Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: January 12, 2018

CLAIM NO. 199024930

GEORGE YOUNG PETITIONER

VS. **APPEAL FROM HON. JOHN B. COLEMAN, ADMINISTRATIVE LAW JUDGE**

YOUNG PAINTING
THERESE A LEVAN M.D.
and HON. JOHN B. COLEMAN,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION
AFFIRMING
* * * * * *

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

STIVERS, Member. George Young ("Young") appeals from the August 16, 2017, Opinion and Order of Hon. John B. Coleman, Administrative Law Judge ("ALJ"). In the August 16, 2017, Opinion and Order, the ALJ resolved a post-award medical fee dispute, filed by R.E. Young Painting ("Young Painting"), in its favor by determining treatment rendered

by Dr. Therese-Ann LeVan to be non-compensable pursuant to KRS 342.020(7). On appeal, Young asserts the ALJ erred in finding his treatment with Dr. LeVan is non-compensable.

The record indicates Young Painting filed "Motions to Reopen, For Leave to Select Plaintiff's Physician and to Join Plaintiff's Treating Physician" (hereinafter "Motion to Reopen") and a Form 112 Medical Fee Dispute on June 13, 2016.

In the Form 112, the nature of the dispute was described as follows:

> Defendant Employer, R.E. Young Painting, by counsel, states that because of the physician selected by Plaintiff, George A. Young, to treat his injury Mr. Young is not receiving proper medical treatment and/or his recovery is being substantially affected or delayed and/or the funds for medical expenses are being spent without reasonable benefit to Mr. Young, Defendant Employer moves pursuant to KRS 342.020(7) for an order granting Defendant Employer leave to select a physician to treat Mr. Young. Defendant further moves for a determination that the treatment currently provided by Dr. Levan is not reasonable and necessary for the cure and relief of Mr. Young's condition.
>
> As grounds for the motion, counsel for Defendant Employer states, under oath, that Mr. Young, according to the September 8, 2015, and November 17, 2015, reports of Richard H. Du Bou, M.D., is being treated by his current physician primarily with the

> administration of opiates without any true medical treatment being rendered. Dr. Du Bou has expressed the opinion Mr. Young is not receiving proper medical treatment and/or his recovery is being substantially affected or delayed and/or the funds for medical expenses are being spent without reasonable benefit to Mr. Young. Dr. Du Bou also opined that Mr. Young is, because of the current treatment regimen, addicted to opioid analgesic medications. The aforementioned reports of Dr. Du Bou are attached to this motion and are incorporated herein by reference. Also attached are the previous settlement agreements.
>
> Further, Defendant Employer, by and through its medical payment obligor, has confirmed with Restart FX and Ajith Nair, M.D., that they will provide Mr. Young treatment to reduce the amount of his opioid use and with Huey Tien, M.D., a board certified hand surgeon, that he will undertake the care of Mr. Young's injured hand in the event Defendant Employer is granted Leave to select the physician to treat Mr. Young.

Attached to Young Painting's Motion to Reopen is a Form 110-I Settlement Agreement entered into between Young and Young Painting upon reopening and approved by Hon. Donald G. Smith, Administrative Law Judge ("ALJ Smith") on January 25, 2002. The Form 110 indicates Young's injury took place on January 7, 1990, while working as a painter, when his wedding band caught on a truck gate causing the following injuries: "Degloving of left ring

finger and partial amputation; psychological (disputed)." Under "diagnoses" is the following: "Degloving injury to left ring finger, formation of neuromas, hypersensitivity and swelling of left hand." An addendum attached to the Form 110 reads as follows:

> 1. The Employee, George Allen Young, shall receive a settlement based on a lump sum. The reopening of the left ring finger/hand injury is settled for a lump sum. The reopening of the left ring finger/hand injury is settled for a lump sum amount of $32,500.00. The parties to this Agreement recognize and agree that the Employee is permanently and totally disabled. Of the aforesaid $32,500.00, $20,000.00 represents a payment for any and all future temporary total disability; $5,000.00 is for a waiver of any future permanent partial and/or permanent total disability benefits; and $7,500.00 is for a waiver of the Employee's right to reopen in order to claim any future disability benefits whatsoever.
>
> 2. As part of this reopening, the Employee has alleged a psychological condition for the first time. Hence, this is a compromise settlement of a doubtful and disputed psychological workers' compensation claim. In addition to the aforesaid amount, the Defendant-Employer agrees to pay $1,000.00 for a waiver of all past and future psychological indemnity benefits; $1,000.00 for a waiver of past and future psychological expenses; and $500.00 for a waiver of the Employee's right to reopen on the basis of a psychological claim. The Employee recognizes that the Defendant-Employer has bought its peace and curtailed its

> litigation expenses without accepting any liability for the psychological claim.
>
> 3. The Defendant-Employer shall remain responsible for all reasonable and necessary medical expenses to the left ring finger/hand to be paid pursuant to the Workers' Compensation Act. The parties recognize that there can be an overlap between pain medications and medications prescribed for a psychological condition, however. The Defendant-Employer agrees to pay for any reasonable medications prescribed as management of pain associated with the left ring finger/hand. The Defendant-Employer will not be permitted to deny payment of medications prescribed for management of left hand pain on the grounds that such prescriptions can be prescribed for a psychological condition. However, the Defendant-Employer can deny payment for medications prescribed for a psychological condition which is not related to pain management of the left ring finger/hand.

Attached to Young Painting's Motion to Reopen is a letter from Dr. Richard H. DuBou, dated September 8, 2015, which reads as follows:

> Thank you very much for the opportunity to see Mr. George Young. As you may remember, this 53-year-old male on July 7, 1990 sustained a degloving injury secondary to a ring. The initial doctor, Mr. Dorothy Clark, initially repaired one of the digital arteries and he underwent necrosis due to injury to the intima. The doctor completed the amputation through the middle of the middle phalanx and then more proximally. This was revised again

still more proximally in 1993 and she did a series of neuroma excisions.

Her partner, Dr. Levan [sic], at one time did a wrap-around vein graft apparently, in the records you were kind enough to send, this was referred to as an accessory digital nerve.

The reason for the visit at this point is due to his large amount of pain medication.

At the present time, he takes 40 mg of oxycodone in the morning, 20 at noon, and 40 in the evening. He takes 1 mg of Xanax twice a day, 800 mg of Elavil at bedtime, 75 mg of Lyrica t.i.d., 40-50 mg of metoprolol (a heart medication) daily, and approximately 40 mg of simvastatin for cholesterol. On specific questioning, he states this is approximately the medication he has been on since 2003.

Although Mr. Young stated that I would be able to examine his hand, any degree of physically touching is impossible. He states the pain starts at the proximal part of his palm and moves on distally. He complains mostly of the radial side of the digits of the index, middle, and fifth, but basically both sides of the digits cause him a good deal of pain.

There appears to be exquisite pain about the stump of the ring finger, but with him pulling the hand away rapidly, it is truly impossible to tell exactly where the pain may or may not be or where the neuroma may or may not be. I could not appreciate any knot that he described in the past.

The x-rays do continue to show the osteopenia of the metacarpal head,

> proximal phalanx of the ring finger, and the remaining digits being relatively normal.
>
> The patient's very complex medical record 12-14 surgical procedures for excision or neuromas. At one point, there was a cadaver graft or a vein graft, he is uncertain of this, in an effort to cover the neuroma which was unsuccessful. The patient has a significant tremor with any degree of exposure of the digit or even any attempt to examine this.
>
> The only hope he says he has is for some type of new procedure involving stem cells which is not ready yet.
>
> I would have to agree with Dr. Burgess who felt it is impossible to tell whether the neuromas exist or not. It is unlikely that his subjective complaints will abate and in all likelihood the need or perceived need for his narcotics will continue.
>
> I feel as Dr. Burgess did, that in spite of these statements made within a reasonable degree of medical probability, without being able to truly examine the patient or go through a physiologic exam, a good deal of this is based on probability.

Attached to the Motion to Reopen is a second letter from Dr. DuBou, dated November 17, 2015, which states as follows:

> Thank you very much for your letter of November 4, 2015. I do think the amount of medicine being spent on opiates by Mr. Young without any true medical treatment being done is not helping him. As such, giving him just opiates

> indicates he is not receiving proper medical treatment and his recovery is being delayed. Additionally, funds for medical expenses are being expended without reasonable benefit.
>
> I do think another physician would be better able to see the forest without [sic] the trees and perhaps be able to reduce the amount of pain medicine Mr. Young requires or at least the amount of pain that he has.
>
> With the amount of psychological overlay that Mr. Young has, I would prefer not to be his treating physician.

Young Painting filed the June 6, 2016, medical report of Dr. Jeffrey E. Hazlewood. After performing a medical records review only, Dr. Hazlewood opined as follows regarding Young's current treatment regimen:

> With respect to the current treatment regimen of opioids, I have several concerns. First of all, I think it is essential when one is on over 100 mg of Morphine equivalent daily dose that the claimant be followed by a board certified pain specialist. Tennessee has such recommendations strongly in place per the Department of Health chronic pain guidelines for chronic opioid usage in non-malignant pain. He is on at this time 100 mg Oxycodone a day (Oxycontin), which is equal to 150 mg Morphine equivalent daily dose. Research data indicates that when one is over 100 mg Morphine equivalent daily dose that the adverse events risk is elevated nine fold. All evidence based peer review medicine guidelines are now strongly suggesting that patients remain below 100-120 mg

Morphine equivalent daily dose, and the most recent published Center for Disease Control Guidelines actually recommend most patient [sic] below 50 mg Morphine equivalent daily dose (at most 90 mg Morphine equivalent daily dose). The reasons for these recommendations and the changing research literature indicates that there are no long term benefits sustained by chronic use of opioids. There is no indication in this case of Visual Analog Scale Scores indicating efficacy of opioid effects. Apparently he is working, so he is getting some functional improvement out of the opioids, but it appears to me that the risks in this case far outweigh the benefits. If he has such pain that he cannot even have his hand examined, it is difficult for me to understand how he works unless he is working one handed. Also, it does not appear to me that this is a case where opioids are having a huge impact on pain control given the findings on the IME's [sic] examinations. The risks are many, especially when one is over 100 mg Morphine equivalent daily dose, including addiction, unintentional overdose death especially at these dosages (and especially when mixed with benzodiazepines and other mid [sic] altering drugs, such as Elavil and Lyrica), physical and psychological dependency, tolerance, opioid induced mood disorder including anxiety, which is actually increased by the use of opioids, not the pain itself, opioid induced hypogonadism, opioids hyperalgesia that may be present in this case (the higher dose one is on of opioids the more pain that is actually caused by the opioids), respiratory depression, immunocompromised side effects, increased risk for osteoporosis and fracture, cognitive

effects and impairment, genitourinary and gastrointestinal side effects, tooth decay, and endocrine abnormalities. Two different research studies have shown anywhere from a four to ten times elevated risk for unintentional overdose, including death, when one mixes benzodiazepines with opioids, especially high dose opioids. It is also concerning in this case that benzodiazepines are being written by a surgeon for 'poor sleep', and Xanax is not indicated chronically for such usage. I agree with other physicians that if he does have anxiety disorder related to his injury, then it is essential that he be evaluated by a psychiatrist for determination of appropriateness of chronic benzodiazepines in such a case given the high risk with mixing these with the high dose opioids. I think the use of Lyrica and Elavil for neuropathic pain are certainly reasonable. There have not been urine drug screens done to monitor for appropriate use of opioids and monitoring for any potential diversion, misuse, or abuse. I do not see that an opioid agreement has been signed by the claimant to understand the risks and benefits that have been explained to him in great detail of chronic use of opioids and the expectations that only this physician will write the opioid, he will use only one pharmacy, he will submit to random urine drug screens, that there is a high risk for addiction, etc. I do not see that the state database for controlled substances has been queried (KASPAR report in Kentucky) on a regular basis. I do not see that pill counts have been performed. All of these are measures that are strongly recommend [sic] by all evidence based peer review guidelines as well as many state opioid

> guidelines when one uses chronic opioids. Such guidelines are usually carried out by board certified pain specialists, not typically surgeons treating chronic pain with high dose opioids. For all of these reasons, it appears to me that the risks of chronic opioid usage in this case outweigh the benefits, especially when the exactly [sic] etiology for the pain cannot be determined because the claimant refuses to have his hand examined.

When asked about treatment recommendations for Young, Dr. Hazlewood opined as follows:

> I do recommend a gradual weaning down and hopefully off of opioids. He may very well have opioid hyperalgesia after all these years of opioid usage. I am sure he has developed quite a bit of tolerance. There is no way to state whether he has a true addiction as there has been no documentation of aberrant behavior, pill counts performed, etc. He certainly most likely is physically [sic] and physically dependent on the medication, but it is difficult for me to state whether he has developed a true 'craving' addiction presentation. It is definitely possible he has. If he does have a true opioid addiction, then it is not appropriate to continue using opioids in such a situation. I agree with the IME physicians that it will be a very hard task to get this gentleman off opioids, and I do recommend a multi-disciplinary type pain management program to have any chance of success. Such a program works with professionals to wean off of opioids in a setting of a team approach with use of physical therapy, nutritionists, counselors, and psychologists, especially with strong usage of cognitive behavioral therapy

> type programs to shift the emphasis on functional improvement rather than just pain improvement with opioids. These psychologists work with fear avoidance behavior, which obviously is present in this case as he would not allow his hand to be examined. They work with catastrophizing type mental philosophies. I think trying to wean this gentleman off successfully in an outpatient setting will be impossible given the presentation and length of time as well as the dose of opioids he is currently taking. Also, an interventional pain specialist might be able to perform some sort of nerve blocks intermittently that could control the pain without using chronic opioids. I don't know that sympathetic nerve blocks will be of efficacy here given the lack of what appears to be true sympathetic mediated pain/Complex Regional Pain Syndrome, but it is possible they could perform some sort of peripheral nerve block that could provide some lasting relief. Also, if he has not been [sic] an anti-depressant, such as Cymbalta or Effexor I definitely would consider a trial of these for neuropathic pain and also they can have an effect on associated anxiety and depression that factors into the pain syndrome.

Young Painting filed the October 24, 2016, medical report of Dr. Danesh Mazloomdoost. After performing an examination of Young and a medical records review, Dr. Mazloomdoost answered certain questions as follows:

> 1 & 2) Is continued opioid use (short-term & long-term) is [sic] warranted:
>
> While chronic opioid use for neuropathic pain is known to promote

hyperalgesic response, given over 17 years of reliance, it would be inappropriate to rapidly abstain patient from opioids. It is reasonable, however, to aggressively taper and consider switching to an agonist/antagonist therapy such as buprenorphine or a harms reductionist approach using methadone for basal agonism rare breakthrough agent (a few times a week or month). While initially jarring, I believe an opioid taper may provide more [sic] effective pain relief in the long-term but abstinence may not be realistic. I have however seen very motivated patients bridge into opioid abstinence after years of use, but this is <2% of the population.

3) Whether Mr. Young would benefit from referral to a Board Certified hand surgeon for recommendations and/or treatment?

A second opinion by a board-certified hand-surgeon may be warranted at some point but I believe it would be more helpful to identify the neuroanatomic distribution of pain (central versus peripheral) prior to further surgical evaluation. I would prioritize the following prior to further surgical interventions:

- Improved neuropathic control with neuroleptics, tricyclic antidepressants, or SNRI anti-depressants to augment thalamic filtration of pain

- Identify origin of pain: peripheral, sympathetic, or centralized pain. Identify any confounding neuropathic pain such as cubital tunnel or Guyon’s canal compression; this can be accomplished simultaneous to any interentional [sic] work-up

- Rehabilitate with desensitization occupational therapy

- Identify any psychological overlays or opioid-dependency

Dr. Mazloomdoost was deposed on January 20, 2017. When asked if Young was deriving any benefit from his current opioid regiment, he testified as follows: "It's not benefiting his condition. I think it can give the illusion of improvement, but it's like taking baby steps down, but overall the hill is going up." He testified further:

> Q: If you were to become Mr. Young's treating physician, what treatment would you recommend?
>
> A: It depends on how much resistance he does show. I mean, if he's – if he really is significantly concerned about changing medication, then there are some alternatives that do not seem to have been explored in his – in caring for neuropathic pain.
>
> It sounds like when he did see a pain specialist the only option offered was a spinal cord stimulator, which is – which, you know, for somebody who's endured 17 or – several many surgeries, it can be a very scary prospect.
>
> But there are things that mimic the outcomes from a spinal cord stimulator, which would be worth exploring, and I'd be very confident that he would have a positive outcome from those treatments.
>
> If he was very resistant to changing, I would start with those treatments first

to give him a level of comfort that there are some escape medications – escape treatments, meaning things that would help address the pain if it gets out of control.

Then I would say, let's take this leap of faith, let's just drop the oxycodone and switch to a different medication.

Methadone would be a good choice if we're sticking with an agonist medication. If we're looking at an agonist/antagonist, buprenorphine would be a good choice too. Either one of those medications, I think, would be a better choice long term than maintaining the oxycodone.

Q: Now, you've mentioned that his condition is not being benefited by this opioid regimen.

Is it dangerous for him?

A: I think the short-term gains are not worth the loss, and in the long run, the concern for overdose is – is the biggest – the biggest concern. And when somebody has been on a maintenance course for as long as he has, I think the probability of that is low, but it's still present.

The probability of not improving or slowly declining I think is a bigger – it's a much higher probability, and that, I can say, is going to be against his long-terms interests.

Q: If Mr. Young were to become your patient, what is your opinion as to whether or not you can reduce his dependency on opioids, make his pain better and improve his quality of life?
A: I think after 17 years of being chronically exposed to pain medication,

going to abstinence, I think, is probably out of the question. It's not going to happen.

Going to lower levels of medication or even, I would say, his best case scenario would be going to the point where it's not a daily physical reliance but a periodic or emergency availability, that would be the ideal scenario.

If we could get there after 17 years of chronic high-dose opioids I'm not – I'm not terribly confident. I think the best case scenario is we're going to be in a medication process where he probably will maintain some level of opioids long term, but at lower levels that may be more sustainable, and then we work on the other modalities that I mentioned to help treat his pain.

Q: Would that lower level of opioid use get below the 50 morphine equivalent doses a day?

A: So the 50 and the 90 milligrams, they're not magic numbers. It's where we've seen thresholds in research showing greater risk or more sustainable risk.

The goal would be to get him as low as possible, and that could even be lower than the 50 milligrams, but it just depends on how much we can – we can encourage him and how much we can – we can get to a lower level. I do think it's very probably to get below 50.

Q: Well, certainly you're confident that you can get him way below 150?

A: I do. One hundred and fifty I definitely think we can get below.

In the May 11, 2017, Benefit Review Conference ("BRC") Order, the following contested issue is listed: "continued treatment with Dr. Levan under KRS 342.020(7) including continuing opioid regimen."

In the August 16, 2017, Opinion and Order, the ALJ set forth the following "Analysis and Conclusions":

ANALYSIS AND CONCLUSIONS

> This medical dispute is unique, as the defendant is not simply requesting a particular medical treatment be found non-compensable, but instead argues the plaintiff is not receiving proper medical treatment, which has the effect of delaying his recovery and causing the expenditure of medical benefits without reasonable benefit to the employee. As such, the defendant requests the right to select a different treating physician for the plaintiff pursuant to KRS 342.020 (7). The first step in the analysis is whether the treatment is shown to be unproductive or outside the type of treatment generally accepted by the medical profession. This finding is made by the ALJ based upon the facts and circumstances surrounding each case. Square D Company v. Tipton, 862 SW2d 308 (Ky. 1993). In making the determination, it must be kept in mind it is the employer who has the burden of proving that contested medical treatment is not reasonable or necessary for the cure and relief of a work injury. National Pizza Company v. Curry, 802 SW2d 949 (Ky. App., 1991).
>
> A review of the entirety of the facts and circumstances surrounding this case presents a clear picture the

plaintiff did sustain a serious injury in the course and scope of his employment, which necessitated multiple surgeries. The surgeries performed by Dr. LeVan, a plastic surgeon, have not been questioned. However, although Dr. LeVan in 2013 and again in 2016, indicated a pain management referral would be appropriate, she continues to opine that she would be in the best position to continue rendering treatment to the plaintiff (for the last nine years, treatment has consisted entirely of medication management including high doses of opioid medications). The pain management specialists who have reviewed the treatment history question whether this long-term opioid usage is helpful to the plaintiff or instead is dangerous to the plaintiff causing increased risks of adverse effects including mortality. Curiously, although the records reflect the plaintiff allows Dr. LeVan to examine his affected hand, he clearly did not allow such examination by Dr. Burgess, a hand surgeon or Dr. DuBou, a plastic surgeon. The physicians who attempted to examine the plaintiff in connection with a prior reopening reached different conclusions about continuation of opioid management although they both agreed that it was impossible to determine the presence of a painful neuroma due to the plaintiff's failure to cooperate in the examination.

In the current proceedings, Dr. Wheatley clearly outlined numerous concerns for the continuation of the medication management, which the plaintiff has been on for a number of years. Initially, Dr. LeVan defended the medication management plan in her note of June 2016 and again in the

report of August 2016. However, by September of 2016, she discussed the new recommendations by the CDC with the plaintiff and recommended decreasing the opioids to the maximum allowable recommendation at the current time. This change in events is an indication that Dr. LeVan was certainly slow to react to the changes recommended by the CDC and the change in pain management philosophy described by Dr. Mazloomdoost in his deposition. While both pain management physicians are clearly under the belief the plaintiff has opioid induced hyperalgesia, which they believe to be a source of his continuing complaints of severe pain, Dr. LeVan continues to cite to the recurring neuromas as the source of the plaintiff's pain. However, Dr. Mazloomdoost made it clear that neuromas themselves are not necessarily painful. The plaintiff was uncooperative with both Dr. DuBou and Dr. Burgess in their attempts to examine his hand for the presence of a neuroma. After reviewing the entirety of the medical evidence, I am convinced by the medical opinion of Dr. Mazloomdoost the plaintiff's continued pain perception is the result of sympathetic stimulation. I am convinced there are treatment recommendations, which could help the plaintiff by first determining the source of his pain and then providing treatment, which would decrease his dependency on opioid usage and thus decrease the possibility of adverse side effects.

Additionally, the plaintiff made it clear in his testimony at the hearing that if he were allowed to continue treatment with Dr. LeVan he would likely again request increased narcotic pain medications as he refused to answer the question in that regard.

The plaintiff has also shown an unwillingness to accept any other opinion other than the opinion that he needs increasing narcotic medications to control pain caused from neuromas. He refused to allow examination of his hand by either Dr. DuBou or Dr. Burgess. He described his experience with Dr. Mazloomdoost as a, "nightmare" when Dr. Mazloomdoost attempted to decrease his reliance on narcotic medications. While Dr. LeVan has certainly provided appropriate surgical treatment for the plaintiff's work injury, it is clear that her continuation of treatment of the plaintiff through the use of narcotic pain medications, which until recently exceeded the maximum dosage recommended by the CDC and pain management physicians, is not the proper medical treatment to allow the plaintiff recovery from the effects of his work injury. The continuation of that type of treatment clearly results in the funds for medical expenses being spent without a reasonable benefit to the plaintiff other than short-term perceived benefits due to the effects of "rebound" as discussed by Dr. Mazloomdoost in his deposition. I am convinced by the medical opinions of Dr. Mazloomdoost and Dr. Hazlewood the likelihood of adverse side effects outweigh the plaintiff's perceived benefit from this type of treatment. As such, the medical dispute and request for the right to change the plaintiff's treating physician must be resolved in favor of the defendant.

Significantly, Young did not file a petition for reconsideration contesting any of the ALJ's findings or requesting additional findings.[1]

KRS 342.020(7), the applicable statute, reads, in relevant part, as follows:

> Upon motion of the employer, with sufficient notice to the employee for a response to be filed, if it is shown to the satisfaction of the administrative law judge by affidavits or testimony that, because of the physician selected by the employee to treat the injury or disease, or because of the hospital selected by the employee in which treatment is being rendered, that the employee is not receiving proper medical treatment and the recovery is being substantially affected or delayed; or that the funds for medical expenses are being spent without reasonable benefit to the employee; or that because of the physician selected by the employee or because of the type of medical treatment being received by the employee that the employer will substantially be prejudiced in any compensation proceedings resulting from the employee's injury or disease; then the administrative law judge may allow the employer to select a physician to treat the employee and the hospital or hospitals in which the employee is treated for the injury or disease.

Pursuant to KRS 342.020(7), the ALJ has the discretion, after considering the entirety of the evidence,

[1] Young Painting filed a petition for reconsideration pointing out a typographical error that was corrected by Order dated September 19, 2017.

to determine, as in the case *sub judice*, that continued treatment with Dr. LeVan "is not the proper medical treatment to allow the [Young] recovery from the effects of his work injury," and its continuation "clearly results in the funds for medical expenses being spent without a reasonable benefit to the plaintiff." The burden of proof to sustain its Motion to Reopen rested on Young Painting, and the record indicates Young Painting supported its motion with ample evidence the ALJ ultimately, in a proper exercise of discretion, relied upon. This evidence includes the two letters, dated September 8, 2015, and November 17, 2015, of Dr. DuBou, the June 6, 2016, report of Dr. Hazlewood, the October 24, 2016 report of Dr. Mazloomdoost, and the January 20, 2017, deposition of Dr. Mazloomdoost. The August 16, 2017, Opinion and Order firmly establish the ALJ relied upon the opinions expressed by Drs. Hazlewood and Mazloomdoost, and these medical opinions constitute substantial evidence in support of the ALJ's decision to allow Young Painting to select a physician to treat Young pursuant to KRS 342.020(7). Further, the opinions of Dr. DuBou constitute substantial evidence supporting the ALJ's decision.

This Board is cognizant of the fact that there is medical evidence filed in the record by Young, including

reports, letters, and records by Dr. LeVan, that support Young's continued treatment with the same. We are also aware that Dr. LeVan, as expressed in her letter of August 29, 2016, agrees that an evaluation by a pain specialist may be beneficial to Young and, "[i]dealy, other medication or modes of treatment could be instituted and his narcotic requirement reduced." However, in rendering a decision, KRS 342.285 grants an ALJ as fact-finder the sole discretion to determine the quality, character, and substance of evidence. Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993). As in the case *sub judice*, an ALJ may draw reasonable inferences from the evidence, reject any testimony, and believe or disbelieve various parts of the evidence, regardless of whether it comes from the same witness or the same adversary party's total proof. Jackson v. General Refractories Co., 581 S.W.2d 10 (Ky. 1979); Caudill v. Maloney's Discount Stores, 560 S.W.2d 15 (Ky. 1977). Magic Coal Co. v. Fox, 19 S.W.3d 88 (Ky. 2000). Although a party may note evidence supporting a different outcome than that reached by an ALJ, such proof is not an adequate basis to reverse on appeal. McCloud v. Beth-Elkhorn Corp., 514 S.W.2d 46 (Ky. 1974). Rather, it must be shown there is *no* evidence of substantial probative value

to support the decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

The function of this Board in reviewing an ALJ's decision is limited to a determination of whether the findings made are so unreasonable under the evidence that they must be reversed as a matter of law. Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000). The Board, as an appellate tribunal, may not usurp the ALJ's role as fact-finder by superimposing its own appraisals as to weight and credibility or by noting other conclusions or reasonable inferences that otherwise could have been drawn from the evidence. Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999). This is particularly the case when Young failed to file a petition for reconsideration contesting any of the ALJ's factual findings or requesting additional findings. Therefore, inadequate, incomplete, or even inaccurate fact-finding on the part of an ALJ does not justify reversal or remand when substantial evidence supports the ultimate conclusion.

Young Painting's Motion to Reopen was properly filed and the ALJ's decision is supported by substantial medical evidence, and the mandates of KRS 342.020(7) were properly followed and applied. Consequently, this Board

would be committing error should it reverse the ALJ's decision.

Accordingly, August 16, 2017, Opinion and Order is **AFFIRMED**.

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