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Commonwealth of Kentucky

Court of Appeals

NO. 2009-CA-002010-WC

AMERICAN GENERAL LIFE AND
ACCIDENT INSURANCE COMPANY — APPELLANT

v.

PETITION FOR REVIEW OF A DECISION
OF THE WORKERS' COMPENSATION BOARD
ACTION NO. WC-93-48241

SHARON HALL; HON. GRANT
ROARK, ADMINISTRATIVE LAW
JUDGE; AND WORKERS'
COMPENSATION BOARD — APPELLEES

OPINION
AFFIRMING

** ** ** ** **

BEFORE: CAPERTON AND CLAYTON, JUDGES; BUCKINGHAM,[1] SENIOR JUDGE.

[1] Senior Judge David C. Buckingham sitting as Special Judge by assignment of the Chief Justice pursuant to Section 110(5)(b) of the Kentucky Constitution and Kentucky Revised Statutes (KRS) 21.580.

BUCKINGHAM, SENIOR JUDGE: American General Life and Accident Insurance Company appeals from an opinion of the Workers' Compensation Board that vacated and remanded an opinion and order of an administrative law judge (ALJ). American General asserts that the opinion of the ALJ was supported by substantial evidence, was in conformity with KRS Chapter 342, and did not constitute an abuse of discretion. We disagree and thus affirm.

Hall began working for American General as an insurance agent in 1989. She filed a workers' compensation claim against American General, alleging an injury date of July 15, 1993, for psychological injuries including depression and post-traumatic stress disorder (PTSD), which she asserted occurred as a result of sexual harassment by her supervisor.

On April 29, 1996, the ALJ issued an opinion, order, and award, finding that Hall had sustained a compensable psychological injury as a result of sexual harassment in the workplace. Specifically, the ALJ found that Hall had sustained an occupational disability of 50 % as a result of the harassment. American General was ordered to pay reasonable, necessary, and related medical expenses pertaining to Hall's psychological injury. Thereafter, Hall reopened her claim and was found on December 11, 2001, to be permanently and totally disabled as a result of her psychiatric condition.

Since 1995, Hall has been receiving treatment from psychiatrist Dr. Charles Shelton. That treatment has consisted of psychiatric therapy as well as

numerous psychiatric medications including Bupropion, Prozac, Temazepam, Dextrostat, Ativan, Wellbutrin, Remeron, and Risperdal.

On February 16, 2004, Dr. Shelton issued a treatment plan for Hall in which he stated that she was still being treated for PTSD related to the work injury in July 1993. Dr. Shelton advised that he was currently prescribing eight medications to Hall, including Effexor, Lorazepam, Wellbutrin, Dextrostat, Risperdal, Ambien, Neurontin, and Remeron. Dr. Shelton stated that in his opinion the need for all those medications was related to the PTSD and depression that Hall incurred as a result of her work injury.

Thereafter, on August 16, 2006, Dr. Robert Granacher performed a psychological examination of Hall. On that date, Hall complained of depression, poor concentration, and memory impairment. In addition, she reported that she did not get out of bed and could not keep track of her medications. Dr. Granacher noted that Hall was taking seven psychiatric medications, including Lorazepam, Temazepam, Bupropion, Cymbalta, Risperdal, Remeron, and Dextrostat.

Dr. Granacher found that during the course of the examination, Hall demonstrated a significantly reduced level of cognitive functioning. He noted that she arrived a day late for the examination, appeared to be confused and staggering, displayed poor attention and concentration, and was slurring her speech. Dr. Granacher ultimately diagnosed dementia and aggravation of confusion and dementia symptoms from excessive psychiatric medication. Dr. Granacher initially concluded that Hall's current mental state was related to an emerging

dementia and not to her original claim of sexual harassment. Accordingly, he assigned a 0 % whole body psychiatric impairment in relation to the work injury.

Subsequently, Dr. Granacher provided testimony in this claim on January 23, 2007. At that time, he confirmed that he had evaluated Hall on two separate occasions, both on April 25, 1995, during her original claim, and again on August 16, 2006. Dr. Granacher testified that Hall demonstrated an entirely different presentation during the second visit of August 16, 2006. He stated that at the initial examination, she was functioning at a normal level of intelligence but that at the time of the second examination exhibited significant cognitive decline.[2]

Dr. Granacher explained that as Hall appeared remarkably different in 2006, he proceeded to conduct a neuropsychiatric evaluation and also to conduct an MRI scan of the brain, which revealed white matter changes in portions of the brain, as well as an abnormal genetic defect indicating the presence of dementia likely related to Alzheimer's disease. He found that the likelihood of Hall having Alzheimer's was higher than 90 %. Dr. Granacher estimated that Hall was in the moderately impaired range of Alzheimer's disease patients and estimated her current life expectancy at between six and eight years. Dr. Granacher also again testified as to his belief that Hall was being overmedicated by her treating physician.

[2] Dr. Granacher stated that Hall scored below the first percentile in cognitive capacity on the Mini-Mental State Exam during the 2006 evaluation, compared to a score in the 18th to 27th percentile when he examined her in 1995.

Thereafter, on April 30, 2007, Dr. Shelton issued a supplemental report in which he stated that he has been treating Hall on a regular basis for depression and PTSD since 1994 and that he had last examined her on February 13, 2007. During the February 13, 2007, examination, Hall reported an increase in nightmares and flashbacks, which Dr. Shelton attributed to a discontinuation of various medications.[3] Dr. Shelton stated that Hall still suffers from PTSD with onset as a result of sexual harassment and that she needed to continue her current treatment regimen. At that time, he also noted that a mini-mental status examination had been performed with a score of 29 out of 30, which he believed was not indicative of dementia.

Dr. Granacher subsequently issued a supplemental report on April 30, 2007. In that report, he confirmed that Hall was grossly confused and exhibited slurred speech during the August 16, 2006, examination. Accordingly, Dr. Granacher stated that he was standing by his opinion that Hall was showing evidence of dementia, but he also explained that it was possible that Hall's poor level of functioning was due to her excessive use of medication.

On the basis of Dr. Granacher's findings, American General initiated a medical fee dispute on September 7, 2006. Due to concerns regarding Dr. Granacher's diagnosis of dementia, Hall was referred to Dr. Timothy Allen for a University Psychiatric Medical Evaluation. That evaluation was performed on September 5, 2007. Dr. Allen noted that on that date, Hall presented with

[3] The medications were discontinued because Hall's workers' compensation payments for those medications had ceased.

complaints of depression, along with fear and anxiety related to being in public or meeting strangers. Dr. Allen noted that Hall was currently taking Fosamax, Fluoxetine, Temazepam, Risperdal, Wellbutrin, and Remeron for her psychological symptoms.

As part of the evaluation, Hall underwent a series of psychological tests that were administered by Dr. John Ranseen and reviewed by Dr. Allen. According to Dr. Allen, that testing revealed that Hall provided adequate effort and did not attempt to feign impairment. It was noted that Hall did not exhibit cognitive impairment on tests, but she appeared quite distractible, cognitively inefficient, and emotionally labile during the course of the evaluation. Further, it was noted that the testing suggested long-standing, severe personality disorder, perhaps aggravated by intense stress at the time of the evaluation.

After reviewing the test results, Dr. Allen diagnosed major depressive disorder, borderline personality traits, osteoporosis, and moderate social isolation. He also stated that Hall suffers from depression and symptoms of PTSD, although he did not actually diagnose PTSD, as he believed that Hall did not meet enough of the criteria for that diagnosis. Dr. Allen further opined that testing revealed Hall to be of average intelligence and normal memory on two separate measures and that there was no evidence of dementia, cognitive problems, or other neurological process. Dr. Allen felt that Hall may have been overmedicated during her evaluation and testing with Dr. Granacher, which could have led to Dr.

Granacher's diagnosis of early onset dementia. Dr. Allen opined that Hall required ongoing psychiatric treatment for recurrent major depression.

On November 16, 2007, Dr. Allen provided testimony in this claim. At that time, he confirmed the findings in his report and again explained his belief that Hall was likely overmedicated at the time of her examination with Dr. Granacher but that Dr. Granacher's diagnosis of dementia was reasonable in light of Hall's performance during his evaluation. Dr. Allen also provided testimony concerning reasonable psychiatric treatment, explaining that Hall needed ongoing medication therapy, as well as four visits with her psychiatrist per year. In so doing, Dr. Allen specifically stated,

> I also believe that there has to be a reconsideration of her medication regimen. She's on, as I recall, six psychiatric medications, three anti-depressants, a sedative, an anti-psychotic, and a stimulant. It would be wise for her treating physician to either get a colleague's consult or sort of reconsider the effective – the side effects of all these medications.[4]

Further, Dr. Allen stated that

> [I]t would be quite unusual for someone with a diagnosis of major depression to be on six psychiatric medications. I think the goal should be two to three at max, and there should be strong consideration that she might have increased problems due to side effects of all these medications.[5]

[4] *See* November 16, 2007, deposition of Dr. Timothy Allen, p. 20.

[5] *Id.*

During the course of his deposition, Dr. Allen explained that his biggest concern was the sedative medication, as it could have long-term effects on Hall's cognition. Dr. Allen also stated that, based upon the records that he reviewed, Hall has not improved during her long-term psychological treatment with Dr. Shelton, remarking that "the aggressive medication management she's had has not really improved her very much, which further raises my concern for her being on six psychiatric medications."[6]

Nevertheless, on cross-examination, Dr. Allen conceded that Hall required continued treatment with some adjustment of her medication in order to remain stable. He stated that, in his opinion, Dr. Shelton had overall done a pretty good job in trying to keep a handle on Hall's current condition. Ultimately, with respect to which antidepressants to prescribe and in what combination, Dr. Allen opined that it was difficult for him to comment.

Subsequently, Dr. Granacher issued a final report on September 24, 2008, following a review of additional records, including the report of Dr. Allen and Dr. Allen's deposition. In his final report, Dr. Granacher again reiterated that he questioned the extreme number of medications Hall is currently receiving. He further explained that her medication levels were so high at the time of his August 16, 2006, examination that Hall failed a dementia examination commonly used to assess Alzheimer's patients. Nevertheless, Dr. Granacher acknowledged, based on Dr. Allen's examination, that he does not now believe that Hall has Alzheimer's

[6] *Id.* at 21-22.

disease and, instead, attributed her reduced cognitive functioning to overmedication.

With respect to future treatment, Dr. Granacher recommended a single antidepressant of Hall's doctor's choice and, if augmentation was required to enhance the antidepressant, the use of either Risperdal 1 mg or Abilify 2 mg, as well as a simple hypnotic such as Temazepam for sleep. Dr. Granacher did not believe it was reasonable to prescribe amphetamines in a case of Hall's nature and again stressed his opinion that sexual harassment 15 years previously would not be expected to produce, in any reasonable person, such a severe mental syndrome as to require the treatment that Hall is now receiving.

Dr. Shelton also issued a final report on October 16, 2008, stating that he believes his current course of treatment to be both reasonable and necessary. Dr. Shelton reiterated his opinion that Hall suffers from major depression and PTSD. He further stated that the resistant nature of her condition requires aggressive pharmacotherapy, which allows her to maintain some degree of functionality and has allowed for some degree of improvement. In that report, Dr. Shelton explained specifically why he believed each of the medications prescribed are necessary. Additionally, Dr. Shelton attributed Hall's behavior during the course of Dr. Granacher's evaluation to anxiety.

On April 17, 2009, the ALJ issued an opinion and order. Therein, he concluded that not all medications being prescribed to Hall by Dr. Shelton were reasonable and necessary. In so finding, the ALJ relied upon the opinions of Dr.

Granacher and stated that he believed the opinions of Dr. Granacher to be supported by those of Dr. Allen, which he stated were afforded presumptive evidentiary weight pursuant to KRS 342.315. Accordingly, the ALJ held that Hall should be maintained on only a single antidepressant, either Risperdal 1 mg or Abilify 2 mg, as well as a single hypnotic like Temazepam.[7]

Thereafter, Hall filed a petition for reconsideration on April 24, 2009, which was overruled by the ALJ in an order dated May 14, 2009. Hall then appealed to the Board, arguing that American General had not met its burden of proof to establish that Dr. Shelton's treatment regimen was unreasonable or unnecessary and, further, that the ALJ's opinion was not supported by substantial evidence.

After reviewing the matter, the Board issued an opinion on September 28, 2009, in which it concluded that the opinion of Dr. Allen did not support the medical conclusions of Dr. Granacher. Accordingly, the Board vacated the ALJ's order and remanded the matter to the ALJ for additional findings on the part of the ALJ, explaining why the more measured approach recommended by Dr. Allen should properly be rejected. It is from that finding by the Board that American General now appeals to this Court.

On appeal, American General argues that the Board substituted its opinion for that of the ALJ as to the weight of the evidence on a question of fact,

[7] While we find the ALJ's award in this regard to have been worded rather confusingly, we believe the ALJ's intention was to award compensation for one antidepressant, to be augmented by either Risperdal 1 mg or Abilify 2 mg, as well as a single hypnotic like Temazepam.

specifically arguing that the opinions of Drs. Granacher and Allen constitute substantial evidence and that the ALJ was entitled to rely on those opinions in his findings. Further, American General disagrees with the Board's determination that the report of Dr. Allen does not support the conclusions of Dr. Granacher. American General asserts that, to the contrary, Dr. Allen agreed with Dr. Granacher that a reconsideration of Hall's medications was necessary, noting that Dr. Allen suggested a goal of two to three medications at the most.

In a post-award medical fee dispute, it is the employer who bears the burden of proving that the contested medical expenses are unreasonable or unnecessary. *See Square D Company v. Tipton*, 862 S.W.2d 308, 309 (Ky. 1993); *National Pizza Co. v. Curry*, 802 S.W.2d 949, 951 (Ky. App. 1991). It is the burden of the claimant to prove work-relatedness. *See Addington Resources, Inc. v. Perkins*, 947 S.W.2d 421, 423 (Ky. App. 1997). Further, we note that when reviewing a decision of the Workers' Compensation Board, the function of the Court of Appeals is to correct the Board only where it perceives the Board has overlooked or misconstrued controlling statutes or precedent or committed an error in assessing the evidence so flagrant as to cause gross injustice. *Western Baptist Hosp. v. Kelly*, 827 S.W.2d 685, 687-88 (Ky. 1992).

The Board's opinion in this case stated in part as follows:

> In this case, although both Dr. Allen and Dr. Granacher, on whom the ALJ relied, felt Hall was overmedicated, it is clear from reading Dr. Allen's deposition that he never concluded that Dr. Shelton's treatment was not reasonable or not necessary. Rather, he recommended

> that Dr. Shelton obtain a colleague's consult or reconsider the side effects of all the prescribed drugs. In acknowledging his concern on Hall's cognitive functioning of the combined effects of the drugs, Dr. Allen concluded it would be difficult for him to comment on which of the antidepressants to prescribe and in what combination.

The Board finally concluded by stating that

> Contrary to the ALJ's assertions, Dr. Allen's opinion, which is to be given presumptive weight, does not support Dr. Granacher's conclusions. This is specifically true when Dr. Allen acknowledged on cross-examination that Dr. Shelton overall had done a pretty good job in trying to keep a handle on Hall's current condition.

To summarize the views of the three doctors as to the appropriate amount of psychiatric medications that Hall should be taking: Dr. Shelton, Hall's treating physician, was prescribing her six different medications based on his belief that she still suffers from PTSD; Dr. Granacher concluded that Hall was no longer suffering from PTSD and should be prescribed a single antidepressant (as well as something for sleep) with perhaps a drug such as Abilify if augmentation of the antidepressant was necessary; and Dr. Allen, who also did not diagnose PTSD but acknowledged symptoms of that disorder, took somewhat of the middle ground and concluded that Dr. Shelton should either get a colleague's consult or reconsider the side effects of all her medications. Dr. Allen stated that the goal should be for Hall to be prescribed two to three psychiatric medications "at max" because it "would be quite unusual for someone with a diagnosis of major depression to be on six psychiatric medications."

The opinion of the University Medical Evaluator (Dr. Allen) is entitled to presumptive weight. KRS 342.315. As stated by the Board, Dr. Allen's opinion provided the "more measured approach" in dealing with the appropriate amount of medications that should be prescribed by Hall. We disagree with the ALJ's conclusion that Dr. Allen's opinion is more consistent with that of Dr. Granacher, who concluded that Hall's medications should be reduced to a single antidepressant contrary to the treatment of her treating physician and the "measured approach" of the university evaluator. *See Whitaker v. Peabody Coal Co.*, 788 S.W.2d 269, 270 (Ky. 1990).

Therefore, we affirm the Board's opinion.[8]

CLAYTON, JUDGE, CONCURS.

CAPERTON, JUDGE, DISSENTS.

BRIEF FOR APPELLANT:

Ronald J. Pohl
P. Gregory Richmond
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BRIEF FOR APPELLEE, SHARON HALL:

Thomas W. Moak
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[8] We note that the Board's opinion merely vacates the ALJ's decision for additional findings with possibly a different result.