judgment concerning the importance of pulmonary embolism symptoms occurring “almost immediately” after a physical injury.

Kindle takes issue with the ALJ’s statement that the university evaluator did not have any medical records to rebut Kindle’s reported history. Kindle notes the medical records Dr. Perez reviewed clearly contain evidence of the approximate symptom onset date and increases in symptoms in February and March 2010. He notes Dr. Mathew’s records recorded a four-month history of shortness of breath and Dr. Uragoda stated in March 2010 Kindle reported shortness of breath over the last four months. Thus, Kindle argues Dr. Perez’ opinion is completely supported by substantial indications of the symptom onset date. Kindle states Dr. Perez performed an examination, reviewed pre and post-injury medical records, summarized them accurately, and properly exercised a physician's judgment when interpreting them. Kindle notes Dr. Broudy, who clearly had numerous medical records, never commented on the history Kindle gave

or upon the timing of Kindle's complaints to the doctors or upon the progression of symptoms. Rather, Kindle notes Dr. Broudy refused to accept that there was any injury to the left leg.

Kindle notes the clinical findings and opinions of university evaluators are presumed accurate and the ALJ is required to state a reasonable basis for rejecting them. Kindle notes the ALJ rejected Dr. Perez' opinion based upon allegedly inaccurate history. However, Kindle notes Dr. Perez did not rely solely on the history he provided. Kindle contends there is nothing in the report to indicate the history Dr. Perez received was any more important to the doctor than the medical records he reviewed or the tests he performed. Dr. Perez indicated Kindle's symptoms and objective studies helped him to reach his medical opinions.

Kindle acknowledges Dr. Perez found there was a pre-existing aneurysm in the left leg and Kindle had a pre-existing untreated pulmonary embolism. Despite these conditions, Kindle notes he was able to work hard and he was active in recreation with few or no symptoms of his pre-existing condition until the work injury. At some point between the injury and February 23, 2010, both

conditions became life-threatening and required surgery. He notes the medical records and medical opinions agree his condition required little or no medical treatment prior to the work injury. Dr. Perez stated Kindle hurt both legs during the work injury.

Kindle concedes the parties presented conflicting medical causation evidence and the ALJ was required to weigh the evidence and determine which was more persuasive. Given the complicated facts and circumstances of this claim, Kindle argues the ALJ should have relied upon Dr. Perez' opinion regarding causation.

The ALJ as fact-finder is granted considerable authority concerning the weight and credibility to be assigned the evidence. Paramount Foods, Inc. v. Burkhardt, 695 S.W.2d 418 (Ky. 1985); Miller v. East Kentucky Beverage/Pepsico, Inc., 951 S.W.2d 329 (Ky. 1997). Mere evidence contrary to the ALJ's decision is not adequate to require reversal on appeal. To withstand appellate scrutiny the decision must be supported by substantial evidence. *See*, Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986). However, the ALJ's authority is not without certain limits. Concerning the content of his opinion, the ALJ is required to render findings of fact sufficient to apprise

the parties of the basis for his decision and to permit informed review of that decision on appeal. Shields v. Pittsburgh and Midway Coal Mining Co., 634 S.W.2d 440 (Ky. App. 1982). The parties are entitled to reasonable assurance that the ALJ's decision was a product of a thorough and accurate understanding of the evidence. Cook v. Paducah Recapping Service, 694 S.W.2d 684 (Ky. 1985). *See* also KRS 342.275.

In the case *sub judice*, the ALJ's departure from the requirement to render findings of fact requires that the decision be vacated.[1] In addition, because the ALJ appeared to have a misunderstanding concerning the evidence regarding whether Kindle's condition arose from the work injury, the ALJ's decision must be vacated and remanded because his recitation of the evidence upon which he relied is, in part, inaccurate.

It appears the ALJ believed that, if the work incident was involved in accelerating the release of emboli from the site of the aneurysm, the effect should have been immediate. In determining Dr. Perez received inaccurate history, the ALJ also appears to interpret Dr. Perez' statement that, following the event of November 23, 2009,

[1] Examination of the ANALYSIS, FINDINGS OF FACT AND CONCLUSIONS OF LAW section reveals no findings of fact on any issue.

there was a “dramatic decrease” in Kindle’s ability to perform activities as meaning immediately following the incident. Dr. Perez actually stated there was “a dramatic decrease in his abilities to perform any physical activity as demonstrated by his symptoms and the objective studies noted above.” The studies referred to include those done in February 2010.

In the ALJ’s findings set forth above, the ALJ also stated “The number one factor mentioned by Dr. Perez in his assessment of causation [is] that Plaintiff’s dyspnea symptoms ‘occurred only after the injury.’” It is clear from Dr. Perez’ report he believed Kindle had an ongoing process prior to the work incident and that process was accelerated by the work injury. Dr. Perez actually stated the debilitating symptoms and high pulmonary arterial pressures occurred only after the injury. It was the increased clot burden after the date of injury that produced severe symptoms. He stated “A series of thromboembolic events to the lungs was sufficient to produce the severe pulmonary hypertension found after the injury.” The clear import of his report is that the work injury involved the left leg, accelerating the thromboembolic process culminating in severe problems in

February, 2010 when the debilitating symptoms arose and objective studies confirmed the condition.

Contrary to the ALJ's assertion, the opinions of Dr. Perez were entitled to presumptive weight. Here, because Kindle filed a Form 102-OD Application for Resolution of Occupational Disease Claim, he was referred by the Department of Worker's Claims for a university evaluation pursuant to the provisions of KRS 342.315 which states in part:

> **(1)** The executive director shall contract with the University of Kentucky and the University of Louisville medical schools to evaluate workers who have had injuries or become affected by occupational diseases covered by this chapter. Referral for evaluation may be made to one (1) of the medical schools whenever a medical question is at issue.
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> **(2)** The physicians and institutions performing evaluations pursuant to this section shall render reports encompassing their findings and opinions in the form prescribed by the executive director. Except as otherwise provided in KRS 342.316, the clinical findings and opinions of the designated evaluator shall be afforded presumptive weight by administrative law judges and the burden to overcome such findings and opinions shall fall on the opponent of that evidence. When administrative law judges reject the clinical findings and opinions of the designated evaluator, they shall specifically

> state in the order the reasons for rejecting that evidence.

In the case *sub judice* the commissioner directed a university evaluation be conducted in connection with Kindle's claim of an occupational disease as the statute directed. Thus, the referral was not in error as suggested by the ALJ. In addition, as Kindle has noted Meuth failed to object to inclusion of the university evaluator's report. We, therefore, conclude the report was properly in evidence and entitled to presumptive weight unless overcome by clear and convincing evidence.

An ALJ has the discretion to reject the evaluator's testimony where it is determined the presumption has been overcome by other evidence and he expressly states his reasons for doing so within the body of his decision. Bullock v. Goodwill Coal Co., 214 S.W.3d 890, 891 (Ky. 2007); Morrison v. Home Depot, 197 S.W.3d 531, 534 (Ky. 2006); Magic Coal Co. v. Fox, 19 S.W.3d 88 (Ky. 2000). Whether a party overcomes the presumption established under KRS 342.315(2) is not an issue of law, but rather a question of fact at all times subject to the ALJ's discretion as fact-finder to pick and choose from the evidence. Magic Coal Co. v. Fox 19 S.W.3d at 96.

Because of the absence of specific findings of fact we are unable to discern from the ALJ's decision whether he believed the work-related injury produced any physical trauma to Kindle's left leg. This is a crucial determination since Dr. Broudy, based upon the absence of any left leg complaints in the contemporaneous medical reports, did not believe the work-related accident was related to the emboli in any way. Conversely, Dr. Perez clearly believed the work injury involved both legs.

On cross-appeal, Meuth argues Kindle failed to give notice of an occupational disease. However, Meuth states "Because Plaintiff has abandoned any argument that his claim constituted an occupational disease, the Defendant-Employer's cross-appeal is moot." Since Kindle did not appeal dismissal of the occupational disease claim, we agree the cross-appeal is moot.

On remand, the ALJ is directed to render findings of fact sufficient to apprise the parties of the basis for his decision and to permit informed review of that decision on appeal. Shields, *supra*. After reconsideration of the evidence of record, the ALJ may or may not arrive at the same conclusions as in his previous decision. We certainly

are not attempting to substitute our judgment for that of the ALJ as the final result may be the same.

Accordingly, the decision of the Administrative Law Judge is **VACATED** and this matter is **REMANDED** for further findings consistent with the opinion expressed herein.

ALL CONCUR.

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