

Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: December 6, 2019

CLAIM NO. 199788319

DAVID JOHNSON

PETITIONER

VS.

APPEAL FROM HON. CHRIS DAVIS,
ADMINISTRATIVE LAW JUDGE

REYNOLDS BRANCH MINING
DR. SARA SALLES, D.O.
and HON. CHRIS DAVIS,
ADMINISTRATIVE LAW JUDGE

RESPONDENTS

OPINION
REVERSING IN PART & REMANDING

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

STIVERS, Member. David Johnson (“Johnson”) seeks review of the September 5, 2019, Opinion and Order of Hon. Chris Davis, Administrative Law Judge (“ALJ”) resolving a medical fee dispute filed by Reynolds Branch Mining (“Reynolds Branch”) concerning three medications, an MRI, and office visits to Dr. Sara Salles, D.O. Relying upon the opinions of Dr. Salles and Dr. Gregory Snider, the ALJ found an MRI and office visits every six months to Dr. Salles reasonable, necessary, and work-

related. Relying upon Dr. Snider's opinion, the ALJ concluded the medication Pantoprazole was not work-related and non-compensable. Relying upon Dr. Salles' opinion, the ALJ determined Tramadol was reasonable and necessary treatment of the work injury. Although the ALJ made no specific finding regarding the reasonableness and necessity of Gabapentin, based on the reports of Drs. Salles and Snider, he permitted Johnson to continue using Gabapentin/Neurontin.¹ However, based on Dr. Snider's recommendation, the ALJ reduced Johnson's daily dosage from 2400 mg to 1200 mg. Johnson also appeals from the September 16, 2019, Order overruling his petition for reconsideration.

On appeal, Johnson challenges the ALJ's determination regarding the reduction in the daily dosage of Gabapentin asserting there is no evidence his current dosage is not reasonable and necessary treatment of his work injury.

BACKGROUND

In an April 15, 1999, Opinion and Award, Hon. Irene Steen, Administrative Law Judge ("ALJ Steen") found Johnson to be totally occupationally disabled "due to his back injury and surgery." ALJ Steen found Johnson "appears to suffer from a failed low back syndrome, with development of scar tissue and nerve root compression, which continues to create problems in terms of low back and left leg pain." No further proceedings were instituted until July 11, 2018, when Reynolds Branch filed a motion to reopen, Form 112 medical fee dispute, and motion to join Dr. Salles as a party to the medical fee dispute. The motion to reopen and Form 112 frame the dispute as the "medical reasonableness/necessity of prescriptions of

¹ Hereinafter, we will refer to the medication as Gabapentin.

Gabapentin Tramadol, and Pantoprazole, including name branded/generic equivalents, and related routine office visits.” Reynolds Branch attached to the pleadings the Utilization Review report of Dr. Amitabh U. Goswami. Within his report, Dr. Goswami expressed the opinion that the medical records he reviewed did not support the continued use of Gabapentin, Tramadol, and Pantoprazole. He also opined routine office visits and further imaging studies were not reasonable or necessary.

By Order dated August 14, 2018, the ALJ found Reynolds Branch had made a *prima facie* showing for reopening and sustained the motion to reopen and joined Dr. Salles as a party to the proceeding. A Benefit Review Conference (“BRC”) would be scheduled by separate order.

Reynolds Branch submitted a November 1, 2018, Independent Medical Evaluation report of Dr. Snider based upon a medical records review and physical examination. Dr. Snider’s March 13, 2019, letter was also introduced. Johnson introduced portions of his past medical records including Dr. Salles’ treatment notes of February 11, 2016, January 26, 2017, February 1, 2018, August 16, 2018, and February 14, 2019. Johnson also submitted Dr. Salles’ August 16, 2018, treatment plan and June 12, 2019, response to his counsel’s letter. No testimony was taken and Johnson waived a hearing.² The parties did not file briefs.

² A July 16, 2019, Order reads, in relevant part, as follows: “The contested treatment is set forth in the November 13, 2018 BRC Order. All sides have filed evidence. The Plaintiff waives his Hearing. The matter stands submitted as of today’s date. An Opinion (decision) is due no later than September 19, 2019.”

The ALJ's November 13, 2018, Order reflects that a BRC was attended by counsel for both parties and "the disputed treatment is Gabapentin, Tramadol, Pantoprazole, lumbar diagnostic studies and office visits."

The September 5, 2019, Opinion and Award identified the treatment in dispute and provided the following:

SUMMARY OF THE EVIDENCE

1. The following facts were stipulated and/or proven by the parties:
 - A. Coverage under the Workers' Compensation Act,
 - B. An employment relationship existed between the parties at all times relevant,
 - C. Plaintiff's date of injury is July 9, 1996.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

2. As fact finder, the ALJ has the authority to determine the quality, character and substance of the evidence. *Square D Company v. Tipton*, 862 S.W.2d 308 (Ky. 1993). Similarly, the ALJ has the sole authority to judge the weight and inferences to be drawn from the evidence. *Luttrell v. Cardinal Aluminum Co.*, 909 S.W.2d 334 (Ky. App. 1995). In weighing the evidence, the ALJ must consider the totality of the evidence. *Paramount Foods Inc., v. Burkhardt*, 695 S.W. 2d 418 (Ky., 1985).

While I have no doubt that Dr. Goswami is a qualified physician I note that Dr. Goswami has never examined Mr. Johnson, only prepared a UR report. His conclusions while no doubt supported by general principles are not adequately addressed to Mr. Johnson's individualized needs or presentation.

As such, I will rely on the doctors who have physically examined the Plaintiff, Drs. Salles and Snider. To the extent their opinions and recommendations differ, I will analysis [sic] that and make the necessary Orders.

Dr. Salles and Dr. Snider agree that the MRI and office visits every six months are reasonable and necessary and work-related. As such, they are compensable.

The medical records from Dr. Salles initially explain the need for the Pantoprazole as due to GERD aggravated by anxiety, exercise and movement. There is no mention of any of the medicines aggravating it. Since that time, as early as June 7, 2016, Mr. Johnson has been taking a proton pump inhibitor. At no time has he been prescribed NSAIDs. Dr. Snider states that none of the medications he takes should cause him to need Pantoprazole. In reliance on the above analysis and Dr. Snider, the Pantoprazole is non-compensable as not work-related.

Dr. Snider does not actually say that the Tramadol is not reasonable and necessary he says that it is reasonable, but not necessary. In lieu of the Tramadol, he recommends Ultram. I respect Dr. Snider and it maybe [sic], or may not be, that if given the choice I would defer to his recommendations over Dr. Salles for myself. But given the manner in which Dr. Snider has addressed the question it is just that, a choice. The Tramadol, according to Dr. Snider is reasonable but a different choice might be better. Under these circumstances, I will defer to Dr. Salles. The Tramadol is compensable.

Finally, I have the Gabapentin. Dr. Salles and Dr. Snider record that Mr. Johnson reports doing very well on his dose. Dr. Salles reports there are no side effects. Dr. Snider notes that 2400 mg per day is a tremendous dose. He also reports that the EMG1 he recommended was normal, thereby supporting the notion that the Gabapentin is too high. Dr. Snider recommends reducing the dose to 1200 mg a day. He also recommends changing the prescription to Lyrica but I cannot Order that if Dr. Salles and Mr. Johnson do not agree.

I do, however, find, in agreement with Dr. Snider, that the Gabapentin dose is excessive. In reliance on Dr. Snider, the compensable dose of Gabapentin is limited to 1200 mg per day.

The ALJ ordered in relevant part as follows:

1. The Pantoprazole and Gabapentin in excess of 1200 mg per day non-compensable.
2. The lumbar MRI, office visits every six months, the Tramadol and Gabapentin of up to 1200 mg per day are compensable.

Johnson filed a petition for reconsideration taking issue with the ALJ's reliance upon Dr. Snider and his disregard of the treatment regimen formulated by Dr. Salles. Johnson asserted there was nothing unreasonable or unnecessary about the specific dosage which provides a benefit to him. Johnson also pointed out the ALJ failed to find he was not receiving a benefit from the medication. Johnson argued a physician with the University of Kentucky ("UK") is more qualified and more experienced in managing complex medical conditions. Further, he asserted Dr. Snider is not an expert in pain management and is biased. Johnson argued a recommendation of a specific dosage is not the same as finding a dosage unreasonable or unnecessary.

The ALJ overruled the petition for reconsideration reasoning as follows:

This matter comes before the undersigned on the Plaintiff's Petition fo [sic] Reconsideration and the Medical Payment Obligor's Response thereto. It is an allowable basis to find treatment non-compensable based on the frequency and dosage of the treatment. It is allowed to find the dosage unreasonable if it is excessive and potentially harmful. ALJs are allowed to rely on one time examining physicians in lieu of regular treating doctors. The Petition does not point out any patent errors appearing on the face of the Opinion. The Petition is OVERRULED.

On appeal, Johnson contends the medical evidence compels a finding in his favor. Johnson asserts KRS 402.315 allows for university evaluations based on the legislative mandate that physicians at UK and the University of Louisville are more qualified and more experienced managing complex medical conditions. He contends

Kentucky law recognizes physicians affiliated with these medical schools are experts in their fields and are not biased. As he did in his petition for reconsideration, Johnson notes the ALJ accepted the report of Dr. Snider who is not an expert in pain management and rejected Dr. Salles' opinions, a board certified specialist who practices in the UK Department of Physical Medicine and Rehabilitation.

Johnson also maintains the ALJ applied an improper standard in determining whether his treatment was reasonable or necessary. Johnson argues nothing in Dr. Snider's report states he does not receive substantial benefit from the use of Gabapentin. Rather, he posits Dr. Snider is attempting to micromanage his treatment by suggesting a lower dose of Gabapentin or trial of Lyrica. Johnson notes that although Dr. Snider stated Johnson was on a high dose of Gabapentin, he did not state the dosage is unreasonable or unnecessary. Johnson maintains Dr. Salles addressed Dr. Snider's concerns and explained in detail why he required a specific dose of Gabapentin. He asserts Dr. Salles also reported Johnson had been stable for years with no side effects and had received adequate pain relief. Thus, there is no medical evidence in the record supporting a finding that a specific dose of Neurontin was unreasonable or unnecessary. Consequently, the ALJ's decision regarding the allowable dosage of Gabapentin should be reversed.

ANALYSIS

Since Reynolds Branch was successful below, the question on appeal is whether the ALJ's finding regarding the use/dosage of Gabapentin is supported by substantial evidence. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). Substantial evidence is defined as evidence of relevant consequence, having the fitness

to induce conviction in the minds of reasonable persons. Smyzer v. B. F. Goodrich Chemical Co., 474 S.W.2d 367 (Ky. 1971). 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).

In order to reverse the decision of the ALJ it must be shown that there is no evidence of substantial or probative value to support his decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

KRS 342.020 provides the employer must pay for medical benefits that are reasonable and necessary for the cure and relief of an employee's work-related injury. National Pizza Co. v. Curry, 802 S.W.2d 949 (Ky. App. 1991). 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, 862 S.W.2d 308 (Ky. 1993). 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 worker. 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.

In the case *sub judice*, the parties agreed the sole issue was the reasonableness and necessary of the treatment modalities. That being the case, Reynolds Branch was required to establish by substantial evidence that Gabapentin was not reasonable and necessary treatment of the work injury. In C & T of Hazard v. Stollings, 2012-SC-000834-WC, rendered October 24, 2013, Designated Not To Be Published, the Kentucky Supreme Court held as follows:

“The party responsible for paying post-award medical expenses has the burden of contesting a particular expense by filing a timely motion to reopen and proving it to be non-compensable.” *Crawford & Co. v. Wright*, 284 S.W.3d 136, 140 (Ky.2009) (citing *Mitee Enterprises v. Yates*, 865 S.W.2d 654 (Ky.1993) (holding that the burden of contesting a post-award medical expense in a timely manner and proving that it is non-compensable is on the employer)). As stated in *Larson's Workers' Compensation Law*, § 131.03[3][c], “the burden of proof of showing a change in condition is normally on the party, whether claimant or employer, asserting the change ...”. The burden is placed on the party moving to reopen because it is that party who is attempting to overturn a final award of workers' compensation and thus must present facts and reasons to support that party's position. It is not the responsibility of the party who is defending the original award to make the case for the party attacking it. Instead, the party who is defending the original award must only present evidence to rebut the other party's arguments.

...

Thus, C & T had the burden of proof to show that Stolling's treatment was unreasonable and not work-related.

Slip Op. at 2.

Finding Dr. Snider's opinions set forth in his report and supplemental letter do not constitute substantial evidence in support of the ALJ's decision to limit Johnson's daily consumption of Gabapentin, we reverse. On remand, the ALJ is instructed to find the dosage of Gabapentin prescribed by Dr. Salles to be reasonable and necessary treatment of the work injury. Our reasoning follows.

In his initial report of November 1, 2018, Dr. Snider noted Johnson informed him that Dr. Salles had been seeing him for ten or twelve years and had been able to get him off narcotics and find a combination of medications that seemed to help. The first of Dr. Salles' notes reviewed by Dr. Snider was dated February 11, 2016. He noted Dr. Salles deemed his condition stable except for "issues of reflux due to GERD and hiatal hernia." Johnson had seen Dr. Salles yearly although she suggested seeing him every six months. Dr. Snider believed Johnson was on a very high dosage of Gabapentin taking four 300 mg pills four times a day. Johnson insisted this helped to relax him, allowing him to sleep about four hours a night. Dr. Snider's current impression was Johnson "suffers from chronic postoperative back pain." He recommended "EMG/NCV studies to determine if there is a neurologic deficit and, if so, whether it is related to his lower lumbar pathology." He believed the use of Tramadol on an as-needed basis was reasonable, although not necessary. He saw "no clear indication that Pantoprazole was necessary in relation to the 7/9/96 injury." Dr. Snider opined, "it is reasonable for Johnson to see Dr. Salles on an every six-month

basis.” He suggested EMG/NCV studies to clarify Johnson’s neurologic status. An anti-inflammatory as a baseline medication and generic Ultracet taken on an as-needed basis was reasonable. With respect to Gabapentin, Dr. Snider recommended as follows: “consideration of a trial of Lyrica in lieu of Neurontin; if not, I recommend weaning back to 2400 mg total daily dose.”³ Dr. Snider also opined the recent x-rays and MRI “were reasonable in an effort to better understand Johnson’s anatomy and to exclude rapidly advancing degenerative changes or unexpected anatomic deficits.”

In a letter dated March 13, 2019, Dr. Snider stated, in relevant, part, as follows:

The EMG/NCV studies performed by Dr. Gutti show chronic left S1 radiculopathy combined with sensorimotor neuropathy. In short, this confirms an element of chronic radiculopathy relatable to the original work injury.

Mr. Johnson was taking an extraordinarily high dose of gabapentin at 4800 mg q.d. I suggested that, at least to reduce his pill burden, that he take 800 mg tablets 2 p.o. t.i.d. I suggested a trial of Lyrica, but, because of its cost, unless Mr. Johnson reports dramatic and documentable improvement in function and symptoms I would revert him back to Neurontin. Otherwise, my opinions and recommendations as documented in my 11/01/18 report remain unchanged.

Dr. Salles saw Johnson on August 16, 2018, and in addition to her note of that same date, she provided a treatment plan. In the treatment plan, Dr. Salles set forth Johnson’s current work-related diagnosis as “low back pain, neuropathic pain, gait disorder, mood d/o, PUD.” Dr. Salles stated the prescription regimen was needed

³ Earlier in his report, Dr. Snider stated: “At the very least, to reduce the pill burden, I suggest taking 800 mg 2 p.o. t.i.d. Also, a trial of Lyrica is a consideration; however, unless Mr. Johnson has a dramatic improvement in function and symptoms with Lyrica, I would not recommend its continuation, mostly on the basis of high expense.”

for management of back pain and neuropathic pain. The benefit derived from the treatment was “pain relief, able to do ADL’s and walk.” The risk with termination of treatment was “worse pain, unable to walk and care for self, and depression.” The projected period of future treatment is “lifetime.” Dr. Salles stated there was no need for prescription and drug addiction prevention and management. The reasonable and necessary office visits for the cure and/or relief of Johnson’s work injury was every six months. Johnson’s prognosis was fair.

Dr. Salles’ February 14, 2019, record reflects Johnson had a history of work-related injury in 1996 with lumbar fusion and failed back syndrome with chronic low back pain and neuropathic pain. Johnson was last seen in August 2018 and at that time, “there was concern for worsening radicular symptoms in the left lower extremity with associated neurogenic claudication.” Johnson had previous x-rays of the back which showed significant degenerative joint disease and disc disease. A request was made for an EMG/NCV study which was declined by the workers’ compensation carrier. Johnson continued to complain of left lower extreme weakness as well as sensory changes in the S1 distribution. Johnson had taken his medications as prescribed and received an MRI since his last visit showing small disc protrusions, the greatest at L2 through L5 with mild spinal canal compromise and chronic changes. An EMG/NCV study had been approved. Dr. Salles discussed medication changes with Johnson including changing his Ultram to Ultracet. Her assessment was:

1. DDD (degenerative disc disease), lumbar (M51.36)
2. Low back pain (M54.5)
3. Lumbosacral radiculopathy (M54.17)
4. Neuropathic pain (M79.2)

Dr. Salles planned to stop Acetaminophen ER 650 mg oral tablet extended release and Tramadol HCl, 50 mg oral tablet and start Tramadol-Acetaminophen 37.5-325 mg (Ultracet) 1 tablet three times daily. She renewed Diclofenac Sodium 75 mg oral tablet delayed release, 1 tablet twice daily and “Gabapentin 300 mg oral capsule (Neurontin); 4 tabs po qid.” She discontinued Ultram and Tylenol and started Ultracet 37.5 325 mg 3 times a day for pain. Johnson was to continue on Gabapentin as it was “working effectively for him at this time for neuropathic pain.” Dr. Salles would see him for a follow-up in six months.

On June 12, 2019, in response to a letter from Johnson’s counsel, Dr. Salles wrote Johnson was currently taking Gabapentin (Neurontin) 300 mg, four tablets four times daily “which he has been stable on for years with no side effects and adequate pain relief.” She stated, “The current dosage of Gabapentin is reasonable and necessary to treat Johnson’s work-related condition which includes failed back syndrome with chronic low back pain and neuropathic pain.”

Dr. Snider’s opinions do not rebut the opinions of Dr. Salles as recited herein. Dr. Snider did not state the current dosage of Gabapentin was unreasonable and unnecessary treatment of Johnson’s work-related back condition. In his initial report, with respect to Gabapentin, Dr. Snider suggested that at the very least in order to reduce the pill burden, taking 800 mg two po and a trial of Lyrica. However, if Johnson did not have dramatic improvement of function and symptoms, it should be discontinued. Later, Dr. Snider recommended “consideration of a trial of Lyrica in lieu of Neurontin; if not, I recommend weaning back to 2400 mg total daily dose.” In his subsequent March 13, 2019, letter, Dr. Snider again reiterated Johnson was taking

an extraordinary high dose of Gabapentin and made the same suggestion as in his previous letter of Johnson taking 800 mg tablets twice daily. He again suggested a trial of Lyrica and stated unless Johnson did not report dramatic and documented improvement in functions and symptoms, the use of Neurontin be resumed. Dr. Snider's suggestion and recommendations do not rise to the level of an opinion expressed in terms of reasonable medical probability that the use of Gabapentin, specifically the dosage prescribed by Dr. Salles, do not comprise reasonable and necessary treatment. Consequently, we agree with Johnson that the ALJ incorrectly limited his future daily dosage of Gabapentin.

Although Dr. Snider recommended a reduction in the dosage of Gabapentin, he did not assert the current dosage of Gabapentin was unreasonable and unnecessary. Absent a statement from Dr. Snider to that effect, the ALJ erred in the September 16, 2019, Order by stating he was "allowed to find the dosage unreasonable if it was excessive and potentially harmful." Significantly, Dr. Snider did not state the medication was excessive and potentially harmful. Moreover, there is no finding by the ALJ that the use of Gabapentin 4800 mg q.d. was unreasonable and unnecessary treatment of Johnson's work injury. Assuming, *arguendo*, the ALJ made such a finding in the September 16, 2019, Order when he stated he "is allowed to find the dosage unreasonable if it is excessive and potentially harmful," there is no medical evidence in the record supporting such a finding. Significantly, Dr. Snider, upon whom the ALJ relied, did not proffer the opinion the dosage was excessive and potentially harmful. The ALJ's statement is clearly erroneous.

Since Dr. Snider did not opine the current dosage of Gabapentin was unreasonable and unnecessary treatment of Johnson's work injuries and Dr. Salles' records establish the current dosage of Gabapentin provided cure and relief of the injury, and provided a reasonable benefit to Johnson, as a matter of law, the ALJ erred in reducing his dosage of Gabapentin.

Accordingly, those portions of the September 5, 2019, Opinion and Award and September 16, 2019, Order finding Gabapentin in excess of 1200 mg per day non-compensable is **REVERSED**. This claim is **REMANDED** to the ALJ for entry of an Order resolving the medical fee dispute regarding Gabapentin in favor of Johnson.

ALVEY, CHAIRMAN, CONCURS.

RECHTER, MEMBER, DISSENTS WITHOUT SEPARATE
OPINION.

DISTRIBUTION:

COUNSEL FOR PETITIONER:

HON THOMAS W MOAK **LMS**
P O BOX 510
PRESTONSBURG KY 41653

COUNSEL FOR RESPONDENT:

HON RONALD J POHL **LMS**
HON FREDRICK O RODGERS **LMS**
3292 EAGLE VIEW LN STE 350
LEXINGTON KY 40509

RESPONDENT:

DR SARA SALLES DO **USPS**
740 S LIMESTONE ST STE D135
LEXINGTON KY 40536

ADMINISTRATIVE LAW JUDGE:

HON CHRIS DAVIS **LMS**
MAYO-UNDERWOOD BUILDING
500 MERO ST 3RD FLOOR
FRANKFORT KY 40601