Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: December 17, 2018

CLAIM NOS. 199603889, 199331693, 199112897, 198942636,
198920726 & 198632151

APPALACHIAN REGIONAL HOSPITAL PETITIONER

VS. **APPEAL FROM HON. BRENT E. DYE,
ADMINISTRATIVE LAW JUDGE**

SHERRY L. BARKER
DR. JAY NAROLA
KIMBERLY GREEN, APRN
and HON. BRENT E. DYE,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

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

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

STIVERS, Member. Appalachian Regional Hospital ("ARH") seeks review of the August 23, 2018, Opinion, Award, and Order of Hon. Brent E. Dye, Administrative Law Judge ("ALJ") resolving three medical disputes in favor Sherry L. Barker ("Barker"). ARH also appeals from the September 5, 2018, Order denying its petition for reconsideration. The ALJ determined SI joint injections with related massage

therapy, epidural injections, the current frequency of visits to Dr. Jay Narola, and the medication Clonazepam are reasonable and necessary treatment of Barker's work-related injuries.[1]

On appeal, ARH contends the ALJ erred as a matter of law in finding the contested medical treatment reasonable and necessary. ARH asserts it filed three separate utilization review ("UR") reports from Dr. Avrom Gart which were uncontraverted; yet, the ALJ found Dr. Leon Briggs' findings and opinions more credible regarding the contested SI joint injections and related physical therapy, and epidural injections. ARH also complains the ALJ's reliance upon Dr. Briggs' opinions is erroneous since none of his medical records or reports were filed in the record. Similarly, ARH contends the ALJ erred in relying upon Dr. Narola's findings and opinions in determining the current frequency of the psychiatric treatment and Clonazepam were reasonable medical treatment. Again, ARH contends none of Dr. Narola's medical records or reports were filed into evidence in these proceedings. It notes Dr. Narola did not respond to the medical fee dispute.

ARH also contends that, in his September 5, 2018, Order ruling on its petition for reconsideration, the ALJ erroneously stated since ARH had the burden of proof regarding the reasonableness and necessity of the medical treatment, Barker could still prevail even if she did not provide any evidence in this claim. Citing to Mengel v. Hawaiian-Tropic Northwest and Central Distributors, Inc., 618 S.W.2d 184 (Ky. App. 1981), ARH argues since the reasonableness and necessity of the contested

[1] Clonazepam is also known as Klonopin. Because the medical fee dispute references Clonazepam, we will refer to the drug as such.

medical treatment falls within the province of medical experts, lay testimony on the issue cannot constitute substantial evidence upon which the ALJ may rely. ARH argues in Kingery v. Sumitomo Electric Wiring, 481 S.W.3d 492, 500 (Ky. 2016), the Kentucky Supreme Court held an ALJ cannot ignore uncontroverted medical evidence and rely on lay testimony and the ALJ's own proclivities and experience when resolving medical issues.

ARH maintains the uncontradicted medical evidence solely supports a finding Barker's contested medical treatment is neither reasonable nor necessary. It argues the ALJ cannot disregard Dr. Gart's medical opinions regarding the reasonableness of the medical treatment, because the contested issues involved medical questions falling solely within the province of medical experts. It requests the Board remand with instructions to find, in accordance with Dr. Gart's opinions, Barker's contested treatment of SI injections with related physical therapy, lumbar epidural injections, Clonazepam, and the current frequency of psychological office visits are unreasonable and unnecessary treatment.

BACKGROUND

The record reveals that in a December 29, 1997, Opinion and Award, Hon. Ronald W. May, Administrative Law Judge, determined Barker sustained a September 25, 1994, work injury resulting in a 35% permanent disability. He apportioned 3/5 or 21% of the permanent disability to a back injury which had aroused pre-existing dormant degenerative disc disease with the remaining 2/5 or 14% of the disability attributable to an ankle injury with no arousal factor. Barker was awarded income and medical benefits. The decision was not appealed.

In an April 16, 2001, Opinion and Award, Hon. Donald G. Smith, Administrative Law Judge ("ALJ Smith"), determined upon reopening that Barker had a psychological condition, which was caused "at least in part," by the 1994 work injury and she was entitled to psychiatric treatment. ALJ Smith also concluded the proof established Barker's "injury has resulted in an increase in occupational disability since the original opinion and award was rendered," and Barker suffered "a total occupational disability of 100%" The decision was not appealed.

In a July 5, 2005, decision, Hon. A. Thomas Davis, Administrative Law Judge, determined Barker was entitled to epidural steroid injections to relieve the pain in her lumbar spine and leg as reasonable necessary treatment of her work injury. That decision was not appealed.

In an Agreed Order dated October 18, 2012, the parties resolved the challenged Transcranial Magnetic Stimulation Therapy, and the medical dispute initiated by ARH concerning the therapy was settled.

On September 30, 2016, ARH filed a Motion to Reopen contesting the request for a left SI joint injection and physical therapy as medically unnecessary. It relied upon the August 30, 2016, UR report of Dr. Gart which it attached. On that same date, ARH filed a Motion to Join Kimberly Green ("Green"), APRN, as a party to the action and a Form 112 contesting the treatment proposed by Green in the form of a left SI joint injection and physical therapy as unreasonable and unnecessary medical treatment of the work injury. By Order dated November 29, 2016, Hon. Robert Swisher, Chief Administrative Law Judge ("CALJ Swisher"), sustained the motion to reopen and ordered Green joined as a party to the dispute.

On January 30, 2017, ARH filed a Form 112 medical dispute contesting treatment proposed by Green in the form of three lumbar epidural steroid injections at L4-5 as unreasonable and unnecessary medical treatment of the work injury. ARH attached Dr. Gart's January 5, 2017, UR report in support of the medical dispute. On March 20, 2017, CALJ Swisher transferred the claim to the ALJ.

On August 23, 2017, Barker filed the report pertaining to the lumbar MRI performed on June 28, 2017.

On January 2, 2018, ARH filed a third medical dispute and a Motion to Join Dr. Narola as a party. The medical fee dispute challenged the reasonableness and necessity of the frequency of Dr. Narola's treatment and the prescription medication Clonazepam. ARH attached Dr. Gart's December 7, 2017, UR report in support of its position. By Order dated January 8, 2018, the ALJ sustained the motion to join Dr. Narola.

On January 11, 2018, Barker filed a motion to set for additional telephonic status conference or benefit review conference. In her motion, Barker pointed out the claims adjuster approved her seeing Dr. Brendon Coughtry as her new pain management physician. However, the claims adjuster sent a November 17, 2017, letter, which Barker attached to her motion in which she accused Barker of certain things that Barker contended were not entirely correct. As a result, Dr. Coughtry's office desired to see a copy of the approval letter before his office scheduled her appointment. Barker contended that, upon reading the letter, Dr. Coughtry's office refused to accept her as a patient. Consequently, Barker maintained a hearing was

necessary. ARH filed a response and attached Green's August 30, 2017, five-page progress note.

The May 31, 2018, Benefit Review Conference Order and Memorandum listed the following contested issues: "Medical dispute issue." Under the heading "Other contested issues" listed the following: "(1) The reasonableness and necessity of: (a) recommended lumbar injections; (b) recommended physical therapy; (c) the frequency of Plaintiff's psychiatric treatments' visits; and (d) Clonazepam prescriptions; & (2) Whether the Plaintiff is entitled to see a pain management physician without the claims representative sending a cover letter highlighting her prior alleged pain management violation."

Barker testified at the July 23, 2018, hearing that she began seeing Dr. Briggs in 2003 or 2004 at Pikeville Medical Center and continued to see him when he moved to Ashland. She testified Dr. Briggs had administered lumbar injections in the past which were helpful. She acknowledged that the period of time over which the injections were beneficial varied. Barker explained they help "as to her activities." She obtained relief from the severe pain for almost a year after receiving a set of three injections. Because of this set of injections, the quantity of the medication she was taking at the time lessened. She received other injections and believed Dr. Briggs last administered an injection on July 19, 2016. Even though Dr. Briggs' request to administer additional injections had been denied, she would like to receive additional injections. She explained she also received therapy after each injection for which Dr. Briggs had also requested future approval. These, too, had been denied. Barker described the therapy occurring after the injection:

A: The therapy is not fully explained. Once you have an SI injection they take you into the other physical therapist room and they do a massage on your back following the procedure and that's the only therapy they do.

Barker testified that, on April 23, 2004, she signed a pain management agreement with Dr. Briggs' office at Kings Daughters Hospital. She acknowledged there was a violation of that agreement and provided the following explanation:

Q: Okay. Now there's been an incident that's come up – that the Claim Adjustors brought up and we'll go into some more detail that you violated this Pain Management Agreement. Tell us about that. Tell us what occurred, approximately when you were confronted with this and that type of thing.

A: I had a problem with my back. I went to the emergency room which I had done before and Dr. Browning was in the ER. I had had – I went in a wheelchair. He saw me that day and he wrote me a prescription for eight Oxycontin. I didn't take - well the prescription was filled.

Q: By whom?

A: By our pharmacy at ARH. That's where I have all my prescriptions filled.

Q: Okay. Did you fill the prescription?

A: My sister did.

Q: Did you tell your sister to fill the prescription?

A: No, I did not. No.

Q: But she filled it?

A: She filled it.

Q: Did you take any of those medications?

A: I took one.

Q: Okay. Is this the actual bottle that was filled by your sister?

A: Yes, it is.

Q: And on the front of it, it says ARH Pharmacy Sherry Barker, 1-13-16. It says eight tablets of Hydrocodone. Are there still seven tablets in this bottle?

A: I think so, yes.

Q: Okay. So only one tablet was taken out of this bottle?

A: Yes.

Q: And were you confronted with this at Dr. Briggs' office after the first – or after January of 2016?

A: Yes, I was.

Q: And when you were confronted with this did you explain this to them?

A: Yes, I did.

Q: Did they discharge you that day from their care?

A: No – no.

Q: So they continued to see you?

A: Yes, they did.

Q: In fact you got more injections after that didn't you?

A: Yes, I did.

Q: Did Dr. Briggs' office continue to write you prescriptions after that?

A: Yes, they did.

At some point, Barker requested Dr. Briggs to allow her to transfer to another physician closer to home. Barker explained that, after a workers' compensation representative had visited his office, Dr. Briggs had discontinued Lyrica and pain patches and "turned it into a prescription for Neurontin." She took Neurontin for three months. However, during either her next appointment or when she called Dr.

Briggs' office for a refill, she was told Neurontin is now a controlled substance and could no longer be prescribed. That was when she requested to go to another pain management facility. In accordance with her wishes, Dr. Briggs recommended Barker see Dr. Coughtry. She estimated it took two to three months for the claims adjuster to send the information to Dr. Coughtry.[2]

Barker testified Dr. Narola has provided her psychological treatment for the last 13 years. Dr. Narola primarily treats her work-related anxiety and depression. Dr. Narola was requested to change her medication regimen which consisted of Prozac, Trazadone, and Clonazepam.[3] Barker testified Dr. Narola discontinued Trazadone and started her on Elavil. Two or three months ago, he discontinued the Prozac which increased her anxiety and depression. However, he increased the Amitriptyline dosage. Barker remained on Clonazepam which she stated, "settles [her] brain down" and relieves anxiety. Before this switch in medication, she saw Dr. Narola once a month, but since the change in her medication, she sees him every two weeks and sometimes weekly. Barker testified the change in the frequency of her visits to Narola is due to the change in her medication and because she was not prescribed pain medication. She explained as follows:

> A: Because of the change in medication and because I was having so much trouble no one was giving me any pain medication so he was trying to work that in with my medication that I was taking …

[2] This is the information Barker contended was not entirely accurate and was contained in the letter she attached to her motion to set an additional telephonic status conference or BRC.

[3] Barker stated Klonopin was what she was receiving.

She currently takes 40 mg of Prozac each morning, 75 mg of Amitriptyline, and one and a half 0.5 Clonazepam for pain, anxiety, and depression, all of which were prescribed by Dr. Narola. The Clonazepam and Amitriptyline are taken before she goes to bed. Her visits to Dr. Narola last approximately ten to fifteen minutes.

In his decision, the ALJ provided a summary of Barker's testimony along with the following summary of the medical evidence:

> **Dr. Avrom Gart Utilization Reviews:** Dr. Gart issued a utilization review denial on August 30, 2016, denying the request for left SI joint injection and physical therapy. Dr. Gart reviewed APRN Green's June 24, 2016 report, as well as Dr. Allen's February 22, 2016 independent psychiatric evaluation. Dr. Gart noted Barker was a 71-year-old female, who sustained an injury on September 25, 1994. Barker received lumbar degenerative disc disease diagnosis, as well as congenital spondylolysis, sacroiliitis, thoracic spinal stenosis, and major depressive disorder. Dr. Gart documented Barker was evaluated by her treating provider on August 24, 2016.
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> Barker underwent three epidural steroid injections in July with 65% relief. Barker now has issues with her left sacroiliac joint. Barker reported six out of 10 pain, and her exam demonstrated increased pain, left sacroiliac and lumbar tenderness, facet tenderness and pain, radicular pain radiating around the left abdomen, and sensory deficit in the left L5-S1 distribution. Her last sacroiliac injection was in December 2015 on the left side.
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> Dr. Gart opined diagnostic sacroiliac joint injections are not recommended. He stated there was no further definitive treatment that could be recommended, based on any diagnostic information potentially rendered. Dr. Gart stated current guidelines do not support the use of this injection procedure type, thus he does not recommend Barker undergo it.
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> Dr. Gart noted the provider did not clarify frequency, duration, or body part to be treated, with physical therapy. The medical records do not establish when

Barker last participated in physical therapy, the number of treatment sessions completed, or any functional improvement evidence.

Dr. Gart cited the ODG guidelines. He noted consideration could be made if the injection is required for one of the recommended indications for sacroiliac fusion. The ODG does not recommend sacral lateral branch nerve blocks and/or dorsal blocks in anticipation of sacroiliac radiofrequency neurotomy.

On January 5, 2017, Dr. Gart issued a utilization review denial, denying lumbar epidural steroid injection treatment, at L4-5 (x3). Dr. Gart reviewed Dr. Briggs' medical reports from July 13, 2016 through December 21, 2016. These records documented Barker received her first lumbar epidural steroid injection on July 13, 2016. Her pain level was 10 /10.

Barker underwent her second lumbar epidural steroid injection on July 20, 2016. Her reported pain level was 5/ 10. Barker received her third lumbar epidural steroid injection on July 27, 2016. Barker reported 60% relief from her second injection. She reported she was able to perform some housework. Barker's pain level was a 2-4/10.

Dr. Gart noted Barker underwent three lumbar epidural steroid injections, which provided 65% overall relief. On August 24, 2016 Dr. Briggs' records, which Dr. Gart reviewed, detailed Barker's low back complaints with left leg. She reported a 4/10 pain level since her last injection. On December 21, 2016, Barker had low back pain complaints with slight left leg numbness. Her reported pain was 10/10.

Dr. Briggs documented left SI joint tenderness and decreased lumbar range of motion. He noted positive facet tenderness in the thoracic spine. Barker's sensory deficit in the left S1 lower extremity [sic]. Records indicate Barker underwent previous lumbar injections three times in July and had 65% overall relief. Barker wanted to repeat the injections.

In conclusion, Dr. Gart noted Barker underwent previous epidural injections. He noted the guidelines do not recommend routine use of three-series injections, either

diagnostically or therapeutically. Dr. Gart noted Barker underwent these injections in a short span of time during July 2016. He documented as per the guidelines, and epidural injection should produce 50 to 70% pain relief for at least 5 to 8 weeks before considering repeat procedures.

Barker was given epidural injections on one-week intervals, which is not consistent with the guidelines. Dr. Gart opined another three-series injection is not supported. He also stated guidelines require for radiculopathy be documented on physical exam and corroborated with imaging studies. Dr. Gart stated there was not any MRI scan, which demonstrated any neural impingement evidence.

On December 7, 2017, Dr. Gart noted Barker had been treating with Dr. Narola on a monthly basis for psychiatric medication. Her visits increased to every one to two weeks, in July 2017. Dr. Gart opined Barker had been relatively stable from a psychiatric perspective. Most of Barker's visits with Dr. Narola are primarily administrative, without much change in the overall medical/psychological condition.

Dr. Gart reviewed Dr. Narola's May 9, 2017 report. This report documented Barker continued her medications without side effect. Barker reported hoping to get better pain management treatment and that she was denied for injections. Dr. Narola noted Barker did not have looseness of association or flight of ideas. Her insight and judgment were fair, without suicidal or homicidal ideation. Dr. Narola provided a one-month prescription.

Dr. Gart reviewed Kimberly Green, APRN's May 23, 2017 report. Barker attended a six-month follow-up. Green documented facet tenderness with radicular pain radiating to the left abdomen. She noted a sensory deficit in the L5-S1 distribution in the left lower extremity, and left foot numbness. Green diagnosed sacroiliitis, degenerative lumbar disc disease, and thoracic spinal stenosis. Green noted she planned to order an MRI due to the left lower extremity pain worsening. Barker's previous MRI was in March 2016. Green documented a previous SI joint injection, in 2000, provided good relief. She noted previous L4-5 epidurals provided 60% relief.

Dr. Gart reviewed a lumbar spine MRI from June 28, 2017, which revealed multi-level disc bulges, and severe L1-2 arthritis. Dr. Gart reviewed Dr. Narola's July 18, 2017 report, documenting Barker had fatigue since beginning Neurontin. Dr. Narola told her to take one capsule in the morning and at night. He reassured Barker that the psychiatric medicines could be adjusted while she is adjusting to Neurontin.

Dr. Gart reviewed Dr. Narola's July 28, 2017 report. Barker continued to feel tired since starting Neurontin. Barker continued taking other psychiatric medication as prescribed. Dr. Narola felt Barker was started on an unusually high Neurontin dose, and was advised to take trazodone only as needed. He recommended she continue with Klonopin.

Dr. Gart reviewed Dr. Narola's August 4, 2017 report. Barker was advised she was taking two sedating medications. Dr. Narola told her again to only use trazodone on an as-needed basis. He also told Barker to address the sedation issues, from Neurontin, with her pain management practitioner.

Dr. Gart reviewed Dr. Narola's August 16, 2017 report. Barker reported increased nervousness and requested more Clonazepam. She took trazodone the night before. KASPER system showed her medications were being filled appropriately. Dr. Narola noted Barker's affect is distressed.

Dr. Gart reviewed Kimberly Green's August 30, 2017 report. Barker reported 8/ 10 pain that could increase to 10/10. She stated it radiated to her lower back and into her foot. Green noted the plan to wean Neurontin, as it is now a controlled substance and Barker had a history of a broken narcotic agreement. Green provided a two-week weaning dose for Neurontin. Barker reported she did not want to continue treatment in that office because she was not being prescribed substances.

Dr. Gart reviewed Dr. Narola's September 11, 2017 report, which documented Barker was taking her medication as prescribed without problems. He noted she had been referred to a new pain management physician and had been given a tapering Neurontin dose. Dr.

Narola noted Barker's affect was sad, worried, and frustrating.

Dr. Gart reviewed Dr. Narola's September 18, 2017 report, which indicated Barker was taking her medications as prescribed. He noted she had been prescribed Neurontin 300 mg twice a day, pending a visit with the new pain management doctor.

Dr. Gart reviewed Dr. Narola's September 26, 2017 report indicating Barker ran out of Neurontin. Barker did not have an appointment with the new pain management doctor. Dr. Narola noted Barker took her psychiatric medication as prescribed, and was taking fewer clonazepam pills. He described her affect as distressed and frustrated. Dr. Narola advised Barker to stay active in getting adequate pain management treatment.

Dr. Gart diagnosed sacroiliitis, lumbar degenerative disc disease, congenital lumbar spine spondylosis, spinal thoracic stenosis, anxiety, and depression. He listed her current medications as clonazepam, trazodone, and Fluoxetine. Dr. Gart noted Neurontin was discontinued recently on August 30, 2017.

Dr. Gart noted Dr. Narola has treated Barker for 15 years. Barker has a chronic back pain diagnosis. Dr. Narola noted that despite a lack of significant MRI findings, Barker has significant pain, depression and anxiety. Dr. Narola provides both medication management and therapy to Barker. Barker visits on a biweekly to monthly basis dependent on her pain levels and psychological status.

Barker was noted to be in between pain management specialist, currently without a pain physician pending a new evaluation. She is not using any opiates. Dr. Gart suggested limiting the frequency of psychiatric visits. However, Dr. Narola has stated unless her pain level is better controlled it would not be possible.

Dr. Gart noted Barker's anxiety and depression diagnoses associated with her chronic pain. She has been prescribed fluoxetine on an ongoing basis. Dr. Gart opined given the apparent benefit in this case continued use of fluoxetine is medically reasonable. Alternatively, Barker could be considered for a tricyclic antidepressant medication. Dr.

Gart noted Barker had also been prescribed trazodone on an ongoing basis. Trazodone is considered a sedating antidepressant. He opined continued trazodone use is medically reasonable.

Dr. Gart documented Barker has treated with Dr. Narola every one to two weeks since July 2017. He treats her for her psychiatric conditions, but continues to focus his treatment on issues surrounding her chronic pain. Dr. Gart stated although continued follow-up is reasonable, there is no medical reason why Barker would need to be seen every one to two weeks. Dr. Gart opined her psychiatric condition has been stable.

Dr. Gart stated continued long-term use of benzodiazepines was not recommended. Dr. Gart opined at this time, it would be reasonable to allow follow-up visit with Dr. Narola every two weeks until clonazepam is discontinued. He stated once it is weaned, Barker should not need see Dr. Narola more than once every 3 to 4 months. He stated subsequent office visits should only be for monitoring of the psychiatric condition and refills of psychiatric medication.

Dr. Gart noted Barker needed to be established at a new pain management office for chronic pain, as she was just discharged by Kimberly Greene, APRN. Dr. Gart stated there is no medical reason why Dr. Narola should be managing her chronic pain condition, [sic]

Dr. Gart noted evidence-based guidelines do not recommend the long-term use of benzodiazepines, because long-term efficacy is unproven and there is a risk for dependence with long-term use. He stated most guidelines recommend limiting their use to four weeks. Barker has been chronically prescribed clonazepam.

Dr. Gart stated a more appropriate treatment for an anxiety disorder is an antidepressant, such as an SSRI. Barker is already being prescribed an SSRI and should be considered for further optimization of the dose of that medication to allow for benzodiazepine discontinuation. Dr. Gart noted in the presence of a broken narcotic agreement, there is elevated potential abuse or risk. He noted there is a risk for withdrawal with abrupt discontinuation of benzodiazepines. Dr. Gart opined another peer review follow-up is necessary, in 3 to 4

months, to ensure Barker has been weaned from clonazepam, and optimized on antidepressants to treat depression, anxiety, and chronic pain.

Kimberly Green, APRN: Barker attended a three-month follow-up with APRN Green on August 30, 2017. Green noted they would discuss Neurontin refills. Barker reported 8/10 low back pain. She stated it radiates to her foot, and is constant and sharp at times. Green documented past medical history, including degenerative disc disease diagnosis, and lumbar disc degeneration.

Green listed Barker's prescriptions including 300 mg Neurontin, one capsule twice a day. On exam, Barker had musculoskeletal tenderness, lumbar facets, bilateral hips, left SI tenderness, and left thigh and intermittently to the left foot. Barker had decreased lumbar range of motion and tenderness, with facet tenderness and pain. She did not have any lumbar spasm. Barker had normal neurological strength, with sensory deficit and left foot numbness. Green noted Barker's gate was abnormal, and she used a cane.

Green documented that Barker stated, "I don't feel anyone is taking care of my pain. I can't understand why something that happened two years ago is keeping me from getting my pain medicine, and now you are taking my Neurontin away." Green documented lumbar degenerative disc disease, bulging lumbar disc, and sacroiliitis, as well as thoracic spinal stenosis. She noted Barker had broken a pain management agreement.

Greene reviewed a lumbar MRI, which indicated multi-level disc bulges and severe L2-3 arthritis. Green noted a plan to wean Neurontin, as it is now controlled medication, and Barker had a broken narcotic agreement history. Green offered a two-week weaning dose.

Green documented Barker underwent lumbar epidural steroid injections at the L4-5 level in 2016, with 65% relief. Barker underwent injections in 2015 with 75% relief. Green noted she discussed repeating the injections, however Barker expressed she wanted to transfer her care to a pain clinic closer to home.

Green documented Barker attended multiple physical therapy visits. Barker did not want to continue care

> because Greene would not prescribe any controlled medications. Barker requested to have her care transferred to a pain clinic closer to home. Dr. Briggs recommended Dr. Coughtry in Pikeville. Green noted not to reschedule Barker with herself or Dr. Briggs, as this is now no longer a conducive patient/provider relationship. Green noted Barker had been a long-term patient of the clinic, but they could not continue her care.
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> **MRI:** A June 28, 2017 lumbar MRI revealed severe arthritis at L2-3 with grade 1 retrolisthesis, and severe disk space narrowing. There was a mild annular bulge at T12-L1. There was a moderate annular bulge, causing bilateral neural foreman narrowing, at L2-3. There was also a mild annular bulge and spinal canal stenosis, due to slippage, at L2-3. There was a mild broad-based herniation at L3-4. There was a moderate annular bulge at L4-5, and a mild annular bulge at L5-S1. The MRI documents disc bulges at multiple levels and severe arthritis at L1-2.[4]

In resolving the medical disputes in favor of Barker, the ALJ provided the following findings of fact and legal conclusions:

> **I. Lumbar & SI joint injection, including physical (massage) therapy**
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> After reviewing the medical evidence, as well as Barker's testimony, the ALJ finds ARH did not meet its burden. ARH did not prove the recommended injections, including the post-SI injection massage therapy, are unreasonable and unnecessary medical treatment. The ALJ rules in Barker's favor. ARH is liable for the injections.
>
> **A) SI joint injection and physical (massage) therapy**
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> Dr. Briggs' findings, opinions, and conclusions, are more credible than the ones Dr. Gart issued. Dr. Briggs, as well as his assistants, have treated Barker, on numerous occasions, since approximately April 23, 2004. Dr. Gart has never personally examined Barker.

[4] Although the ALJ summarized the letter from Tammy Unrue, the Claims Adjuster, to Dr. Coughtry since that issue is not before us we will not set forth that summary.

During his 13-year treatment, Dr. Briggs has closely monitored Barker's treatment, symptoms, and her conditions' progression. He has examined (physically and neurologically) Barker and documented his findings. Dr. Briggs and his assistants' opinions are based on their personal knowledge and the objective exam findings. Dr. Gart's opinions, however, are based on his records review, and how he interprets the medical literature.

Dr. Briggs has provided numerous treatment forms, including: administering injections (lumbar epidural and SI joint), ordering physical therapy, obtaining sophisticated diagnostic studies, including MRIs and x-rays, and prescribing medications. The ALJ finds Dr. Briggs' knowledge and hands-on experience places him in a unique position. He is the most qualified physician to determine Barker's treatment course – not a California physician, who lives over 2,300 miles away, has never examined Barker, and is not even licensed to practice medicine in the Commonwealth.

Dr. Gart, in part, also based his opinion on the ODG. The ODG are merely guidelines, and have no binding authority, at least in Kentucky. They may in California, Tennessee, or Texas – where Dr. Gart holds medical licenses. Dr. Gart took general guidelines and statistics, and applied them to a specific individual, with a specific condition – similar to a one size fits all theory. The undersigned ALJ does not find this persuasive, at least in this case. Barker is more than a statistic. She is a unique individual, with a unique condition.

Dr. Briggs' medical records support the recommended SI joint injection. On August 24, 2017, Dr. Briggs and his assistant documented Barker experienced left SI joint tenderness and pain. They documented Barker had radicular type pain, radiating down her left side. Dr. Briggs found Barker had a left L5-S1 sensory deficit distribution pattern.

On August 30, 2017, Dr. Briggs and his assistant documented similar findings. Barker exhibited left SI tenderness, and had a left S1 sensory deficit distribution pattern. He diagnosed sacroiliitis. Dr. Briggs noted Barker last underwent SI injections in 2015, and obtained 75% relief. This signifies the injections had previously provided meaningful relief.

Barker's testimony supports Dr. Briggs' statement. Barker testified she previously underwent an SI injection, approximately five or six days before she underwent a hip procedure, and it provided relief. The ALJ finds Barker credible.

Based on the evidence's totality, the ALJ finds ARH did not prove the recommended SI joint injection is unproductive treatment or outside the type that the medical profession generally accepts. The evidence shows the treatment has previously provided meaningful relief, and Barker has symptoms that warrant an SI joint injection. ARH is liable for one injection, if an eventual pain management physician recommends it. The ALJ notes Barker currently does not have a pain management physician.

This award includes physical (massage) therapy. Barker testified that immediately following her prior SI joint injection, she received a massage, at the injection facility, where the physician had administered the injection. Barker admitted the physical therapy was not fully explained. The ALJ infers the recommended physical therapy is actually the post-SI injection massage therapy. This award does not include regular physical therapy. However, again, it does not appear regular physical therapy is actually at issue.

B) Lumbar epidural injections

Dr. Briggs' findings, opinions, and conclusions, are more credible than the ones Dr. Gart issued. The above rationale applies, concerning why Dr. Briggs and his assistants are in the best position to issue an opinion, at least in this ALJ's mind, on this issue. The ALJ also finds Barker credible.

Barker's testimony, as well as the medical records, support awarding the injections. Barker testified the injections have always helped and provided meaningful relief. They decrease her symptoms, and increase her physical functioning. Significantly, Barker testified her prior injections have even led to Dr. Briggs reducing her prescribed medications' amount and/or dosage.

The medical records support Barker's testimony. Barker last underwent injections in July 2016. Before the first

injection, which Barker received on July 13, 2016, her pain level, on a 0 to 10 scale, equaled 10. She received her next injection on July 20, 2016. At that time, she experienced a five pain level. This illustrates the first injection provided 50% relief.

Finally, Barker received her third injection on July 27, 2016. Dr. Briggs documented Barker only experienced a two pain level. Moreover, he documented Barker was able to perform some housework. This, again, illustrates the injections provided meaningful relief. The injections provided enough meaningful relief that Dr. Briggs and his assistant did not recommend additional injections for over a year.

Dr. Briggs' August 24, 2017 and August 30, 2017 office notes document Barker experienced sensory deficits, had reduced lumbar motion, experienced radicular type symptoms, and experienced significant pain. Barker experienced similar symptoms, when Dr. Briggs recommended and administered the prior injections- the ones that provided meaningful relief.

Based on the evidence's totality, the ALJ finds ARH did not prove the recommended lumbar epidural injections are unproductive treatment or outside the type that the medical profession generally accepts. The evidence shows the treatment has previously provided meaningful relief, and Barker has symptoms that warrant them. ARH is liable for one injection, if an eventual pain management physician recommends it. The ALJ notes Barker currently does not have a pain management physician.

C) Clonazepam prescription & psychiatric treatment's frequency

After reviewing the medical evidence, as well as Barker's testimony, the ALJ finds ARH did not meet its burden. ARH did not prove the Clonazepam and Barker's psychiatric treatment's frequency are unreasonable and unnecessary medical treatment. The ALJ rules in Barker's favor. ARH is liable for this treatment.

Dr. Narola's findings, opinions, and conclusions, are more credible than the ones Dr. Gart issued. The ALJ also finds Barker's testimony credible. Dr. Narola has treated Barker, on numerous occasions, for over 13 years.

During his 13-year treatment, Dr. Narola has closely monitored Barker's treatment, symptoms, and her conditions' progression. He has evaluated Barker and documented his findings.

Dr. Narola's opinions are based on his personal knowledge. Dr. Gart's opinions, however, are based on his records review, and how he interprets the medical literature. Dr. Gart, however, has never personally examined or evaluated Barker. The ALJ finds Dr. Narola's knowledge and experience places him in a unique position. He is the most qualified physician to determine Barker's treatment course.

Barker testified a prior ALJ awarded her 100% occupational disability due to her anxiety and depression. Barker indicated her depression and anxiety increased, when Dr. Narola began changing her medications. Barker testified she still takes Clonazepam. It helps relieve her anxiety, and settles her down.

Dr. Narola's records show Barker has consistently reported increased nervousness, distress, and frustration. On August 16, 2017, Dr. Narola recommended Barker take Clonazepam 0.5mg QHS (at bedtime) for her nervousness. Barker testified this is exactly when she takes the Clonazepam, and it helps her anxiety.

On September 11, 2017, Dr. Narola documented Barker was sad, worried, and frustrated. He further indicated Barker had increased stress related to her transition to a new pain management office. Dr. Narola recommended Barker to continue her Clonazepam.

Dr. Gart primarily recommended against continued Clonazepam, based on the ODG criteria. He also indicated Barker had an elevated abuse risk, because she previously violated a narcotic agreement. First, the ALJ finds Barker credible. Barker explained she experienced severe back pain, and sought emergency room treatment. The emergency room physician prescribed eight OxyContin pills. Barker's sister filled this prescription, and Barker only took one pill. At the hearing, Barker presented the prescription bottle, and it contained the other seven pills. The ALJ finds Barker's violated pain management agreement was due to her taking one OxyContin pill.

Dr. Gart also based his opinion on the ODG. Again, the ODG are merely guidelines, and have no binding authority, at least in Kentucky. Dr. Gart took general guidelines and statistics, and applied them to a specific individual, with a specific condition – similar to a one size fits all theory. The undersigned ALJ does not find this persuasive, at least in this case. Barker is more than a statistic. She is a unique individual, with a unique condition. The evidence shows Barker experiences anxiety, and the Clonazepam helps alleviate it.

The ALJ finds Dr. Narola's treatment frequency is currently reasonable and necessary. Dr. Gart indicated there are not any medical reasons Dr. Narola should manage Barker's chronic pain. He indicated a pain management specialist should handle and treat Barker's chronic pain symptoms. The problem is Barker does not have a pain management physician.

Dr. Narola is essentially wearing two hats. He is treating Barker's psychiatric conditions, as well as helping manage her chronic pain. Dr. Gart has recommended limiting the psychiatric visits' frequency. Dr. Narola opined that unless Barker's pain level is better controlled, this is ill advised. The ALJ agrees. This will not occur until Barker finds a pain management physician.

Barker's chronic pain has caused significant anxiety and depression. Dr. Narola treats Barker's psychiatric conditions, and also her chronic pain. An ALJ previously found her permanently totally disabled. Even Dr. Gart indicated Barker needed to find a pain management specialist to treat her chronic pain.

Based on the evidence's totality, the ALJ finds ARH did not prove the Clonazepam prescriptions and Barker's psychiatric treatment's frequency are unproductive treatment or outside the type that the medical profession generally accepts. The evidence shows the treatment has previously provided meaningful relief, and Barker has symptoms that warrant them.[5]

[5] Again, we have not included the ALJ's findings regarding the letter from the Claims Adjuster to Dr. Coughtry.

ARH filed a petition for reconsideration asserting the same arguments it makes on appeal. If the ALJ declined to alter his decision, ARH requested a finding as to when Barker filed the medical records of Drs. Briggs and Narola. The ALJ was also requested to cite to the evidence he relied upon in refuting the medical opinions of Dr. Gart, and the date it was filed or designated into evidence. In overruling the petition for reconsideration, the ALJ responded as follows to ARH's request:

> The Defendant asserts the ALJ patently erred, because he found the Defendant did not meet its burden and prove that challenged medical treatment was unreasonable and unnecessary. Specifically, the Defendant asserts the uncontroverted and unrebutted medical evidence, as a matter of law, demanded a finding in its favor. The ALJ respectfully disagrees.
>
> It was the Defendant's burden to prove the challenged treatment was unreasonable and unnecessary. The Plaintiff did not have to prove the treatment is reasonable or necessary. Therefore, the Plaintiff did not have to submit any medical evidence on this issue. The Defendant, however, did have to submit evidence.
>
> Although the Defendant submitted medical evidence, the ALJ did not find it credible, reliable, or persuasive. The ALJ's decision thoroughly explains the reasons. The Defendant's position is essentially that it automatically prevails, because the Plaintiff did not file a medical report, directly addressing Dr. Gart's opinions or the challenged treatment. The ALJ disagrees.
>
> The Defendant ignores the fact that it had to submit competent, credible, reliable, and persuasive, evidence that was sufficient to convince reasonable people. The ALJ did not find the Defendant's evidence credible. The ALJ asserts he provided sufficient reasons and justifications for not following Dr. Gart's opinions on each and every issue.
>
> The Defendant asserts the ALJ could not consider the findings, opinions, conclusions, etc. contained within Drs. Briggs and Narola's medical records – as Dr. Gart summarized them. The ALJ respectfully disagrees.

> First, Dr. Gart is the one that summarized Drs. Briggs and Narola's medical records, and made them a part of his report. The record does not contain any objections concerning Dr. Gart's utilization review. The decision addresses this issue.
>
> Secondly, the Defendant's position ignores the fact Dr. Gart, at least in part, relied on them in formulating his opinions. Again, Dr. Gart is the one that summarized Drs. Briggs and Narola's medical records, and made them a part of his report. The ALJ asserts the medical records Dr. Gart summarized and addressed pertain to his opinions. The ALJ can examine and rely on them to assess Dr. Gart's opinions and to determine whether the Defendant met its burden. The Defendant is requesting the ALJ to just consider Dr. Gart's ultimate opinions and to disregard their bases.
>
> Finally, the Defendant requests additional factual-findings. It specifically requests the ALJ to pinpoint when the Plaintiff designated Drs. Briggs and Narola's medical records/reports as evidence. The Plaintiff did not have the designate Drs. Briggs and Narola's medical records. Again, Dr. Gart summarized the records and made them a part of his report, which the Defendant filed into evidence. The ALJ found the Plaintiff's testimony, as well as the Drs. Briggs and Narola's medical records (as Dr. Gart summarized them) more credible than Dr. Gart's opinions. The Defendant did not meet its burden.
>
> The ALJ respectively asserts he properly reviewed, summarized, and understood, the evidence. The ALJ understood this claim's issues, and what they entailed. The ALJ made all the necessary and appropriate factual findings, as well as sufficiently explained his reasoning, in reaching the ultimate result.

ANALYSIS

In a post-award medical fee dispute, the burden of proof and risk of non-persuasion with respect to the reasonableness and necessity of medical treatment falls on the employer. National Pizza Company vs. Curry, 802 S.W.2d 949 (Ky. App. 1991).

Since ARH was unsuccessful before the ALJ, the sole issue in this appeal is whether the evidence compels a different conclusion. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984).

> The claimant bears the burden of proof and risk of persuasion before the board. If he succeeds in his burden and an adverse party appeals to the circuit court, the question before the court is whether the decision of the board is supported by substantial evidence. On the other hand, if the claimant is unsuccessful before the board, and he himself appeals to the circuit court, the question before the court is whether the evidence was so overwhelming, upon consideration of the entire record, as to have compelled a finding in his favor.

Id.

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). In other words, an unsuccessful party on appeal must prove that the ALJ's findings are unreasonable and, thus, clearly erroneous, in light of the evidence in the record. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986). For an unsuccessful party, this is a great hurdle to overcome. In Special Fund v. Francis, supra, the Supreme Court said:

> If the fact-finder finds against the person with the burden of proof, his burden on appeal is infinitely greater. It is of no avail in such a case to show that there was some evidence of substance which would have justified a finding in his favor. He must show that the evidence was such that the finding against him was unreasonable because the finding cannot be labeled "clearly erroneous" if it reasonably could have been made. Thus, we have simply defined the term "clearly erroneous" in cases where the finding is against the person with the burden of proof. We hold that a finding which can reasonably be made is, perforce, not clearly erroneous. A finding which is unreasonable under the evidence presented is "clearly

> erroneous" and, perforce, would "compel" a different finding.

Id. at 643.

As fact-finder, the ALJ has the sole 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 to be accorded the evidence and the inferences to be drawn therefrom. Miller v. East Kentucky Beverage/Pepsico, Inc., 951 S.W.2d 329 (Ky. 1997); Luttrell v. Cardinal Aluminum Co., 909 S.W.2d 334 (Ky. App. 1995). The fact-finder 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 parties' total proof. Magic Coal Co. v. Fox, 19 S.W.3d 88 (Ky. 2000); Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999); Halls Hardwood Floor Co. v. Stapleton, 16 S.W.3d 327 (Ky. App. 2000).

Although a party may note evidence that would have supported a different outcome than that reached by an ALJ, such proof is not an adequate basis to reverse on appeal. McCloud v. Beth-Elkhorn Corp., 514 S.W.2d 46 (Ky. 1974). 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 record. Whittaker v. Rowland, 998 S.W.2d 479, 481 (Ky. 1999). 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.

KRS 342.020 provides the employer must pay for the medical benefits that are reasonable and necessary for the cure and relief of an employee's work-related

injury. National Pizza Co. v. Curry, supra. A medical procedure will not be considered reasonably necessary for the cure and relief of an injury if it is unproductive or outside the type of treatment accepted by the medical profession as reasonable. Square D Co. v. Tipton, supra. Temporary relief may be sufficient to justify payment for treatment depending on the circumstances of a given case. However, a demonstration of "relief" alone is not the standard for compensability. KRS 342.020. The treatment provided must also be reasonable and necessary, providing a "reasonable benefit" to the injured workers. Id. The issue of what is a "reasonable benefit" is a medical question of fact that must be decided by the ALJ on a case-by-case basis. Where the medical proof regarding the issue is conflicting, the ALJ may pick and choose what evidence is most credible.

Contrary to the assertions of ARH, we find substantial evidence supports the ALJ's determination the SI joint injections are reasonable and necessary treatment. In Conley v. Super Services, LLC, 557 S.W.3d 917, 921 & 922 (Ky. 2018), the Kentucky Court of Appeals held that a procedure from which the claimant received greater than 50% relief constituted reasonable and necessary treatment explaining as follows:

> The ALJ determined that the proposed caudal epidural injection was not reasonable and necessary based upon Dr. Lewis's opinion that there was no evidence of improved functioning and no documentation that the injections resulted in any decrease in pain medication for any period. However, KRS 342.020(1) requires neither of these conclusions. "It is clear that KRS 342.020(1) places responsibility on the employer for payment of medical and nursing services that promote **cure and relief** from the effects of a work-related injury.... All that is required is that the services be for **cure and relief** of the effects of

> injury." *See Bevins Coal Co. v. Ramey*, 947 S.W.2d 55, 56 (Ky. 1997) (emphases added).
>
> Dr. Lewis's UR report indicates that he reviewed Dr. Gutti's April 7, 2017, progress note, which "highlights [that Conley] received greater than 50% relief of pain from the caudal epidural steroid injection in March. [He] reported good relief with the radicular component of pain and the residual pains were tolerable on medications." Prior to the injection, Conley had suffered intractable back pain despite his many medications according to Dr. Gutti's office notes, which Conley filed as evidence. We cannot consider or imagine any evidence more compelling that a procedure is reasonable and necessary for the "cure and relief from the effects of an injury" than one which actually affords relief from the devastating misery of intractable pain. We agree with Conley that the ALJ did not use the proper standard in denying the epidural injection, and to that extent, we vacate the Board's opinion.

Id. at 921-922.

As in Conley, supra, Green's medical record, introduced by ARH, establishes the 2015 SI joint injection provided 75% relief. In Dr. Gart's August 30, 2016, report, he noted Barker's last SI joint injection was in December 2015 on the left side. However, he did not include the fact that the injection provided 75% relief. The holding in Conley, supra, unequivocally demonstrates that Green's August 30, 2017, report constitutes the requisite medical evidence supporting the ALJ's determination that the SI joint injections as well as the accompanying massage therapy, as described by Barker, are reasonable and necessary treatment of her work-related injury. The ALJ clarified that the issue was not over physical therapy but rather the physical massage therapy following the injections. Thus, the massage therapy would only be permitted if the pain management physician recommends additional injections.

In finding the SI joint injection with massage therapy reasonable and necessary treatment, the ALJ, within his discretion, chose not to rely upon Dr. Gart's opinions for a number of reasons including the fact that he had never seen Barker. Important to the ALJ was the fact that Dr. Briggs had treated Barker for 13 years during which he closely monitored her treatment, symptoms, and condition. The ALJ was also unimpressed with the directions contained within the guidelines noting they were guidelines and, at that time, not binding authority.[6] Further, the ALJ relied upon the findings set forth in Dr. Briggs' August 24, 2016, note. It appears there is a typographical error, as the ALJ cited to an August 24, 2017, report when in fact Dr. Gart's report reflects he was summarizing an August 24, 2016, record. As found by the ALJ, Dr. Gart's summary of that record reflects Barker had experienced left SI joint tenderness and pain as well as radicular pain radiating down the left side. Dr. Gart's summary also reflects Dr. Briggs detected a sensory deficit distribution pattern. Similarly, the August 30, 2017, note of Green reflects a similar finding as well as noting the 2015 SI joint injection provided 75% relief leading the ALJ to conclude the SI joint injections had provided meaningful relief. Based upon Dr. Briggs' August 24, 2016, record, as summarized by Dr. Gart, and Green's August 30, 2017, record, the ALJ concluded the evidence demonstrated symptoms which warranted the SI joint injection and massage therapy. Also significant to the ALJ was Barker's credible testimony buttressing Dr. Briggs' observations. We note the ALJ only allowed one SI joint injection if the pain management physician recommended it. Further, he did not

[6] We note that the guidelines were subsequently adopted by the Commonwealth of Kentucky. However, the import of the adoption has yet to be determined.

permit the conventional type of physical therapy. We refuse to invade the discretion afforded the ALJ in determining the medical evidence upon which he will rely. Here, the ALJ chose to rely upon Dr. Briggs' August 24, 2016, record, as summarized by Dr. Gart, and Green's August 30, 2017, record in resolving this issue. Significantly, we note ARH does not contest the accuracy of Dr. Gart's summary of Dr. Briggs' record nor does it contest the accuracy of the ALJ's summary of the medical evidence contained in Dr. Gart's August 30, 2016, report. Consequently, the ALJ's determination concerning the SI joint injections and the accompanying massage therapy will not be disturbed.

Similarly, we find substantial evidence supports the ALJ's determination the epidural steroid injections are reasonable and necessary treatment. We again reference Green's August 30, 2017, report in which she notes Barker had undergone epidural injections at the L4-5 level and had obtained a percentage of relief. A copy of that report was attached to ARH's response to Barker's motion to set an additional telephonic conference or BRC. Although the copy contains deleted letters and numbers, but it is apparent from other documents that the 2016 SI joint injections provided at least 65% relief. Indeed, Dr. Gart's January 5, 2017, report notes the medical records revealed Barker's first lumbar epidural steroid injection occurred on July 13, 2016, at which time her pain level was 10 out of 10. When she presented for her second lumbar epidural steroid injection on July 20, 2016, her pain level was 5 out of 10. When Barker presented for her third lumbar epidural steroid injection on July 27, 2016, she reported 60% relief from her second injection which permitted her to engage in housework. Her pain level was then between 2 and 4 out of 10. Dr. Gart

noted that according to the August 24, 2016, report these three lumbar steroid injections provided 65% overall relief, and the last injection reduced the pain to 4 out of 10.

Significantly, in recommending the lumbar epidural steroid injections be denied, Dr. Gart noted the guidelines state epidural injections should produce pain relief of at least 50% to 75% for at least 6 to 8 weeks prior to repeating the procedures. The records of Dr. Briggs summarized by Dr. Gart and Green's August 30, 2017, report demonstrate the epidural injections produced pain reduction of between 50% to 75%. Barker's unrebutted testimony reflects she received relief from severe pain for almost a year after receiving three injections. Thus, in accordance with the guidelines cited by Dr. Gart, further epidural steroid injections should be permitted. Consequently, the August 30, 2017, report of Green and the January 7, 2017, report of Dr. Gart containing his summary of Dr. Briggs' records constitute the requisite medical evidence supporting the ALJ's decision. As such, this medical evidence constitutes substantial evidence supporting the ALJ's decision on this issue. We add that Dr. Gart's August 30, 2016, report also indicates the three epidural steroid injections in July 2016 provided 65% overall relief. We find no error in the ALJ's determination the epidural steroid injections constitute reasonable and necessary treatment of Barker's injuries. We, again, note the ALJ limited the injections to one if the eventual pain management physician recommends it.

In relying upon the opinions of Dr. Briggs and Green, the ALJ adopted the previous rationale utilized in resolving the need for the SI joint injection and massage therapy. In short, he concluded they were in the best position to offer an

opinion as to the reasonableness and necessity for the treatment. The ALJ cited to the August 24, 2016, record and the August 30, 2017, record, both of which revealed pain and radicular symptoms supporting the need for the injections. Thereafter, meaningful relief from pain was obtained after each injection. The ALJ was also impressed with Barker's testimony indicating the injections always helped in reducing the pain thereby allowing her to function better. As Green's August 30, 2017, record and the records of Dr. Briggs as summarized by Dr. Gart constitute substantial evidence this Board may not disturb the ALJ's discretion in choosing to rely upon them in resolving the reasonableness and necessity of the SI joint injection. Again we note ARH does not contest the accuracy of Dr. Gart's summary of Dr. Briggs' records nor the accuracy of the ALJ's summary of the medical evidence set forth in Dr. Gart's January 5, 2017, report.

We find no merit in ARH's argument positing the medical evidence does not support the ALJ's determination the current frequency of Barker's visits to Dr. Narola and Clonazepam are reasonable and necessary treatment of Barker's work injury. In his December 7, 2017, UR report, Dr. Gart summarized various medical reports of Dr. Narola. Dr. Gart noted Dr. Narola's July 28, 2017, report reflects Barker continued to feel tired during the daytime since starting Neurontin. She was taking the psychiatric medication as prescribed, and her mood was one of worry due to adjusting to the medication. He felt Barker was taking an unusually high dose of Neurontin, and she was advised to take Trazadone only on an as needed basis. She was to continue with Clonazepam .5 mg at bedtime and two Prozac 40 mg in the morning. The plan was for Barker to follow up in one week. Specifically, Dr. Gart noted Dr. Narola's

August 4, 2017, report reflects he advised Barker to take Trazadone on an as needed basis and continued Clonazepam and Prozac without changes. Dr. Gart summarized Dr. Narola's August 16, 2017, record as reflecting Barker reported increased nervousness and had requested to take more Clonazepam. Dr. Gart indicated the record revealed the KASPER system showed the medications were being filled appropriately and Barker's affect/effect was distressed; consequently, Dr. Narola advised her to take "Clonazepam 0.5 mg qhs (bedtime) and a half for nervousness." Dr. Gart's summary of Dr. Narola's September 11, 2017, report indicates Barker was taking the medication as prescribed and did not have any problems. She was referred to a new pain management physician. Her affect/effect was sad, worried, and frustrated. Dr. Gart noted she was to continue with Clonazepam, Prozac, and Trazadone. He further noted that given the recent increased stress related to transitioning to a new pain management physician, Dr. Narola's plan was to follow the patient closely. Dr. Gart summarized Dr. Narola's September 18, 2017, report as indicating Barker was taking medications as prescribed and reportedly had been prescribed Neurontin twice daily. She had a pending visit to a new pain management doctor. Dr. Gart summarized Dr. Narola's September 26, 2017, report as revealing Barker had run out of Neurontin and did not have an appointment with a pain management doctor. Barker was taking psychiatric medication as prescribed and was taking fewer Clonazepam. Her affect/effect was distressed and frustrated. She was advised to stay active and to get adequate pain management treatment. Significantly, Dr. Gart's report reflects he had a discussion with Dr. Narola which he summarized as follows:

> Peer discussion was performed with Dr. Narola on 12/1/17. He has been seeing the patient for 15 years. She has a diagnosis of chronic back pain. However, MRI scan results do not show any major pathology. Dr. Narola noted that despite a lack of significant MRI findings, the patient has significant pain, depression and anxiety. He is providing both medication management and therapy for the patient. The patient averages visits on a biweekly to monthly basis. The frequency of visits is dependent on her pain levels and psychological status. She was noted to be in between pain management specialists, currently without pain physician and is pending a new evaluation. She is not using any opiates. I suggested limiting the frequency of psychiatric office visits, however, Dr. Narola stated that unless the patient's pain level is better controlled, this would not be possible.

Dr. Gart recommended Barker continue to use Prozac and Trazadone. Regarding Barker's visits to Dr. Narola and the Clonazepam, Dr. Gart recommended as follows:

> Although continued follow up with Dr. Narola is reasonable, there is no medical reason why the patient would need to be seen every 1-2 weeks. Her psychiatric condition has been largely stable. Additionally, as detailed below, the continued long term use of benzodiazepines would not be recommended in this case. At this time, it would be reasonable to allow follow up visits with Dr. Narola every two weeks until clonazepam is discontinued. However, once clonazepam is weaned, the patient should not need to be seen more than once every 3-4 months. Subsequent office visits with Dr. Narola should only be for monitoring of the psychiatric condition and for refills of psychiatric medications.

Dr. Gart identified Clonazepam as a medication not providing benefit or having been over-utilized stating as follows:

> The patient has been chronically prescribed clonazepam, which is a benzodiazepine. Evidence-based guidelines do not recommend the long-term use of benzodiazepines, as long term efficacy is unproven and there is a risk for dependence with long term use. In fact, most guidelines

> recommend limiting their use of four weeks, which has clearly been exceeded in this case. The patient is treating for anxiety and depression. However, guidelines state that tolerance to the anxiolytic effects of benzodiazepines occurs within months and long term use may actually increase anxiety. A more appropriate treatment for an anxiety disorder is an antidepressant, such as an SSRI. The patient is already being prescribed an SSRI and should be considered for further optimization of the dose of that medication to allow for discontinuation of benzodiazepines.

Dr. Gart's opinions aside, the reports of Dr. Narola and his opinions expressed in the telephone conversation as summarized by Dr. Gart constitute substantial evidence supporting the ALJ's determination regarding the frequency of Barker's visits to Dr. Narola and the use of Clonazepam as a treatment modality. In his summary of his conversation with Dr. Narola, Dr. Gart admitted Dr. Narola stated Barker is not using opiates, and when he suggested limiting her office visits, Dr. Narola stated that unless her pain level is better controlled that would not be possible. Dr. Narola unequivocally believed the frequency of Barker's visits were necessary and reasonable in light of the changes in medication and her inability to secure a new pain management physician. Regarding the use of Clonazepam, Dr. Narola set forth the reasons for prescribing Clonazepam for Barker's use at bedtime. As such, the medical evidence contained in Dr. Gart's December 7, 2017, report constitutes substantial evidence supporting the ALJ's decision concerning the frequency of Barker's visits to Dr. Narola and the use of Clonazepam.

As he did in resolving the other two issues, the ALJ was not impressed by the fact that Dr. Gart had never seen Barker. Also important was the fact Dr. Narola had monitored Barker's treatment, symptoms, and condition for years. The ALJ

believed Dr. Narola was in a unique position because his opinions were based on personal knowledge. He concluded Dr. Gart's summary of Dr. Narola's records and of his conversation with Dr. Narola established Barker was consistently nervous and frustrated. Therefore, Dr. Narola had directed Barker to take one and a half pills of Clonazepam only at bedtime. The ALJ also addressed the violation of the pain management agreement and found Barker's explanation as to what occurred credible. Again, ARH did not object to the contents of Dr. Gart's report or contest the accuracy of his summaries of Dr. Narola's records. Similarly, ARH does not contest the accuracy of the ALJ's summary of the medical evidence.

We find the facts in Kingery, supra, to be markedly different from the case *sub judice*. In Kingery, supra, the Kentucky Supreme Court characterized the medical evidence available to the ALJ as follows:

> Aside from Dr. Randolph's report and deposition, the post-award medical evidence in this case is quite sparse. The record contains two treatment notes from Dr. Douglas, dated February 1 and February 29, 2012, which were her final two visits with him related to the work injury. Dr. Randolph also reviewed and summarized in his report more than 50 medical records documenting Kingery's treatment with Dr. Douglas from 1999 through 2011. According to those notes, Dr. Douglas's treatment had been directed, in relevant part, toward Kingery's complaints of pain—in her low, middle, and upper back, and neck—as well as stress, anxiety, and depression. This treatment exclusively involved prescribing various narcotics and other drugs. No objective abnormalities are noted.

Id. at 495.

The Supreme Court noted Kingery filed no evidence to rebut Dr. Randolph's opinions and, instead, testified about her original work injury, work

history, medical history, and current medical condition. Despite the absence of any medical evidence to the contrary, the ALJ disregarded Dr. Randolph's opinions and instead relied solely on Kingery's lay testimony to find her current complaints were related to the 1989 work injury, and the drugs being prescribed for those complaints were reasonable and necessary. Here, there is an abundance of medical evidence supporting the ALJ's decision on all issues.

In summary, there is medical evidence consisting of Green's August 30, 2017, record, and Dr. Gart's summary of Drs. Briggs' and Narola's medical records, which demonstrate the epidural steroid injections with accompanying massage therapy and the SI joint injections provided reasonable and necessary treatment for the cure and relief from the effects of an injury. The medical reports summarized by Dr. Gart and Green's August 30, 2017, five-page record indicate both type of injections provided more than 50% relief. In light of that information, we believe the ALJ could reasonably discern the procedures were reasonable and necessary treatment of Barker's work injury. The case *sub judice* does not bear any resemblance to the facts in Kingery, supra. Rather, we believe Conley, supra, mandates the ALJ's determination regarding the epidural steroid and SI joint injections be affirmed. Also, Dr. Gart's lengthy summary of Dr. Narola's records, and his conversation with Dr. Narola, support the ALJ's finding that the frequency of Barker's visits to Dr. Narola and the use of Clonazepam constitute reasonable and necessary treatment of her work injuries.

Accordingly, the August 23, 2018, Opinion, Award & Order and the September 5, 2018, Order denying the petition for reconsideration are **AFFIRMED**.

ALL CONCUR.

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