Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: November 13, 2013

CLAIM NO. 200594085

IVA REED PETITIONER

VS. **APPEAL FROM HON. STEVEN G. BOLTON, ADMINISTRATIVE LAW JUDGE**

UNIVERSITY OF KENTUCKY MEDICAL CENTER
DR. WILLIAM SHAFFER
DR. WILLIAM WITT
and HON. STEVEN G. BOLTON,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

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

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

STIVERS, Member. Iva Reed ("Reed") appeals from the December 20, 2012, opinion and order of Hon. Steven G. Bolton, Administrative Law Judge ("ALJ Bolton") denying her motion to reopen seeking an increase in income benefits and medical benefits from the University of Kentucky Medical

Center ("UK") and resolving three medical fee disputes in favor of UK. Reed also appeals from the August 1, 2013, "order denying petition for reconsideration as amended."

Reed's Form 101 filed December 12, 2005, and subsequent amendment thereto alleged on January 6, 2004, August 30, 2005, December 21, 2005, and March 14, 2006, she sustained injuries to her knees and lower back. At the time of her injury, Reed was employed in the medical records division at UK.

On August 17, 2007, Hon. Marcel Smith, Administrative Law Judge ("ALJ Smith") rendered an opinion and award determining, based on the opinions of Dr. Daniel Primm, Reed sustained a right knee injury resulting in a 1% impairment and a low back injury meriting a 5% impairment.[1] ALJ Smith concluded KRS 342.730(1)(c)1 was applicable and enhanced Reed's permanent partial disability ("PPD") benefits by the three multiplier.

During the initial proceedings before ALJ Smith and thereafter, Reed was treated by various physicians at UK but primarily by Dr. William Shaffer. After reviewing her x-rays and an MRI of the lumbar spine, a January 12,

[1] In a September 27, 2007, order, ALJ Smith amended her opinion and award to reflect she found a 1% impairment was due to work-related knee complaints. She also corrected the date the opinion was rendered to reflect August 17, 2007.

2009, note reveals Dr. Shaffer recommended Reed undergo a left foraminal discectomy and bilateral recess decompression foraminotomies for lateral recess stenosis.

On March 19, 2009, UK filed a motion to reopen and to join Drs. Shaffer and William Witt, and two Forms 112, medical fee disputes. In the motion to reopen, UK asserted Dr. Shaffer had requested authorization to perform the heretofore mentioned surgery and a physician's utilization review report dated February 17, 2009, concluded the treatment was not related to the work injury.[2] Accordingly, it was contesting the compensability of the proposed surgery on the grounds it is not causally related. It also stated Dr. Witt had prescribed several medications including Lyrica and Lamictal and a physician's review report of November 2, 2008, established the medications were not related to the work injury. Attached to the Form 112 disputing the need for the surgery was the physician's review report of Dr. Peter Kirsch who indicates he reviewed the information in the chart and noted Reed had suffered from injuries on August 30, 2005, consistent with low back strain superimposed upon pre-existing non-work-related degenerative changes. He referenced Dr. Primm's

[2] Dr. Shaffer's February 18, 2009, letter reveals he was advised on February 17, 2009, UK's carrier was "denying this procedure."

examination on July 18, 2006, which identified no neurologic compromise and no evidence of radiculopathy. Dr. Kirsch opined that more likely than not the active effects of any injuries suffered on August 30, 2005, ceased as the tissues were healed and Reed returned to pre-injury status. He did not believe Reed's current complaints of low back pain and radiculopathy were related to the 2005 work injury, and more likely than not reflected pre-existing advanced degenerative changes.[3]

To the Form 112 relating to the contested medications, UK attached the report of Dr. Patricia Blackwell. Based on the available documentation as well as her discussion with Dr. Witt, Dr. Blackwell concluded the use of Lamictal and Lyrica did not appear to be related to the 2005 work injury.[4]

On April 3, 2009, Hon. J. Landon Overfield, Chief Administrative Law Judge ("CALJ") entered an order sustaining the motion to reopen, joining Drs. Shaffer and Witt as parties and giving them twenty days to respond to the motion.

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[3] UK later filed the signed report of Dr. Kirsch dated February 17, 2009.

[4] Because Reed does not contest ALJ Bolton's decision regarding the contested medications, we will not discuss the evidence relating thereto.

Reed, *pro se*, filed a response which included the March 30, 2009, letter of Dr. Shaffer and the April 16, 2009, letter of Dr. Witt. In his letter, Dr. Shaffer, a professor and vice-chairman and residency program director in the Department of Orthopedic Surgery, stated he had followed Reed for some time and she clearly had an injury to her back that included a radicular component and although in the early evaluation they were unable to find a disc herniation, an injury to the annulus was noted in earlier studies. Reed was treated conservatively because they could not find a clear cut surgical lesion. Over time Reed underwent selective nerve blocks which confirmed she had radiculopathy at the L3 level. Her most recent MRI revealed "a disc herniation into the foramen at the L3-4 level, consistent with all her symptoms from the 2005 workers compensation injury up to the date of her surgery." Reed's post-operative course was marked by improvement in her radiculopathy and improvement in her overall medical condition. Dr. Shaffer felt her 2005 injury was an annular injury that subsequently developed a disc herniation over time. He believed this was a reasonable and well-founded hypothesis based on the natural history of degenerative disc disease. Dr. Shaffer asked for a "re-review of the

denial for care" since Reed's disc herniation was "causally and temporally related" to her work injury at UK.

On May 19, 2009, the dispute was assigned to Hon. Joseph Justice, Administrative Law Judge ("ALJ Justice").

Thereafter, UK filed the report of Dr. Gary T. Bray. After conducting an examination and reviewing x-rays of the lumbar spine, Dr. Bray concluded Reed was on a "plethora of medications" which she did not need. Based on the information he received, Dr. Bray concluded the March 2009 surgery was not medically necessary. Further, he did not feel the diskectomy was related to Reed's "multiple falls." He noted she had an MRI in June 2007 that did not show any disk disease. Based on Reed's multiple medical complaints over a long period of time Dr. Bray concluded she was a "very poor candidate for surgical intervention."

UK filed Dr. William Mitchell's utilization review report concerning the surgery. His February 11, 2009, handwritten note indicates the surgery planned was denied based on the following rationale: "due to chronic degenerative spine and disc disease, fibromyalgia and lymphedema and are not work related, the requested service is not directed at treating a work injury."

UK filed portions of the record filed during the initial litigation before ALJ Smith which included the

reports of Dr. Primm, Dr. David Shraberg, and Dr. David Changaris. It also filed the records of Dr. Witt which Reed filed in the original litigation pertaining to nerve root injections administered on the right at L5 and other treatment she received.

It appears Reed filed the June 15, 2010, independent medical evaluation ("IME") report of Dr. Michael Heilig in which he assessed pursuant to the 5th Edition of the American Medical Association, Guides to the Evaluation of Permanent Impairment ("AMA Guides"), a 14% impairment rating for her post-surgery work-related back condition and her knee condition. Dr. Heilig provided future treatment she may require and permanent work restrictions.

UK filed the physician review report of Dr. Albert Olash, Jr. regarding the work-relatedness and medical necessity for Trammadol, Topamax, Hydrocodone, Lidoderm, and Flector patches. Dr. Olash discussed Reed's prior history and the nature of her injury as determined by Dr. Primm. After discussing the treatment Reed received from Dr. Cassidy and at UK, Dr. Olash concluded Reed had suffered a fairly minor work injury in August 2005. He stated her claim went before an ALJ and was settled for impairment ratings of 1% for the knee and 5% for the back.

There was no history of herniated disc or radicular problems following the injury. Reed subsequently developed back problems requiring surgery which was not due to the work injury. Reed is being treated for fibromyalgia, pererforal neuropathy, cervical radiculopathy, and severe depression; none of which are due to the work injury. Therefore, the medications were not medically necessary and appropriate for the work injury.

UK filed the April 28, 2011, report of Dr. Cassidy in which he noted Reed had significant pain in her low back, feet, and both legs. He noted an MRI and EMG of both lower extremities were performed within the past few weeks and she was very frustrated because of a myriad of issues with her knees. Most of Reed's pain occurs when she sits or stands and she gets some pain relief with walking and feels no numbness or tingling in her legs when lying down. After reviewing the MRI, Dr. Cassidy concluded Reed had minimal disc degeneration post-surgery and the EMG and nerve conduction velocity ("EMG/NCV") of both lower extremities was without evidence of radiculopathy, nerve compression, or neuropathy. He saw nothing in the lower back which would cause Reed's bowel or bladder issues. Dr. Cassidy concluded some of the pain and neurological issues could be due to a thoracic spinal cord lesion which would

be very unusual. Since she had not had an MRI of the thoracic spine in five years, he recommended a repeat of this procedure. Dr. Cassidy had nothing else to offer her surgically.

On May 16, 2011, ALJ Justice conducted a hearing pertaining to the medical fee dispute which was attended by Reed and UK's counsel. Reed testified regarding the medication she is currently taking and her current physical problems. Reed also discussed various medications she had stopped taking as a result of UK's refusal to pay for her medication. Reed introduced nine exhibits which included medical bills and records relating to her treatment.

Thereafter, Reed obtained counsel who on June 7, 2011, filed a notice of representation, a motion to set aside the hearing and briefing order, and a motion to reopen asserting there had been a worsening of Reed's condition since the August 21, 2007, decision and seeking an award of additional income and medical benefits. Attachments to the motion included Reed's affidavit and the operative report and discharge summary of Dr. Shaffer. Also attached were Dr. Shaffer's February 18, 2009, and March 30, 2009, letters, Dr. Cassidy's January 26, 2011,

letter, and the report of Dr. Heilig which had been previously introduced.[5]

Dr. Shaffer's operative report reflects a diagnosis of left L3-L4 foraminal herniated nucleus pulposus and lumbar stenosis at L3-L4. The procedure performed was "Microdiskectomy at L3-L4 with Michael decompression of the left L3 and L4 nerve roots and the right L4 nerve root." The indication for the procedure was Reed's long-standing problem with anterior thigh pain. She had been treated conservatively for almost two years and recently her pain increased. A repeat MRI showed a change of a foraminal disk at the L3-L4 level. Reed had selective nerve blocks which had been of benefit and presented for decompression bilaterally with L3-L4 foraminal discectomy.[6]

By order dated July 6, 2011, ALJ Justice sustained Reed's motion to reopen, set aside the order of submission and directed the matter would be considered along with the reopening on the merits.

On August 4, 2011, UK filed a medical fee dispute concerning the compensability of the post-surgery EMG/NCV

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[5] Dr. Cassidy's letter noted Reed's history of injuries to her back and knees and that she had been taken off work and surgery was performed by Dr. Shaffer.

[6] Dr. Shaffer's February 18, 2009, letter addressed "To Whom It May Concern" merely noted Reed's surgery scheduled for February 18, 2009, was canceled on February 17, 2009, because UK's carrier had denied the surgery.

studies asserting they did not relate to the work injury. UK relied upon Dr. Kirsch's March 31, 2011, report which it previously filed in the record. It also disputed the bill for the tests because it was not submitted within forty-five days of service.

In response to Reed's motion to reopen, UK introduced the November 28, 2011, report of Dr. Timothy Kriss generated after conducting an examination and reviewing various records and diagnostic studies. Dr. Kriss stated Reed is status post left L3-L4 diskectomy for treatment of left L3-L4 foraminal herniated nucleus polpusus which was compressing the left L3 exiting nerve root and bilateral L3-L4 hemilaminectomy/lateral recess decompression for treatment of lumbar stenosis at L3-L4. With respect to causation, Dr. Kriss stated as follows: "Causation: L3/L4 Diskectomy Surgery: 'Wrong Level' and 'Wrong Side.'" He was not convinced Reed had a correlating left L3 lumbar radiculopathy before, during, or after the March 4, 2009, surgery. Nor did he believe Reed's L3-L4 disk herniation and subsequent surgery at that level had anything to do with her previous work injuries. Dr. Kriss noted on March 29, 2006, Dr. Shaffer saw Reed in a follow-up of her MRI and EMG and determined the EMG was negative but noted the MRI showed a left foraminal disk herniation.

However, Dr. Shaffer failed to designate which lumbar level had a foraminal disk herniation. He also omitted any description of Reed's symptoms. Although Dr. Kriss did not have the February 20, 2006, lumbar MRI report available, he noted the neuroradiologist who interpreted Reed's July 14, 2006, lumbar MRI scan had the February 20, 2006, lumbar MRI scan available and stated the foraminal disk protrusion was on the right at L4-5. Dr. Kriss stated, in other words, the foraminal disk herniation for which Dr. Shaffer considered surgical intervention in March 2006 was at a completely different level, the L4-5 level, than the L3-L4 level where the 2009 surgery was performed. Further, the February 2006 foraminal disk herniation was on Reed's right side completely opposite the eventual left-sided L3-4 diskectomy in 2009. He stated "[t]hus we have an atrocious and absolute lack of correlation" between the disk pathology as imaged on MRI scanning relative to the eventual surgery. Dr. Kriss stated "the 2009 surgery is performed on the 'wrong' side (LEFT) as well as the 'wrong' level (L3/L4)." He stated making matters even worse the interim follow-up lumbar MRI scan from July 2006 "emphatically documents (spontaneous and complete) RESOLUTION of the right L4/L5 foraminal disk protrusion." He also noted neither the February 2006 nor the July 2006

lumbar MRI scans reveal any disk pathology at the L3-L4 level. Since both studies obviously post-date all of Reed's work injuries, the L3-L4 lumbar diskectomy surgery in 2009 cannot in any way be causally connected to the 2004 and 2005 work injuries. Dr. Kriss noted in September 2006 a lumbar MRI indicated surgery was not required as the report indicated the MRI was almost "normal looking." Therefore, clinically and radiographically Reed's potential lumbar disk problems unequivocally ended as of the September 6, 2006, evaluation of Dr. Cassidy. Dr. Kriss pointed out Dr. Cassidy stated the right L4/L5 disk protrusion has resolved and is not pathologic. Further, there was no disc pathology whatsoever at the L3-L4 level. He stated Dr. Cassidy could not see anything else that could be causing Reed's pain.

Dr. Kriss stated as follows: "almost every point raised by Dr. Shaffer in March 30, 2009 postoperative 'appeal letter' is 'just plain wrong.'" He noted Reed had three lumbar work injuries in 2004 and 2005 but none of those injuries were associated with any radicular symptoms much less radicular findings. Further, there was no disk herniation with correlating nerve root compression causing radiculopathy. There was no documentation of radicular pain, sciatica, "or anything remotely

dermatomal/radicular." He noted Reed attended dozens of physical therapy evaluations in the six months immediately after December 21, 2005, and not once complained of radicular pain in either leg or specific left L3 radicular pain. Therefore, he concluded Dr. Shaffer's presumption Reed had left L3 correlating radicular leg pain from the time of her 2005 work injury until the 2009 surgery is "emphatically wrong."

Dr. Kriss observed Dr. Shaffer noted he and Dr. Cassidy were unable to find any disc herniation or surgical lesion in their early evaluation. In response to that statement, Dr. Kriss stated "the obvious;" if Reed did not have a disc herniation or surgical lesion after her 2004 and 2005 work injuries then surgery for a new disk herniation arising years later, cannot be attributed to those work injuries. Dr. Kriss also noted Dr. Shaffer cited Reed's response to selective L3 nerve root blocks as medical evidence of L3 radiculopathy and justification for the L3-L4 diskectomy. However, he believed the main problem with that line of reasoning is that Reed never underwent left L3 nerve blocks. The only nerve blocks performed on Reed were right-sided at the L5 level in 2007 at UK's Interventional Pain Associates Clinic. Therefore, he opined Dr. Shaffer's primary diagnostic test and

resulting primary diagnosis are both completely wrong as he had diagnosed radiculopathy on the wrong side of the body, left instead of right, and at the wrong lumbar level, L3 instead of L5. He opined the diskectomy surgery was not medically necessary or reasonable based on Reed's selective nerve root blocks "which are egregiously misinterpreted by Dr. Shaffer, and therefore cannot possibly serve as medically reasonable justification for L3/L4 diskectomy surgery."

Dr. Kriss addressed Dr. Shaffer's "causation hypothesis" that injury to the (left L3/L4 disk) annulus was noted in Reed's early diagnostic studies, and this forms "the anatomic basis for years-later development of a new left L3/L4 disk herniation necessitating discectomy surgery." He noted the problem is that no annular injury was ever noted in any of Reed's multiple post-injury lumbar MRI scans from 2005 and 2006. All three of Reed's immediate post-injury lumbar MRI scans were completely negative for any L3/L4 annular tear or injury. Therefore, Dr. Shaffer's premise of a work-related annular injury at L3/L4 "is simply not true" and his hypothesis a work-related L3/L4 annular injury will years-later cause a work-related disk herniation cannot be true since there was "no L3/L4 annular injury to begin with."

Lastly, Dr. Kriss noted Dr. Shaffer stated it is an expected "natural history" for a post-traumatic work-related annular disk injury at L3/L4, shown on Reed's early diagnostic studies, will subsequently cause a symptomatic disk herniation at that level years-later necessitating surgery. Dr. Kriss opined "if 'this reasonable and well founded hypothesis' is true, then Dr. Shaffer needs to publish all of his supporting objective medical evidence," because Dr. Kriss was unaware of any medical text book, Journal or article supporting "such a hypothesis, much less 'proving' any such hypothesis within a reasonable degree of medical probability." Dr. Kriss concluded as follows:

> Even today, Ms. Reed's lower extremity symptoms are unequivocally nonradicular, much less specifically consistent with left L3 radiculopathy, and she states that her current symptoms are exactly the same today as what she had prior to the March, 2009 diskectomy surgery. Any attempt to correlate Ms. Reed's lower extremity symptoms with a need for left L3/L4 disckectomy is nothing short of abysmal. Nor has Ms. Reed even once demonstrated a single objective medical finding of left L3 radiculopathy. Never mind the fact that neither the February, 2006 nor the July, 2006 MRI scan ever revealed even the smallest disk herniation on the left at L3/L4.

With regard to her psychological problems, Dr. Kriss noted Reed is "overflowing with psychopathology." He concluded as follows:

> All of these conditions (panic attacks, anxiety, depression, symptom magnification, and somatization) fabricate symptoms;
>
> all of these 5 conditions greatly exaggerate any true physical symptoms;
>
> all of these conditions transform unresolved psychological stress into purely psychosomatic body "symptoms";

Dr. Kriss could not assign an increased impairment "on the basis of worsening subjective complaints only." However, in accordance with the AMA Guides, Dr. Kriss stated Reed's lumbar impairment rating had increased from 5% to 10% as a direct consequence of the 2009 left L3/L4 lumbar diskectomy surgery. Since the surgery was not in any way causally related to Reed's original 2004/2005 lumbar work injuries, the additional 5% whole person impairment is not related to the work injuries. He believed Reed's increase in her impairment rating is a consequence of age-appropriate, naturally occurring degenerative disk disease, lumbar facet hypertrophy from osteoarthritis, and lumbar spondylosis, not any work injury.

Dr. Kriss stated Reed may benefit from a simple lumbar corset, reinforced lumbar support or “warm and form” type brace, mostly as a preventative measure to minimize future flare ups. The brace should not be worn all the time but only when driving or physically active “as a preventative mechanical measure.” Reed needed to engage in a daily home exercise program in order to minimize deconditioning, minimize secondary musculoskeletal complaints, and to maximize function. She also needed to lose weight as she is morbidly obese which Dr. Kriss believed was directly responsible for her meralgia paresthetica, likely responsible for her adult onset diabetes, and is most certainly contributing to her chronic back pain.

In response, Reed filed various medical reports of Drs. Shaffer, Witt, Cassidy, Robert Hosey, J.A. Jagger, J. Grider, and Karen Swartz. Dr. Hosey’s record consisted of the report concerning the March 16, 2005, MRI of the lumbar spine without contrast which revealed a mild symmetric disc bulge at L3-4. There was only mild to minimal central canal narrowing. The impression was, in relevant part, mild degenerative disc disease in the lumbar spine with only mild central canal and neural foraminal

narrowing as well as mild to moderate degenerative facet disease in the lower lumbar spine.

Dr. Cassidy's February 8, 2006, record reveals a March 2005 MRI was reviewed which showed a very small forward left L3-4 disc herniation without neural impingement. Dr. Cassidy stated this was somewhat confusing as the pain Reed was experiencing was not explained by any findings on examination or radiographs. He would like to obtain a new MRI with contrast and believed an EMG/NCV was necessary to see if diabetic neuropathy was Reed's problem.

At the bottom of Dr. Cassidy's report is Dr. Shaffer's "attending addendum" indicating he had seen Reed on an urgent consultation from Dr. Witt for bilateral leg pain. Dr. Shaffer noted Dr. Witt had been treating Reed with injection and she had gotten no better. The MRI conducted in March 2005 showed some mild asymmetry of the L3-4 disc and possible small protrusion on the left which appeared to be benign. Reed's symptoms appeared to be primarily right-sided. He noted diabetic neuropathy may be the problem but they would move ahead with an EMG/NCV and repeat an MRI of the lumbar spine.

The February 28, 2006, MRI of the lumbar spine requested by Dr. Cassidy revealed moderate size right paracentral foraminal L4-5 disc herniation.

Dr. Shaffer's March 29, 2006, note reflects the EMG was negative and there was no evidence of diabetic neuropathy. The MRI revealed a left foraminal disc herniation. Reed was having increased symptoms.

Dr. Cassidy's April 5, 2006, note reflects Reed was seen for a follow-up on her disc herniation. She continued to have slightly rightward symptoms but had a L4-5 disc herniation on the left. Dr. Cassidy prescribed medication and a back strengthening and stretching program. He indicated he would see Reed in six to eight weeks.

Dr. Shaffer's May 31, 2006, note reveals Reed continued to be symptomatic with bilateral leg pain and the study revealed a left lower small disc protrusion. He did not believe back surgery would be helpful and recommended Reed continue with her program.

The November 20, 2006, letter of Dr. Swartz, a professor with the neurosurgery department, reveals she saw Reed on that date for a second opinion. Reed informed her she was seen by Dr. Cassidy and was told she had an L4-5 disc herniation as evidenced by the February 2006 MRI. A July 2006 MRI indicated the condition had improved and was

essentially normal. Reed was returned to work without restrictions but felt limited by her pain. Dr. Swartz reviewed the MRI scan of July 14, 2006, which showed the small right L4-5 disc protrusion had resolved, and noted the imaging of the MRI spine was very unremarkable. Dr. Swartz recommended she continue with treatment and since Reed had no surgical lesions, recommended treatment with Dr. Witt. She stated she agreed with Drs. Shaffer and Cassidy there were no surgical lesions.

Dr. Shaffer's December 13, 2006, note reflects Reed continued to be symptomatic. His concern was they were dealing with a foraminal disc at the L4-5 causing the right L5 radiculopathy and a left L3-4 foraminal disc causing an L4 radiculopathy. Dr. Shaffer noted this would be an unusual situation but may explain the complexity of Reed's case. He would discuss with Dr. Witt performing selective nerve blocks which might be helpful.

The October 22, 2008, lumbar MRI without contrast revealed a mild multi-level degenerative disc disease and facet hypertrophy mostly prominent at L3-4 and L4-5, on the L3-4 a small left posterolateral disc protrusion with mild left foraminal narrowing, and T12-L1 small posterior central disc protrusion superimposed upon high intensity zone compatible with annular tear.

Dr. Shaffer's October 30, 2008, note reflects Reed's MRI showed a foraminal disc at L3-4 on the left and some foraminal stenosis on the right. There was a central L5-S1 disc bulge with an annular tear. He noted with these findings and based on Reed's pain, it may be that the L3-4 level is her symptomatic level. Dr. Shaffer stated he would consider a repeat selective nerve block, first on the left at L3-4, and possibly on the right. He concluded if they can show this segment is the cause of Reed's ongoing symptomology they would finally have a potential for resolution of Reed's chronic pain.

Dr. Grider's reports relate to a nerve root injection at the L3 and L4 level on the left performed on December 11, 2008, and an L4-L5 single nerve root injection performed on December 18, 2008, on the right side.

Dr. Shaffer's January 12, 2009, report indicates he saw Reed following the selective nerve blocks and noted she had significant relief of her leg pain with both the left and right selective L3 nerve blocks which would indicate a foraminal disc and stenosis are a significant issue. He will obtain a new x-ray, scoliosis series, and flexion extension series to make sure there is no structural lesions. Dr. Shaffer noted the decompression of the L3 nerve roots appear to be a significant potential for

controlling Reed's symptoms. An addendum to the report reflects they had reviewed the x-rays and MRI and the plan was to move ahead with the surgery which he ultimately performed.

At the October 3, 2012, hearing, Reed testified she had been employed in the medical records department at UK Medical Center and recounted how the March 2006 injury occurred. Reed acknowledged UK's carrier paid her bills for the March 2006 injury. She testified Underwriter's Safety & Claims directed her to see Dr. Jagger who was "over employee health."[7] Dr. Jagger set up the medical appointments "through the company." Reed testified the workers' compensation carrier set up her appointments with the UK physicians for treatment of her work injuries. Dr. Jagger sent her to Dr. Hosey who set up physical therapy for her knees and back. Reed was sent to Dr. Tim Wilson who performed surgery on her left knee. UK "assigned" her to Dr. Shaffer who she initially saw in 2005 and continued to see until 2010 or 2011.

[7] Within the medical records filed on January 6, 2012, is a Worker Care Return to Work Report completed by Dr. J.A. Jagger on March 14, 2006. Dr. Jagger described the work incident and noted it aggravated her back pain and right shoulder. His diagnosis was "HNP L4-L5 and L3-L4." Reed was to see Dr. Shaffer on March 28, 2006, and remain off work for a week and would be rechecked then.

Reed returned to work in 2006 and was fired in January 2007. After 2007, Reed's condition gradually worsened and she returned to Dr. Shaffer in 2008. Dr. Shaffer ordered an MRI because she could not sit or walk. Dr. Shaffer's request for approval of surgery was denied by the workers' compensation carrier. Reed testified UK directed her to see Dr. Shaffer and she did not know the basis for the denial of the proposed surgery. Because she was in so much pain, Reed underwent surgery and her private insurance paid for it.

After the surgery, Reed felt much better. She could sit for longer periods of time and could walk longer without using a cane. In 2010, her condition began to worsen and she returned to physical therapy. Reed's leg had weakened and her pain was worse. She is unable to sit for long periods. She explained she has numbness in both legs and pins and needle sensations in two toes on the left foot and three toes on the right foot. Since June 2011, she has experienced "lots of pain." She cannot perform any of her previous jobs and cannot do any of the work she did prior to August 17, 2007. In 2007, Reed was able to walk the length of the hospital and now she cannot. Because her back hurts she spends most of her days in a reclining or lying position. She has trouble sleeping and her pain

prevents her from sitting for more than thirty minutes. Reed believed that as of 2009, Dr. Shaffer and, Dr. Grider her pain therapist, possessed the most knowledge about her condition.

In his analysis, ALJ Bolton noted UK filed a medical fee dispute relying upon the opinions of Dr. Peter Kirsch asserting the surgery was not related to the work injury. Further, even though utilization review resulted in UK's refusal to pay for the surgery, Reed elected to undergo the proposed surgery on March 4, 2009, which was paid for by her health insurance carrier.

ALJ Bolton analyzed the medical evidence regarding the necessity for and work-relatedness of the surgery as follows:

> The surgery was recommended and performed by Dr. William Shaffer, an orthopedic surgeon who was on staff at the University of Kentucky Medical Center at the time, and thus eligible to treat the Plaintiff under the terms of the University's workers compensation program. As pointed out by the Plaintiff, Dr. Shaffer was originally averse to surgical intervention, but was apparently turned around in his opinion by a repeat MRI of the lumbar spine dated 10/22/2008. In his March 4, 2009 Operative Report, Dr. Shaffer stated that the repeat MRI demonstrated a small left posterolateral disc protrusion with a mild left foraminal narrowing. That narrowing did not exist pre-August 17,

2007 as demonstrated by an MRI on that date. The evidence of the foraminal disc at the L3-L4 level was the reason for the microdiscectomy surgery of 3/4/2009 in order to decompress the pressure exerted by the herniated discs at L3-L4 and the lumbar stenosis at L3-L4.

Dr. Shaffer is the primary source of support for Plaintiff's contention that her 3/4/2009 surgery flowed out of her original work-related injuries.

On the other hand, Drs. Kirsch, Mitchell and Bray did not believe that the Plaintiff's 3/4/2009 surgery was either medically necessary or related to her work as more specifically set out in the summation of evidence set out herein above.

As noted in Plaintiff's brief, Dr. Timothy Kriss, M.D., a neurosurgeon, rendered an IME at the request of the Defendant Employer that rather emphatically rebutted Plaintiff's assertions that her current problems arise out of the original work-related injury. Dr. Kriss opines that the surgery advised and performed by Dr. Shaffer on 3/4/2009 was neither medically necessary nor work related. Although Dr. Kriss assigns a wpi to the Plaintiff of 10% (1/2 of that being attributable to the prior existing injury), he also states that the additional 5% is solely attributable to the 3/4/2009 surgery performed by Dr. Shaffer.

In truth, although one might perceive Dr. Kriss' criticisms as being couched in overly critical language, his analysis is supported by every other physician who addressed the issue, except Dr. Shaffer.

Dr. Cassidy first saw the Plaintiff post 2006 on 4/28/2011 when she came in with continuing complaints of back pain and a new complaint of fecal incontinence. He, like Dr. Shaffer, had been a treating physician to the Plaintiff. Her physical examination was normal as to the cervical and lumbar shell, including all reflexes. Her most recent MRI of the lower extremities was “very benign appearing”. There was nothing on the lumbar MRI that would cause any sort of bowel or bladder issues. He also noted minimal disk degeneration status post L3-4 diskectomy, which he characterized as “very clean”. The EMG and nerve conduction studies were also “without any evidence of radiculopathy, nerve compression or neuropathy. He had nothing else to offer her surgically.

Dr. Swartz, a neurosurgeon who saw the Plaintiff in 2006, diagnosed her with Fibromyalgia or some other connective tissue-type disorder (differential of her diffuse pain), and Peripheral neuropathy (dysesthesia in her legs).

Dr. Swartz’s recommendations included weight loss, water therapy (for stretching and strengthening), anti inflammatories and pain management with Dr. Witt. Dr. Swartz also recommended that her primary care physician, Dr. Michael Huang, investigate peripheral neuropathy with a metabolic work-up including HB-A1C, thyroid studies, folate, B12, etc. Dr. Swartz did not recommend surgical intervention.

Dr. Witt, a pain management specialist, is not qualified to make a judgment as to the efficacy of the 3/4/2009 surgery, but did note “She

(Plaintiff) has undergone a surgical procedure as a result of the work-related issue. This type of operation produces scar tissue that often results in neuropathic pain. Indeed she has pain that is radiating into her lower extremities in a radicular fashion".

Dr. Heilig, whose report is almost completely useless, examined the Plaintiff on June 15, 2010. He did not attempt to determine if the Plaintiff's post award surgery was related to her injuries of 1993-2006. He did not discuss his rationale for assigning 100% of his assessed wpi to "this work related injury". Neither did he distinguish or define what "this work related injury" is. Finally, there is no indication in his report that he reviewed any of the Plaintiff's medical records, appearing to rely almost completely on the history given to him by or on behalf of the Plaintiff and his own physical examination.

Pursuant to the AMA *Guides to the Evaluation of Permanent Impairment,* 5th Edition, Dr. Heilig assigned a 14% whole person impairment due to her "work-related injuries", apportioning 13% for the lumbar spine and 1% for the knee, but completely neglecting to further apportion those ratings between the pre and post award dates. He mentioned the 3/4/2009 surgery in passing, his reference being only to the history given to him by the Plaintiff.

Dr. Bray, upon physical examination of the Plaintiff and x-ray, stated the findings were essentially normal. Dr. Bray also noted the June, 2007 MRI that did not show "any disk disease". He opined that the March, 2009 surgery was not medically

> necessary and was not related to her multiple falls. Based on her history of "a plethora of medical complaints over a long history of time, she would be a very poor candidate for surgical intervention."
>
> Dr. Olash's review of the records led him to state that they "clearly reveal" that the Plaintiff suffered a "fairly minor work injury on August 30, 2005". He noted she was found to have a 6% wpi with no history of herniated disk or radicular problems following the work injury. He goes on to state that she has subsequently developed back problems requiring surgery that was not due to the work injury. He opines that the fibromyalgia, peripheral neuropathy, cervical radiculopathy and severe depression for which she is receiving treatment are not diagnoses that are due to the work injury.
>
> Thus, the great weight of the evidence in the record supports a conclusion not only that the 3/4/2009 surgery was not medically necessary or work related, but may well have exacerbated the Plaintiff's problems.
>
> Further, as Dr. Heilig's wpi rating must be disregarded for the reasons explained herein above, the only other wpi based on the *AMA Guides to the Evaluation of Permanent Impairment, 5th ed.*, is that of Dr. Kriss, which the ALJ finds to be persuasive and upon which he relies.

Regarding the applicability of Elizabethtown Sportswear v. Stice, 720 S.W.2d 732 (Ky. App. 1986), ALJ Bolton concluded:

Plaintiff cites Eliabethtown Sportswear v. Stice, Ky. App., 720 S.W.2d 732 (1986) [sic] for the proposition that this employer is liable *per se* for any disability or worsening of condition due to the treatment of the Plaintiff by the treating physician selected by the employer. However, upon review, it appears that this case is not only distinguishd [sic] by its facts, but subject to different law that would be frustrated if Plaintiff's theory were adopted.

In this case, the Defendant Employer, University of Kentucky Medical Center, operates under the University's managed care plan which authorized by specific statutory provisions enacted since the holding in Stice (supra). This plan apparently (according to Plaintiff's testimony) requires an employee seeking medical services covered by either the university health plan or workers compensation to utilize health care providers either directly employed by, or affiliated with, or approved by the University. She states that she was assigned to Dr. Shaffer, among others.

Here, however, her treatment was not dictated by the employer, except to the extent that it could commission utilization reviews and physician reviews the same as any other employer under the law. As was the case here, the Plaintiff chose to rely on certain medications and receive certain medical procedures to which the University objected and would not reimburse under its worker's comp coverage, but did reimburse under Plaintiff's health coverage. Further, although all of Plaintiff's treating physicians were affiliated with the University, there

> is no evidence that any of them were coerced or even influenced by the University in the independent exercise of their medical judgment.
>
> It seems that Stice is inapplicable here, both factually and legally. To adopt Plaintiff's interpretation would be to render almost all managed care plans ineffective as to employees, a result that would be inconsistent with the apparent legislative intent to promote managed health care in the field of workers compensation.

Significantly, ALJ Bolton provided no analysis of Reed's claim of permanent total disability upon reopening.

Relying upon the opinions of Drs. Kriss, Bray, Mitchell, and Olash, ALJ Bolton concluded the surgery performed by Dr. Shaffer on March 4, 2009, was unrelated to the work injuries as defined by ALJ Smith and medically unnecessary treatment. ALJ Bolton also found Reed failed to carry her burden of proof and that any additional impairment assigned by Dr. Kriss did not arise out of the work-related injuries as set out in ALJ Smith's opinion and award.

Since he found Reed did not have "any work-related disability in excess of that awarded" by ALJ Smith, and ALJ Smith found her not to be permanently totally disabled, ALJ Bolton found Reed was not totally and permanently disabled. ALJ Bolton also relied "to a lesser

extent on [the] history" Reed gave to treating physicians that she was able to perform bookkeeping services for her husband, which was a vocational skill transferrable to the general economy. Accordingly, ALJ Bolton denied Reed's claim for increased benefits. He also resolved all medical fee disputes in UK's favor.

Reed filed a petition for reconsideration making many of the same arguments she now makes on appeal. Except to request ALJ Bolton "to provide a more detailed explanation of the legal basis for his ruling Elizabethtown Sportswear v. Stice, 720 S.W.2d 732 (Ky. App. 1986)," she did not request further findings of fact or explanations. Reed filed a supplement to her petition for reconsideration making an argument she abandons on appeal. By order dated August 1, 2013, ALJ Bolton denied the petition for reconsideration.

On appeal, Reed asserts ALJ Smith's August 17, 2007, decision determined her permanent low back impairment and disability were due to work-related arousal of pre-existing dormant degenerative disc disease. Therefore, ALJ Bolton erred as a matter of law when he failed to conform his decision to the principle of *res judicata* which precluded a *de novo* review of the evidence. Consequently, ALJ Bolton was required to enter an award for the increase

in permanent impairment and disability attributable to the worsening of Reed's degenerative disc disease. Reed asserts ALJ Bolton erred in basing his decision on the reports of Drs. Kriss and Kirsch since both ignored or were ignorant of the fact that since ALJ Smith found "arousal of the underlying degenerative condition was a causal element in Reed's work-related impairment and disability," any post-2007 worsening of the degenerative condition continued to be a part of the work-related injury for which UK is responsible.

Reed argues ALJ Bolton's finding all of her post-award worsening is not compensable because it is due to natural aging constitutes a patent error of law. She maintains that once aroused into disabling reality by a work injury, the degenerative disc disease is causally related to her permanent impairment and disability. Reed asserts both Drs. Kriss and Kirsch began their review with the misunderstanding the work-related causation found by ALJ Smith had no meaning and they falsely assumed there could be no "carry over" of the original finding that "arousal of the degenerative back disease was a compensable causation." Reed argues Drs. Kriss and Kirsch failed to understand the continuum of UK's liability for the symptoms caused by the original arousal of the underlying

degenerative disc disease. Therefore, their opinions cannot be relied upon by ALJ Bolton.

Reed next argues ALJ Bolton erred by not applying the ruling in Stice, to the case *sub judice*. Reed maintains in Transport Associates v. Butler, 892 S.W.2d 296 (Ky. 1995), the Supreme Court relied upon Stice in holding an employer was liable for surgery even though another physician opined it was unnecessary. She argues Dr. Shaffer was the physician under UK's managed care system charged with the responsibly for treatment of her work injury. A review of Dr. Shaffer's testimony, as recounted by ALJ Bolton, clearly shows he performed surgery to treat the worsening of her work-related low back symptoms. She posits the March 2009 surgery was performed by one of the physicians designated by UK to treat Reed and was treatment of her work injury. Therefore, any worsening of that injury caused by the surgery is compensable.

Reed takes issue with ALJ Bolton's statement "he would not apply the holding in Stice" thereby causing UK to be liable for the medical costs associated with the surgery and Reed's worsened condition. Reed asserts without explanation ALJ Bolton stated if he were to apply the ruling in Stice and hold UK liable for the surgery and the change of condition due to the surgery, such application

would render almost all managed care plans ineffective. Reed argues the application of Stice would not prevent UK or any other employer from making the managed care program function properly. Reed asserts she requested a more detailed explanation of the legal basis for ALJ Bolton's ruling the Stice decision can be ignored and he summarily denied that request.

Reed also argues ALJ Bolton erred when he summarily refused to consider the testimony of Dr. Witt, a pain specialist with UK, on the grounds he was not qualified to make a judgment as to the efficacy of the March 4, 2009, surgery. Reed asserts ALJ Bolton did not provide any explanation for that statement. Reed posits as the physician responsible for treatment of her increasing pain level, Dr. Witt's responsibility is to determine the "efficacy of the March 4, 2009, surgery." Reed submits ALJ Bolton is required to explain why he rejected Dr. Witt's testimony. Reed argues the claim should be remanded to ALJ Bolton to either consider the testimony or explain why he does not believe Witt was qualified to offer such an opinion.

Finally, Reed argues ALJ Bolton should have awarded permanent total disability benefits. Reed maintains she testified her condition worsened and she

became more and more functionally disabled to the point that by the year after the March 2009 surgery she was "completely incapable of public employment." Reed argues ALJ Bolton refused to consider her testimony concerning the significant adverse change in her ability to engage in work since the rendition of the original award. Rather than summarily rejecting her testimony she had become totally disabled by the time she filed the motion to reopen, ALJ Bolton should have performed a meaningful analysis of the issue. Reed also takes issue with ALJ Bolton's reliance on an unidentified medical record which stated she could perform light work. Reed argues ALJ Bolton never identified the note or the physician. Reed asserts this statement is far more in keeping with her testimony prior to ALJ Smith's decision than after the March 2009 surgery.

Alternatively, Reed asserts the law mandates she must be determined to have a 10% or 13% impairment rating as a result of her worsened condition. Accordingly, Reed requests the decision of ALJ Bolton be reversed and remanded for entry of an amended decision in conformity with the law.

On reopening, Reed had the burden of proving there had been a change in her occupational disability, and since she was unsuccessful in that burden, 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 that 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 on appeal. McCloud v. Beth-Elkhorn Corp., 514 S.W.2d 46 (Ky. 1974). The Board, as an appellate tribunal, may not usurp the ALJ's role as fact-finder by superimposing its own appraisals as to 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).

In the April 17, 2007, opinion and award, ALJ Smith relied upon Dr. Primm's opinions in determining Reed had a 5% impairment due to her work-related lower back injury. ALJ Smith did not identify the site of the injury within the lumbar region. Thus, a review of Dr. Primm's October 18, 2006, report is required in an attempt to determine where within the lumbar region the injury occurred. Dr. Primm's report reflects x-rays of the lumbar spine revealed a disc space narrowing at L5-S1 and small osteophytes at the superior anterior aspect of the L3, L4 and L5. His diagnosis was lumbar strain superimposed on pre-existing degenerative changes following the January 6,

2004, injury and a lumbar strain following the September 30, 2005, slip and fall injury at work. Dr. Primm did not express an opinion as to the level of the lumbar spine which was injured. Rather, he referred to the low back in assessing a 5% impairment to the body as a whole pursuant to the AMA Guides. His impairment rating was based on chronic degenerative changes which by history had been aggravated by all three of Reed's reported injuries. ALJ's Smith's decision and Dr. Primm's report are of little assistance in determining the level or levels of Reed's lumbar region which were injured in 2004, 2005, and 2006. Consequently, the particular level or levels of the lumbar spine which were injured was hotly disputed in the reopening proceedings. Moreover, we agree with Reed the work injuries involve the aggravation of degenerative changes within the lumbar spine.

Addressing Reed's first argument, we point out ALJ Bolton did not rely upon the opinions of Dr. Kirsch in finding the 2009 surgery and the resulting increase in Reed's impairment rating to be unrelated to the work injuries. Rather, his decision on this issue was based upon the opinions of Drs. Kriss, Bray, Mitchell, and Olash. Notwithstanding Reed's argument Dr. Kriss did not understand aggravation of degenerative changes was part of

the injury, we conclude the opinions of Drs. Kriss and Bray constitute substantial evidence supporting ALJ Bolton's decision regarding the medical necessity for the surgery and whether the surgery was causally related to the work injuries.

Significantly, Reed does not argue the opinions of Dr. Bray concerning this issue is not substantial evidence. As recounted herein, Dr. Bray expressed the opinion that the diskectomy performed in March 2009 was not medically necessary. Thus, the impairment rating assessed by Dr. Kriss was not work-related. Although he stated the June 2007 MRI did not show any disk disease, Dr. Bray explained because of Reed's numerous medical complaints over a long period of time she was a very poor candidate for surgical intervention. Therefore, Dr. Bray's opinion standing alone constitutes substantial evidence supporting ALJ Bolton's determination the surgery was not medically necessary or reasonable treatment of the work-related injuries. Further, part and parcel of Dr. Bray's letter is that the surgery was not casually related to the work injury.

In addition, we believe ALJ Bolton could reasonably conclude Dr. Kriss' opinion the surgery was not reasonable and necessary, or causally related to the work

injury, is not due to a misunderstanding of the nature of Reed's work injury which clearly involved the arousal of degenerative changes. As we have already summarized Dr. Kriss' pointed and scorching opinions, they will not be reiterated. Dr. Kriss' opinions permit ALJ Bolton to conclude the surgery performed by Dr. Shaffer was not medically necessary, or worse, was performed at the wrong level and on the wrong side. Regardless of what else Dr. Kriss may have said in his report, ALJ Bolton was free to rely upon Dr. Kriss' statement Dr. Shaffer performed surgery at a level in the lumbar spine which was unaffected by the work injuries as defined by ALJ Smith. That portion of Dr. Kriss' opinion standing alone or in conjunction with Dr. Bray's opinion constitutes substantial evidence supporting ALJ Bolton's determination the surgery performed by Dr. Shaffer was medically unnecessary treatment of and unrelated to the work injuries.

Similarly, the opinions of Drs. Bray and Kriss constitute substantial evidence supporting ALJ Bolton's decision that any increase in Reed's impairment due to the surgery is not related to the work injury as Dr. Kriss opined the increase in her impairment was solely due to the surgery in question. Consequently, the record does not compel a contrary result.

We disagree with Reed's assertion ALJ Bolton erred in determining Stice is not applicable. The application of Stice to the facts in the case *sub judice* is a mixed question of law and fact and thus subject to *de novo* review. On questions of law, or mixed questions of law and fact such as in the case *sub judice*, this Board's standard of review is *de novo*. *See* Bowerman v. Black Equipment Co., 297 S.W.3d 858 (Ky. App. 2009). "When considering questions of law, or mixed questions of law and fact, the reviewing court has greater latitude to determine whether the findings below were sustained by evidence of probative value." Uninsured Employers' Fund v. Garland, 805 S.W.2d 116, 117 (Ky. 1991). As such, this Board is not bound by ALJ Bolton's conclusions. Although ALJ Bolton could have provided a better explanation for his ruling Stice is inapplicable, we believe he reached the right conclusion.

In Stice, the claimant had suffered a work-related back injury and received treatment for recurring pain. Stice was hospitalized for a lumbar myelogram and within twenty-four hours of this procedure she lapsed into a coma and died. Id. at 733. The necessity for the lumbar myelogram was not in dispute. Thus, Stice's death was a direct result of necessary treatment of the work injury.

In the case *sub judice*, UK contested Dr. Shaffer's request for approval of the lumbar surgery and after submitting the claim to utilization review filed a medical fee dispute on March 18, 2009. Reed does not contend UK did not timely comply with the administrative regulations pertaining to the medical fee dispute it filed. In her testimony Reed acknowledged that even though UK had denied the compensability of the surgery, she chose to proceed with surgery for which her personal health insurance carrier bore the financial responsibility. Unlike in Stice, there was a dispute concerning the need for the surgery. UK timely raised the compensability of the surgery by filing a medical fee dispute and prevailed. Therefore, it was not responsible for the consequences of the surgery.

Similarly, we find Transport Associates v. Butler, supra, to be inapplicable. In Transport Associates v. Butler, the claimant complained of leg and back pain. His family physician referred him to an orthopedic surgeon who diagnosed a temporary muscle spasm and recommended Butler return to work believing he was not a candidate for surgery. Butler was dissatisfied with this opinion and sought treatment with Dr. Malik, another orthopedic surgeon who diagnosed spondylolysis and spondylolisthesis. Upon

Dr. Malik's recommendation Butler was scheduled for spinal fusion surgery.

Because he was afraid of the surgery, Butler contacted the rehabilitation specialist assigned to him by Transport Associates' insurance carrier. After consulting with her, Butler decided to consult a neurosurgeon for a second opinion regarding the necessity of surgery. The neurosurgeon concluded Butler did not have a condition warranting surgery. In her report, the rehabilitation specialist indicated she had been unable to reach Butler by telephone and he did not respond to the messages she had left after the appointment with the neurosurgeon. She also learned Butler had not returned to work, not responded to Transport's telephone calls, and had returned to Dr. Malik for treatment. The rehabilitation specialist called Dr. Malik's office and confirmed he had seen Butler and had advised him to return in six weeks. Butler had an appointment to see Dr. Malik. The report indicated the carrier approved closure of the rehabilitation file secondary to non-compliance. Id. at 297. Thereafter, because of Butler's continuing complaints of back and leg pain he consented to surgery and a partial diskectomy and fusion were performed.

Although Butler believed the surgery had helped him regain sensation in his legs, his pain continued. His family physician believed his condition was worse than it had been at the time of the initial injury and assessed a significant impairment. The initial orthopedic surgeon to whom Butler was referred testified the surgery was unreasonable and unnecessary. The neurosurgeon from whom Butler sought a second opinion testified he was disabled as a result of the surgery and Butler's condition was worse than it would have been without the surgery.

The ALJ determined the claimant was permanently and totally occupationally disabled and the disability is attributable to surgery which was deemed to be unwarranted and inappropriate. Id. at 298. The ALJ found the surgery was performed in an attempt to treat the work-related injury; the employer terminated the supervision of the claimant's progress; and the employer failed to move for a selection of a different physician pursuant to KRS 342.020(3). Therefore, the ALJ determined any disability resulting from the surgery was compensable. The Board affirmed and the Court of Appeals affirmed the Board. In affirming, the Supreme Court held that under those circumstances it was not unforeseeable that if Dr. Malik continued to treat Butler, eventually unnecessary surgery

would be performed. It also added there was no requirement an injury or its consequences be foreseeable in order to be compensable. Therefore, under the circumstances, the Supreme Court concluded it was not unreasonable for the ALJ to have expected the employer to exercise its right pursuant to KRS 342.020(3) and request a physician, other than Dr. Malik, be selected to continue treating Butler's condition if Transport Associates did not wish to be responsible for the results of Dr. Malik's treatment. Id. at 299.

In the case *sub judice*, the facts are completely different. UK immediately contested the surgery recommended by Dr. Shaffer and his February 18, 2009, letter confirms the carrier advised him it was refusing to pay for the procedure and surgery was canceled. Because UK followed the appropriate procedures in contesting the proposed surgery, the holding in Transport Associates v. Butler, supra, does not cause it to be liable for the surgery and its disabling effects.

We find no merit in Reed's argument ALJ Bolton erred in summarily refusing to consider the testimony of Dr. Witt. An ALJ is not required to provide his reasons for rejecting certain medical testimony. As the sole fact-finder, ALJ Bolton is entitled to believe or disbelieve the

evidence from any medical expert. As noted by ALJ Bolton, Dr. Witt is a pain management specialist and not a surgeon. We find nothing in the record establishing Dr. Witt offered an opinion as to the need for surgery. In his April 16, 2009, letter addressed "To Whom It May Concern," Dr. Witt stated Reed had undergone a surgical procedure as a result of the work-related issue. Based on this one statement, we believe ALJ Bolton could conclude Dr. Witt was recounting what UK's medical records revealed; that Dr. Shaffer performed a surgical procedure due to a work-related issue. Dr. Witt's letter dealt solely with the pain medication regimen he believed was appropriate to deal with Reed's post-surgery pain. Dr. Witt's letter does not address the need for surgery. Therefore, ALJ Bolton acted within his discretion in refusing to give Dr. Witt's testimony any weight. Pertaining to the issues of whether the surgery is related to the work injury and is reasonable treatment of the work injury, ALJ Bolton was not required to provide his reasons for concluding Dr. Witt, a pain medication specialist, was not qualified to express an opinion regarding the need for surgery. The medical records do not reflect he was involved in the decision to perform surgery.

We first address the second part of Reed's last argument, which is even if ALJ Bolton did not conclude she

was totally disabled, he should have found she had an increased impairment and disability based on the impairment ratings of either Drs. Kriss or Heilig. As we have affirmed ALJ Bolton's determination the surgery was not reasonable, necessary, or casually related to the injury and the additional impairment rating assessed by Dr. Kriss is not connected to the work injury, Reed is not entitled to increased permanent partial disability benefits.

In Colwell v. Dresser Instrument Div., 217 S.W.3d 213, 218 (Ky. 2006), the Supreme Court instructed:

> Whether a worsening of impairment rises to the level of greater compensability is determined under KRS 342.730(1) and KRS 342.0011(11). KRS 342.730(1)(b) and KRS 342.0011(11)(b) require a worker who remains partially disabled to show a greater permanent impairment rating in order to obtain a greater award. But KRS 342.730(1)(a) and KRS 342.0011 (11)(c) require a worker who was partially disabled at the time of the initial award and totally disabled at reopening to show only that a worsening of impairment due to the injury is permanent and causes the worker to be totally disabled.

Thus, in order to be awarded additional PPD benefits arising out of her work injuries, Reed must show she sustained a greater permanent impairment rating. Here, since ALJ Bolton relied upon the impairment rating of Dr. Kriss and his opinion the increase in Reed's impairment

rating is not causally related to the work injury, Reed is not entitled to additional PPD benefits.

That said, in order to obtain permanent total disability ("PTD") benefits, Reed is not required to show there has been an increase in her impairment rating. Rather, there must only be a worsening of impairment. Reed complains about ALJ Bolton's reliance, in part, upon a history given by her to a treating physician that she is able to perform bookkeeping services for her husband which is a transferrable vocational skill. Reed complains ALJ Bolton did not identify the medical record in which this history was provided. In her petition for reconsideration, Reed complained about ALJ Bolton's failure to explain when and to whom she made this remark to a physician, but did not request additional findings explaining where in the record this history appears and when it was provided.

Similarly, although Reed argues ALJ Bolton should have conducted a more meaningful analysis as to whether she was totally disabled, she made no request for additional findings on this issue.

Despite Reed's failure to request further clarification and an analysis on this issue, in reviewing ALJ Bolton's opinion, we conclude he did not provide a sufficient basis for his determination Reed is not

permanently totally disabled. ALJ Bolton first addressed Reed's claim she is permanently totally disabled in paragraph six of his findings of fact stating as follows:

> With regard to Plaintiff's claim that she is permanently totally disabled, as I have not found her to have any work-related disability in excess of that awarded to her by the Opinion and Award of August 17, 207, and as she was specifically found therein not to be permanently and totally disabled, I find her not to be permanently and totally disabled. I also rely to a lesser extent on history given by the Plaintiff to treating physicians that she was able to perform bookkeeping services for her husband, a vocational skill that is transferrable to the general economy.

We conclude the reasons cited by ALJ Bolton in support of his determination Reed is not permanently totally disabled are insufficient to support his decision. First, the statement he had found Reed not to have any work-related disability over and above that awarded in ALJ Smith's August 17, 2007, opinion and award is incorrect. ALJ Bolton found Reed did not have any additional work-related impairment in excess of that found by ALJ Smith. He made no finding Reed had no further work-related disability. As pointed out in Roberts Bros. Coal Co. v. Robinson, 113 S.W.3d 181, 183 (Ky. 2003), "[i]mpairment and disability are not synonymous."

Second, while ALJ Bolton did not identify the physician to whom Reed made the statement and the date of the medical record upon which he relied, we have sifted through the record and found that specific history is contained in a May 9, 2007, medical record of Interventional Pain Associates at UK. There, Dr. Mark Etscheidt notes Reed's husband is self-employed and she has been able to help out somewhat with bookkeeping for him. That statement was made prior to ALJ Smith's award and ALJ Bolton erred in relying upon such a generic non-specific statement made years prior to the reopening in resolving whether on reopening Reed is totally occupationally disabled. This is especially true since Reed testified her problems with walking and sitting caused her to return to Dr. Shaffer in 2008. Reed alleged her condition greatly worsened since ALJ Smith's decision.

In summary, although Reed failed to request clarification regarding the history ALJ Bolton relied upon and to request further findings regarding her claim she is permanently totally disabled, because ALJ Bolton's reasoning on this issue is flawed his determination Reed is permanently totally disabled must be vacated.

In Colwell Dresser Instrument Div., supra, the Supreme Court further instructed:

> As amended effective December 12, 1996, KRS 342.125(1)(d) permits an award to be reopened upon evidence of a post-award "change of disability as shown by objective medical evidence of worsening or improvement of impairment ...." A finding of permanent partial or permanent total disability under KRS 342.0011(11)(b) or (c) must be supported by evidence of a permanent disability rating, which requires a permanent impairment rating as determined under the latest available edition of the *Guides.* KRS 342.0011(36) and KRS 342.730(1)(b) base a worker's permanent disability rating on the individual's AMA impairment rating and a statutory factor. However, KRS 342.0011(11)(c) and KRS 342.730(1)(a) base a finding of permanent total disability on different criteria. A totally disabling injury must result in a permanent impairment rating and a complete and permanent inability to work. *See Copar, Inc. v. Rogers, 127 S.W. 3d 554 (Ky. 2003); Ira A. Watson Department Store v. Hamilton, supra.*

Id. at 217.

ALJ Bolton failed to consider and discuss the appropriate criteria as outlined above. As paragraph six is the only portion of the opinion dealing with Reed's assertion that she is totally occupationally disabled, the analysis by ALJ Bolton is deficient as a matter of law.

On remand, ALJ Bolton must determine whether Reed has met her burden of proving by objective medical evidence that she sustained a post-settlement worsening of her impairment from the injury, the change was permanent, and

it has caused her to be permanently totally disabled under the standard set forth in Ira A. Watson Department Store v. Hamilton, Id. at 219.

Accordingly, those portions of the December 20, 2012, opinion and order and the August 1, 2013, order relating to the determination the surgery performed by Dr. Shaffer is unrelated to Reed's work injury and not medically necessary for the cure and relief of her work-related injury and the increased impairment rating due to the surgery is not work-related are **AFFIRMED**. Further, the determination Elizabethtown Sportswear v. Stice, supra, is not applicable and the rejection of Dr. Witt's opinion is also **AFFIRMED**. Those portions of the December 20, 2012, opinion and order and the August 1, 2013, order relating to the determination Reed is not permanently totally disabled are **VACATED**. This matter is **REMANDED** to ALJ Bolton for entry of an amended opinion as to whether Reed is permanently totally disabled in accordance with the views expressed herein.

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