OPINION ENTERED: JUNE 7, 2013

CLAIM NO. 199774551

ELKHORN EAGLE MINE #7 PETITIONER

VS. **APPEAL FROM HON. JOHN B. COLEMAN, ADMINISTRATIVE LAW JUDGE**

BILLY G. MEADE,
DR. SAI GUTTI
and HON. JOHN B. COLEMAN,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION
AFFIRMING

* * * * * *

BEFORE: ALVEY, Chairman, STIVERS, Member.

ALVEY, Chairman. Elkhorn Eagle Mine #7 ("Elkhorn") appeals from the April 17, 2012 Opinion and Order, and the November 30, 2012 Opinion and Order rendered by Hon. John B. Coleman, Administrative Law Judge ("ALJ"). Elkhorn also appeals from the June 11, 2012 and January 17, 2013 orders denying its petitions for reconsideration.

On appeal, Elkhorn argues the ALJ applied an incorrect standard in reaching his decision. Because the ALJ's determination regarding medical treatment rendered to Billy G. Meade ("Meade") is supported by substantial evidence, we affirm.

Meade sustained a back injury on August 5, 1997 when a shuttle car ran over a rock, causing him to impact the roof of a mine. The claim was settled by agreement approved on September 30, 1998, based upon a 5% impairment rating pursuant to the American Medical Association, Guides to the Evaluation of Permanent Impairment, 5th Edition, for a lumbosacral strain with arousal of pre-existing dormant degenerative disc disease.

Elkhorn filed a motion to reopen on September 19, 2011 to contest treatment administered by Dr. Sai Gutti, including monthly office visits, epidural steroid injections, sacroiliac joint injections and prescription medications. In support of the medical dispute, Elkhorn submitted the report of Dr. David J. Jenkinson who performed an evaluation on August 3, 2011. Dr. Jenkinson opined the 1997 injury may have caused a relatively minor sprain or strain of the lumbar spine, but Meade's current subjective complaints were out of proportion to any objective abnormality. Dr. Jenkinson stated Meade had an established

chronic pain/disability syndrome and therefore it was unlikely he could be weaned from his medications. Dr. Jenkinson stated epidural steroid injections were not indicated for chronic back pain and were neither appropriate nor medically necessary for Meade's back strain injury. He further stated sacroiliac injections were not indicated since Meade had never experienced a problem with his sacroiliac joint. Dr. Jenkinson opined Lyrica and Zanaflex were unnecessary since Meade only had a relatively minor back strain with no neurological abnormalities. Dr. Jenkinson felt a tapering dose of Hydrocodone may be appropriate in order to wean Meade from the medication.

Elkhorn submitted the report and December 8, 2011 deposition of Dr. F. Albert Olash who completed a review on September 6, 2011. Dr. Olash opined there was no reason for Meade to receive treatment at a pain clinic, and injection therapy was unnecessary because it had not provided a benefit and carried significant risks. Dr. Olash stated continued epidural steroid blocks, sacroiliac joint injections, and monthly office visits were unnecessary and inappropriate. He further stated Diazepam, Lyrica, Hydrocodone/APAP and Zanaflex were neither reasonable nor necessary.

Dr. Olash testified there was no documentation establishing epidural steroid injections increased Meade's functional capacity. Further, the injections had not allowed a reduction in his medication. Dr. Olash stated objective studies did not establish a herniated disc, nerve impingement, or entrapment. Dr. Olash indicated spasms detected in a recent examination were inconsistent with a strain/sprain injury thirteen years earlier. He did not believe Meade would respond to any type of medication thirteen years post-injury.

Elkhorn filed records from Pikeville Methodist Hospital and St. Joseph Hospital. According to Dr. Dennis Halbert, the MRI of the lumbosacral spine performed December 12, 1997 demonstrated a herniated disc at L2-3. X-rays revealed degenerative changes including disc space narrowing at L2-3 and spurring throughout the lumbar region. A March 2, 1998 CT scan of the lumbar spine revealed disc bulges from L2-3 through L4-5 as well, as hypertrophic spurs from L2 through L5. A lumbar myelogram also dated March 2, 1998 revealed central dural defects of L2 through L5, probably representing disc bulges.

Elkhorn submitted treatment records from Dr. Gutti documenting office visits from January 25, 2002 through August 2, 2011. Elkhorn also deposed Dr. Gutti on January

26, 2012. Dr. Gutti testified electro-diagnostic testing performed by Dr. Sujata Gutti, his wife, correlated with Meade's complaints of decreased sensation at L5-S1 following the injury. Dr. Gutti disagreed with Dr. Scott's 2002 opinion that Meade did not have radiculopathy. Dr. Gutti stated the H-reflex abnormality on the electro-diagnostic testing is an indication of a problem with the S1 nerve root. Dr. Gutti testified Meade also had a problem with the L5 nerve root.

Dr. Gutti explained the purpose of injection therapy is to decrease pain and the need for oral medication. He noted the injections contained powerful medication to reduce inflammation and swelling, thereby reducing pain. He stated steroids are long-acting medications, providing an anti-inflammatory effect for several weeks. Dr. Gutti stressed Meade had been maintained on a low dose of Hydrocodone because his pain had been controlled in part by the injections. Dr. Gutti stated Meade's dosage had not been decreased following administration of the injections, but would be increased without them. Dr. Gutti acknowledged the treatment he administered is provided to manage, not cure Meade's pain. Dr. Gutti noted the dosage of Lortab had been increased to 10 mg from 7.5 mg when the workers' compensation insurer ceased paying for injections. Dr.

Gutti testified he had administered twenty epidural injections over the past ten years, which was within the standard of care. Dr. Gutti disagreed with Dr. Jenkinson's conclusions Meade's injury was more of a strain or sprain injury.

Meade submitted an undated report from Dr. Gutti indicating he currently had back pain with a radicular component. Dr. Gutti stated Meade had significant spasms in the lumbar spine because he had no recent epidural steroid injections. Dr. Gutti noted Zanaflex was prescribed for spasms and Lyrica helped the neuropathic component of Meade's pain. Dr. Gutti noted Meade was taking a minimal dose of Lortab. He stated injection therapy and Meade's current treatment regimen were reasonable and necessary for the treatment of the work injury.

Meade testified at the hearing held February 22, 2012. He stated he had treated with Dr. Gutti since 2000. Meade continued to take Lortab, Lyrica and Celebrex. He had been receiving injection therapy until approximately one year prior to the hearing, when the workers' compensation insurer ceased payment. He received injections approximately every two months which provided temporary relief. He stated medication also provided some relief from pain. Meade

testified he has never been pain free following his injury and his condition has worsened since 2003.

In the April 17, 2012 Opinion and Order, the ALJ's findings of fact relevant to this appeal were as follows:

> The defendant argues that the plaintiff had sustained only a minor low back strain and should have no need for continuing medical treatment such as that rendered in this claim in the form of injection therapy and continued medications. The defendant argues there is no evidence to substantiate anything other than the minor strain as outlined by Dr. Jenkinson and Dr. Olash. However, a review of the record indicates that Dr. Mortara, a respected neurosurgeon, had noted the plaintiff to have SI joint pain as well as a possible herniated disc. It was questioned also whether an MRI had revealed a herniated disc at the L2-3 level. While there may have been a lack of evidence of radiculopathy, even Dr. Scott felt the plaintiff had mechanical low back pain syndrome with referred leg pain. A review of the diagnostic studies further reveals that a lumbar myelogram confirmed extra dural defects at L2 through L5. It cannot be overlooked that the plaintiff has been undergoing treatment for fifteen years with the last eleven being treatment with Dr. Gutti. While the plaintiff's medication regimen has remained the same, Dr. Gutti testified that the use of injection therapy has prevented the plaintiff from having to take increasing dosages of medications. The plaintiff's own testimony was that the injection therapy provided him relief of six to eight weeks duration. The plaintiff was desirous of continuing his treatment with Dr. Gutti although he freely

> admitted he had not been pain free since the work injury. While Dr. Gutti may be incorrect in his diagnosis of radiculopathy, he was quite credible in his testimony that the treatment had provided the plaintiff relief of his symptoms and has allowed the plaintiff to participate in more activities of daily living. On the other hand, the evidence presented by the defendant simply seems to indicate that since the plaintiff had not recuperated in the fifteen years since the injury, he should no longer be entitled to relief of his symptoms. While this may not be the treatment Dr. Jenkinson or Dr. Olash would choose to give the plaintiff, I have not been convinced that necessarily means the treatment rendered by Dr. Gutti is unreasonable or unnecessary for the relief of the plaintiff's symptoms. The plaintiff is clearly happy with the treatment and there is no evidence that the medication is being abused or misused. The treatment rendered by Dr. Gutti, has been shown by his own testimony as well as the plaintiff's testimony to have provided relief from the symptoms of his work related injury. I have not been convinced that it is dangerous or outside the type of treatment generally accepted by the medical profession. Therefore, the medical fee dispute regarding the treatment with Dr. Gutti including medication and injection therapy is resolved in favor of the plaintiff.

On April 30, 2012, Elkhorn filed a petition for reconsideration raising the same arguments it now raises on appeal. In his June 11, 2012 order on reconsideration, the ALJ denied Elkhorn's petition as a re-argument of the merits. The ALJ noted Dr. Gutti indicated injection therapy

prevented Meade from taking increased dosages of medication, and the treatment permitted him to participate in more activities of daily living. The ALJ further noted Meade testified the injections provided pain relief for four to six weeks.

Elkhorn filed a medical dispute on July 20, 2012 regarding epidural steroid injections, a TENS unit and supplies. Elkhorn filed an additional dispute on November 8, 2012 contesting the compensability of Omeprazole and Lidoderm patches. The appeal of the ALJ's decision in the prior dispute was placed in abeyance pending resolution of the additional disputes.

Meade testified at the hearing held October 18, 2012, he continues to have pain in his low back and right hip. He has been receiving samples of Omeprazole and Lidoderm patches. Meade testified the Lidoderm patches enabled him to take half the recommended dosage of his oral pain medication while Omeprazole helped with the upset stomach caused by other medications.

Records from Dr. Gutti were introduced documenting treatment from April 26, 2012 through August 31, 2012 for intractable low back pain, radiculitis, right L5 radiculopathy, neuropathy and periods of aggravation of pain. Dr. Gutti prescribed Zanaflex, Mobic, Neurontin,

Lortab, Omeprazole and Zoloft. Additionally, Dr. Gutti recommended lumbar epidural injections and a TENS unit.

Elkhorn submitted the July 11, 2012 utilization review report of Dr. Peter Kirsch. Dr. Kirsch stated Meade had findings consistent with a soft tissue sprain of the low back fifteen years earlier, but the effects of the injury ceased, with no significant objective residual. Based upon Dr. Jenkinson's August 3, 2011 report, Dr. Kirsch did not believe a TENS unit and supplies would be medically necessary or reasonable for the treatment of the work injury.

Elkhorn submitted the July 26, 2012 report of Dr. John Rademaker who conducted a peer review, stating the TENS unit is not recommended for chronic low back pain and does not appear to have an impact on perceived disability or long term pain. Dr. Rademaker concluded there was no medical rationale to disagree with the utilization review denial by Dr. Kirsch.

Elkhorn filed an August 1, 2012 memorandum from Charlotte Benson of the Centers for Medicare and Medicaid Services, indicating a TENS unit is not reasonable or necessary treatment for chronic low back pain.

Elkhorn filed the November 1, 2012 utilization review report of Dr. Olash who stated prescriptions for Omeprazole

and Lidoderm patches were not related to the 1997 work injury, and not reasonable or medically necessary. Dr. Olash noted medical records strongly support the contention Meade suffered a strain/sprain, and there is no convincing evidence he has any longstanding nerve pathology due to the work injury. Further, Dr. Olash opined there was no documentation Lidoderm continues to provide a benefit.

On November 30, 2012, the ALJ found as follows:

> This particular dispute originated when the plaintiff's treating physician, Dr. Gutti, recommended the prescription of a TENS unit and supplies while the defendant's previous medical fee dispute regarding prescription medications and epidural steroid injections was on appeal. In this medical fee dispute, the defendant relies on the recommendations of Dr. Kirsch and Dr. Rademaker as well as documentation regarding Medicare policies toward the compensability of a TENS unit for chronic lower back pain. These physicians both indicate that a TENS unit is not recommended for soft tissue sprain or chronic low back pain. However, Dr. Gutti indicated he prescribed the TENS unit and supplies in an attempt to alleviate the pain for which the plaintiff was suffering and to increase strength. The recommendation for a TENS unit was added while the prior dispute regarding epidural steroid injections remained on appeal. Therefore, it is clear the plaintiff was not receiving the recommended treatment for his condition and Dr. Gutti's records clearly show that he was continuing to request the epidural injections as well. After reviewing the

entirety of the evidence as well as the prior opinion, I believe the same logic applies to the request for a TENS unit. While Dr. Kirsch recommended against the TENS unit for a soft tissue sprain, this clearly overlooks the plaintiff's prior diagnosis of herniated disc and strain with arousal of degenerative disc disease. Therefore, simply classifying the plaintiff's injury as a soft tissue sprain, is somewhat misleading. The treating physician's record and the opinion indicate his belief the plaintiff suffers from radiculopathy which was set forth in his testimony as well as his records. Given this fact, the defendant has [not] met its burden on this additional treatment recommendation.

The medical fee dispute was amended to include the recommendations for Lidoderm patches and the medication Omeprazole. In regards [sic] to the Lidoderm patch the plaintiff has been afforded samples of that product which he has found to be very helpful and allowed him to begin decreasing his usage of pain medicine. Dr. Olash indicated his opinion that there was no evidence of neuropathic pain and therefore the Lidoderm patches would not be recommended. However, as indicated in the prior opinion, Dr. Gutti testified there was electrodiagnostic evidence of radiculopathy and radiculitis. He also noted that Zanaflex was utilized because the plaintiff had significant spasms and that Lyrica helped the neuropathic component to his pain. Therefore, the treating physician [h]as indicated there is a neuropathic component to the plaintiff's pain and the plaintiff's own testimony has indicated a trial of the Lidoderm patches has been helpful in reducing his pain. Therefore, I am

> convinced that this is a reasonable and necessary medical expense under *KRS 342.020.* I am further convinced that the usage of Omeprazole is a reasonable and necessary expense to alleviate problems with the plaintiff's stomach caused by his medication usage. It is clear from a review of the entirety of the medical records that Dr. Gutti simply changed the plaintiff from Zantac to this new medication as part of his treatment regimen to help alleviate the condition of which the plaintiff indicated he suffered from taking his numerous medications.

On December 10, 2012, Elkhorn filed a petition for reconsideration arguing the ALJ's findings regarding the compensability of the TENS unit, Omeprazole, Lidoderm patches and lumbar epidural steroid injections were not supported by substantial evidence and were internally inconsistent. Elkhorn noted the ALJ found epidural injections were appropriate for radicular or neuropathic pain, which it contended was unsupported by objective evidence. Elkhorn asserted the ALJ improperly approved the TENS unit as a substitute for injection therapy since it was never intended to treat the condition for which such treatment was administered. Finally, Elkhorn argued the ALJ's finding regarding Omeprazole was not supported by substantial evidence.

By order dated January 17, 2013, the ALJ denied Elkhorn's petition for reconsideration as a re-argument of the claim.

On appeal, Elkhorn argues the ALJ cited the correct legal standard regarding medical fee disputes but applied an incorrect standard in reaching his decision. The ALJ indicated he had not been convinced Dr. Gutti's treatment is "dangerous or outside the type of treatment generally accepted by the medical profession." Elkhorn observes there is no requirement the treatment be "dangerous" before the treatment is determined non-compensable. Instead, the determination must be based upon whether the treatment is reasonable or necessary for the cure or relief from the effects of the injury. Here, Dr. Gutti acknowledged his treatment did not provide a cure for Meade's condition. Thus, Elkhorn contends the determination turns upon whether the treatment is providing relief. Elkhorn argues the evidence from Dr. Olash establishes the injection therapy is risky and does not provide any real benefit to Meade.

Elkhorn argues the ALJ's decision is not supported by substantial evidence. Elkhorn contends Dr. Gutti's notes and testimony do not support the ALJ's finding injection therapy prevented Meade from having to take increasing dosages of medication and provided enough relief to

participate in more activities of daily living. Elkhorn notes Meade's dosage was never reduced following the administration of injections. Elkhorn asserts Dr. Gutti's statement the injections prevented increased dosages is pure speculation. Elkhorn requests the Board to remand this matter to the ALJ for review using the correct standard to determine the reasonableness and necessity of the contested medical treatment, Elkhorn argues the ALJ should be directed to find the testimony of Dr. Gutti is not evidence of substance upon which to find the contested treatment reasonable and necessary.

In a post-award medical fee dispute, the burden of proof regarding the reasonableness and necessity of treatment is with the employer. *See* KRS 342.020; Mitee Enterprises vs. Yates, 865 S.W.2d 654 (Ky. 1993); National Pizza Company vs. Curry, 802 S.W.2d 949 (Ky. App. 1991). However, the burden remains with the claimant concerning questions of work-relatedness or causation of the condition. *See* Addington Resources, Inc. vs. Perkins, 947 S.W.2d 421 (Ky. App. 1997). Concerning the contested treatment, Elkhorn had the burden to prove the medical treatment was not reasonable and necessary for the treatment of Meade's work injury. Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Since the ALJ found in Meade's

favor, the standard of review on appeal is whether the evidence compelled the result Elkhorn now seeks. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984).

The ALJ, as fact-finder, is the sole judge of the weight and inferences to be drawn from the evidence and determines the quality, character, and substance of the evidence. *See* Square D Company v. Tipton, 862 S.W.2d 308 (Ky. 1993). The ALJ may reject any testimony and believe or disbelieve various parts of the evidence. *See* Magic Coal Co. v. Fox, 19 S.W.3d 88 (Ky. 2000). Where the evidence is conflicting, the ALJ may choose whom or what to believe. Pruitt v. Bugg Brothers, 547 S.W.2d 123 (Ky. 1977). Although an opposing party may note evidence supporting a conclusion contrary to the ALJ's decision, such evidence is not an adequate basis for reversal on appeal. McCloud v. Beth-Elkhorn Corp., 514 S.W.2d 46 (Ky. 1974).

On appeal, Elkhorn outlined evidence which could have supported a determination the ongoing treatment is non-compensable. Elkhorn seeks to have this Board impermissibly make a factual determination. Much of Elkhorn's argument centers on its argument the contested treatment provided no cure or long-term benefit. However, non-curative treatment is compensable if it is palliative.

In National Pizza v. Curry, *supra*, the Kentucky Court of Appeals held:

> We are convinced that our legislature by using the conjunctive "and" did not intend that only one who has sustained a "curable" work-related injury or disease should be entitled to medical benefits for relief therefrom. Accordingly, we hold that the words in KRS 342.020(1) "cure and relief" should be construed as "cure and/or relief." See KRS 446.080 and Firestone Textile Company Division, Firestone Tire and Rubber Company v. Meadows, Ky., 666 S.W.2d 730 (1984), which states that "[a]ll presumptions will be indulged in favor of those for whose protection the enactment [the Workers' Compensation Act] was made." Id. at 732. Thus KRS 342.020(1) requires the employer of one determined to have incurred a work-related disability to pay for any reasonable and necessary medical treatment for relief whether or not the treatment has any curative effect. Id. at 951.

Based on the testimony of Dr. Gutti and Meade, the ALJ found the injection therapy provided relief for a number of weeks. Their testimony constitutes substantial evidence supporting the ALJ's determination the contested medical treatment is reasonable and necessary.

Contrary to Elkhorn's assertions, the ALJ applied the correct standard in finding the contested treatment compensable. In the April 17, 2012 opinion, the ALJ clearly identified evidence from Dr. Gutti establishing the

treatment provided relief. Further, the ALJ stated the evidence presented by Elkhorn "simply seems to indicate that since the plaintiff had not recuperated in the fifteen years since his injury, he should no longer be entitled to relief of his symptoms." The ALJ indicated Elkhorn's evidence did not persuade him the contested treatment was unreasonable or unnecessary. It is clear from the ALJ's June 11, 2012 order the ALJ rejected Elkhorn's argument it had shown the treatment was unreasonable and/or unnecessary. In the November 30, 2012 opinion, the ALJ specifically found Lidoderm patches and Omeprazole were reasonable and necessary medical expenses. The ALJ discussed the conflicting opinions of Dr. Gutti, Drs. Kirsch and Rademaker regarding the TENS unit and found Dr. Gutti more persuasive. The ALJ, faced with conflicting evidence as to the reasonableness and necessity of the contested expenses, found Drs. Gutti and Meade's own testimony more persuasive.

While the ALJ noted the treatment rendered by Dr. Gutti had not been shown to be dangerous or outside the type of treatment generally accepted by the medical profession, that was not the sole basis for his finding of compensability. The ALJ appropriately enunciated the determination of compensability is based upon whether the contested treatment is reasonable and necessary for the cure and relief of the

work injury. There being substantial evidence to support the ALJ's determination, a different result is not compelled, and it will not be disturbed.

Accordingly, the April 17, 2012 Opinion and Order, the November 30, 2012 Opinion and Order and the June 11, 2012 and the January 17, 2013 orders on reconsideration rendered by Hon. John B. Coleman, Administrative Law Judge, are **AFFIRMED**.

STIVERS, MEMBER, CONCURS.

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