Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: June 26, 2015

CLAIM NO. 201200743

RICKY DEAL PETITIONER

VS. **APPEAL FROM HON. R. ROLAND CASE, ADMINISTRATIVE LAW JUDGE**

KTK MINING OF VIRGINIA, LLC
and HON. R. ROLAND CASE,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION
VACATING AND REMANDING
* * * * * *

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

STIVERS, Member. Ricky Deal ("Deal") seeks review of the February 9, 2015, Opinion, Award, and Order of Hon. R. Roland Case, Administrative Law Judge ("ALJ") finding Deal contracted coal worker's pneumoconiosis ("CWP") Category 1/1, while in the employ of KTK Mining of Virginia, LLC ("KTK"). The ALJ awarded retraining incentive benefits ("RIB") and other associated benefits should Deal avail

himself of designated educational opportunities as set forth in KRS 342.732(1)(a) 1. through 6. The ALJ also awarded medical benefits.

Deal challenges the ALJ's award on two grounds. Deal first argues the ALJ never set a "60-30-15 proof schedule" as required by 803 KAR 25:010 Section 8.[1] Deal contends the parties never waived their procedural rights set forth in the regulations. In the alternative, he argues even if the "standard procedures" do not apply, the ALJ should have ruled on his request for additional proof time "to obtain proof" from Dr. Sanjay Chavda, the physician appointed by the Department of Workers' Claims ("DWC"). He notes the DWC received his motion on February 9, 2015, which was before the expiration of the proof time. Deal contends the ALJ's decision was rendered on that same date apparently without reference to the DWC's records. Thus, he requests remand for consideration of his motion for an extension of time.

Next, Deal argues the ALJ erred in determining his highest spirometic values were above 80% of the predicted normal value. He notes Dr. Chavda's largest FVC

[1] Deal references the proof schedule of sixty days for all parties, thirty days for the defendant, and fifteen days rebuttal for the Plaintiff.

value was 3.14 liters and his largest FEV1 value was 2.47 liters.[2] Dr. Chavda noted Deal is sixty years old and 66.5 inches tall which converts to 168.91 centimeters. Deal asserts use of the predicted values contained in the 5th Edition of the American Medical Association, Guides to the Evaluation of Permanent Impairment ("AMA Guides") is required by both 803 KAR 25:009 Section 6, and KRS 342.732. Deal notes 803 KAR 25:009 Section 6, requires his height be rounded to the nearest centimeter and if his height is an odd number, the next highest even height in centimeters shall be used. He notes "168.91 rounds up to 169, but the next highest even height is 168." Therefore, under the latest table of predicted normal values and the directions given under the regulation, a sixty year old man of 168 centimeters height would have a predicted normal FVC of 4.15 liters and a predicted normal FEV1 of 3.30 liters. An FVC of 3.14 liters is 75.66% of 4.15 and an FEV1 of 2.47 liters is 74.85% of 3.30.[3]

Deal argues the ALJ erroneously relied upon Dr. Matt Vuskovich who based his opinions upon the "Knudson '76 reference values" ("Knudson"). Deal notes Dr. Vuskovich

[2] FVC is the Predicted Normal Forced Vital Capacity. FEV1 is the Predicted Normal Forced Expiratory Volume in the first second.
[3] The predicted normal FVC and FEV1 for men are set forth in Tables 5-2a and 5-4a on pages 95 and 97 of the AMA Guides, respectively.

utilized Dr. Chavda's measurements and determined the predicted FVC and FEV1 based on Knudson. He represents that utilizing the Knudson values results in a predicted FVC of 3.78 rather than 4.15 and the predicted FEV1 is 2.96 rather than 3.30. Thus, Dr. Vuskovich found the highest FVC and highest FEV1 to be 83% for both, as opposed to the values provided in the regulations.

Deal argues in determining whether his FVC and FEV1 levels are above or below 80% of predicted normal values the physicians must consult the AMA Guides. He maintains application of the predicted FVC and FEV1 contained in the AMA Guides results in his spirometric test values being no more than 75.66% of predicted normal values. Therefore, as a matter of law the ALJ could not find he had spirometric test values of 80% or more of predicted normal values.

Deal also argues he is entitled to income benefits pursuant to KRS 342.732(1)(b) since he had Category 1/1 and his spirometric test values were greater than 55% but less than 80% of predicted normal values. He contends an irrebuttable presumption attaches that he has a disability rating of 25%.

As a sub-part of that argument Deals asserts as follows: "[t]he ALJ [sic] ruling concerning causation as a

requirement for tier II benefits is not consistent with the statute."

Deal's August 9, 2012, deposition establishes his date of birth is September 17, 1954, and he stopped working due to a heart condition which necessitated implantation of six stents. He worked for KTK for ten years as a maintenance worker at its prep plant. He testified during the course of his employment he was constantly exposed to coal dust. Deal estimated he worked eight years underground and twenty-eight or twenty-nine years in and around coal. Deal provided the following testimony regarding his history as a cigarette smoker:

> Q: Have you ever been a cigarette smoker?
>
> A: Yes.
>
> Q: Are you still smoking?
>
> A: I'm trying to cut back. I smoke half a pack to a pack a day. But I bought me one of the electronic cigarettes and …
>
> Q: How many years have you smoked?
>
> A: I'd say – I'd say ten or fifteen year [sic].
>
> Q: No longer than that?
>
> A: No. I did, but I quit and got away from them, then started back. I was stupid.

> Q: You said that you are now trying to keep it somewhere between a half a pack and a pack?
>
> A: Yes, ma'am.
>
> Q: What were you doing before that?
>
> A: That's basically all I've ever smoked. I'm not – I was never a heavy smoker.
>
> Q: Never smoked a couple of packs a day or more than that?
>
> A: I'd say probably I have, you know. Probably two or three year [sic] I probably did. But when I had the stents put in, that's – that's when they really told me it's time to give them up.

Deal introduced the x-ray report of Dr. Thomas Miller who opined Deal had radiographic classification of category 1/1. Dr. Miller determined Deal's highest FVC and FEV1 were 76.

KTK introduced the August 27, 2012, report of Dr. Bruce Broudy generated as a result of his examination and testing of Deal on that same date. The pulmonary studies resulted in a pre-broncodialator FCV of 68% and FEV1 of 66% and post-broncodialator FCV of 70% and FEV1 of 64%. Dr. Broudy concluded there was no evidence of clinical pneumoconiosis even though there is a sufficient history of exposure. He noted chronic bronchitis is far more likely due to cigarette smoking since Deal continued to be a

smoker until the time of the examination and also because chronic bronchitis associated with coal dust exposure usually subsides with cessation of exposure. Dr. Broudy noted chronic obstructive airways disease is also characteristic of cigarette smoking. Therefore, he concluded Deal did not have “legal pneumoconiosis.” He also noted the results of spirometry, “in spite of less than maximal effort,” still exceed the minimum federal criteria for disability in coal workers.

Pursuant to KRS 342.315 and 342.316(3)(b)4.b., Deal underwent a medical evaluation on October 30, 2014, performed by Dr. Chavda and his report of the same date was filed in the record. With respect to causation, Dr. Chavda concluded Deal’s disease was the result of exposure to coal dust in the severance or processing of coal. However, he concluded the pulmonary impairment was not the result of exposure to coal dust in the severance or processing of coal. A written narrative attached to the Form 108-CWP states Deal had a history of smoking from 1972 to 2014 and for thirty years smoked one pack a day and for three years one-half pack a day. Dr. Chavda noted chest x-rays

revealed pneumoconiosis category 1/1.[4] The FCV and FEV1 functions Dr. Chavda obtained are as follows:

PRE-BRONCHODILATOR PFT:

Best FVC 3.14, 74% of predicted.

Best FEV1 2.47, 78% of predicted.

POST-BRONCHODILATOR PFT:

Best FVC 2.92, 69% of predicted.

Best FEV1 2.44, 77% of predicted.

Dr. Chavda stated the spirometry shows mild obstructive airway disease with no bronchodilator response. Dr. Chavda's diagnosis was pneumoconiosis, CAD, and chronic tobacco abuse. Dr. Chavda reiterated Deal's disease was the result of exposure to coal dust and the pulmonary impairment was not due to exposure to coal dust. Dr. Chavda's Pulmonary Function Analysis attached to the Form 108-CWP and narrative report contains the following:

> POST TEST COMMENTS:
>
> Good patient effort, comphension [sic] & cooperation. The results of this test meet the ATS standards for acceptability and repeatability. Provential used for bronchodilation. DLCO less than 85% inspiration.

By Order dated November 15, 2014, the ALJ conducted a telephonic Benefit Review Conference ("BRC") on

[4] Dr. James Crum interpreted the chest x-ray to reveal pneumoconiosis.

December 22, 2014. The December 22, 2014, BRC Order contains the following: “Case to be submitted on record on 2/7/15. Hearing waived unless motion filed requesting a hearing” and “Proof time for all parties thru 2/7/15.” The ALJ noted both parties had seen and agreed to the order “by phone.”

On December 24, 2014, KTK filed the December 6, 2014, Pulmonary Function Study Validation report of Dr. Vuskovich. Dr. Vuskovich’s introduction reads, in relevant part, as follows:

> Recognizing that standardization is critical for establishing the validity of any medical test, the guidelines and recommendations published by the National Institute for Occupational Safety and Health (NIOSH) that address standardization issues are utilized. To compare miner generated pulmonary function values with population normal values standardized for age and height. The 1976 [footnote omitted] edition Knudson population normal values are utilized. As a supplement to this document specific references are provided.

On page two of his report, Dr. Vuskovich notes Dr. James Crum interpreted Deal’s October 30, 2014, chest x-ray and found simple pneumoconiosis ILO 1/1. Dr. Vuskovich utilized Dr. Chavda’s October 30, 2014, spirometry results in calculating the percentage of predicted results based on Knudson. Accordingly, based on

Deal's age of sixty, height of 66.5 inches, Dr. Vuskovich calculated the pre-bronchodilator FVC and FEV1 to be 83%. His FVC post-bronchodilator was 77% and his FEV1 was 82%. In providing these results, Dr. Vuskovich again cited to Knudson. Although he was not present at Dr. Chavda's examination, Dr. Vuskovich stated Deal did not put forth the effort required to generate valid spirometry results and his inspiratory efforts were variable which artificially lowered his FVC and FEV1 results. He concluded Deal prematurely terminated his expiratory efforts.

On February 2, 2015, KTK filed the x-ray interpretation of Dr. William A. Kendall. Dr. Kendall concluded the film quality was "[g]ood, [g]rade 1" and there was no evidence of CWP.

On February 9, 2015, Deal filed a motion for an extension of time which was served on February 6, 2015. He sought a ten day extension of time in order to obtain an opinion from Dr. Chavda which he requested on January 6, 2015. Deal's counsel represented he had called Muhlenberg Community Hospital several times inquiring whether Dr. Chavda would respond to his correspondence. He represented he was told on February 6, 2015, that Dr. Chavda was still unavailable. Deal asserted that given the importance of

the question of causation raised by Dr. Chavda's report, a ten day extension was necessary. On that same date, the ALJ entered the Opinion and Order.

After summarizing the test results from the various physicians, the ALJ entered the following findings of fact and conclusions of law:

> Although the report of Dr. Chavda is not entitled to presumptive weight pursuant to KRS 342.315(2) since it was not performed by a University Evaluator, the Administrative Law Judge finds the report of Dr. Chavda to be the most persuasive. Dr. Chavda was independently selected by the Commissioner of the Department of Workers' Claims for his evaluation. Dr. Miller was selected by the plaintiff and Dr. Broudy was selected by the employer. The Administrative Law Judge has considered all of the evidence in accordance with Magic Coal v. Fox, 19 SW 3d 88 (Ky. 2000). The Administrative Law Judge chooses to rely on and is persuaded by the opinion of the [sic] Dr. Chavda who was independently selected by the Commissioner of the Department of Workers' Claims.
>
> It is further found the plaintiff has established the presence of x-ray evidence of coal workers' pneumoconiosis Category 1/1. Pursuant to KRS 342.732(2), the Administrative Law Judge must use the highest FVC value or highest FEV1 value determined from the totality of all such spirometric testing. Additionally, pursuant to Fields v. Carbon Coal Company, 920 SW 2d 880 (Ky. App. 1996), the Administrative Law Judge does not have the discretion to choose between

> pre-bronchodilator or post-bronchodilator testing, but must accept the highest. Therefore, consistent with the above, the Administrative Law Judge must accept the pre-bronchodilator study performed by Dr. Vuskovich indicating an FVC of 83% and FEV1 of 83%. The Administrative Law Judge can rely on either the highest FVC or highest FEV1. Additionally, Dr. Chavda noted any reduction in pulmonary impairment was not causally related to the plaintiff's exposure to coal dust. It is therefore found the Plaintiff has established the presence of Coal Workers' Pneumoconiosis, Category 1/1 and no respiratory impairment resulting from exposure to coal dust as evidence by pulmonary function studies greater than 80%, and therefore limits entitlement to benefits pursuant to KRS 342.732(1)(a)1. However, the plaintiff only has an eleventh grade education and he could receive benefits pursuant to KRS 342.732(1)(a)3 for a period up to 17 weeks while pursuing a GED.

We find no merit in Deal's first argument the ALJ erroneously failed to comply with the regulations concerning the proof schedule and the claim should be remanded for consideration of his motion for extension of time. The December 22, 2014, BRC Order reflects the parties agreed the claim would be submitted based on the status of the record on February 7, 2015. A hearing was waived unless a motion was filed requesting one. The parties had until February 7, 2015, to file proof. The BRC Order establishes Deal willingly waived any right to object

to the ALJ's failure to comply with the specific regulation pertaining to the proof schedule for the parties.

More importantly, Deal's motion for an extension of time served on February 6, 2015, one day before expiration of the proof time, was not timely as it was not filed in the record until February 9, 2015. In addition, Deal's motion for an extension of time was not timely pursuant to 803 KAR 25:010 Section 15 which reads, in relevant part, as follows:

> Section 15. Extensions of Proof Time.
>
> (1) An extension of time for producing evidence may be granted upon showing of circumstances that prevent timely introduction.
>
> (2) A motion for extension of time shall be filed no later than five (5) days before the deadline sought to be extended.
>
> (3) The motion or supporting affidavits shall set forth:
>
> (a) The efforts to produce the evidence in a timely manner;
>
> (b) Facts which prevented timely production; and
>
> (c) The date of availability of the evidence, the probability of its production, and the materiality of the evidence.
>
> (4) In the absence of compelling circumstances, only one (1) extension of thirty (30) days shall be granted to

> each side for completion of discovery or proof by deposition.

Deal's motion for an extension of time was not filed five days or more before the deadline of February 7, 2015. Further, Deal did not demonstrate circumstances that prevented a timely introduction of the evidence. Deal merely indicated that on January 6, 2015, he requested information from Dr. Chavda and he had called his office several times to find out whether he had any response. The motion did not provide the facts which prevented timely production of the evidence, the date of availability of the evidence, the probability of production, and the materiality of the evidence. Further, Deal did not file a petition for reconsideration raising this error of the ALJ. Consequently, we find no error in the ALJ's failure to rule upon Deal's untimely motion.

However, Deal's second argument has merit. 803 KAR 25:009 Section 6 reads as follows:

> Section 6. Use of American Medical Association's "Guides to the Evaluation of Permanent Impairment" in Coal Workers' Pneumoconiosis Cases. (1) Predicted normal values for FVC and FEV1 shall be determined in accordance with the latest edition of the American Medical Association Guideline. Age shall be determined as of the date of the evaluation. Height shall be measured while the plaintiff stands in his stocking feet and shall be rounded

> to the nearest centimeter. If the plaintiff's height is an odd number of centimeters, the next highest even height in centimeters shall be used.
>
> (2) Formulas established by the guidelines for predicted normal FVC and FEV1 shall be applied and predicted values computed.

Without question, the predicted normal values for Deal's FVC and FEV1 are to be determined in accordance with the tables contained in the AMA Guides. Since Dr. Vuskovich's calculation of Deal's pre-bronchodilator and post-bronchodilator FVC and FEV1 was not based on the AMA Guides, his calculations and opinions should have been rejected and not considered by the ALJ. On the first and second page of Dr. Vuskovich's report he unequivocally states his FVC and FEV1 results were obtained utilizing the Knudson '76 population spirometry references values.

Deal's failure to raise this issue with the ALJ does not defeat his argument on appeal, as it is clear the ALJ could not rely upon the opinions expressed by Dr. Vuskovich regarding the FVC and FEV1 values as they were not based upon the AMA Guides. The ALJ's reliance upon Dr. Vuskovich's opinions was an error of law and not an error of fact. As an appellate tribunal, 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 were sustained by evidence of probative value. Uninsured Employers' Fund v. Garland, 805 S.W.2d 116 (Ky. 1991). Here, the ALJ's award was not supported by evidence of probative value as Dr. Vuskovich's opinions could not constitute substantial evidence supporting the ALJ's award. In Jones v. Brasch-Barry General Contractors, 189 S.W.3d 149 (Ky. App. 2006), the Kentucky Supreme Court instructed:

> Under our law, the AMA Guides are an integral tool for assessing a claimant's disability rating and monetary award. So to be useful for the fact-finder, a physician's opinion must be grounded in the AMA Guides, meaning that a physician's personal antagonism toward the AMA Guides, such as that demonstrated by Dr. Reasor in this case, is legally irrelevant. And any assessment that disregards the express terms of the AMA Guides cannot constitute substantial evidence to support an award of workers' compensation benefits.

Accordingly, the ALJ's decision must be vacated and the claim remanded for a decision based upon the evidence in the record without consideration of Dr. Vuskovich's report.

We decline to remand this matter to the ALJ with instructions to enter an award of income benefits based upon a 25% occupational impairment pursuant to KRS 342.732(1)(b)1. To say that KRS 342.732(1) is poorly written is an understatement. KRS 342.732 Section 1(a)1 allows a one-time award of RIB benefits:

> If an employee has a radiographic classification of category 1/0, 1/1, coal workers' pneumoconiosis, and spirometric test values of 80% or more…

KRS 342.732(1)(b)1 provides an irrebuttable presumption the employee has a 25% occupational disability,

> If the employee has radiographic classification category 1/0, 1/1, CWP, and respiratory impairment evidenced by spirometric test values of fifty-five percent (55%) or more but less than eighty percent (80%) of the predicted normal values or category 2/1, 2/2, or 2/3 coal workers' pneumoconiosis and spirometric test values of eighty percent (80%) or more of the predicted normal value.…

KRS 342.732 (1)(c) states there is an irrebuttable presumption that the employee has a 50% occupational disability,

> If it is determined that an employee has a radiographic classification of category 1/0, 1/1, or 1/2, and respiratory impairment resulting from exposure to coal dust as evidenced by spirometric test values of less than fifty-five percent (55%) of the predicted normal values, or category

> 2/1, 2/2, or 2/3 coal workers' pneumoconiosis and respiratory impairment evidenced by spirometric test values of fifty-five percent (55%) or more but less than eighty percent (80%) of the predicted normal values, or category 3/2 or 3/3 coal workers' pneumoconiosis and spirometric test values of eighty percent (80%) or more...

KRS 342.732(1)(d) states there is a presumption of 75% occupational disability,

> If it is determined that an employee has a radiographic classification of category 2/1, 2/2, or 2/3 coal workers' pneumoconiosis, based on the latest ILO International Classification of Radiographics, and respiratory impairment as evidenced by spirometric test values of less than fifty-five percent (55%) of the predicted normal values or category 3/2 or 3/3 pneumoconiosis and respiratory impairment evidenced by spirometric test values of fifty-five percent (55%) or more but less than eighty percent (80%) of the predicted normal values,…

KRS 342.732(1)(e) states there is an irrebuttable presumption the employee is totally disabled due to coal dust,

> If it is determined that an employee has radiographic classification of 3/2 or 3/3 occupational pneumoconiosis and respiratory impairment evidenced by spirometric test values of less than fifty-five percent (55%) of the predicted normal values, or complicated pneumoconiosis (large opacities category A, B, or C progressive massive fibrosis), ...

KRS 342.732(1)(a)1 does not require the spirometric test values of 80% or more be due to a respiratory impairment resulting from exposure to coal dust. The same holds true for KRS 342.732(1)(b)1, (1)(d) and 1(e). Only KRS 342.732(1)(c) specifically states the respiratory impairment must result from exposure to coal dust. However, KRS 342.732(2) reads:

> (2) The presence of respiratory impairment resulting from exposure to coal dust shall be established by using the largest forced vital capacity (FVC) value or the largest forced expiratory volume in one second (FEV1) value determined from the totality of all such spirometric testing performed in compliance with accepted medical standards.

Further, KRS 342.732(3) reads, in relevant part, as follows:

> When valid spirometric tests are not provided and a physician certifies to the administrative law judge that spirometric testing is not medically indicated because of the permanent physical condition of the employee, the administrative law judge shall make his or her decision on the basis of evidence admitted which establishes the existence of a diagnosis of occupational pneumoconiosis and respiratory impairment due to the occupational pneumoconiosis. …

Thus, in order for income benefits to be awarded for CWP the respiratory impairment must result from the

exposure to coal dust. Although Newberg v. Reynolds, 831 S.W.2d 170 (Ky. 1992) dealt with different versions of KRS 342.316 and KRS 342.732, we believe it firmly supports our conclusion. After reviewing various statutes, the Supreme Court concluded:

> Evidence of the required degree of respiratory impairment, as prescribed by KRS 342.732(2), is objective and based on the claimant's performance on the spirometric tests, the results of which are to be obtained and reported in accordance with KRS 342.316(2)(b)2.b. We note also that both KRS 342.732(1)(b) and KRS 342.732(2) refer to "respiratory impairment resulting from exposure to coal dust." It is apparent when reviewing the American Medical Association's *Guides to the Evaluation of Permanent Impairment,* upon which the legislature relied in drafting these statutes, that depressed spirometric test values may measure respiratory impairment caused by factors other than exposure to coal dust. Therefore, in a claim for benefits pursuant to KRS 342.732(1)(b) the claimant must prove not only that his spirometric test results indicate the requisite degree of respiratory impairment, he must also prove that his exposure to coal dust was a significant factor in causing the impairment.

Id. at 171-172.

On remand, if the ALJ chooses to again rely upon Dr. Chavda's report, he cannot award RIB benefits or permanent partial disability benefits as Dr. Chavda has

specifically stated Deal's respiratory impairment did not result from exposure to coal dust.

Accordingly, the February 9, 2015, Opinion, Award, and Order awarding RIB benefits pursuant to KRS 342.732(1)(a)1 through 6 and medical benefits is **VACATED**. This claim is **REMANDED** to the ALJ for a decision in conformity with the views expressed herein.

ALL CONCUR.

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