# Commonwealth of Kentucky
# Workers' Compensation Board

**OPINION ENTERED: April 29, 2016**

CLAIM NO. 198428329

PYRO MINING COMPANY
(LODESTAR ENERGY, INC.) PETITIONER

VS. **APPEAL FROM HON. JEANIE OWEN MILLER, ADMINISTRATIVE LAW JUDGE**

JOE D. WALKER
and HON. JEANIE OWEN MILLER,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

**OPINION**
**AFFIRMING**
* * * * * *

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

**STIVERS, Member.** Pyro Mining Company (Lodestar Energy, Inc.)("Lodestar") appeals from the October 14, 2015, Opinion and Order and the November 19, 2015, Order on Petition for Reconsideration of Hon. Jeanie Owen Miller, Administrative Law Judge ("ALJ"). The October 14, 2015, decision resolved a Medical Fee Dispute filed by Joe D.

Walker ("Walker") determining Walker's gait disorder and increase in back pain are work-related and his request for medical benefits for these conditions is not prohibited by *res judicata* or the statute of limitations. The ALJ also determined treatment for Walker's ankle fusion, below knee amputation, gait disorder, and back pain is reasonable and necessary for the cure and relief for the effects of his work injury.

On appeal, Lodestar asserts Walker's Medical Fee Dispute filed on January 19, 2012, seeking medical benefits for treatment of his back is barred by the statute of limitations and *res judicata*.

The protracted procedural history of this claim was adequately summarized by the ALJ in the October 14, 2015, Opinion and Order and is recited verbatim herein:

> 1. **Opinion and Award – 6/22/1987**. The former "Workers' Compensation Board" (prior to the present ALJ system) found Plaintiff had sustained a 50% occupational disability and also awarded approximately two years of TTD. Importantly, the decision included an award of medical benefits per KRS 342.020.
>
> 2. **Opinion and Award – 7/13/1990**. Upon Plaintiff's reopening claiming an increase in occupational disability, ALJ Tom Nanney awarded 100% permanent and total disability. Judge Nanney noted: "Following the entry of the Award, Plaintiff's condition

continued to deteriorate with the determination that the venous insufficiency was permanent in nature." ALJ Nanney awarded the Plaintiff medical benefits pursuant to KRS 342.020.

3. **Benefit Determination by Arbitrator – 7/20/1999.** The Arbitrator found Plaintiff's low back condition barred by the failure to join the matter in the original claim or subsequent re-opening – citing Slone vs. Jason Coal Co., Ky., 902 SW2d 820 (1995). Arbitrator King found: 'if treatment or medication for the Plaintiff's leg, head, or neck pain also happens to relieve his back pain, that treatment or medication is compensable." Arbitrator King also found Plaintiff's depression work-related and the treatment for same compensable as well as his high blood pressure and impotence.

4. **Opinion and Award - 9/18/2000.** ALJ Don Smith found that res judicata did not prohibit his review of the Plaintiff's claims for medical treatment of his back or psychological conditions – primarily because they had not been previously addressed. The ALJ also citing Slone vs. Jason Coal Co., *supra*, found Plaintiff had "prior knowledge of both his back and psychological conditions for more than two years prior to this last motion to reopen, it does appear that such conditions are now prohibited by the statute of limitations." He found compensable treatment for his left leg, facial problems, high blood pressure, impotency, arthritis, gastrointestinal distress, Nikken Magnetic Sleep System and pain medication as outlined in the above decision.

5. **Opinion and Order – 10/7/2004.** ALJ Overfield ruled in a medical dispute (that threatened both parties with sanctions if either brought the issues again) that ALJ Smith's decision that the low back, neck and psychological injuries were barred by the statute of limitations and as such any medical expenses relating to treatment of those conditions were non-compensable. Judge Smith's ruling was not appealed and therefore the matter was res judicata.

6. **Medical Disputes -** Despite ALJ Overfield's warning to both parties, several medical disputes (MD) have been filed since 2004. In 2011 the Defendant/employer filed a Motion to Reopen to contest the reasonableness and necessity of a proposed left ankle fusion by Plaintiff's treating orthopedic surgeon, Dr. Paul Alley. In 2012 the Plaintiff filed a MD stating: "The carrier is refusing to agree to pay for medical treatment recommended to be performed in [sic] future, so no bills or rendered services are involved." Attached to the Form 112 was a letter from Dr. Quill to Dr. Paul Alley regarding the issue of whether Plaintiff should have a left pantalar arthrodesis. Also attached were two medical bills – one owed to Dr. Tibbs, apparently paid by Humana, and one prescription medication bill from Thrifty Pharmacy, which had been only partially paid and with a notation on it "Payment by Workers Comp **account has been closed** please remit payment in full."

On January 19, 2012 the Plaintiff filed another medical dispute regarding "future medical care" regarding treatment for a gait disorder due to his left ankle injury, along with

> possible mental disorder and addiction to oxycodone. Eventually, the Defendant/employer accepted as compensable the treatment for the lower extremity but excepted-out the alleged gait disorder and back pain. An Order was entered on February 13, 2012 dismissing the Defendant/employer's MD regarding treatment for the left lower extremity treatment, including the proposed surgery (but excluding the back and gait disorder). The Plaintiff's MD regarding an alleged back and gait disorder was abated until his ankle fusion, which was performed on March 29, 2012. The Plaintiff then underwent a below the knee amputation by Dr. Alley on February 18, 2013 because of the failed fusion.
>
> At the Formal Hearing in this matter on August 28, 2015, the parties agreed the contested issues in this case are unpaid and contested medical expenses. The other issue was whether Res Judicata barred the issues of the compensability of the medicals and statute of limitations as it relates to Plaintiff's back.

The December 13, 2011, report of Dr. Robert Vraney was introduced in the proceeding before the ALJ. In this report, Dr. Vraney stated as follows:

> Please be advised that I have provided care for Mr. Walker's cervical and lumbar spines for several years now. This letter is dictated on behalf of Mr. Walker with respect to some ongoing difficulties that he is having that are represented by walking-associated achiness that he has in the area of the posterior-superior iliac spine and left gluteal area. His history of back

> difficulties began in the mid 1980s when he was involved in a fairly dramatic mining accident. It is certainly very likely that the injuries sustained at that time, which led to initially a discectomy and later an interbody fusion of his lumbar spine, in large part account for some expected degree of difficulties with back pain symptoms. Largely, he has done well with respect to centralized low back pain as a result of the surgeries he has had. Residual deficits involving his foot have been attended to by my partner, Dr. Paul Alley, and have resulted in an ankle fusion being performed. The alterations in his gait have, in all likelihood, contributed mightily to joint pathology and difficulties with the short hip rotators as a result of the associated gait disturbances. I would certainly hope that these facts would be taken into account with respect to settlement of Mr. Walker's case.

The September 12, 2014, report of Dr. David King was introduced into evidence. In his report, Dr. King opined as follows:

> Please be advised that Joe Walker was under professional care in my office by myself and my partners Dr. Paul Alley and Dr. Robert Vraney. Mr. Walker underwent a left below knee amputation by Dr. Paul Alley after failed ankle and subtalar joint fusions. Mr. Walker was then referred to me by my partner for a non-healing wound from the amputation. Dr. Paul Alley has declared Joe Walker to be rendered with a gait abnormality from the left below knee amputation and believes it may affect proximal joints, including the knee,

> hip, and spine. Dr. Robert Vraney has also concurred Mr. Walker's back pain to likely be secondary to a gait abnormality.
>
> Upon general examination of Mr. Walker's gait pattern, I determined Mr. Walker to have a gait abnormality, as he ambulates with a prosthesis on the left lower extremity. I concurr [sic] the opinions of my partners Dr. Paul Alley and Dr. Robert Vraney in that Joe Walker's gait abnormality is rendered from he [sic] left below knee amputation and that his back pain is likely secondary to this gait abnormality, as it may affect proximal joints.

In his December 6, 2011, report, Dr. Paul Alley opined as follows: "Joe Walker has been seen and treated in our office for his left ankle. An adaptive gait pattern may over stress surrounding joints in the same foot, opposite foot or more proximal joints including the knee, hip or back."

In a report dated August 27, 2014, Dr. Alley stated as follows:

> Joe Walker had left below knee amputation after failed ankle and subtalar joint fusion. This would render him with a gait abnormality which may affect proximal joints including the knee, hip, and spine. The patient was evaluated by Dr. King and Vraney as well. They also concurred his back pain was likely secondary to a gait abnormality.

Dr. Alley’s April 28, 2015, deposition was introduced. Dr. Alley testified he first treated Walker's left ankle with conservative methods on March 29, 2010. In September 2010, Dr. Alley performed a subtalar joint fusion. Four months after the fusion, Walker experienced pain and redness in the ankle. Dr. Alley provided the following testimony regarding Walker’s subsequent problems:

> A: Yes. And- So, again, he did reasonably well until four months out, and then that was 12-29-2010. He was having some swelling and discomfort; and, essentially, we tried to treat that conservatively. We ended up getting a CAT scan that showed more degenerative changes through the ankle joint as well, and none of the patient's- or the efforts we made conservatively seemed to work good enough and, for that reason, that we took him back to surgery, removed the screws from the subtalar joint and then expanded the fusion to include the ankle joint there. Here it is. Yeah. That was 3-29-2012. That was the- two years. Yeah. Then subsequent to that, the patient developed chronic pain that was unremitting; and, despite our best efforts, tried to consult other partners to see if they had any other ideas of something to do. We sent him to pain management. Perhaps he had had reflex sympathetic dystrophy; and none of that. The pain management didn't help either. The patient was insistent on a below-knee amputation. I got a second opinion from one of my partners that really had not been involved with Mr. Walker's treatment and he reviewed the case and agreed that that was a reasonable treatment option, so he

underwent a- here we go- a below-knee amputation. And, actually, I need to back up a little bit. Between the ankle fusion and the eventual below-knee amputation, he developed some wound problems that- for which he was admitted to the hospital for IV antibiotics; and one of my partners, Dr. King, who's also a fellowship trained foot and ankle orthopedist, did debridements and irrigation. We got him set up on a wound vac to try to help close the infected wound, and he had progressed reasonably well with that to get to- here we go- to the- to a point where we were just doing wet-to-dry dressing changes. Eventually, though, he still had ongoing pain. We did get, through the cultures that were taken intraoperatively, he had methicillin resistant Staph aureus or MRSA. We consulted Dr. Zahid, who is an infection [sic] disease specialist, for antibiotics; and, again, despite our best efforts, he had unrelenting- or unrelenting pain; and, so, I asked him to see Dr. Beck, who is another one of our partners, for a second opinion and he agreed that a below-knee amputation may be a viable treatment option.

He underwent that procedure on 2-18-2013. In his postop course after the below-knee amputation, he had a couple of falls. He had some redness around the incision line. It didn't appear to be deeply infected. Nonetheless, as he continued to have problems- and I believe he ended up having some opening of the incision site, drainage, so we- he underwent another- a revision to the below-knee amputation to remove scar tissue and some of the deeper infected soft tissues. The culture results ended up showing still some gram-positive cocci, and I believe he ended up with some enterobacter, which is gram-

> negative bacillus; and, so, he had at least two more wash-outs. We followed him until essentially that was healed over.
>
> He had been fitted with a below-knee prosthesis and had revisions to that based on irritation and wear around the socket, but we followed him until things had cleared up and- or had healed over and have not seen him since.

Dr. Alley did not remember when Walker first complained of back pain. Regarding when Walker first suffered gait derangement, Dr. Alley testified as follows:

> Q: So, would it be fair to say that Mr. Walker- in your opinion, did Mr. Walker suffer from a gait derangement prior to the fusion you performed on 9-7-2010?
>
> A: Yes. I would say that's reasonable.
>
> ...
>
> Q: Okay. So, would it be possible for this crush injury that he suffered in 1984 to his left leg to render him with a gait derangement which leads to complaints of back pain?
>
> A: It may- it may be part of the overall picture, but I understood that he also had spine fractures, facial fractures, and, you know, he had fractured his left ankle, you know, during that particular injury, so all of those things could certainly contribute to a painful gait.
>
> Q: So, in your opinion, it's more of a totality thing from all the injuries he suffered from?

A: I think that's- that's reasonable.

Dr. Alley testified Walker also experienced gait abnormality after the amputation:

> A: Currently, I don't know; but, as of the writing of this letter in August 2014, he had a gait abnormality after the amputation. That could relate to the prosthetic fit, and, certainly, he could develop some pain in more proximal joints as well, so-. Yeah. It says back pain. And that may be, because, at least according to Dr. Vraney's note, the back pain was likely to sacroiliac joint pain, and that can develop as a gait- a gait- well, a gait change or compensatory gait after having a prosthesis placed, so-.
>
> Q: So, assuming that Mr. Walker had made complaints of a gait derangement leading to back pain prior to his treatment with you and Orthepaedic [sic] Associates, does the gait derangement that you said that he exhibited after his amputation, does that differ in any way from any prior gait derangement he may have complained of?
>
> A: I don't know. the- what I was trying to comment on, with regards to the letter that you have, was that he had some ongoing problems with walking; and, at least from the foot/ankle standpoint, I thought that might relate to the previous below-knee amputation and the differing gait that he would assume with wearing a prosthesis. I had an understanding that he had had back injuries subsequent to his injury, but I don't know the details of that; so, if some of that was pre-existing to seeing me for his ankle, I can't

> comment on that. I'd have to refer you to Dr. Vraney's evaluations there.

Dr. Alley last saw Walker on July 12, 2013, at which time Walker was still experiencing gait derangement:

> Q: And just to reiterate, so, as of the last date that you saw him, which was 7-12-2013, at that time, did Mr. Walker suffer from a gait derangement which could lead to complaints of back pain; do you recall?
>
> A: Let's see. I'll have to- at my age, I don't remember. All right.
>
> It just says, 'Ambulates with a prosthesis left lower extremity.' It didn't say anything specifically about an antalgic gait; however, I think when his- yeah. He does have some wound opening, so I would imagine he had pain likely just from still an ongoing wound complication. They got an MRI of his knee that showed some internal derangement, osteoarthritis within his knee.

Dr. Alley continued his testimony concerning Walker’s gait derangement as follows:

> Q: So, in your medical opinion, if Mr. Walker does continue to suffer from a gait derangement, when would it have originated from? What event?
>
> A: Well, I think I'd have to kind of look- or step back and look. If the pain seemed to be- or the complaint of pain seemed to center around the- you know, the residual left leg, then I'd have to say that there still may be some ongoing healing, remodeling, but-

well, two years down the road, I think that would be pretty stable; but, again, it could have to do with prosthesis fit, you know, the way the socket's placed, and I generally refer those sort of concerns straight back to the prosthetist. If he has pain- the pattern's different and it starts somewhere and moves somewhere, that could be coming from his hip or back.

It's all- it's kind of speculative no matter what I try to put together there.

Q: So you mentioned that the pain could be coming from his hip or back. If that is the case- assuming that that's the case, then would the gait derangement- where would it originate from?

A: If it was coming from the hip or back, the primary problem could be coming from one of those particular areas. If the problem- if there is an ongoing problem in his residual leg through an altered gait, compensatory gait, that kind of thing, he could certainly overload the joints that are proximal to the surgical site, so the knee, the hip, the back, or he could even start to get pain or problems on the other side, too, so it could be either way. I think it would depend on what the pattern of complaint would be, so-.

Q: Okay. But it would be possible for the gait derangement to be- the source of it to predate the amputation or the fusion?

A: It could. It certainly could.

Q: And it depends on the pattern.

A: Yeah.

Concerning what would typically develop from an injury of the left lower extremity of the magnitude of Walker's, Dr. Alley opined:

> A: Well, typically, a patient may assume an altered gait where they'll externally rotate the lower extremity to try to prevent a heel-to-toe progression of weight-bearing, and, in so doing, they'll often further stress the ankle, the subtalar joint, the knee and even the hip on that- on the injury side, or the ipsilateral side; and, at the same time, occasionally the patient will put more pressure on the contralateral foot, ankle, knee, hip that may be in an effort to off-load the injured side. And the back- the back issues can develop because of, oh, trying to lean towards or away from the injured side, so that's how I would see that.
>
> Q: And by 'back' you mean spine.
>
> A: Yes.
>
> Q: And this is an expected sequala of an injury of that magnitude to the left lower extremity, wouldn't you say?
>
> A: It's certainly not unreasonable that that might develop.
>
> Q: Do you think that it did develop in the case of Mr. Joe D. Walker?
>
> A: To the best of my knowledge, yes, I think that the crush injury likely was behind his chronic venous insufficiency, the injury to the ankle and the mal-union of the fracture site along with post-traumatic arthritic changes, that certainly that was a

> reasonable consequence to that severity of injury.
>
> Q: Including development of spinal pain?
>
> A: And that- I never really was involved with that part of it. I don't really know what the specifics were with his back or his spine, and I'd have to refer- defer to Dr. Vraney in those regards.
>
> Q: Well, whatever Dr. Vraney says, but you know that spine problems do develop under these circumstances over time.
>
> A: That's- that's true. It can.

When Dr. Alley was asked if Walker's gait derangement would have worsened after undergoing the procedures, he testified as follows:

> ***Q: Assuming that he walked with an altered gait from and after the 1984 injury, would his gait derangement kind of be the same as before he treated with Orthopaedic Associates? Would it be affected at all after the procedures? (emphasis added).***
>
> ***A: Oh, sure.*** I think the gait derangements that he had leading up to the- I guess the subsequent changes in the subtalar and ankle joints, the goal of any treatment is to certainly try to support those joints, you know, conservatively; and that's when we use different orthotics, or shoe arch supports, or ankle supports and things, and none of that seemed to help; so, once we had exhausted the reasonable conservative treatments, then that's our indication for surgically fixing

> it. Whenever you fuse major joints in the rear part of the foot, that is, the ankle joint, subtalar joint, you're certainly going to limit- well, when you have limited motion in those joints, what you're trading is flexibility for stability; so, by realigning the subtalar joint, it's an effort to off-load or reduce the pressures or the pain that's occurring in the surrounding joints. However, sometimes- of course, when you fuse the joints, you're going to end up overloading those joints somewhere down the road; so 20 years or so he may develop some ankle joint arthritis if everything was healing ideally, so it's all possible. (emphasis added).

The January 14, 2015, report of Dr. Eric Goebel was introduced in which he opined as follows under the heading "assessment/plan":

> Mr. Walker will return to see [sic] in 6 weeks for another checkup. He has some concerns regarding disability and how disabling his left lower extremity amputation was. ***This certainly has affected his gait to some degree and this probably contributes to some of the lumbar disease and would certainly affect the gait and mechanics of his lumbar spine and can contribute to some of that disease.*** Again, I will see him back in 6 weeks. (emphasis added).

Dr. Goebel was deposed on April 22, 2015. He testified he performed a L4-5 fusion on December 17, 2014. Dr. Goebel testified further:

Q: In your opinion, did Mr. Walker's degenerative changes exist prior to this amputation procedure?

A: I'm sure- I'm sure there were some change [sic] before then, given that he had a fusion six years before I operated on him, so you're gonna see some degeneration there over time.

Q: So, would it be fair to say that Mr. Walker's complaints of back pain are due to his degenerative changes and not the below-knee amputation specifically or any effects from the below-knee amputation?

A: Well, it's attributable to the back pain. Now, the question is, was his altered gait over time causative of his changes in his back, and that would be debatable, and- I mean, no doubt about it, abnormal gait can affect your back and cause degeneration, abnormal mechanics, so that's the question is, did the abnormalities of his gait cause his degenerative changes that he had?

Q: Are you aware that Mr. Walker complained of a gait derangement and had an abnormal gait leading to back pain- leading to complaints of back pain prior to the amputation?

A: I think he did, yeah, because he's had it for years. Even after his crush injury, he had problems before that, from what I recall.

Q: Does the gait derangement that he suffered from after his- he got his left below-knee amputation differ in any way from the gait derangement he complained about prior to the amputation?

A: Not that I'm aware of. I don't recall that basically.

Q: So kind of just to rephrase that, if he had complained of a gait derangement, you know, before he got his leg cut off and then he's still complaining of a gait derangement after the amputation, it's kind of the same?

A: The same problem; yes.

Q: The same problem.

A: Exactly. It's not so much related to the amputation itself, it's related to the abnormal mechanics that he may have had with his leg before that even.

...

Q: Did Mr. Walker ever ask you specifically if his altered gait was caused by the left leg amputation that he underwent?

A: I can't recall if it's from the left- I know he asked about whether his left leg issues would've caused his altered gait, and I can't remember whether it was his knee replacement or the prior injuries, but he did ask if the leg issues were causing- could've caused his back issues, and it's- I knew all that.

***Q: What did you tell him regarding this?***

***A: I told him it certainly could. So the leg- altered gait, if you have a leg problem and you're not walking, your mechanics are off, that could contribute to back problems such as that he has.*** (emphasis added).

Dr. Goebel testified that he still agrees with his original assessment set forth in his January 14, 2015, report. However, he also testified:

> ***Q: Now, a gait disorder based on a crush injury to an ankle that later results in an amputation of the ankle would be expected to accelerate the degenerative change in other ambulatory joints. Would that be a fair thing to say?***
>
> ***A: That is a real possibility; yes. Yes.***
>
> Q: It's a probability, isn't it?
>
> A: A fairly high probability.
>
> Q: All right. (emphasis added).

We first note the October 14, 2015, Opinion and Order, reveals some factual errors. The "Order" states the ALJ is overruling Lodestar's September 6, 2011, Medical Fee Dispute "to the extent that it seeks to deny treatment for Plaintiff's ankle fusion, amputation and resulting gait disorder and increase in back pain." However, Lodestar's September 6, 2011, Medical Fee Dispute describes the nature of the dispute as follows: "Plaintiff saw Dr. Alley on 8/8/11. Dr. Alley planned to proceed with left ankle removal of screws subtalar joint fusion ankle joint, talonavicular joint with calcaneocuboid joint fusion, possible ICBG, UR approved the screw removal but denied the

fusion." It is clear Lodestar's September 6, 2011, Medical Fee Dispute did not contest Walker's gait disorder and back pain. The record indicates Walker's January 19, 2012, Medical Fee Dispute asserts entitlement to future medical care for his alleged gait disorder. Additionally, Lodestar voluntarily withdrew its September 6, 2011, Medical Fee Dispute. The ALJ's order dated February 13, 2012, provides this specific notation:

> The Defendant/employer has agreed to be responsible for the left lower extremity treatment, including the proposed surgery (but excluding the back and gait disorder) and therefore the Defendant/employer's Motion to Reopen is voluntarily dismissed.

Therefore, there was no Medical Fee Dispute filed by Lodestar to be decided in the October 14, 2015, Opinion and Order. However, in light of the substantial evidence supporting the ALJ's resolution of Walker's Medical Fee Dispute, we find this to be harmless error.

Lodestar's first argument on appeal is Walker's reopening for medical expenses related to his back is barred by the statute of limitations as set forth in KRS 342.185 and KRS 342.125. We disagree and affirm on this issue.

As indicated by the ALJ in the October 14, 2015, Opinion and Order, the case of Addington Resources, Inc. v. Perkins, 947 S.W. 2d (Ky. App. 1997), is directly applicable. In Addington, supra, the Court of Appeals discussed the "direct and natural consequences" rule stating as follows:

> The applicable rule has been referred to as the direct and natural consequence rule and is explained in Larson, *Workmen's Compensation Law* § 13.11 (1996), as follows: "The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury." *See also Dutton v. Industrial Commission of Arizona,* 140 Ariz. 448, 682 P.2d 453 (Ct. App. 1984); and *Beech Creek Coal Co. v. Cox,* Ky., 314 Ky. 743, 237 S.W.2d 56 (1951).

Id. at 423.

As found by the ALJ in the October 14, 2015, Opinion and Order, substantial evidence links Walker's back pain to his gait abnormality, and Walker's gait abnormality is a direct result of his ankle fusion and subsequent amputation. Since his surgical treatment is work-related, treatment of the gait derangement is also work-related. The ALJ relied upon the opinions of Drs. King, Alley, and Goebel, as discussed herein, to conclude that Walker's worsened left lower extremity injury, *which Lodestar has*

*accepted as work-related and compensable*, has "caused or contributed to a gait abnormality and his current back pain is secondary to the gait abnormality." In other words, a direct and natural consequence of Walker's ankle fusion and subsequent amputation is his gait abnormality, and the heightened back pain stems from this gait abnormality. The ALJ aptly noted, "[t]his isn't a matter of the original back condition worsening." Thus, the two-year statute of limitations as set forth in KRS 342.185 is inapplicable.

As to whether the statute of limitations as set forth in KRS 342.125(3) serves as a bar to the medical dispute, as articulated by the ALJ in the October 14, 2015, Opinion and Order, KRS 342.125(3) provides an exemption from the four-year statute of limitations "for reopening solely for determination of the compensability of medical expenses." We agree with the ALJ's assessment that "[h]ere, KRS 342.125(3) provides both parties with the mechanism by which a determination can be made as to the reasonableness, necessity and work-relatedness of medical treatment. ***That mechanism has been utilized by both parties in this claim.***" (emphasis added). Thus, the four-year statute of limitations as set forth in KRS 342.125(3) is inapplicable.

Lodestar's second argument on appeal is that Walker's reopening is barred by *res judicata*. We disagree and affirm on this issue.

*Res judicata* prohibits the re-litigation of issues which have been finally determined on the merits. *See* Garrett Mining Co. v. Nye, 122 S.W.3d 513 (Ky. 2003). As pointed out in Whittaker v. Reeder, 30 S.W.3d 138 (Ky. 2000):

> Workers' compensation is a creature of statute. As set forth in Chapter 342, workers' compensation proceedings are administrative rather than judicial. Although the principles of error preservation, *res judicata,* and the law of the case apply to workers' compensation proceedings, they apply differently than in the context of a judicial action. For that reason, authority based upon judicial proceedings is not necessarily binding in the context of proceedings under Chapter 342.

Id. at 143.

As explained by the ALJ in the October 14, 2015, Opinion and Order, the fact that Walker was barred from bringing a claim regarding his back condition "is a separate and distinct issue from whether his lower extremity injury has caused a gait derangement and back pain that is 'secondary' to that gait derangement." This

distinction is critical and ends the argument regarding the applicability of *res judicata*. The ALJ further opined,

> This isn't a matter of the original back condition worsening- but rather the ankle fusion and ultimately the below the knee amputation causing an acceleration of his gait abnormality and the pain being secondary to the gait abnormality. The back pain is related to the medical treatment (and the resulting gait abnormality) for the left lower extremity.

We find Slone v. Jason Coal Co., 902 S.W.2d 820 (Ky. 1995) to be inapplicable. In Slone, supra, the claimant failed to assert a psychiatric injury in his original claim "although it was known to him by the use of ordinary prudence and diligence." Id. at 822. The claimant then asserted a worsening of the known psychiatric condition on reopening. In the case *sub judice*, Walker did not assert a worsening of back pain in his January 19, 2012, Medical Fee Dispute. Instead, Walker's Medical Fee Dispute pertained, in part, to future medical care regarding treatment of a gait disorder caused by his work-related left ankle injury.

Accordingly, the October 14, 2015, Opinion and Order and the November 19, 2015, Order on Petition for Reconsideration are **AFFIRMED**.

ALL CONCUR.

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