

Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: January 16, 2015

CLAIM NO. 201198399

WILLIE SLONE, JR.

PETITIONER

VS.

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

ICG KNOTT COUNTY, LLC
AND HON. STEVEN G. BOLTON,
ADMINISTRATIVE LAW JUDGE

RESPONDENTS

OPINION
AFFIRMING

* * * * *

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

ALVEY, Chairman. Willie Slone, Jr. ("Slone") appeals from the Opinion, Award and Order rendered May 22, 2014 by Hon. Steven G. Bolton, Administrative Law Judge ("ALJ"), finding he sustained a work-related left shoulder injury on July 30, 2010 while working for ICG Knott County, LLC ("ICG"). The ALJ awarded Slone temporary total disability ("TTD")

benefits, permanent partial disability ("PPD") benefits, and medical benefits. Slone also seeks review of the July 25, 2014 Order denying his petition for reconsideration.

On appeal, Slone argues the ALJ erred in finding he retains the physical capacity to return to the type of work he performed at the time of his injury. Slone also argues the ALJ erred by finding he did not suffer from psychological impairment due to his work-related injury. Because substantial evidence supports the ALJ's determinations, and no contrary result is compelled, we affirm.

Slone filed a Form 101 on July 27, 2013 alleging he injured his left shoulder and arm on July 30, 2010, when a clamp slipped off the conveyor belt. The Form 101 was later amended to include a psychological component. In support of his claim, Slone attached the September 15, 2010 note of Dr. Keith Hall, who stated he experienced persistent shoulder pain since the July 30, 2010 work injury. He diagnosed left shoulder rotator cuff tear and recommended surgical intervention.

Slone testified by deposition on January 21, 2013 and at the hearing held March 24, 2014. Slone is a resident of Wheelwright, Kentucky and was born on February 5, 1967. He is right hand dominant and completed the ninth grade.

Slone testified he cannot read or write. Slone has both surface and underground mining certificates. His work history includes jobs as a security guard, janitor and general laborer in the 1980's. Slone has worked in the underground coal mining industry for approximately twenty years, performing a variety of job duties. Slone began working underground for ICG in 2003 on third shift. Slone would "put belt line in, and we bolted, dusted, and just about anything they needed us to do, the day shift."

On July 30, 2010, Slone and two others had loaded one thousand feet of belt line onto a trailer to transport into the mines. At some point, a portion of the belt line slipped off causing Slone to fall backwards onto the ground. Slone heard a pop in his left shoulder, and experienced immediate pain and burning. Slone went home and sought medical treatment at the emergency room the same day.

Slone followed up with his family physician, Dr. Prem Verma, who prescribed pain medication and restricted him to light duty. Subsequently, Dr. Verma ordered a left shoulder MRI. He then took Slone off work and referred him to Dr. Hall. Dr. Hall performed left shoulder surgery on September 30, 2010 and ordered post-operative physical therapy. After no improvement, Dr. Hall ordered a second MRI and referred Slone to Dr. Kaveh Sajadi. Dr. Sajadi

performed a second procedure on the left shoulder on July 13, 2011. Thereafter, Slone continued to complain of left shoulder symptoms for which Dr. Sajadi ordered a third MRI. Based upon the results, Dr. Sajadi advised Slone he could provide no more help and released him from his care. Dr. Verma prescribed Zoloft and referred Slone to Mountain Comprehensive Care Center. Slone treats with Dr. Gonzales there every three months, who continues to prescribe Zoloft.

Following the work injury on July 30, 2010, Slone returned to work for ICG on light duty for five or six weeks until he was restricted from work by Dr. Verma. Slone has not returned to work since that time. Slone applied for and has been awarded Social Security disability benefits. Slone testified he experiences constant pain and occasional aching, throbbing and burning. His left shoulder pops and cracks when he raises his arm, and he has limited strength or movement. Since the work injury, Slone experiences nervousness, has concentration problems, and finds it difficult to talk to strangers or be in front of a large group of people. Slone currently takes Lorcet, Motrin 800 and Zoloft for his left shoulder and mental health. Slone testified he is unable to return to any of his previous work because "I can't use my arm the way I use to." In light of

his mental condition and physical limitations, Slone does not know of any other jobs he could do.

Both parties filed the treatment records generated as a result of Slone's work injury. Slone received conservative treatment and was restricted to light duty by Rural Healthcare in August and September 2010 due to left shoulder pain complaints following his work accident. Slone was referred to Dr. Hall after a September 4, 2010 left shoulder MRI revealed a complete disruption of distal supraspinatus tendon with proximal retraction. Dr. Hall rendered treatment from September 2010 to May 2011. On September 30, 2010, Dr. Hall performed a left shoulder mini-open rotator cuff repair and arthroscopic subacromial decompression. Thereafter, Slone underwent physical therapy and was prescribed pain medication. Dr. Hall ordered a left shoulder MRI arthrogram in March 2011 due to continued pain, stiffness and weakness. He referred Slone to Dr. Sajadi for a second opinion based upon the MRI results.

Dr. Sajadi treated Slone from April 2011 through May 2012. Dr. Sajadi opined the diagnostic studies revealed a mostly healed large rotator cuff tear, but he found evidence of a persistent tear in a couple of areas. Dr. Sajadi diagnosed persistent rotator cuff tear and possible adhesive capsulitis. Dr. Sajadi performed a left

arthroscopic rotator cuff repair, subacromial decompression, lysis of adhesions and capsular release on July 13, 2011. Despite the surgery and post-operative physical therapy, Slone continued to complain of left shoulder symptoms for several months. Dr. Sajadi ordered additional testing. The January 25, 2012 MRI report indicated a "defect within the supraspinatus tendon. This may represent a postsurgical defect or recurrent tear." On January 27, 2012, Dr. Sajadi noted he disagreed with the radiologist's reading of the MRI suggesting a persistent tear, and stated there were no significant findings other than possible early stage I fatty infiltration of the cuff. Dr. Sajadi diagnosed persistent pain and limitation after revision rotator cuff repair and found Slone had attained maximum medical improvement ("MMI"). Dr. Sajadi recommended no additional surgeries and stated he could not offer any more treatment. Dr. Sajadi referred Slone for a functional capacity evaluation ("FCE") to determine formal limitations. The FCE report is discussed on multiple occasions by several evaluating physicians but was not independently filed into evidence for review.

On May 16, 2012, Dr. Sajada assessed a 4% impairment rating pursuant to the 5th Edition of the American Medical Association, Guides to the Evaluation of

Permanent Impairment ("AMA Guides"). Dr. Sajadi provided no opinion regarding Slone's ability to return to his previous job. Regarding restrictions, Dr. Sajadi only stated Slone "also had a [FCE], which delineated permanent restrictions of his function."

Slone filed the October 29, 2012 Form 107-I report of Dr. James Owen, who examined him on October 24, 2012. Dr. Owen diagnosed persistent diminished range of motion and strength in the left shoulder status post two surgeries for severe rotator cuff tear and adhesive capsulitis. Dr. Owen stated Slone's injuries caused his complaints. Dr. Owen found Slone had reached MMI at the time of his evaluation and assessed a 10% impairment rating pursuant to the AMA Guides. Dr. Owen opined Slone does not retain the physical capacity to return to the type of work performed at the time of injury. He stated Slone's left shoulder "should not be used for any type of lifting or carrying greater than approximately 20 pounds and should not be used over the shoulder for any weight at all."

ICG filed the January 8, 2013 report of Dr. David Jenkinson who also reviewed the February 6, 2012 FCE and quoted several portions of the report. In the report, the therapist noted Slone's "perception of abilities is less than those the client was actually able to do safely," "pain

behavior such as grimacing, exaggerated movement patterns and pain talk were displayed" and Slone demonstrated "self-limiting behavior resulted in the inability to identify maximum work abilities." Likewise, Dr. Jenkinson noted evidence of self-limitation during his own examination, in that Slone actively restricted range of motion of his shoulder.

Dr. Jenkinson concluded Slone has no significant objective abnormality to explain his severe symptoms, which are not consistent with a well repaired relatively minor rotator cuff injury. Dr. Jenkinson found Slone had reached MMI and assessed a 3% impairment rating pursuant to the AMA Guides. He opined the following:

It is my opinion that Mr. Slone requires no further treatment and that he retains the capability to return to normal activities including the duties of an underground coal miner. There is no reason why he should have any work restrictions.

. . . .

It is my opinion that he retains the capability to return to his regular occupation without restriction and that he requires no further treatment.

ICG also filed the February 11, 2013 report of Dr. Gregory Snider, who also testified by deposition on February 26, 2013. Dr. Snider performed an examination and noted

evidence of submaximal effort and symptom magnification. Dr. Snider reviewed the medical records and the February 2012 FCE, noting the therapist recorded self-behavior and that Slone perceived he was more disabled than he was. Dr. Snider diagnosed status post rotator cuff repair, status post rotator cuff revised repair, and persistent left shoulder pain. Dr. Snider stated Slone had reached MMI. Dr. Snider assessed a 4% impairment rating pursuant to the AMA Guides. Under work status, Dr. Snider stated as follows:

I am unable to explain Mr. Slone's assertions of disability. His exam suggests a functional component. Limitations are based on subjective complaints. FCE results indicate self-limiting behavior and perceived disability in excess of tested ability. From an anatomic standpoint I do not have a good explanation for why Mr. Slone could not return to his pre-injury activity level.

At his deposition, Dr. Snider confirmed his opinions contained within the February 11, 2013 report. Dr. Snider testified Slone gave a poor effort during his examination, and exhibited pain behavior seemingly in excess of other objective findings. His examination revealed no evidence of any gross crepitus or grinding of the shoulder. Dr. Snider testified as follows regarding restrictions:

Q: Now Doctor, based upon your evaluation, would you place any restrictions or limitations on Mr. Slone related to this injury?

A: From an anatomic standpoint, he appears to have had an excellent mechanical repair, meaning as far as I can tell, the rotator cuff has been repaired; his shoulder has all the functional components there to perform essentially whatever he would want to do.

He's been left with a lot of subjective complaints that are not well explained and those are the limiting factors. The FCE that Dr. Sajadi ordered also suggested some self-limiting behavior and his perception of excess disability.

So if he has restrictions, they're based on his subjective complaints. The FCE results I suppose would have to speak for themselves there.

Q: Doctor, as far as being able to raise his arm above his shoulder, to hold his arm out, based on your objective findings, is there any basis to place any restrictions or limitations on those movements for Mr. Slone related to this injury?

A: Not really, no. He has what I would call a functional range of motion . . . meaning he has enough range of motion to do what most people would need to do even if he had no pain associated with that.

Slone filed the October 30, 2012 psychological report and 107-P form of Dr. Eric Johnson. Dr. Johnson diagnosed social anxiety disorder, generalized; reading

disorder; r/o borderline intellectual functioning. Dr. Johnson was unable to estimate Slone's permanent impairment since he had not reached MMI at the time of his examination. However, pursuant to the 2nd and 5th Editions of the AMA Guides, Dr. Johnson assessed a 22% impairment rating for Slone's current level of impairment. He attributed 10% to pre-existing chronic social phobia, and 12% due to exacerbation of social phobia which has been reinforced by two years of unemployment resulting in withdrawal from social activity. Dr. Johnson recommended psychiatric consultation and counseling.

Finally, ICG filed the January 28, 2013 psychiatric report of Dr. David Shraberg, who evaluated Slone at its request on January 22, 2013. Dr. Shraberg diagnosed adjustment disorder of adult life associated with occupational uncertainty, resolved; history of reading disorder, with average intelligence and elements of symptom magnification. He found no evidence of a social phobia or anxiety. He noted Slone demonstrated some elements of self-consciousness due to his lack of education, which has not impaired his ability to work over the years. Dr. Shraberg stated the FCE suggested objectively Slone could do more than he claims he can do. Dr. Shraberg stated Slone's primary stressor is occupational uncertainty. He opined

"This is primarily an adjustment disorder and transient stressor associated with occupational uncertainty" and found no evidence of a chronic pain condition causing a mood disorder. Therefore, Dr. Shraberg found "no evidence of an active psychiatric impairment." Dr. Shraberg concluded by stating:

From a psychiatric vantage point, I find no obvious permanent psychiatric impairment either preexistent by history or by symptoms of a social anxiety disorder or subsequent mood disorder associated with pain or otherwise. It appears that he is at [MMI] and certainly has the adaptive ability, social skills, and personality structure to respond to some vocational counseling and re-introduction to the workplace.

Using the [AMA Guides], therefore, I find no active psychiatric impairment. This is primarily an adjustment disorder of adult life associated with a somewhat inflated sense of impairment relating to his injury as well as attenuation and motivation to rehabilitate and return to the workplace within reasonable limitations imposed upon him by the various evaluators and limitations per Dr. Hall, Dr. Sajadi, and the [FCE]. . .

Dr. Shraberg assessed a 0% impairment rating pursuant to the 5th and 2nd Editions of the AMA Guides. He recommended Slone be encouraged to return to the workplace at a level of employment consistent with his physical limitations of his left arm, which in turn, would solve the primary situational

stressor. He declined to recommend psychotropic medications or psychotherapy.

The March 24, 2014 benefit review conference order reflects benefits per KRS 342.730 as the contested issue. In his brief to the ALJ, Slone argued he is permanently totally disabled.

After summarizing the lay and medical evidence of record, the ALJ found Slone sustained a work-related injury on July 30, 2010 based upon the stipulations of the parties, Dr. Sajadi's opinions, and Slone's testimony concerning causation. Relying upon Dr. Sajadi's and Dr. Snider's assessments of an impairment rating, the ALJ found the July 30, 2010 work-related injury warranted a 4% impairment rating pursuant to the AMA Guides. Relying upon the opinions of Drs. Sajadi, Snider, and Jenkinson, the ALJ found the three multiplier not applicable stating, "Slone is under no significant physical restriction, and therefore retains the physical capacity to return to the type of work performed at the time of injury." The ALJ determined Slone reached MMI on January 27, 2012, per Dr. Sajadi. The ALJ also concluded Slone has a 0% impairment rating for his alleged psychological injury based upon the opinions of Dr. Shraberg. The ALJ did not engage in an analysis to determine whether Slone is permanently totally disabled.

The ALJ awarded TTD benefits, PPD benefits and medical benefits.

Slone filed a petition for reconsideration asserting the same arguments he now makes on appeal. Importantly, Slone neither requested additional findings of fact regarding permanent total disability nor argued entitlement to PTD benefits.

On appeal, Slone argues the ALJ erred in finding he is under no significant restrictions, and therefore retains the physical capacity to return to his former work with ICG. Slone asserts Dr. Sajadi noted the FCE delineated permanent restrictions of his function, and did not give any opinion regarding his ability to return to his former job. Likewise, Dr. Hall did not render an opinion regarding his ability to return to the type of work he was performing at the time of his injury. Slone also directs our attention to the opinions of Dr. Owen and the January 25, 2012 MRI report indicating a defect within the supraspinatus tendon, which may represent a postsurgical defect or recurrent tear.

Embedded within Slone's argument for the application of the three multiplier is an argument he is permanently totally disabled. Slone quotes the definitions of "disability" and "work" pursuant to KRS 342.0011(11)(c) and (34), as well as KRS 342.730(1)(c)1 regarding the

application of the three multiplier. Slone then states the evidence demonstrates due to a combination of his injuries to his left upper extremity, the complications and/or limitations as a result thereof, his limited education, and past work experiences, in junction with the opinions of Dr. Owen, he is permanently totally disabled pursuant to KRS 342.0011(11)(c).

Slone also argues the ALJ erred in finding he did not suffer from psychological impairment due to his work-related injury based upon the report prepared by Dr. Johnson. Slone also points out Dr. Shraberg's report reveals the Personality Assessment Inventory indicates he has levels of depression and anxiety which exceed the norm. Therefore, since testing results indicated an active psychiatric condition during both evaluations by Dr. Johnson and Shraberg, Slone argues an impairment rating must be assessed pursuant to Dr. Johnson's opinions.

As the claimant in a workers' compensation proceeding, Slone had the burden of proving each of the essential elements of his cause of action, including extent and duration of his alleged disability, and the applicability of the multipliers contained in KRS 342.730(1)(c). Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Because Slone 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 that is so overwhelming, no reasonable person could reach the same conclusion as the ALJ. REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985). The function of the Board in reviewing the ALJ's decision is limited to a determination of whether the findings made by the ALJ are so unreasonable under the evidence they must be reversed as a matter of law. Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000).

As fact-finder, the ALJ has the sole authority to determine the weight, credibility and substance of the evidence. Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993). Similarly, the ALJ has the sole authority to judge 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); Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999). Mere evidence contrary to the ALJ's

decision is not adequate to require reversal on appeal. Id. In order to reverse the decision of the ALJ, it must be shown there was no substantial evidence of probative value to support his decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

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 could otherwise have been drawn from the record. Whittaker v. Rowland, supra. So long as the ALJ's ruling with regard to an issue is supported by substantial evidence, it may not be disturbed on appeal. Special Fund v. Francis, supra.

On review, we find Slone's appeal to be nothing more than a re-argument of the evidence before the ALJ. Slone impermissibly requests this Board to engage in fact-finding and substitute its judgment as to the weight and credibility of the evidence for that of the ALJ. This is not the Board's function. See KRS 342.285(2); Paramount Foods, Inc. v. Burkhardt, 695 S.W.2d 418 (Ky. 1985).

Regarding the applicability of the three multiplier, the ALJ relied upon the opinions of Drs. Sajadi, Snider and Jenkinson in concluding Slone "is under no significant physical restriction, and therefore retains

the physical capacity to return to the type of work performed at the time of injury." We acknowledge the treatment records and final report of Dr. Sajadi are equivocal at best regarding Slone's ability to return to his former job. In the May 16, 2012 report, Dr. Sajadi provided no discussion regarding Slone's ability to return to his previous job. Regarding restrictions, Dr. Sajadi only stated Slone "also had a [FCE], which delineated permanent restrictions of his function." The FCE to which Dr. Sajadi refers was not filed into the record for our review.

However, the opinions of Drs. Snider and Jenkinson are clear, and constitute substantial evidence upon which the ALJ was free to rely upon in determining Slone retains the physical capacity to return to the type of work he was performing at the time of his work injury. Dr. Jenkinson ultimately concluded Slone has no significant objective abnormality to explain his severe left shoulder symptoms and characterized his work injury as a "well repaired relatively minor rotator cuff injury." He specifically stated Slone "retains the capability to return to normal activities including the duties of an underground coal miner" and "retains the capability to return to his regular occupation without restriction and that he requires no further treatment." Likewise, in his February 11, 2013 report, Dr.

Snider expressed he was unable to explain Slone's alleged disability by noting his examination evidenced functionality, and noted Slone's limitations are based upon subjective complaints. Dr. Snider concluded "I do not have a good explanation for why Mr. Slone could not return to his preinjury activity level." Dr. Snider reiterated this opinion in his February 26, 2013 deposition, as quoted above on pages 9 and 10 of this opinion. The opinions of Drs. Jenkinson and Snider regarding permanent restrictions and Slone's ability to return to his former work constitute substantial evidence, and no contrary result is compelled.

Likewise, the ALJ acted well within his discretion in relying upon the opinion of Dr. Shraberg in determining Slone has a 0% impairment rating for his alleged psychological injury. In his January 28, 2013 report, Dr. Shraberg found no permanent psychiatric impairment either pre-existing or by symptoms of a social anxiety disorder or subsequent mood disorder associated with pain or otherwise. Pursuant to the AMA Guides, Dr. Shraberg found "no active psychiatric impairment" explaining Slone suffers from "an adjustment disorder of adult life associated with a somewhat inflated sense of impairment relating to his injury as well as attenuation and motivation to rehabilitate and return to the workplace within reasonable limitations" He

assigned a 0% impairment rating and declined to recommend psychiatric treatment. Simply stated, the ALJ was faced with the conflicting opinions of Dr. Johnson and Dr. Shraberg and choose to rely in whole upon the latter. The interpretation of testing results administered during a psychiatric evaluation lies solely within the expertise of the evaluating physician. Therefore, Dr. Shraberg's opinion constitutes substantial evidence upon which the ALJ was free to rely, and no contrary result is compelled.

Finally, Slone generally argues on appeal he is permanently totally disabled. It is reasonable to conclude the ALJ dismissed this argument in his opinion when he determined Slone's work-related injury warranted an award of PPD benefits without the application of the three multiplier. Importantly, Slone did not request additional findings of fact regarding the issue of permanent total disability in his petition for reconsideration. Rather, he argued the evidence supported a finding of psychiatric impairment and the applicability of the three multiplier.

Therefore, the May 22, 2014 Opinion, Award and Order and the July 25, 2014 Order on petition for reconsideration by Hon. Steven G. Bolton, Administrative Law Judge, are hereby **AFFIRMED**.

ALL CONCUR.

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