Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: December 23, 2020

CLAIM NO. 201973879

LARRY RHINEHART — PETITIONER

VS. **APPEAL FROM HON. CHRIS DAVIS**
ADMINISTRATIVE LAW JUDGE

CMTA, INC.;
MEDICAL CENTER HEALTH ANESTHESIA;
BAPTIST HEALTH CORBIN;
PROFESSIONAL SURGICAL ASSISTANCE;
ANESTHESIA HEALTH;
SOUTHEASTERN EMERGENCY SERVICSE, PC;
JELLICO COMMUNITY HOSPITAL;
SOUTHERN EMERGENCY MEDICAL SPECIALISTS;
IMAGING CONSULTANTS OF KENTUCKY;
THE MEDICAL CENTER AT BOWLING GREEN;
BAPTIST HEALTH MEDICAL GROUP;
BOWLING GREEN ASSOCIATED PATHOLOGITS, PSC;
BOWLING GREEN NEUROSURGICAL ASSOCIATES;
ANCHORAGE AMBULANCE;
GRAVES GILBERT CLINIC; AND
HON. CHRIS DAVIS,
ADMINISTRATIVE LAW JUDGE — RESPONDENTS

OPINION
AFFIRMING

* * * * *

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

BORDERS, Member. Larry Rhinehart ("Rhinehart") appeals from the August 14, 2020 Opinion, Order, and Award and the September 10, 2020 Order on Petition for Reconsideration rendered by Hon. Chris Davis, Administrative Law Judge ("ALJ").

Rhinehart filed a Form 101 alleging he suffered permanent work-related injuries to his cervical and lumbar spine in a motor vehicle accident ("MVA") on November 11, 2017 while employed by CMTA, Inc. ("CMTA"). The ALJ determined Rhinehart suffered a temporary injury to his cervical spine and awarded a limited period of temporary total disability ("TTD") benefits, and medical benefits. The ALJ likewise dismissed Rhinehart's claim for a lumbar injury, finding he failed to prove entitlement to TTD, permanent partial disability, or medical benefits. Rhinehart filed a Petition for Reconsideration arguing the ALJ did not issue an appropriate award concerning temporary medical benefits, or perform the proper analysis of the medical evidence concerning the low back claim, and requested additional findings and clarification. The petition was overruled by the ALJ in an Order dated September 10, 2020. This appeal followed. For reasons to be set forth herein, we affirm.

Rhinehart testified by deposition on March 20, 2020 and at the hearing held June 24, 2020. Rhinehart began working for CMTA in 2015 as a construction manager. On November 30, 2017, Rhinehart was driving a truck when it was hit on the passenger side, causing his truck to hit another vehicle. Rhinehart experienced immediate numbness in his head, double vision, light sensitivity, and pain in the right side of his spine. An ambulance took him from the scene of the

accident to the hospital. Rhinehart returned to the emergency room later in the evening due to unbearable pain. The following day, Dr. David Williams, Rhinehart's family physician, restricted him from working until December 26, 2017. Rhinehart was off work for approximately one month after the accident. There were additional periods when he missed work for medical procedures or when he took time off when his back was "out." Rhinehart treated with Camellia Hutchinson, APRN, at BHMP Neurology in December of 2017, and began treating with Dr. Steven P. Kiefer in 2018. Dr. Kiefer administered injections that increased Rhinehart's symptoms. Dr. Kiefer referred Rhinehart to Dr. Nessa Timoney for treatment of lower back and neck pain. Rhinehart testified as follows regarding his work during the time he treated with Dr. Timoney.

> Q. How long did you miss after the lumbar surgeries with Dr. Timoney?
>
> A. The first one I think I was out for, like, two or three weeks. I went back to work on restricted duty, and that's just pointing fingers and telling other people what to do. And then, of course, I had to have the revision surgery, so I was right back out again for the second surgery. I was out of work similar for that, two or three weeks, and then they let me come back on limited duty. And then I was out for the staph infection, and the staph infection I was probably out about the same, two weeks or so. And then I didn't go back to full duty until 18 November of last year.
>
> Q. Okay. 2019?
>
> A. Right.

Rhinehart continues to have numbness on the side of his head, vision issues, neck pain, and right arm pain. Rhinehart also experienced urinary issues after

the accident. He testified he cannot do the lifting required in his position with CMTA. Rhinehart's medical bills have been paid by his personal health insurance obtained through CMTA. He last worked for CMTA in November 2019. He is currently working forty hours per week for a different employer earning $75.00 per hour.

Rhinehart had a prior back injury in 2006 while working for a different employer. Dr. Kiefer performed lumbar fusion surgery in 2007 for which he assessed a 20% impairment rating. Rhinehart was off work from the time of the injury until July or August 2008. He returned to work as a supervisor. Rhinehart was able to do heavy lifting and climb scaffolding and ladders. He experienced a loss of motion and aching after returning to work.

Rhinehart was involved in a prior MVA in September 2009. He treated with Dr. John E. Harpring for neck issues and neuropathy in the hands. Dr. Harpring performed a cervical fusion. The neuropathy in the hands resolved with the surgery, but he continued to have muscle cramping and spasms in the neck. Rhinehart was restricted from looking up for extended periods. Dr. John Ogden performed a second cervical surgery on October 25, 2011. Rhinehart's symptoms resolved after the second surgery. Rhinehart routinely followed up with his surgeons and reported issues he was having at the time. He was able to continue working, golfing, and bowling.

Rhinehart saw Dr. Kiefer on October 3, 2006 with complaints of low back and right lower extremity pain. He also had right hip pain with straight leg raising test. Rhinehart was restricted from working, and a lumbar MRI was ordered.

On October 17, 2006, Dr. Kiefer noted the lumbar MRI showed significant degenerative changes at L4-L5 and L5-S1, right paracentral disc protrusion at L5-S1, modic changes at the endplates, and L4-L5 central prominent disc bulge. Lumbar X-rays noted bilateral L5 pars defects and Grade I anterolisthesis L5 on S1. Dr. Kiefer stated Rhinehart was symptomatic from degenerative disc disease and potentially spondylolisthesis. The symptoms flared up at work. Rhinehart was referred to physical therapy. On November 21, 2006, Rhinehart was advised to find lighter work. Rhinehart was allowed to return to light duty as of February 17, 2007. A May 14, 2007 lumbar CT revealed bilateral spondylolytic defects at L5-S1 with slight slippage. Dr. Kiefer performed a fusion with interbodies placed at L4-L5 and L5-S1 on May 17, 2007. Dr. Kiefer placed Rhinehart at maximum medical improvement ("MMI") on March 28, 2008, and he assigned a 20% impairment rating pursuant to the 5th Edition of the American Medical Association, Guides to the Evaluation of Permanent Impairment, ("AMA Guides"). He was permanently restricted from lifting over fifty pounds and from repetitive bending, twisting, or lifting. Rhinehart returned to Dr. Kiefer on May 5, 2017. A lumbar CT scan showed no acute fracture, postoperative changes from posterior fusion at L4-S1, and multilevel degenerative disc disease, most pronounced at L3-L4 with central stenosis and severe bilateral neural foraminal narrowing. On June 2, 2017, Rhinehart complained of penile pain, gait problem, and weakness and numbness in the legs. The assessment was status post lumbar spinal fusion, spinal stenosis of the lumbar region without neurogenic claudication, and mechanical low back pain. Rhinehart was prescribed Meloxicam and Amitriptyline.

Dr. Harpring initially examined Rhinehart on January 20, 2010. Rhinehart reported constant neck pain, pain radiating down the right upper extremity, weakness in the right arm, numbness and tingling radiating down the right upper extremity, and occasional numbness and tingling down the left arm. An MRI showed cervical spondylitis, spurring and degenerative disc herniation at C6-C7, and chronic herniated disc or uncovertebral joint spurring on the left at C6-C7. Dr. Harpring's impression was chronic severe worsening posterior cervical pain and upper extremity radiculopathy in the C6-C7 distribution, mostly at C5-C6, but also to some degree on the left at the C6-C7 level. Surgery was recommended. A December 17, 2009 cervical X-ray found mild to moderate degenerative spondylosis of the lower cervical spine. Dr. Harpring performed an anterior cervical discectomy and allograft bone graft fusion at C5-C6 on February 15, 2010. On July 7, 2010, Rhinehart reported posterior cervical pain, numbness, and tingling. Physical examination revealed slight tenderness to palpation of the posterior cervical spine. Rhinehart was to continue activity as tolerated.

Records from Central Ohio Neurological Surgeons on March 6, 2011, reflect Rhinehart reported burning pain in the lower back and sharp pain into the hips and waist. He had headaches and pain in the legs. The pain began two to three weeks earlier while getting out of a truck and carrying objects. Rhinehart had an L4-S1 posterior lumbar interbody fusion in 2008. He also had a cervical fusion in 2010. Dr. Christian L. Bonasso stated Rhinehart had a simple strain to the back. He has some suprasegmental disease that should be evaluated. X-rays were ordered.

Dr. Ogden examined Rhinehart on August 17, 2011 for pain in the spine and neck with numbness in the right arm, right hand, and right side. Physical examination revealed decreased bilateral triceps reflexes. A cervical MRI showed a prior fusion at C5-C6 and foraminal stenosis at C6-C7 secondary to osteophytes. Dr. Ogden's impression was status post C5-C6 anterior cervical discectomy; fixation and fusion in February of 2010; status post L3 to S2 fusion in April 2007; neck pain and right upper extremity pain and numbness; foraminal stenosis at C6-C7; and mid back pain. Rhinehart followed up on August 31, 2011 with unchanged symptoms. A right upper extremity EMG showed acute right C7 radiculopathy. Thoracic X-rays found vertebral bodies anatomically aligned without subluxation and no compression fracture. Cervical X-rays found no evidence of instability on flexion and extension. Dr. Ogden recommended a C6-C7 anterior cervical discectomy, fixation, and fusion. Dr. Ogden performed a C6-C7 cervical discectomy, fixation, fusion, arthrodesis at C6-C7 with InterGro Plus, and PEEK interbody placement at C6-C7 on October 27, 2011.

Dr. Williams examined Rhinehart on December 1, 2017 for headache, paresthesia along the left posterior scalp, mild nausea, upper chest wall soreness, and left knee soreness. Dr. Williams' impression was acute post-traumatic headaches, contusion of scalp, and acute cervical strain. A CT of the neck found possible upper cervical foraminal impingement. On December 5, 2017, Rhinehart had increased headaches, nausea, and an episode of vomiting. Dr. Williams determined Rhinehart's symptoms were related to post-concussion syndrome for which he was examined on December 8, 2017. He had been to the emergency room for worsening

headaches. The headaches had improved, but he continued to have left-sided scalp paresthesia and paresthesia in the right fingers. Physical examination revealed decreased cervical range of motion. The assessment was post-concussion syndrome, essential hypertension, history of cervical spine surgery, and strain of the neck muscle. On December 26, 2017, Rhinehart's post-concussive headaches had resolved, but he continued to have cervical pain and upper extremity symptoms. Rhinehart was allowed to return to work from the post-concussive syndrome. He was to follow up with a neurosurgeon.

Dr. Kiefer examined Rhinehart again on December 15, 2017. Rhinehart reported headaches and left neck pain radiating into the right upper arm after a MVA two weeks earlier. Rhinehart had numbness in the right fourth and fifth digits. The assessment was acute cervical strain status post MVA and status post cervical spinal fusion. Rhinehart was referred to physical therapy. On January 5, 2018, Rhinehart reported posterior neck pain into the head. The pain radiated bilaterally from neck to elbows. The right arm had intermittent numbness. The right fourth and fifth digit numbness had resolved. On physical examination, Rhinehart had restricted range of neck motion and paracervical muscle spasms. The assessment was acute cervical strain, status post cervical spinal fusion, and cervical radiculopathy. A cervical MRI on January 5, 2018 revealed status post anterior fusion at C5-C7 without evidence of hardware complication and multilevel spondylitic changes greater at the C3-C4 level with severe neuroforaminal narrowing from left lateralizing discs osteophyte complex and uncovertebral spurring. Rhinehart returned on January 23, 2018 with neck and bilateral upper extremity

pain. The neck pain was worse on the left than the right. Rhinehart reported occasional numbness in the right fourth and fifth digits and numbness into the face and the back of his head. Dr. Kiefer reviewed MRI studies and determined surgery was not an option. Dr. Kiefer referred Rhinehart to pain management for injections.

Dr. Timoney of Bowling Green Neurosurgical saw Rhinehart on November 12, 2018. Rhinehart had been doing well until the November 2017 MVA. Medical records from December 10, 2018 indicated Rhinehart underwent pain management and physical therapy but continued to have cervical pain. A November 29, 2018 CT myelogram showed pervious multilevel fusion with evidence of cervical spondylosis without surgical pathology. On January 15, 2019, Rhinehart reported progressive pain in the neck and back. The assessment was low back pain. A January 30, 2019 lumbar CT scan revealed surgical changes at L4-S1; mild persistent but stable anterolisthesis of L5 on S1; grade 1 retrolisthesis of L3 on L4 with evidence of mild ligamentous laxity of flexion and extension; and mild to moderate canal narrowing dorsal to the L3-L4 level.

On February 11, 2019, Dr. Timoney diagnosed symptomatic L3-L4 adjacent segment disease with previous instrumentation at the L4-S1 level. She recommended an L3-L4 laminectomy to provide central canal decompression and extension of the pre-existing fusion. Dr. Timoney performed a L3-L4 laminectomy with right facetectomy and bilateral foraminotomies; L3-L4-L5 posterolateral arthrodesis to enhance fusion process; L3-L4 interbody graft placement; and L3-L4 posterior segmental instrumentation using pedicle screws and extension rods anchored to previously place L4-L5 and L5-S1 surgery on March 6, 2019. Rhinehart

followed up on April 29, 2019. He reported low back pain after he returned to work a week earlier and had an increase in symptoms while standing on concrete. A CT scan showed migration of the interbody cage. Hardware revision surgery was performed on May 8, 2019. Rhinehart was released from the hospital on May 11, 2019.

Dr. James C. Owen evaluated Rhinehart on February 24, 2020. Rhinehart reported low back pain, occipital neuralgia, pain into the right foot, and numbness in the right leg. Physical examination revealed paraspinal muscle spasm, tenderness bilaterally, loss of cervical range of motion, and sensory loss in the feet. Dr. Owen diagnosed persistent low back and neck pain associated with marked exacerbation in a 2017 work-related MVA. Dr. Owen stated the accident exacerbated pre-existing, dormant non-disabling problems in the neck and low back, necessitating surgery. Dr. Owen assigned an 11% impairment rating due to the 2009 cervical surgery, an 11% impairment rating due to loss of cervical range of motion, a 12% impairment rating due to the lumbar surgery, a 3% impairment for an additional lumbar surgery, and a 17% impairment rating due to loss of lumbar range of motion for a combined 44% impairment pursuant to AMA Guides. Dr. Owen assessed a 22% impairment rating for the work-related November 2017 MVA. Dr. Owen stated Rhinehart does not have the physical capacity to return to the type of work performed at the time of his injury. He also stated Rhinehart should avoid lifting more than ten pounds, bending, squatting, stooping, or rapid neck turning.

Dr. Robert Sexton evaluated Rhinehart on March 2, 2020. He reviewed extensive medical records and diagnostic studies, and performed a physical

examination. Dr. Sexton diagnosed cervical myofibrous strain superimposed on pre-existing anterior cervical discectomy and fusion at C5-C6 and C6-C7, status post ACDF at C5-C6 and C6-C7, status post lumbar fusion at L4-L5 and L5-S1, status post fusion of L3-L4, status post revision fusion at L3-L4, and L3-L4 drainage of incision. Dr. Sexton felt Rhinehart sustained a lumbar strain as a result of the MVA that resolved by December 31, 2017. He stated Rhinehart has no documented objective medical data supporting any additional medical or surgical treatment causally related to the MVA. The initial lumbar surgery performed by Dr. Timoney was medically indicated and necessary. Subsequent procedures directly resulted from the initial surgery. Dr. Sexton stated the 2017 MVA did not etiologically cause the need for these procedures and there is no evidence in the diagnostic studies that, as a result of the 2017 MVA, Rhinehart incurred additional surgical indication. Dr. Sexton assigned a 44% impairment rating for pre-existing active lumbar and cervical conditions pursuant to the AMA Guides. Dr. Sexton agreed with Dr. Williams that Rhinehart could resume his regular job duties on December 26, 2017.

At the Benefit Review Conference and the Final Hearing, the parties set forth the following contested issues: benefits per KRS 342.730, unpaid or contested medical expenses, temporary total disability benefits, work relatedness/causation, injury as defined by the Act, credit for salary continuation, pre-existing, active disability/ impairment, subrogation credit, the BCBS/Anthem lien and any and all issues pertaining to KRS 342.020.

The ALJ rendered the following Findings of Facts and Conclusions of Law, relevant to the issues on appeal, *verbatim*:

The Plaintiff is owed some medical benefits, and some temporary total disability benefits. However, any claim he has for anything beyond a brief period of TTD and medical benefits are dismissed for lack of a permanent work-related injury.

In making, these findings I have very carefully considered the record and the facts of the case. The Plaintiff is clearly a hardworking and credible individual. I credit him and the result in this matter is not a reflection on his subjective credibility or otherwise a negative reflection on him.

I. Work-relatedness/causation and injury as defined by the Act

The Plaintiff has a long history of injuries and surgeries to both his cervical and lumbar spine, which pre-date his motor vehicle accident on November 30, 2017. The timeline of both the cervical and lumbar spines, both pre- and post-November 30, 2017 and what was said at those medical visits was dispositive this matter. The facts of each are thoroughly and accurately summarized above and I will only emphasize the most relevant aspects here.

A. Cervical Spine

The Plaintiff has had two prior cervical spine surgeries. He had surgery at C5-6 on February 15, 2010 and surgery at C6-7 on October 27, 2011. The last date, in the medical records, that he complained of his cervical spine, prior to November 30, 2017, is given as the date of his last surgery, October 27, 2011. It seems reasonable to infer that he had follow up medical appointments after that surgery but I cannot ascertain exactly when.

He had his work-related accident on November 30, 2017. A lapse of 6 years might be sufficient to deem that the cervical condition had gone dormant, especially in light of the fact that he had returned to work at full duty. I also note that the Plaintiff almost immediately after the accident, on December 1, 2017, sought medical treatment, for the cervical spine. However, the Plaintiff

must still prove a permanent change in the human organism to receive permanent benefits.

There is no evidence of any such change. Despite office visits with Drs. Williams, Kiefer and Timoney, no surgical treatment was ever rendered for the Plaintiff. No treatment beyond palliative treatment was ever given to him. He no longer, as far as I can judge from the medical records, receives even palliative treatment for his neck. No MRI, CT scan or x-ray has been introduced to show that there is any change to his cervical spine beyond that already sustained as of October 27, 2011.

The only medical opinion in the record that the Plaintiff had a permanent workrelated cervical spine injury comes from Dr. Owen, who is counter-balanced by Dr.
Sexton.

The totality of the evidence, including the lack of evidence in form of on-going medical care and/or diagnostic tests causes me to find that the Plaintiff has sustained no permanent change to the human organism to the cervical spine. Any claim for permanent benefits is dismissed. A closed period of medical benefits and TTD will be discussed below.

B. Lumbar Spine

Like the cervical spine, the Plaintiff has a long history of prior treatment, which has been accurately and sufficiently summarized above. Specifically the Plaintiff had a L4-5-S1 fusion on May 17, 2007. He was assigned a 20% impairment rating for that surgery. However, unlike the cervical spine the Plaintiff continued to complain about his low back and continued to receive palliative treatment. The last medical record of evidence, prior to the MVA, is date June 2, 2017. Which demonstrates that his low back was bothering him for more than 10 years prior to his accident and that he went to the doctor less than 6 months prior to the accident.

What distinguishes this claim from the cervical spine is that the next record of any complaints by the

Plaintiff for his lumbar spine is included in the January 15, 2019 record from Dr. Timoney. In other words, 14 months after the MVA. This gap in time, even without the prior surgeries would, in of itself, lead me to find the lumbar spine non-compensable. While I don't doubt the Plaintiff subjectively, I think it unlikely the lumbar spine at L3-4 could have been that serious for that long and evade medical treatment.

Further, of particular note, to me, is the difference in the medical records from Dr. Timoney of January 15, 2019 and February 11, 2019 as to history and diagnosis. In those records the Plaintiff voices a history of his current low back condition being related to his MVA but the records make it clear, under "Assessment & Plan", that Dr. Timoney diagnoses his condition at L3-4 as adjacent segment disease, related to his prior non-work-related fusion at L4-5-S1. That is overtly and indisputably not the same as being related to his MVA. Those are two distinct mechanism and causes of injury.

In short, Dr. Timoney has offered a diagnosis for L3-4 that does not relate it to the MVA. The only support for L3-4 being work-related is from Dr. Owen who, again, is counter-balanced by Dr. Sexton. This aspect, in of itself, would also lead me to conclude the low back is not work-related.

The claim for the lumbar spine is dismissed. Unlike the cervical spine, I find that the work-related motor vehicle accident on November 30, 2017 did not cause even a temporary injury and no benefits will be awarded for it.

I understand that Dr. Sexton states the lumbar spine did sustain a temporary injury. I reject this based on the lack of treatment, complaints and the ultimate diagnosis made by Dr. Timoney. Regardless, even if I adopted the opinion of Dr. Sexton that it caused a temporary injury it would not result in any additional or different award.

II. Unpaid or contested medical expenses

I have found the Plaintiff did sustain a temporary aggravation of his pre-existing cervical spine condition. For that he saw Dr. Williams on December 1, 2017. Thereafter he saw Dr. Williams for the temporary aggravation on December 5, 8, and 26, 2017. He saw Dr. Timoney for it on November 12 and December 10, 2018. All of these are compensable and the Defendant is responsible for them with the caveat to be discussed below. The Defendant shall reimburse the Plaintiff for any outstanding copays and/or mileage associated with these medical expenses. No medical benefits are owed for the cervical spine after December 10, 2018.

III. Temporary Total Disability Benefits and credit for salary continuation

The Plaintiff was off-work from December 1, 2017 through December 26, 2017, when Dr. Williams allowed him to return to work. He is entitled to TTD at a rate of $835.04 a week, the maximum allowable rate, for that period.

The issue of credit for salary continuation was listed. The Plaintiff testified that he received employer funded short-term disability. However, I have insufficient documentation and evidence to award any credit.

IV. Benefits per KRS 342.730 and pre-existing, active condition

This issue is moot pursuant to my above findings.

V. Subrogation

Given the award as made and pursuant to the rationale advanced by the Defendant there is no subrogation credit available.

VI. BCBS/Anthem Lien

I allowed this issue to be listed on the BRC Order, as I would any issue raised, but I do not believe I

> have any direct jurisdiction over this issue. My sole jurisdiction is over matters directly covered under KRS 342. My authority in this matter is limited to Ordering the workers' compensation carrier to pay the above medical bills. The appropriate procedure, in an "on paper world" is for the carrier to pay the doctors at the workers' compensation rate and for the doctors to reimburse BCBS/Anthem. Whether that happens is dubious, especially in light of the fact that by the time this matter is final those bills will be between 2-3 years old, if not older due to appeals, and it is doubtful the doctors will be keen on participating. I can, of course, Order them to participate, but I have no enforcement mechanisms of my own. So there it is. This issue dismissed as not being within the Administrative Law Judge's jurisdiction under the Act.

Rhinehart filed a Petition for Reconsideration arguing that all medical bills associated with the temporary aggravation of the cervical spine condition and actually tendered medical bills incurred up to December 10, 2018 should be compensable. Rhinehart further argued the ALJ erred in not accurately addressing the fact he received pain management treatment for his low back in 2018, which reflected he received medical treatment during the 18 months that the ALJ determined he did not. On September 10, 2020, the ALJ entered an Order overruling the petition.

On appeal, Rhinehart argues the ALJ's award of medical benefits for the cervical spine injury does not provide sufficient guidance to determine which bills are compensable. Rhinehart seeks an order directing CMTA to pay the medical expenses that were submitted. Rhinehart also argues the ALJ erred in finding he did not prove a causal connection between his MVA and his current lumbar spine condition. Rhinehart specifically points out he received pain management treatment for his lumbar spine in 2018. Rhinehart argues even though the pain management

treatment records were not submitted into the record, they were referenced by Dr. Owen.

As the claimant in a workers' compensation proceeding, Rhinehart had the burden of proving each of the essential elements of his claim. Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Because Rhinehart was unsuccessful in his burden, the question on appeal is whether the evidence compels a different result. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). "Compelling evidence" is defined as evidence that is so overwhelming, no reasonable person could reach the same conclusion as the ALJ. REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985).

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). 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). Although a party may note evidence supporting a different outcome than 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 was no evidence of substantial probative value to support the decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

The function of the Board in reviewing an ALJ's decision is limited to a determination of whether the findings made are so unreasonable under the evidence they must be reversed as a matter of law. Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000). 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). In addition, causation is a factual issue that must be determined within the sound discretion of the ALJ as fact-finder. Union Underwear Co. v. Scearce, 896 S.W.2d 7 (Ky. 1995). When the question of causation involves a medical relationship not apparent to a layperson, the issue is properly within the province of medical experts. Mengel v. Hawaiian-Tropic Northwest and Central Distributors, Inc., 618 S.W.2d 184, 186-187 (Ky. App. 1981). Medical causation must be proven by medical opinion within "reasonable medical probability." Lexington Cartage Company v. Williams, 407 S.W.2d 395 (Ky. 1966). The mere possibility of work-related causation is insufficient. Pierce v. Kentucky Galvanizing Co., Inc., 606 S.W.2d 165 (Ky. App. 1980). While objective medical evidence must support a diagnosis of a harmful change, it is not necessary to prove causation of an injury through objective medical findings. Staples, Inc. v. Konvelski, 56 S.W.3d 412 (Ky. 2001).

Rhinehart argues the Order from the ALJ ordering CMTA to pay medical expenses for treatment of his cervical spine condition from November 11, 2017 through December 10, 2018 was not detailed enough, and he seeks clarification

on what is to be paid. In the Opinion Award, and Order, the ALJ ordered the medical expenses connected with office visits of December 1, 5, 9, and 26, 2017, and the medical expenses connected to office visits with Dr. Timoney of November 12, 2018 and December 10, 2018 are compensable. On reconsideration, the ALJ stated he "believes the Plaintiff has presented sufficient proof to find the medical treatment for the cervical spine up to December 18, 2018 is compensable". The ALJ has therefore ordered "medical treatment" for the cervical spine compensable, up to December 10, 2018, without exception. However, the ALJ correctly noted there is no mechanism for him to compel the medical providers to send the bills to the employer for payment. Therefore, we believe the ALJ adequately addressed the issue of temporary medical expenses awarded for treatment of the temporary cervical spine injury. We affirm in that regard.

Lastly, Rhinehart argues the ALJ erred in not determining his lumbar spine condition was causally related to the MVA of November 11, 2017. He argues the ALJ improperly determined there was no medical treatment to the low back for 14 months when in fact there was evidence he received pain management treatment at this time. He seeks remand to accurately address this proof.

The ALJ was confronted with conflicting medical evidence regarding whether Rhinehart suffered a temporary or permanent injury as a result of the November 30, 2017 MVA. The pain management records Rhinehart seeks review of were never submitted as evidence in the record and are merely included as records being reviewed by Dr. Owen as part of his evaluation. Dr. Owens opined Rhinehart suffered an injury as defined by the Act, for which he retained an impairment rating.

Conversely, the ALJ was confronted with records indicating a long history of prior low back problems, including surgery, and an opinion from Dr. Sexton finding no permanent work injury occurred on November 30, 2017 as alleged. The ALJ, when confronted with this conflicting evidence, chose to rely on the opinions of Dr. Sexton, as well as the prior medical records, and determined Rhinehart did not suffer either a temporary or permanent injury as defined by the Act. The opinions of Drs. Sexton and Timoney constitute substantial evidence upon which the ALJ could properly rely, and the ALJ's determination in reliance on the same was a proper exercise of his discretion and will not be disturbed on appeal. As such, a contrary result is not compelled.

Accordingly, the Opinion, Award, and Order of August 14, 2020 and the Order on Petition for Reconsideration of September 19, 2020, rendered by Hon. Chris Davis, Administrative Law Judge, are **AFFIRMED.**

ALL CONCUR

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BOWLING GREEN, KY 42104

SOUTHEASTERN EMERGENCY SERVICES, PC **USPS**
3920 DUTCHMANS LN
LOUISVILLE, KY 40207

SOUTHERN EMERGENCY MEDICAL SPECIALISTS **USPS**
1 AUDUBON PLAZA DR.
LOUISVILLE, KY 40217

THE MEDICAL CENTER AT BOWLING GREEN **USPS**
250 PARK ST.
BOWLING GREEN, KY 42101

ADMINISTRATIVE LAW JUDGE: **LMS**

HON CHRIS DAVIS
MAYO-UNDERWOOD BLDG
500 MERO ST, 3rd FLOOR
FRANKFORT, KY 40601