OPINION ENTERED: April 13, 2012

CLAIM NO. 200691157

RONALD B. RICHERSON PETITIONER

VS. **APPEAL FROM HON. DOUGLAS W. GOTT, ADMINISTRATIVE LAW JUDGE**

ABEL CONSTRUCTION COMPANY, INC.
and HON. DOUGLAS W. GOTT,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION
AFFIRMING

* * * * * *

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

ALVEY, Chairman. Ronald Richerson ("Richerson") appeals from the opinion, award and order rendered January 3, 2012 by Hon. Douglas W. Gott, Administrative Law Judge ("ALJ"), dismissing his claim for deep vein thrombosis ("DVT") against Abel Construction Company, Inc. ("Abel"). The ALJ awarded Richerson permanent partial disability ("PPD")

benefits based upon a 7% impairment rating and enhanced by the 3.4 multiplier pursuant to KRS 342.730(1)(c)1 and 3, temporary total disability ("TTD") benefits from February 28, 2006 to April 11, 2006, from October 13, 2006 to November 1, 2006, and from December 17, 2010 through May 25, 2011, and medical benefits. Neither party filed a petition for reconsideration.

Richerson argues on appeal the ALJ acted arbitrarily by adopting the opinion of Dr. Brown in finding his DVT unrelated. He also argues he is entitled to additional TTD benefits from April 12, 2006 to October 13, 2006 for his knee injury because his treating physician, Dr. Mehta, took him off work due to his knee injury. Richerson maintains although he underwent heart surgery, he remained off work because of his knee injury up to and including October 13, 2006. We affirm.

Richerson testified by deposition on January 15, 2010, and again at the hearing held November 15, 2011. Richerson, a resident of Greensburg, Kentucky, was born on March 21, 1947 and obtained his GED. He testified he has been in the construction industry for the majority of his working life. Richerson began working for Abel in 2003 as the director of estimating, the job he was performing on May 12, 2005. As director of estimating, he supervised the

estimating department, prepared estimates and large bids, received bids, drawings and contract documents, traveled to various job sites and attended bid meetings. Richerson testified he spent the majority of his time in his office.

On May 12, 2005, Richerson traveled to an off-site pre-bid conference meeting on a construction project being held in a temporary office trailer. The trailer had a ladder that was placed against the trailer to allow individuals access to the front door. As Richerson climbed the ladder, his right "knee went backwards and it popped real loud." Richerson testified he went into the meeting and his knee started burning and afterward he had difficulty walking due to pain. Richerson self-medicated for approximately a month before seeking treatment. Richerson testified he continued to work for Abel until February 27, 2006, when Dr. Mehta took him off work due to his knee injury and pending knee surgery. He has not worked since that time.

Richerson initially received treatment for his knee at Preston Station Occupational Health before seeing Dr. Mehta on July 26, 2005. Dr. Mehta treated Richerson's knee with injections, physical therapy and medications. He also performed a knee arthroscopy on December 21, 2006, and a medial hamstring release on December 17, 2010.

Richerson testified he had the second surgery in December 2010 after injections proved ineffective and his pain became too severe. Richerson testified the December 2010 surgery improved his condition, but he still experiences knee pain and leg weakness. In addition to Dr. Mehta, Richerson treats with Dr. Verghis for pain management. Dr. Verghis prescribes medications and has administered Novocain and alcohol injections to his knee.

Richerson testified he was diagnosed with DVT in April 2010, but he thought he began experiencing symptoms in 2008 or 2009. He explained he was not very mobile during this time due to his 2005 right knee injury and ensuing surgeries. He spent most of his day sitting in a recliner with his leg elevated. Richerson receives treatment for his DVT from his family physician, Dr. Brooks. He testified he does not have the physical capacity to return to his job as director of estimating.

Richerson treated with Dr. Mehta from July 26, 2005 through February 21, 2006 and did not see him again until October 13, 2006. During his deposition, Richerson testified regarding the gap in treatment as follows:

> Q: Well, my records from Dr. Mehta go through - - start now, July 26th of 05, and then go through February 21 of 06, and then there's a break in the records until October 13 of 06.

A: Okay. That’s correct.

Q: Okay. So from - - that was the period of time that you were not treating with Dr. Mehta because you had had the heart surgery and you were recovering from that?

A: No, I was treating with him, I just wasn’t going to the meetings, because when we did the pre-op for the scope on the knee that he had requested, and got approval for, that - - that showed up some heart problems. And so then we suspended knee treatment until the heart problems were solved.

Q: Okay. So the dates were from February of 06 to October of 06, that sounds correct to you, the time period that your treatment was suspended for your knee?

. . . .

A: But other than that, it’s - - your basically correct, yes.

Q: And I have a date of your bypass surgery as April 12 of 2006, it that correct?

A: That’s correct.

Q: Okay. And then once you recovered from that, you resumed your treatment with Dr. Mehta?

A: I was - -

Q: In October.

A: Yeah, I was cleared on the - - in the - - on the heart stuff, and then when I did - - I went to Dr. Mehta on the 13th of October, yeah.

TTD benefits were paid from February 28, 2006 to April 11, 2006, the day before his heart surgery. TTD payments resumed October 13, 2006, when he next saw Dr. Mehta following his heart surgery. Richerson testified at his hearing regarding the gap in treatment for his knee.

> Q: From April until October of 2006, do you know why those benefits stopped?
>
> A: During the exam for the hospital or to go to the hospital for the knee scope, they - - they found that I had some blockage in my arteries and they weren't - - the biggest or the worse one was 80 percent. A lot of people have them at a hundred percent. And so I had to have bypass surgery.
>
> Q: And when did you have that surgery?
>
> A: April the 12th.
>
> Q: There is no contention here today that the surgery itself was work related or related to your injury, is it?
>
> A: No.
>
> Q: All right. But is it your position that benefits should have remained payable during that time?
>
> A: Yes. I was off work for the knee, I wasn't off work for the heart. And, irregardless, you know, I could not have went back to work. There's no way I could have went back to work.
>
> Q: Was the bypass surgery necessary in terms of moving forward with treatment for your knee?
>
> A: No. No.

TTD benefits resumed October 13, 2006 through November 1, 2006, when Dr. Goldman determined Richerson had reached maximum medical improvement ("MMI") for his knee. Richerson's last period of TTD benefits extended from December 17, 2010, the date of his second knee procedure, through May 25, 2011, the date Dr. Goldman determined he had reached MMI.

In support of his Form 101, Richerson submitted the medical report of Dr. Fadel, an orthopedic surgeon, who examined him on October 27, 2009. Dr. Fadel noted Richerson's knee pain had been ongoing for approximately three and half years. He diagnosed chronic severe medial hamstring tendonitis of the right knee, which was poorly responsive to all palliative measures, and status post knee arthroscopy for partial meniscectomy and joint debridement with trivial residuals. Dr. Fadel noted he had reached MMI, was unable to return to his former occupation and recommended no further treatment beyond suboptimal palliation. Dr. Fadel assigned Richerson to "one of four Classes as outlined in Table 18-3" in the "Moderately Severe Impairment Class" pursuant to the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th Edition ("AMA Guides"), but did not provide a numerical rating.

Abel submitted the medical reports of Dr. Goldman, an orthopedic surgeon, who examined Richerson on May 31, 2007 and November 1, 2007. On May 31, 2007, Dr. Goldman diagnosed status post arthroscopy of the right knee for debridement of chondral defect of medial femoral condyle with continued posterior knee and thigh pain. He noted the torn hamstring tendon had never been documented other than symptomatically and it would be highly unusual for a hamstring tear/strain not to heal after two years particularly since he had significant rest after his bypass surgery. Therefore, Dr. Goldman recommended an MRI of the distal thigh.

Dr. Goldman again evaluated Richerson on November 1, 2007, after the recommended MRI was completed. He diagnosed status post arthroscopy and chondroplasty of medial femoral condyle and reported chronic tear of distal medial hamstring. However, Dr. Goldman noted it was very difficult to understand how his hamstring injury could not be healed after over two years and stated his complaints of pain were far out of proportion to what one would expect even with a complete hamstring tear. Dr. Goldman assessed a 0% impairment rating pursuant to the AMA Guides and stated Richerson had reached MMI. He recommended no further right knee treatment other than home exercises, opined he is not a

candidate for distal medial hamstring release and released Richerson to work with no restrictions.

Abel also submitted the medical report of Dr. Primm, an orthopedic surgeon, who evaluated Richerson on January 13, 2010. Dr. Primm diagnosed medial right hamstring strain, persistent subjective complaints of pain with no objective findings and suspect significant psychosocial overlay. Dr. Primm stated Richerson had sustained a work-related injury, consisting of a right medial hamstring strain which had healed. Dr. Primm assessed a 0% impairment rating with no restrictions. He noted Richerson should have reached MMI no later than three or four months after his injury, and it was difficult to understand why his hamstring had not resolved in light of inactivity following bypass surgery and a subsequent period of rest.

On July 21, 2010, Abel filed a Form 112 medical fee dispute listing Richerson's DVT and prescriptions of Coumadin and Lovenoxa for treatment of the DVT. A Utilization Review by Dr. Bart Olash dated July 13, 2010 was attached. Dr. Olash noted Richerson suffered a strain and a possible partial tear of the right hamstring, for which he was appropriately treated and which should have resolved within six months of the May 2005 accident. Dr. Olash noted

Richerson's DVT was diagnosed in April or May 2010, but he stated no documentation indicated he had any objective significant work-related pathology. Dr. Olash found nothing about the work injury which would have resulted in any functional impairment or immobilization or hyper-coagulation which accordingly he concluded would have caused DVT. Therefore, he opined the Coumadin, Lovenox and DVT treatment were not related to a work injury.

Abel also submitted the medical report of Dr. Brown, dated November 1, 2010, and Dr. Goldman, dated May 25, 2011. Dr. Brown, a vascular surgeon, noted Richerson's difficult recovery, deceased level of activity and current level of immobility due to the May 2005 work-related injury. Dr. Brown noted he was diagnosed with DVT in his right leg on May 7, 2010 but did not have the ultrasound report available to review and he requested a hyper coaguable workup. Dr. Brown found him to be at an elevated factor VIII activity which is an established risk factor for DVT events. Dr. Brown then stated:

> A common triad of symptoms that has been attributed to venous thromboembolism is stasis, hypercoagulability and trauma. The patient certainly did not have any recent trauma. He did have evidence of stasis as he had prolonged immobility and now has been documented as having hypercoagulability. Although his immobility was a risk factor for a blood

> clot, I do not believe that his injury in 2005 caused his most recent DVT.

Dr. Goldman performed a third examination on May 25, 2011 and noted since the last examination in 2007, Richerson had treated with injections and physical therapy and had undergone a distal hamstring tenotomy on December 17, 2010. He also noted he had an issue with blood clots in his leg after surgery. Dr. Goldman diagnosed a chronic medial hamstring strain, status post tenotomy, a reported articular surface cartilage tear of the medial femoral condyle, and status post chondroplasty. Dr. Goldman found Richerson had reached MMI and assessed a 0% impairment rating pursuant to the AMA Guides. He also recommended no further treatment beyond a home program in physical therapy, and weaning from narcotic pain medication. Regarding the DVT condition, Dr. Goldman stated "I can find no way to relate his deep vein thrombosis to the May of 2005 injury."

Richerson submitted a medical note dated August 19, 2010 by Dr. Mehta, his treating physician. Dr. Mehta noted he had developed DVT and explained:

> [H]is risk factors from DVT are the relative level of immobility that he has because of his hamstring injury and therefore there is definitely a cause fact relationship between those two clinical events.

No other medical notes by Dr. Mehta were submitted.

Richerson also submitted a medical note dated August 6, 2010 from Dr. Brooks, noting he had a 2005 right knee/hamstring injury causing constant pain and decreased mobility. His daily activities were more sedentary as a result of the 2005 injury, predisposing him to the development of vascular problems. Dr. Brooks stated: "We feel the occurrence of Mr. Richerson's deep vein thrombosis was due to the decreased mobility." Dr. Brooks noted the appropriate treatment for DVT is anticoagulation therapy for several months or until the clot has resolved.

Richerson submitted an addendum by Dr. Fadel dated August 18, 2010. Dr. Fadel had previously prepared a medical report in October 2009. Dr. Fadel noted an ultrasound report of Richerson's right leg confirmed DVT of the common femoral vein in his right leg which appeared to be chronic. Dr. Fadel assessed a 5% impairment rating for the DVT condition pursuant to the AMA Guides and noted:

> Given nature of this man's injury in May of 2005 and his persistent pain complaints as well as his tendency to maintain an immobile status, it is not unreasonable to conclude these newly discovered thrombi may well have occurred at the time of, or shortly after the work incident.

Richerson also submitted a second medical evaluation by Dr. Fadel performed on September 6, 2011. Dr. Fadel noted Richerson had been diagnosed with DVT in May 2009 and had a medial hamstring release procedure done on December 17, 2010. Dr. Fadel states:

> In the months prior to the discovery of the patient's DVT, his activity level was considerably diminished. He states he spent prolonged timeframes in which he would recline with his leg in extension and elevated for symptom control. The known injury coupled with a clinical of near immobility leads me to conclude the thrombus is work injury related. Certainty beyond dispute cannot be established however.[sic] There are any numbers of cases of DVT without apparent cause but immobility is a well known and widely accepted etiology.

Dr. Fadel opined Richerson had reached MMI and assessed a 7% impairment rating for his right knee injury and a 4% impairment rating for his DVT condition, for a combined 11% impairment rating pursuant to the AMA Guides.

In the opinion, award and order rendered January 3, 2012, the ALJ awarded Richerson PPD benefits based upon a 7% impairment rating, enhanced by the 3.4 multiplier pursuant to 342.730(1)(c)1 and 3, TTD benefits and medical benefits for his right knee/hamstring injury. In dismissing

Richerson's DVT claim and denying additional TTD benefits, the ALJ stated as follows:

> 8. It has long been the rule that the claimant bears the burden of proof and the risk of nonpersuasion before the fact-finder with regard to every element of a workers compensation claim. *Young v. Burgett, 483 S.W.2d 450 (Ky. 1972)*. In order for that burden to be sustained, no less than substantial evidence of each element of the claim must be introduced. Substantial evidence has been defined as some evidence of substance and relevant consequence, having the fitness to induce conviction in the minds of reasonable people. *Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986)*.
>
> As fact finder, the ALJ has the authority to determine the quality, character and substance of the evidence. *Square D Company v. Tipton, 862 S.W.2d 308 (Ky. 1993)*. Similarly, the ALJ has the sole authority to judge the weight and inferences to be drawn from the evidence. *Luttrell v. Cardinal Aluminum Co., 909 S.W.2d 334 (Ky.App. 1995)*. In weighing the evidence the ALJ must consider the totality of the evidence. *Paramount Foods Inc., v. Burkhardt, 695 S.W. 2d 418 (Ky. 1985)*.
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> 9. The ALJ finds that the medical expertise of Dr. Brown placed him in the best position to opine on the cause of Richerson's DVT, and relies on Dr. Brown to find that the blood clot and its residual effects are not work related. Dr. Brown's opinion, plus the diagnosis of the condition some five years after the work injury, supports the conclusion that the DVT is not work related.
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> . . .

12. Richerson claims entitlement to TTD for two additional periods of time. He first claims that his TTD should have been continued from April 12, 2006 through October 12, 2006. His testimony is that Dr. Mehta sought cardiac clearance before knee surgery in April, and surgery was performed when a blockage was found. Plaintiff similarly states in his Brief that, "Richerson was already off work by order of Dr. Mehta prior to the necessity of same." (p. 2). However, no medical evidence substantiates that position. The only evidence from Dr. Mehta in the record is the note summarized at paragraph No. 2 above.

Nevertheless, the ALJ disagrees with the Defendant's suggestion in its Brief that it is not liable for TTD simply because Richerson was recovering from heart bypass surgery from April through October 2006; if there was evidence that his knee condition also rendered him temporarily totally disabled, it would be liable for TTD until recovery from the heart surgery permitted the knee surgery to be carried out. But the ALJ agrees with the Defendant's argument that there is no medical evidence that Richerson's knee condition rendered him temporarily totally disabled during the disputed period of time. The claim for TTD during this period of time is denied.

The second period of time for which TTD is claimed is from November 1, 2006 through December 16, 2010. Richerson argues that because Dr. Goldman recommended a tenotomy in 2007, he was not at MMI (and thus entitled to TTD) until the surgery was eventually performed. The ALJ also denies this claim for TTD. Richerson's testimony

> and argument is an over-reading of Dr. Goldman's initial report. Dr. Goldman expressed the belief that Richerson's complaints were out of proportion to physical exam findings, and that there appeared to be no basis for his complaints. He said Richerson was at MMI and assigned no impairment. His statement, "There is nothing, short of possibly releasing the hamstring, which can be done for him," was not a present recommendation for such a procedure, and not an opinion of temporary total disability. Richerson overlooks a subsequent statement in Dr. Goldman's report that, "I do not believe he would be a candidate for a distal medial hamstring release."

As the claimant in a workers' compensation proceeding, Richerson had the burden of proving each of the essential elements of his cause of action, including entitlement to TTD benefits and causation/work-relatedness. Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Since Richerson was unsuccessful in his 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 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 determining whether the ALJ's findings 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).

Richerson did not file a petition for reconsideration. In the absence of a petition for reconsideration, on questions of fact, the Board is limited to a determination of whether there is any substantial evidence in the record to support the ALJ's conclusion. Stated otherwise, where no petition for reconsideration was filed prior to the Board's review, inadequate, incomplete, or even inaccurate fact-finding on the part of an ALJ will not justify reversal or remand if there is substantial evidence in the record supporting the ALJ's ultimate conclusion. Eaton Axle Corp. v. Nally, 688 S.W.2d 334 (Ky. 1985); Halls Hardwood Floor Co. v. Stapleton, 16 S.W.3d 327 (Ky. App. 2000).

As fact-finder, the ALJ has the sole authority to determine the weight, credibility and substance of the evidence. Square D Company 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 supporting 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 evidence. Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999). So long as the ALJ's ruling is supported by substantial evidence, it may not be disturbed on appeal. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

We find nothing in the evidence of record which would compel a finding Richerson's DVT condition was work-related. Richerson submitted his own testimony, medical notes of Dr. Brooks and Dr. Mehta and the medical report of Dr. Fadel to support a finding of work-relatedness. Abel submitted the medical opinions of Dr. Olash, Dr. Brown and Dr. Goldman to support a finding of no relationship. The ALJ found persuasive Dr. Brown's opinion and the fact Richerson was not diagnosed with DVT until nearly five years

after the work injury to support his finding the condition was not work-related. Richerson points to evidence supporting a different result and asks this Board to substitute our judgment for that of the ALJ by adopting the opinions of Drs. Brooks, Mehta or Fadel, a task which we are prohibited from doing. We believe the ALJ's determination the DVT condition is not work-related is supported by substantial evidence and therefore will not be disturbed.

The evidence does not compel a contrary result regarding an award of additional TTD benefits. KRS 342.0011(11)(a) defines TTD as follows:

> [t]he condition of an employee who has not reached maximum medical improvement from an injury and has not reached a level of improvement that would permit a return to employment.

In Magellan Behavioral Health v. Helms, 140 S.W.3d 579 (Ky. App. 2004), the Court of Appeals instructed that until MMI is achieved, an employee is entitled to a continuation of TTD benefits so long as she remains disabled from her customary work or the work she was performing at the time of the injury. The Court in Helms, supra, stated:

> In order to be entitled to temporary total disability benefits, the claimant must not have reached maximum medical improvement and not have improved

> enough to return to work. Id. at 580-581.

In the case *sub judice*, TTD benefits were paid from February 28, 2006 to April 11, 2006, from October 13, 2006 to November 1, 2006, and from December 17, 2010 through May 25, 2011. Abel suspended TTD payments from April 12, 2006, the date of Richerson's heart surgery, till October 13, 2006, the date he next saw Dr. Mehta. On appeal, Richerson argues he is entitled to additional TTD benefits during this time because Dr. Mehta had already taken him off work for his knee injury prior to the heart surgery, and remained off work because of his knee through and including October 12, 2006. It his brief to the Board, Richerson cites to medical notes of Dr. Mehta dated January 9, 2006 and February 21, 2006. However, after a thorough review of the record, such medical notes were not submitted by Richerson. The only medical note of Dr. Mehta in the record is dated August 19, 2010, and makes no mention of MMI, or whether Richerson could return to work. We do not believe the ALJ erred in finding Richerson had not met his burden in proving entitlement to additional TTD benefits since he provided no medical evidence in support of his position. We will not address the second suspension of TTD benefits because Richerson acknowledges in his brief to the Board the

ALJ acted within his discretion by denying additional TTD benefits from November 1, 2006 to December 16, 2010.

Accordingly, the opinion, award and order rendered January 3, 2012 by ALJ Hon. Douglas W. Gott is hereby **AFFIRMED.**

ALL CONCUR.

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