

Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: February 9, 2015

CLAIM NO. 201069510

DONITA WALKER

PETITIONER

VS.

APPEAL FROM HON. STEVEN BOLTON,
ADMINISTRATIVE LAW JUDGE

TRIAD HEALTH SYSTEMS
and HON. STEVEN BOLTON,
ADMINISTRATIVE LAW JUDGE

RESPONDENTS

OPINION
AFFIRMING IN PART, VACATING IN PART,
AND REMANDING

* * * * *

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

STIVERS, Member. Donita Walker ("Walker") seeks review of the July 16, 2014, Opinion, Award, and Order of Hon. Steven Bolton, Administrative Law Judge ("ALJ") awarding temporary total disability ("TTD") benefits, permanent partial disability ("PPD") benefits, and future medical benefits after finding she sustained a work-related left shoulder

injury. Walker also appeals from the August 7, 2014, Order denying her petition for reconsideration.

In Walker's Form 101 she alleged an injury to her left shoulder and arm occurring on September 27, 2010, and a low back and hip injury occurring on December 15, 2010. Walker introduced the Form 107 prepared by Dr. James C. Owen. Dr. Owen determined as a result of the shoulder injury, Walker had a 2% impairment rating and a compensable 4% impairment rating due to the low back injury.¹

Triad Health Systems ("Triad") relied upon Dr. John Larkin's deposition testimony of October 27, 2011. Attached to the deposition is Dr. Larkin's August 3, 2011, report generated as a result of an independent medical evaluation. Dr. Larkin's testimony and report reveal he believed Walker sustained a work-related left shoulder injury on September 27, 2010. He diagnosed "chronic rotator cuff tendonopathy with a secondary partial rotator cuff tear." He concluded Walker had not reached maximum medical improvement ("MMI") and surgery consisting of a subacromial decompression, rotator cuff repair, and distal clavicle resection was appropriate. Dr. Larkin stated MMI

¹ Dr. Owen assessed an 8% impairment rating but determined one half of the impairment rating was attributable to a pre-existing active condition.

would occur approximately three months after the date of surgery. Utilizing the 5th Edition of the American Medical Association, Guides to the Evaluation of Permanent Impairment ("AMA Guides"), he anticipated Walker would have a 6% impairment rating.

In an Opinion, Award, and Order rendered November 28, 2010, relying upon the opinions of Drs. Owen and Larkin, the ALJ found Walker sustained a work-related left shoulder injury on September 27, 2010. The ALJ found Walker had not reached MMI and surgery recommended by Dr. Larkin was reasonable and medically necessary for the treatment and relief of her work-related shoulder injury. Concerning the alleged low back injury, based on the opinions of Dr. Larkin, the ALJ also found Walker "suffered only a sprain or strain which did not result in a permanent harmful change to the human organism and is therefore not an injury as defined by the Act." Walker was awarded TTD benefits from the date she reported for the surgical procedure until she reached MMI as determined by her treating physician. The ALJ concluded a permanent impairment could not be assessed for the left shoulder condition. Walker's low back injury claim was dismissed.

Dr. Larkin performed shoulder surgery on March 15, 2013.

On July 9, 2013, Triad filed a motion seeking to remove the claim from abeyance representing that on June 5, 2013, Dr. Larkin placed Walker at MMI and released her to full duty. On July 26, 2013, the ALJ sustained Triad's motion and ordered the claim removed from abeyance.

Triad introduced the report of Dr. Gregory Fisher dated June 28, 2013, generated as a result of a physical examination and medical records review. Dr. Fisher noted left shoulder surgery was performed on March 15, 2013, "consisting of diagnostic arthroscopy, decompression, AC joint excision, and an open mini repair of a rotator cuff and labral tear." Walker was released from Dr. Larkin's care on June 5, 2013, with no further treatment being sought or planned. Based on the AMA Guides, Dr. Fisher assessed a 4% whole body impairment caused by the September 27, 2010, injury and provided the basis for the impairment rating:

Does Plaintiff warrant a permanent impairment rating for the left shoulder injury sustained on 9/27/10? If so, pursuant to the AMA Guides 5th Edition, what is the percentage of permanent impairment would you assign?

The answer is yes.

Using the criteria found in Chapter 16, figures 40, 43, & 46 page 476, 477 and 479 for range of motion of the shoulder the following impairment rating can be

given. For 160 degrees of forward flexion she would have 1% UEI, for 50 degrees of extension 0% UEI, 30 degrees of adduction is 1% UEI, 140 degrees of abduction is 2% UEI, external rotation of 90 degrees is 0% UEI, internal rotation of 60 degrees is 2% UEI. Adding these figures of 1,0,1,2,0,2 is 6% upper extremity impairment. Using table 3 page 439 for conversion to the whole body Ms. Walker would have 4% whole body impairment arising from the decreased range of motion of the left shoulder.

The decreased strength of 4+/5 for the abductors, forward flexors and external rotators cannot be rated since using the principal on page 508 stating decreased strength cannot be rated in the presence of decreased motion. Therefore, the final rating for the left shoulder impairment stemming from the injury of September 27, 2010 remains at 4% whole body impairment.

Walker introduced the September 5, 2013, letter of Dr. Larkin in which he stated as follows:

The following is in regard to your correspondence of 9/4/13, specifically as it addresses Ms. Donita Walker. She underwent an extensive reconstruction involving her rotator cuff for a chronic rotator cuff tear on 3/15/13. AC joint arthrosis was present, and at the time of the surgical intervention she was also found to have a SLAP tear. She underwent a decompression, repair of the rotator cuff, repair of the SLAP lesion, and distal clavicle resection. She did amazingly well with that considering the extent of her rotator cuff injury and more importantly the chronicity of it.

In reviewing my medical records, she was returned back to work unrestricted on 6/5/13. That was regarding the shoulder. However, she is disabled. The reason we released her unrestricted is because we had no further intervention to perform. In regard to true MMI status, typically with these I recommend a six-month period from the time of the surgical intervention, which at this juncture would be 9/15/13. However, the patient had regained functional ROM, although she showed a strength deficit. I thought that would be chronic and longstanding in nature. She was released on 6/5/13 unrestricted because she was not returning back to work.

In regard to an impairment rating, utilizing the AMA Fifth Edition Guidelines to Evaluation of Permanent Impairment, her impairment would be 6% based upon the subacromial decompression, distal clavicle resection, and the corresponding rotator cuff repair itself.

The May 7, 2014, Benefit Review Conference Order reflects among the contested issues was the proper calculation of impairment pursuant to the AMA Guides.

After the final hearing and submission of briefs, the ALJ entered the July 16, 2014, Opinion, Award, and Order in which he rejected Triad's argument the distal clavicle resection was not reasonable and necessary treatment of the injury and therefore not work-related. The ALJ determined Walker did not have an underlying pre-existing active condition which was impairment ratable

immediately prior to the September 2010, injury to her left shoulder. Consequently, he concluded the entire surgical procedure performed by Dr. Larkin constituted treatment of the work injury.

Concerning the impairment rating attributable to the left shoulder injury, the ALJ concluded as follows:

Plaintiff's argument that I should adopt the ratings of both physicians, add them and rate her at 10% is also unsupported as Dr. Fisher's rating was based on range of motion for the entire shoulder rather than assigning a rating to each procedure.

I am more concerned with Dr. Larkin's failure to articulate a more specific explanation of how he arrived at his 6% rating.

As is accurately pointed out by the Defendant/Employer, the plaintiff bears the burden of proof and the risk of non-persuasion with respect to every essential element of her claim. Snawder v. Stice, 576 S.W.2d 276 (Ky. App., 1979). She must establish a permanent impairment rating based on substantial evidence. Special Fund v. Francis, 708 S.W.2d 641, 643 (Ky. 1986). In assessing the substantiality of the evidence, I must consider whatever fairly detracts from its weight. The plaintiff must overcome conflicting evidence presented by the employer. Roark v. Alva Coal Corp., 371 S.W.2d (Ky. App. 1963).

KRS 342.730 requires me as the ALJ to select a permanent impairment rating determined in accordance with the 5th Edition *AMA Guides* and based on effects

of the work-related injury. Pella Corp v. Bernstein, 336 S.W.3d. 451, 453 (Ky. 2011); Jones v. Brasch-Barry General Contractors, 189 S.W.3d 149 (Ky. App. 2006).

With all due respect, the 6% permanent impairment rating assessed by Dr. Larkin is not properly cited to the applicable sections of the *AMA Guides* and does not demonstrate how he extrapolated his assigned impairment rating resulting from the work-related injury. Therefore, it may not be relied upon by the ALJ. Rather, the 4% rating from Dr. Fisher is the only rating in the record that accurately reflects impairment resulting from the work-related shoulder injury. It is also faithful to the intent of the *AMA Guides* because it is based on measurable range of motion in the affected body part.

The Workers' Compensation Act requires an individualized determination of what the worker is and is not able to do after recovery from a work injury. Williams v. FEI Installation, 2003 Ky. App. LEXIS 280. The *Guides* likewise contemplate an individualized assessment of impairment. Chapter 1 provides, "Impairment ratings were designed to reflect functional limitations and not disability. The whole person impairment percentages listed in the *Guides* estimate the impact of the impairment on the individual's overall ability to perform activities of daily living, excluding work, as listed in Table 1-2." (*AMA Guides*, 5th Edition, p. 4).

Dr. Fisher's 4% rating is based on residual loss of range of motion demonstrated by Ms. Walker after achieving MMI following her rotator

cuff repair. It reflects her functional limitations attributable to the work-related injury itself, as opposed to an "automatic" rating assigned on the basis of a surgical procedure. An award of PPD benefits should issue on the basis of this 4% permanent impairment rating.

The ALJ concluded Walker was not entitled to enhancement by any multipliers and is entitled to TTD benefits from the date of the surgery through June 5, 2013. Because Walker received TTD benefits through July 4, 2013, Triad was entitled to a credit for the overpayment of TTD benefits. The ALJ entered an award of PPD benefits based on the 4% impairment rating assessed by Dr. Fisher and an award of TTD benefits from March 15, 2013, the date of surgery, until Walker attained MMI on June 5, 2013. The award reads as follows:

1. The Opinion, Award and Order issued herein on November 28, 2012 is hereby reaffirmed, ratified and republished herein, the same as if set out in words and letters. Except as modified herein, it shall remain in full force and effect.

2. Plaintiff, **DONITA WALKER**, shall recover of the Defendant/Employer, **TRIAD HEALTH SYSTEMS, Inc.** and/or its insurance carrier, Temporary Total Disability (TTD) benefits at the rate of \$459.71 per week from March 15, 2013 through June 5, 2013 and thereafter Permanent Partial Disability benefits (PPD) at the rate of \$11.95 per week, not to exceed 425 weeks. The payment of

occupational benefits awarded herein shall terminate pursuant to KRS 342.730 (4) on the date Plaintiff qualifies for normal old-age Social Security retirement benefits.

3. The Defendant/Employer shall be entitled to credit against benefits in the amount of \$1,970.60 for overpayment of TTD.

Walker filed a petition for reconsideration making the same argument she now makes on appeal arguing the ALJ should have combined the impairment ratings of Drs. Larkin and Fisher and entered an award based on a 10% impairment rating.² Finding there was no patent error appearing on the face of the July 16, 2014, Opinion, Award, and Order, the ALJ denied the petition for reconsideration.

On appeal, Walker challenges the ALJ's reliance upon Dr. Fisher's impairment rating arguing, in part, as follows:

It is important to remember that Dr. Larkin and Dr. Fisher used completely different methodologies in calculating an impairment rating in this case. Dr. Larkin assigned a 6% based on the surgery that was performed which included a distal clavicle resection, and his impairment rating is exactly the result that always comes from a distal clavicle resection. See Table 16.7, page 506 of the AMA Guidelines; see also Table 16.2, page 439, Fifth Edition AMA Guidelines.

² Walker also provided an argument regarding the duration of the TTD benefits awarded.

Dr. Fisher made his impairment rating based on loss of range of motion, and no real exception has been made to Dr. Fisher's findings that support a 4% impairment rating.

The problem which Plaintiff submits exists in this case is that the AMA Guidelines are very clear that in the present situation the two impairment ratings must be added together.

In Section 16.9, (II)(3) on page 512 of the Fifth Edition of the AMA Guidelines, specific instructions are given on how to properly evaluate impairments for upper extremities. It specifically states that upper extremity impairments (shoulder region) relating to the loss of motion, and other disorders, must be combined to determine the impairment for the shoulder. (*our emphasis*). Using the combined values chart on page 604 of the Guidelines, the total impairment rating is calculated by straight addition and results in a 10% impairment rating.

Citing Central Baptist Hospital v. Hayes, 2012-SC-00752-WC, rendered August 29, 2013, Designated Not To Be Published, Walker argues since the overwhelming evidence establishes the calculation of the impairment rating is in contravention of the AMA Guides, the ALJ has the responsibility to assign a different rating. Walker concludes as follows:

The facts of the present case present such a situation. Petitioner Walker asked the ALJ to combine the two

impairment ratings in the manner that the Fifth Edition of the AMA Guidelines requires. Petitioner Walker did not ask the ALJ to interpret the Guides or assess an impairment, but instead pointed out that the impairment rating stated by both doctors was incomplete, and therefore incorrect, because the Guidelines make it abundantly clear that the impairment rating assigned by Dr. Larkin for the distal clavicle resection (6%) must be added to the impairment rating for loss of range of motion assigned by Dr. Fisher (4%). The only issue which the ALJ had to resolve was how the two ratings added together, and that is done by using the combined values chart in the Guides. This is not a matter of interpretation, or assessing an impairment, but is simply a matter of looking at the chart and doing the proper addition.

Petitioner Walker submits that the impairment rating employed is erroneous, because it is incomplete, and that the ALJ should have added the two impairments assigned together for a 10% permanent partial disability impairment rating.

Walker requests the matter be remanded to the ALJ for an award based upon a 10% impairment rating.

In Central Baptist Hospital v. Hayes, supra, the Supreme Court stated as follows:

Central Baptist's sole argument is that the Court of Appeals erred by affirming the ALJ's assignment of a 10% impairment rating to Hayes for her gait derangement and arthritis, despite the *Guides* stating that those two lower extremity impairment ratings should not be combined. Key to that court's

holding was the conclusion that the proper interpretation of the *Guides* and assessment of an impairment rating in accordance with the *Guides* are reserved to medical witnesses. [citation omitted] Usually an ALJ may not question a medical expert's interpretation of the *Guides*, but may only determine which expert's findings he finds to be most credible. [citation omitted] But once an ALJ is presented with overwhelming evidence that the impairment rating calculated by the medical expert is in contravention of the *Guides*, he has the responsibility to assign a different rating.

As previously noted, any impairment rating assigned by an ALJ must be in compliance with the *Guides*. KRS 342.0011(35); KRS 342.730(1)(b). In this matter, Central Baptist provided sufficient evidence to show that the combined 10% impairment rating assigned to Hayes was erroneous and not in compliance with the *Guides*. Table 17-2 and Section 17.2c of the *Guides*, state that an impairment rating for gait derangement may not be combined with an impairment rating for arthritis. No medical analysis or expertise is necessary to come to this conclusion. Thus, Dr. Nicholls should not have combined the two different impairment ratings, and Hayes cannot be assigned the combined 10% impairment rating.

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As noted by the ALJ, Dr. Larkin did not provide the basis for his assessment of the 6% impairment rating by citing to the relevant section(s) or table(s) of the AMA Guides he utilized. In his letter of September 5, 2013,

Dr. Larkin merely stated that utilizing the AMA Guides, Walker had a 6% impairment rating based upon the type of surgery performed. Similarly, in his deposition and his August 3, 2011, report attached to his deposition, Dr. Larkin did not cite to a section or table of the AMA Guides in support of his testimony and statement that Walker had a 6% impairment rating. Consequently, within his discretion, the ALJ assigned no weight to Dr. Larkin's impairment rating.

Conversely, in his report Dr. Fisher provided an in depth explanation for his determination Walker had a 4% whole body impairment rating. Dr. Fisher provided the range of motion of Walker's shoulder he observed upon examination and cited to those portions of the AMA Guides on which he relied in assessing the 4% impairment rating. Consequently, we find no error in the ALJ's reliance upon Dr. Fisher's report and his refusal to accept the impairment rating of Dr. Larkin.

Significantly, neither Dr. Larkin nor Dr. Fisher expressed the opinion the impairment ratings should be combined. Moreover, we question the propriety of combining impairment ratings when the ALJ is unable to determine whether one of the physicians' impairment rating is in

accordance with the AMA Guides and has specifically rejected it.

The assessment of impairment for the purposes of arriving at a disability rating in a workers' compensation claim is a medical question solely within the province of the medical experts. Kentucky River Enterprises Inc. v. Elkins, 107 S.W.3d 206 (Ky. 2003). Furthermore, a fact-finding authority does not extend to interpreting the AMA Guides. George Humfleet Mobile Homes v. Christman, *supra*. Although assigning a permanent impairment rating is a matter for medical experts, determining the weight and character of medical testimony and drawing reasonable inferences therefrom are matters for the ALJ. Knott County Nursing Home v. Wallen, 74 S.W.3d 706 (Ky. 2002). Moreover, authority to select an impairment rating assigned by an expert medical witness rests with the ALJ. See KRS 342.0011 (35) and (36); Staples, Inc. v. Konvelski, 56 S.W.3d 412 (Ky. 2001).

Due to the fact neither physician's testimony supports Walker's contention, we believe it was appropriate for the ALJ to assume their expertise in applying the AMA Guides trumps Walker's argument on appeal. The ALJ, as fact-finder, has no responsibility to look behind an impairment rating or meticulously shift through the AMA

Guides to determine whether an impairment assessment harmonizes with that treatise's underlying criteria. Except under compelling circumstances where it is obvious even to a lay person that a gross misapplication of the AMA Guides has occurred, the issue of which physician's impairment rating is most credible is a matter of discretion for the ALJ. REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985).

As noted by the Supreme Court in Central Baptist Hospital v. Hayes, supra, only in situations where there is overwhelming evidence the impairment ratings calculated by the medical experts are in contravention of the AMA Guides, is the ALJ required to assign a different impairment rating. Here, there was no testimony by either physician in support of Walker's argument the impairment ratings should be combined. Further, since the ALJ was unable to determine the basis for Dr. Larkin's 6% impairment rating, we believe it was impossible for the ALJ to determine the AMA Guides mandate Dr. Larkin's impairment rating should be combined with Dr. Fishers. As such, we find no error in the ALJ's failure to combine the impairment ratings.

Finally, we have reviewed the sections and tables of the AMA Guides cited by Walker in her brief as well as other related relevant portions of the AMA Guides. Section

16.9 (II)(3) on page 512 of the AMA Guides reads as follows:

Shoulder Region Determine upper extremity impairments due to *loss of motion* (Section 16.4) and other *disorders* (Section 16.7) and *combine* the values to determine the upper extremity impairment involved in the shoulder region.

Assuming, *arguendo*, Dr. Larkin assessed an impairment rating based on the level of arthroplasty, and utilized Table 16-27 (Impairments of the Upper Extremity after Arthroplasty of Specific Bone or Joints) on page 506, we conclude further calculations were required. Table 16.27 specifies a 10% upper impairment for a "distal clavicle isolated" is appropriate. However, Walker fails to allude to the language contained in Section 16.7 entitled "Impairment of the Upper Extremities Due to Other Disorders" on page 498 which read as follows:

The severity of the impairment due to these disorders is rated separately according to Tables 16-19 through 16-30 and then multiplied by the relative maximum value of the unit involved as specified in Table 16-18.

The above language directs that in arriving at an impairment as suggested by Walker, the 10% upper extremity impairment must then be multiplied by the relative maximum value of the unit involved as specified in Table 16.18.

Table 16-18 directs the maximum value for the Acromioclavicular (AC) joint is 25%. Further, as noted by Triad in its brief, Section 16.7 also contains the following language:³

Impairments from the disorders considered in this section under the category of 'other disorders' are usually estimated by using other impairment evaluation criteria. *The criteria described in this section should be used only when the other criteria have not adequately encompassed the extent of the impairments. . . .*

The above does not support Walker's argument the AMA Guides overwhelmingly establish the impairment ratings should be combined. In summary, in order to grant the relief requested by Walker, the ALJ would have had to sift through the AMA Guides and conduct his own analysis which the case law directs he is not required to do. As Dr. Larkin did not cite to any section or tables within the AMA Guides in support of his 6% impairment rating, we believe there is far from overwhelming evidence establishing the impairment ratings should be combined.

That said, this Board is vested with the authority, pursuant to KRS 342.285, to correct awards which are not in conformity with the statute. Clearly, the ALJ's

³ See page 499.

award of PPD benefits is not in conformity with the statute and relevant case law as he commenced the award of PPD benefits on June 6, 2013, the day after the award of TTD benefits ended. Pursuant to the statute and Sweasy v. Wal-Mart Stores, Inc., 295 S.W.3d 835 (Ky. 2009), the award of PPD benefits should have commenced on September 27, 2010, the date of injury. The payment of PPD benefits are to be suspended from March 15, 2013, through June 5, 2013, and recommence on June 6, 2013, for the remainder of the 425 week period. Further, interest is due Walker on any unpaid benefits. Consequently, the award of PPD benefits is vacated and the claim remanded to the ALJ for entry of the correct award of PPD benefits.

Accordingly, regarding the issue raised on appeal, the ALJ's determination as set forth in the July 16, 2014, Opinion, Award, and Order and the August 7, 2014, Order denying the petition for reconsideration are **AFFIRMED**. However, the award of PPD benefits is **VACATED**. This matter is **REMANDED** to the ALJ for entry of the correct award of PPD benefits in conformity with the views expressed herein.

ALL CONCUR.

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