

OPINION ENTERED: DECEMBER 7, 2012

CLAIM NO. 201075990

LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT

PETITIONER

VS.

**APPEAL FROM HON. GRANT S. ROARK,  
ADMINISTRATIVE LAW JUDGE**

GERALD FLORENCE  
and HON. GRANT S. ROARK,  
ADMINISTRATIVE LAW JUDGE

RESPONDENTS

**OPINION  
AFFIRMING**

\* \* \* \* \*

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

**SMITH, Member.** Lexington-Fayette Urban County Government ("LFUCG"), appeals from the June 4, 2012 Opinion, Order and Award rendered by Hon. Grant S. Roark, Administrative Law Judge ("ALJ"), awarding permanent partial disability ("PPD") benefits and medical benefits to Gerald Florence ("Florence"), as a result of injuries sustained on July 23, 2010 and May 20, 2011. LFUCG also appeals from the July 20, 2012 order denying its petition for reconsideration as it

relates to the issues on appeal. LFUCG argues the ALJ erred in finding Florence's rheumatoid arthritis ("RA") compensable and the ALJ's finding regarding the impairment for Florence's thumb injury was not supported by substantial evidence. We disagree and affirm.

Florence testified by deposition on September 21, 2011 and at the hearing held April 3, 2012. Florence is a fifteen year veteran of the LFUCG Police Department. He testified he was injured on July 23, 2010, when he attempted to avoid falling down a steep set of stairs. In an attempt to avoid injury, he leaped from the stairs and, upon landing, hyperextended his right knee, experiencing immediate pain and instability. Florence stated he had never experienced any manifestation of RA prior to this incident. Florence underwent a knee surgery and subsequently experienced complications, including the immediate onset of pain in his shoulders, elbows, wrists and feet. He testified it was so severe he was unable to ambulate even with the use of crutches. He was first referred to Dr. Peter Hester, an orthopedic surgeon. Dr. Hester then referred him to Dr. Haider Abbas, a board certified rheumatologist, who obtained laboratory test results and diagnosed RA, sudden onset. Florence did not believe he could continue to work as a police officer due to

the problems he experienced with his knee. He applied for disability retirement benefits.

Florence also testified he injured his thumb in the early part of May 2011 when he was attempting to restrain an intoxicated suspect and he ruptured or tore his tendons upon hyperextension. At the hearing, held April 3, 2012, Florence testified he continues to have persistent pain, loss of strength and loss of range of motion in his thumb.

Dr. Phillip Corbett examined Florence on October 26, 2011. Dr. Corbett noted Florence was an active duty patrolman with a history of hyperextension of the right knee. Dr. Corbett noted swelling in the left wrist and referred Florence for arthritic evaluation. Florence also had left shoulder pain which resolved with a cortisone injection. Dr. Corbett noted Florence had been referred to Dr. Abbas, who diagnosed RA. Dr. Corbett noted Florence had undergone knee surgery and had been wheelchair-bound because of the RA during the four to six weeks of his postoperative rehabilitation. Florence denied any symptoms relating to his knee prior to July 2010.

Florence indicated his right foot rotates outward when he walks, and he experiences discomfort at the medial joint line and a burning pain at the patellar tendon.

Florence indicated his thumb injury bothers him approximately once a week. He denied any problems with his right knee or left thumb prior to the date of his injuries. X-rays demonstrated no sign of fracture, dislocation, or loose body, and no sign of a Stener lesion. There was no evidence of degenerative or rheumatoid arthropathy involving the metacarpophalangeal ("MCP") joint. X-rays of the right knee showed no sign of fracture, dislocation, loose bodies or calcifications, satisfactory maintenance of joint space, and no evidence of synovial resorption or rheumatoid involvement.

Dr. Corbett diagnosed status post hyperextension injury of the left thumb with dorsal capsular strain MCP joint, resolved; status post meniscal capsular ligament separation, i.e. meniscal tear, and medial collateral ligament sprain, grade two, right knee with satisfactory evidence of a surgical repair of the meniscus, and persistent evidence of tendinitis and synovitis. Dr. Corbett also noted Florence was seropositive for RA.

Dr. Corbett opined Florence could have suffered a medial meniscal tear in the mechanism described involving a sprain of the medial collateral ligament as well. Dr. Corbett stated:

While there is no evidence of a causal relationship between the injury and the etiology of the rheumatoid arthritis as an autoimmune phenomenon, there is every reason to believe that a patient with rheumatoid disease can experience an increased level of symptoms with the injuries associated with stretching or spraining the medial collateral ligament and tearing the medial meniscus. There is no literature to support the suggestion that the knee injury of July 2010 caused the development of rheumatoid arthritis.

Dr. Corbett stated Florence had reached maximum medical improvement ("MMI") from both injuries. He assigned a 3% impairment rating pursuant to the American Medical Association, Guides to the Evaluation of Permanent Impairment, 5<sup>th</sup> Edition ("AMA Guides") for Florence's knee condition. Dr. Corbett determined that no restrictions were necessary for the knee or thumb injury, and future management should not be necessary barring further injury.

In a November 17, 2011 supplemental report, Dr. Corbett stated there was no objective evidence Florence's right knee had any involvement with rheumatoid synovitis. In the absence of any evidence of rheumatoid changes on other diagnostic studies and the operative description by Dr. Hester, Dr. Corbett stated it was unlikely Florence's rheumatoid condition had any causal relationship to the injury, nor was the injury extended by the RA.

Dr. Abbas testified by deposition on January 11, 2012. He stated RA was an autoimmune disease process, the exact etiology of which is unknown. Dr. Abbas acknowledged Florence never had a manifestation of RA or active disease until he was involved in the work injury and had surgery. Dr. Abbas indicated Florence had a predisposition to develop RA prior to the work injury but was asymptomatic. He agreed Florence's trauma could have been a triggering event or environmental factor. Dr. Abbas was questioned regarding the Oxford Journal article concerning trauma as a triggering event for RA. He stated:

And I've seen that study and it can certainly be reviewed. Anybody can review this article. Unfortunately we do not have a plethora of studies or good studies or randomized controlled trials or double-blind studies to look into this matter.

Dr. Abbas could not definitively state the trauma triggered Florence's RA symptoms. He acknowledged that trauma was the only environmental factor he observed in Florence's case. He stated there was a 50% chance the trauma was the triggering factor. Dr. Abbas indicated the site of the trauma would not necessarily be the first body part affected by RA.

Dr. James Owen examined Florence on January 27, 2012. Dr. Owen reviewed medical records including Dr. Corbett's

independent medical evaluation. Dr. Owen reviewed other materials which he discussed as follows:

From a medical standpoint, there are notes here from the *Journal of Rheumatology* in which Dr. Olivieri indicates that trauma has long been thought to play a triggering role in various types of inflammatory arthritis, including rheumatoid arthritis, gout, chondrocalcinosis, and spondyloarthritides, especially psoriatic arthritis. There are multiple articles apparently indicating a triggering role of trauma inducing arthritis in patients with psoriatic disease. Included in those articles the one by Williams, K.A., *Annals of Rheumatic Diseases* 1967: *The Influence of Trauma on the Development of Chronic Inflammatory Polyarthritides*. Unfortunately, the remainder of the references are not on the chart. There is one other reference in a case control study examining the role of physical trauma in the onset of rheumatoid arthritis that is by Dr. Al-Allaf, and it appeared in *Rheumatology: an Oxford Journal* in 2001. Results of this study indicate 55 of [sic] 21% of the RA patients reported significant physical trauma in the six months before the onset of their disease compared with only 17, 6.5% of the controls. There had been prior to this article earlier studies on the link between trauma and arthritis based upon retrospective case note reviews or studies that did not include a match control group, as did this study. However, this study appears to be the definitive association.

Dr. Owen diagnosed:

1. Persistent rheumatoid arthritis status-post multiple injuries, including injury

to the knee, which was a meniscal capsular ligament separation and medial collateral ligament sprain, grade 2, right knee, with surgical repair of the meniscus and persistent tendonitis, synovitis of the patella.

2. Status-post hyperextension injury to left thumb with dorsal capsular strain MCP that has persisted and left him with diminished grip strength.
3. Past history of shoulder injury and operation that has resulted in persistent diminished range of motion of the right shoulder.

Dr. Owen stated, within reasonable medical probability, Florence's injury was the cause of his complaints. He indicated there was no pre-existing active disability. The RA clearly was pre-existing, dormant, and non-disabling. Pursuant to the AMA Guides, Dr. Owen assigned a 4% impairment rating for Florence's knee. With regard to the thumb, Dr. Owen stated the impairment of the carpometacarpal ("CMC") joint of the thumb could be rated by grip strength which was significantly diminished. However, he stated:

There is a time constraint at the present time and also a constraint based on the grip strength diminution being a result of pain. I do think that would be added into the problem in the distant future. It requires one year from the time of injury for grip strength to be appropriately associated with an impairment rating and that needs to be without pain constraint.

Dr. Owen noted that an impairment rating based upon RA was not available at the present time.

Dr. Owen stated there was no impairment of the knee prior to the work injury and Florence was at MMI for that condition. Dr. Owen also determined Florence did not retain the physical capacity to return to the type of work performed at the time of his injury.

In a March 29, 2012 addendum to his report, Dr. Owen assigned a 6% impairment rating for Florence's thumb pursuant to the AMA Guides. Dr. Owen indicated the thumb pain had subsided and it was appropriate to rate grip strength at that time. Dr. Owen assigned a 0% rating for arthritis.

Dr. Owen testified by deposition on March 15, 2012 and opined it was more likely than not that Florence's work injuries aroused his RA into disabling reality. He agreed the medical community did not know what caused RA. He acknowledged that, prior to being provided the Oxford Journal article by Florence's counsel, he would not necessarily have had the perception that RA was triggered by trauma. Dr. Owen maintained his belief the RA was a dormant, non-disabling condition aroused by the work injury.

Dr. Peter Hester performed a right knee arthroscopy with medial meniscal capsule separation repair on October

20, 2010. On February 7, 2012, Dr. Hester indicated Florence was no longer able to perform activities relating to patrolling or any activity which involved arresting, transporting or physical conflict. Dr. Hester concluded Florence could engage in other less strenuous police work. He indicated Florence was at MMI. Dr. Hester intended to follow Florence with regard to problems with the acromioclavicular joint of his right shoulder.

In his decision rendered June 4, 2012, the ALJ made the following findings relevant to this appeal:

**Causation/Work-Relatedness of  
Rheumatoid Arthritis**

As a threshold issue in this claim, the employer disputes that plaintiff's development of symptomatic rheumatoid arthritis following his knee injury and surgery is causally related to the knee injury or subsequent surgery. In support of his claim, plaintiff relies on the opinion of his treating rheumatologist, Dr. Abbas, who indicated the kind of trauma plaintiff sustained could have triggered the previously dormant rheumatoid arthritis into disabling reality. He also relies on the opinion of his IME physician, Dr. Owen, who testified the trauma was the likely cause of plaintiff's rheumatoid arthritis (RA) becoming symptomatic. Conversely, the employer points out that plaintiff's treating physician, Dr. Owen, testified he could not say the knee trauma or surgery were more likely than not the triggering mechanism of plaintiff's RA; indeed, Dr. Abbas testified only that it was a

possibility, no more than 50%. The employer also points out Dr. Corbett unequivocally concluded plaintiff's RA is not causally related to the knee injury or surgery.

When the causal relationship between the trauma and the injury is not readily apparent to a layman, the question is one properly within the province of the medical experts. *Mengel v. Hawaiian-Tropic Northwest & Central Distributors, Inc.*, Ky. App., 618 S.W.2d 184 (1981); *Elizabethtown Sportswear v. Stice*, Ky. App., 720 S.W.2d 732 (1986). In order to rise to the level of substantial evidence, the opinion of a medical expert must be based upon reasonable medical probability or certainty. *Young v. Davidson*, Ky., 463 S.W.2d 924 (1971). However, an ALJ may combine medical testimony with historical information from the injured worker to find work-relatedness. See, *Union Underwear v. Searce*, Ky., 896 S.W.2d 7 (1995).

Applying the law to the evidence of record, it is first noted this is an unusual situation in which the plaintiff's treating specialist, Dr. Abbas, could not say the RA was due to the injury within a reasonable degree of medical probability. He testified that it was 50% likely in his estimation. On the other hand, plaintiff's IME physician, Dr. Owen, testified the condition was brought into disabling reality by the knee injury and surgery, although the employer points out Dr. Owen's opinion was based on information relayed to him by plaintiff's counsel and an incomplete review of Dr. Abbas' deposition.

Ultimately, the Administrative Law Judge is persuaded by the totality of

evidence in general, and the onset of plaintiff's symptoms in particular, that plaintiff's RA was brought into disabling reality by the work injury and surgery. In reaching this conclusion, the temporal relationship between the knee surgery and the onset of symptoms as soon as he awoke from surgery, combined with the fact that plaintiff never experienced RA symptoms prior to the knee surgery, are considered most persuasive. The Administrative Law Judge is fully mindful that Dr. Abbas' testimony, taken on its own, does not establish medical causation of plaintiff's condition. However, per *Union Underwear v. Searce*, supra., by combining Dr. Abbas' testimony that trauma can cause RA to become symptomatic and the medical testimony of Dr. Owen along with historical information from plaintiff as to the lack of any RA symptoms before the knee injury, the Administrative Law Judge is persuaded it is more likely than not that plaintiff's knee surgery aroused the previously dormant RA predisposition into disabling reality and, as such, the RA is compensable. *McNutt Construction v. Scott*, 40 S.W.3d (2001).

**Extent and Duration/Injury Under the Act-Thumb**

With respect to the extent of plaintiff's impairment, the Administrative Law Judge is persuaded plaintiff suffers a 4% impairment due to his knee injury and a 6% impairment for his thumb injury, based on the opinions of Dr. Owen. Dr. Owen's opinions in this regard are found to most completely take into account plaintiff's symptoms and limitations. Based on Dr. Owen's findings and plaintiff's own credible testimony and the fact that plaintiff underwent surgery to his injured thumb,

it is determined he suffered an "injury" to the thumb within the meaning of KRS 342.0011(1) and (33).

LFUCG filed a petition for reconsideration raising numerous errors including essentially the same arguments it now raises on appeal.

The ALJ issued a July 20, 2012 order providing the following findings:

With respect to the defendant's argument that plaintiff's RA should not be compensable, that is merely a re-argument of the merits which have already been decided. The defendant argues the Administrative Law Judge determined the medical evidence did not establish a causal relationship yet still found a causal relationship between plaintiff's knee injury and his RA. The defendant overlooks Dr. Owen's opinion which does establish causation. As set forth quite clearly in the Opinion, the Administrative Law Judge relied on a combination of Dr. Owen's opinion, Dr. Abbas' opinions, historical information from the plaintiff and the temporal relationship between plaintiff's knee injury and the onset of RA to infer from that totality of evidence a causal nexus. The defendant's petition on this point is therefore denied.

On appeal, LFUCG argues the ALJ's finding of work-related RA resulted from inadequate findings of fact, unsupported by substantial evidence. LFUCG argues Dr. Owen's opinions do not constitute substantial evidence. LFUCG contends Dr. Owen's opinion is not supported by any

other medical expert and he based his opinion regarding causation on a misunderstanding and/or uncertainty as to Dr. Abbas' conclusions, therefore his opinion does not constitute substantial evidence. Further, LFUCG contends Dr. Owen's opinion was based upon a twelve year old journal article which merely posed the possibility of a relationship between trauma and the development of RA. LFUCG states Dr. Owen's opinions were marked by vagueness, uncertainty and irrelevance.

In contrast, LFUCG notes Dr. Abbas is an expert rheumatologist who could not say there was a causal relationship between the trauma and Florence's RA. Further, LFUCG asserts Dr. Abbas dismissed the relevance of the article relied upon by Dr. Owen. LFUCG contends a reasonable person could not rely on the opinion of Dr. Owen over that of Dr. Abbas, a board certified rheumatologist. LFUCG believes the evidence establishes only a possibility of work-relatedness and Florence failed to establish the condition more likely than not resulted from the work trauma.

LFUCG argues the ALJ's award of benefits for the thumb injury is not based on substantial evidence since Dr. Owen did not comply with the protocols of the AMA Guides. LFUCG argues the ALJ failed to reconcile the inconsistencies

between the findings in Dr. Owen's addendum report and his deposition testimony indicating an impairment rating could not be assessed less than one year after the injury and in the presence of pain. LFUCG notes Florence testified at the hearing he was still experiencing pain. LFUCG notes Dr. Owen was the only physician to assess impairment for the thumb and contends his opinion regarding an impairment rating does not constitute substantial evidence.

Florence, as the claimant in a workers' compensation proceeding, had the burden of proving each of the essential elements of his cause of action, including causation. See KRS 342.0011(1); Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Since Florence was successful in that burden, the question on appeal is whether there is substantial evidence of record to support the ALJ's decision. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). "Substantial evidence" is defined as evidence of relevant consequence having the fitness to induce conviction in the minds of reasonable persons. Smyzer v. B. F. Goodrich Chemical Co., 474 S.W.2d 367 (Ky. 1971).

In rendering a decision, KRS 342.285 grants an ALJ as fact-finder the sole discretion to determine the quality, character, and substance of evidence. Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993). An ALJ may draw

reasonable inferences from the evidence, 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. Jackson v. General Refractories Co., 581 S.W.2d 10 (Ky. 1979); Caudill v. Maloney's Discount Stores, 560 S.W.2d 15 (Ky. 1977). An 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). In that regard, an ALJ is vested with broad authority to decide questions involving causation. Dravo Lime Co. v. Eakins, 156 S.W. 3d 283 (Ky. 2003). 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). Rather, it must be shown there was no evidence of substantial probative value to support the decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

The function of the Board in reviewing an ALJ's decision is limited to a determination of whether the findings made are so unreasonable under the evidence they must be reversed as a matter of law. Ira A. Watson

Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000). The Board, as an appellate tribunal, may not usurp the ALJ's role as fact-finder by superimposing its own appraisals as to weight and credibility or by noting other conclusions or reasonable inferences that otherwise could have been drawn from the evidence. Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999).

Causation is a factual issue to be determined within the sound discretion of the ALJ as fact finder. Union Underwear Co. v. Scarce, 896 S.W.2d 7 (Ky. 1995); Hudson v. Owens, 439 S.W.2d 565 (Ky. 1969). In this case, the evidence is conflicting whether Florence developed RA as a result of the trauma during his employment with LFUCG. Where the evidence concerning an issue is conflicting, the ALJ as fact-finder is free to choose whom and what to believe. Copar v. Rogers, 127 S.W.3d 554 (Ky. 2003).

Florence's testimony and the opinions of Dr. Owen constitute substantial evidence supporting the ALJ's determination of a causal relationship between the knee trauma and the onset of RA. The ALJ acted well within his role as fact-finder in choosing to rely on Florence's testimony regarding the absence of any symptoms related to RA prior to the injury and the sudden onset of severe symptoms following the knee surgery. The ALJ was not

relying simply on his own conclusions regarding the temporal relationship of the symptoms and the environment. Medical literature and the testimony of Dr. Owen and Dr. Abbas indicated environmental factors such as trauma can trigger the manifestation of RA symptoms. Although Dr. Abbas stated the trauma was 50% likely to have triggered the manifestation of symptoms in Florence's case; Dr. Owen unequivocally stated the work trauma aroused Florence's previously dormant non-disabling RA into disabling reality. Dr. Owen maintained that belief even after being presented with Dr. Abbas' testimony. Since the evidence establishes the RA condition was a pre-existing dormant condition and was aroused by the work trauma, it is a compensable condition. McNutt Construction/First General Services v. Scott, 40 S.W.3d 854 (Ky. 2001); Finley v. DBM Technologies, 217 S.W.3d 261 (Ky. App. 2007).

For the most part, LFUCG's arguments are addressed to the weight given to the evidence. The Supreme Court in Sweeney vs. King's Daughters Medical Center, 260 S.W.3d 829 (Ky. 2008), determined nothing requires the ALJ to give greater weight to a treating physician's testimony. In considering causation, the ALJ is not obligated to give greater weight to a particular specialist in contradiction to a specialist in another medical field. Yocom vs. Emerson

Electric, 584 S.W.2d 744 (Ky. App. 1979). Here, the ALJ weighed the evidence and, as was his prerogative, found the opinions of Dr. Owen more persuasive. It is not the Board's role to re-weigh the evidence. When the ALJ's findings are supported by substantial evidence, the Board may not disturb those findings. Since it is clear from the ALJ's opinion, award and order, as well as from his ruling on LFUCG's petition for reconsideration, he was laboring under no material misimpression as to the evidence or pertinent law, we affirm.

Finally, in regard to the ALJ's selection of an impairment rating for the thumb, we find no error. The ALJ was free to choose Dr. Owen's impairment rating. Dr. Owen, in his March 29, 2012 addendum, stated Florence's condition could be assessed since his pain had subsided. No medical opinion established his rating was not properly assessed. Admissibility of the impairment ratings was not a contested issue at the benefit review conference. No objection was made to the admission of Dr. Owen's rating. It is within the sole discretion of the ALJ to select the impairment rating he believes best reflects the claimant's disability.

Accordingly, the June 4, 2012 Opinion, Order and Award rendered by Hon. Grant S. Roark and the July 20, 2012 order

denying LFUCG's petition for reconsideration are hereby  
**AFFIRMED.**

ALL CONCUR.

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