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Commonwealth Of Kentucky

Court Of Appeals

NO. 2001-CA-002346-WC

SILVERADO TRUCKING, INC. APPELLANT

v. PETITION FOR REVIEW OF A DECISION
OF THE WORKERS' COMPENSATION BOARD
CLAIM NO. WC-98-62688

MITCHELL K. FARLER;
JOHN B. COLEMAN,
Administrative Law Judge; and
WORKERS' COMPENSATION BOARD APPELLEES

OPINION

AFFIRMING

** ** ** ** **

BEFORE: GUDGEL, Chief Judge; COMBS and HUDDLESTON, Judges.

HUDDLESTON, Judge: Silverado Trucking, Inc. appeals from a Workers' Compensation Board opinion affirming an Administrative Law Judge's opinion and award finding that Mitchell K. Farler has a 60% permanent partial disability and ordering Silverado to compensate him by paying his average weekly wages for 520 weeks, his reasonable and necessary medical expenses and the costs associated with his vocational rehabilitation evaluation. Silverado argues that the ALJ and the Board erred in relying on an impairment rating provided by Dr. John W. Gilbert, Farler's treating physician,

because he failed to comply with the American Medical Association (AMA) Guidelines when evaluating Farler's work-related spinal injuries.

On June 18, 1998, Farler sustained injuries to his lower back, neck and right shoulder when the coal truck he was driving overturned. Although Farler testified that he experienced pain in those areas immediately, he did not visit a hospital until the following morning at which time he was treated and released.

Farler never returned to work for Silverado, but did make an unsuccessful attempt to work for a different employer in the same capacity in December 1998. He worked for only one week and then quit as he was unable to tolerate sitting for the number of hours required to perform the job. Farler has not worked since then and is currently receiving social security disability benefits.

At the time of his injury, Farler was 37 years old (he is currently 41 years of age). He has a ninth grade education and has received no specialized or vocational training with the exception of a sixteen-week training course in simulated coal mining. For the most part, his employment history consists of driving coal trucks for various employers, although he has also worked as a security guard, general laborer and lumber stacker.

Following his release from the hospital, Farler sought treatment from Dr. Thomas Gross, a chiropractor, who prescribed therapy. Noting Farler's lack of improvement, Dr. Gross referred his patient to Dr. Gilbert, Farler's current treating physician. Farler was first seen by Dr. Gilbert on February 24, 1999, for an

initial consultation, at which time he complained of pain in his right leg, both arms and head. After obtaining a medical history, conducting a thorough medical examination and reviewing Farler's MRI results, Dr. Gilbert diagnosed HNP cervical spine, cervicalgia, nerve root injury to both the lumbar and cervical spine, muscle spasms, insomnia, mild anxiety, numbness and tingling. He then reviewed the risks and benefits of both surgical and nonsurgical options with Farler and his family, ordered a cervical discogram, recommended a functional capacity evaluation and gave Farler information about vocational rehabilitation.

On August 12, 1999, Dr. Gilbert performed an anterior cervical discectomy and fusion with instrumentation from C5 to C7. Subsequently, Dr. Gilbert reported that Farler's neck and arm pain had been substantially resolved with only residual pain remaining. Initially, Dr. Gilbert prescribed conservative therapy. However, Dr. Gilbert later noted that Farler's back pain had worsened and disability benefits were a reasonable alternative as he was suffering from chronic pain in his neck and back and was taking controlled substances[1] for related difficulties which limited his ability to think clearly and operate machinery. Dr. Gilbert delayed any diagnostic or therapeutic intervention in order to adequately monitor Farler's post-operation recovery.

On July 19, 2000, Dr. Gilbert completed a medical assessment of Farler, finding that he had a 30% impairment rating pursuant to the Range of Motion (ROM) Model, Table 75, page 113, of

[1] At the hearing before the ALJ, Farler testified that he was taking Lortab 10 twice a day, Soma twice a day, Ultram (a pain medication), and Elavil at night to help him rest.

the AMA Guides. None of Dr. Gilbert's records reflect his reason for utilizing the range of motion model as opposed to the Diagnostic Related Estimates (DRE) model.

In his assessment, Dr. Gilbert diagnosed Farler with cervical and lumbar spine injuries and "strain," muscle spasms, anxiety, insomnia and cervical and lumbar pain that radiates into his right arm and leg. As a result, Dr. Gilbert indicated that certain functional limitations were appropriate. Farler was restricted to carrying or to lifting no more than ten pounds, to standing or to walking less than thirty minutes without interruption or a total of three hours in an eight-hour day and to sitting less than thirty minutes without interruption or less than four hours in an eight-hour day. In Dr. Gilbert's estimation, Farler was precluded from climbing, crouching, kneeling or crawling.

At the request of Farler's attorney, Dr. Christa Muckenhausen evaluated Farler on October 12, 2000. She diagnosed him as having "status post neck and low back strain, secondary to work related injury on 6-17-98, with subsequent surgical intervention and residual cervical and lumbosacral radiculopathy," as well as headaches, "mechanical type," and anxiety, depression and sleep disturbance "in context with pain," dating back to the injury. Ultimately, Dr. Muckenhausen, also using the ROM model, concluded that Farler had a 39%[2] whole body impairment, with 20%

[2] The 39% rating is referenced by the ALJ. However, in the "Impairment" section of her report, Dr. Muckenhausen separately lists two different percentages under the heading of "total combined value," 39% and 43%, and initially indicates that Farler's (continued...)

attributable to the lumbar spine condition and 24% to the cervical spine condition. She also indicated that one-half of the impairment would be attributable to the arousal of a pre-existing, dormant, non-disabling osteoarthritic condition and that he did not have an active impairment prior to the injury. As to functional restrictions, Dr. Muckenhausen's findings were consistent with those of Dr. Gilbert in that she felt Farler should lift a maximum of twenty pounds or ten pounds frequently and that he should stand or sit less than three hours in an eight-hour period. Dr. Muckenhausen also failed to offer any explanation of her reason for using the range of motion model rather than the DRE model.

In addition to the medical evidence summarized above, the ALJ also considered the report of Dr. Russell Travis who examined Farler at the request of Silverado on May 4, 2000. According to Dr. Travis, Farler has an impairment of between 5 and 15% as a result of his cervical spine condition, depending on whether he truly had radiculopathy prior to the fusion surgery. After reviewing Farler's medical records and x-rays, Dr. Travis determined that Farler had an essentially normal cervical discogram in April 1999 and found no evidence of a herniated disc or nerve root/foraminal encroachment. He was also of the opinion that Farler demonstrated significant symptom magnification. As he determined that there was a lack of objective findings with regard to Farler's lower back, Dr. Travis assessed a 0% impairment for that condition. In Dr. Travis's opinion, confirming imaging

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[2](...continued)
classification impairment is 41-44%.

studies should have been performed in accordance with the recommendations of the American Academy of Orthopaedic Surgeons before any surgical recommendation was made by Dr. Gilbert. Dr. Travis used the DRE model in assigning an impairment rating to Farler.

Dr. Bart Goldman examined Farler on December 14, 2000, at Silverado's request. Consistent with Dr. Travis's determinations, Dr. Goldman placed Farler in Cervicothoracic DRE category II with a 5% permanent partial impairment rating. Reportedly giving Farler the benefit of the doubt as to his lumbar spine, Dr. Goldman placed him in Lumbosacral DRE category II with a 5% permanent partial rating. Although Dr. Goldman performed a functional capacity evaluation, he deemed the results invalid due to the fact that Farler's efforts were "less than maximal" and "inconsistent."[3]

After summarizing the medical evidence and reviewing the relevant legal principles, the ALJ concluded that Farler's current disability was directly and proximately caused by his work-related injury of June 1998 and, possibly, his subsequent treatment. He determined that any partial or total disability stemmed from the work injury and/or later events as opposed to any pre-existing condition or the aging process. Noting that Farler was "a believable and credible witness at the hearing," the ALJ concluded

[3] Two vocational witnesses also testified at the hearing in regard to Farler's employability. As their testimony is not at issue, it suffices to say that Dr. Crystal found that Farler would be precluded from employment due to the restrictions imposed by Dr. Gilbert and Dr. Muckenhausen while Dr. Conte, in contrast, relied on the findings of Dr. Travis and Dr. Goldman as a basis for his conclusion that Farler would be capable of returning to a wide variety of employment.

that the "objective medical evidence is less than impressive" with the exception of the fact that Farler did actually have a multi-level fusion in his cervical spine. Considering Farler's age, education and employment history along with the medical restrictions and objective medical evidence, the ALJ was not convinced that Farler was permanently and totally disabled with respect to finding employment as a result of his injuries. Based on the evidence in its entirety, the ALJ agreed that the correct impairment rating for Farler's lumbar and cervical injuries is 30% as found by Dr. Gilbert and concluded that Farler has a 60% permanent partial disability based upon that impairment rating when read in conjunction with Kentucky Revised Statutes (KRS) 342.730. As the medical restrictions recommended by Dr. Gilbert and Dr. Muckenhausen preclude Farler from returning to his previous employment, the ALJ multiplied the 60% permanent partial disability by a factor of 1.5.

In a petition for reconsideration, Silverado asked the ALJ to reconsider his reliance on Dr. Gilbert's impairment rating as it was not in compliance with the AMA Guides, the 4th edition of which expresses a preference for the DRE model in impairment assessments, such as the one at issue, involving the spinal column. In the alternative, Silverado argued that even if Dr. Gilbert was permitted to use the ROM model, he did so incorrectly. The ALJ denied this request without further explanation as to his reasoning for accepting the impairment rating offered by Dr. Gilbert.[4]

[4] The ALJ amended the original award to reflect that temporary total disability benefits were payable from June 19, (continued...)

Silverado appealed to the Board which, in affirming the ALJ's decision, reasoned that: "So long as a physician states his impairment rating is in accordance with the AMA Guides, any challenge to that assessment is an issue of weight and credibility which is exclusively within the province of the ALJ." The proper procedure for challenging a physician's AMA rating, the Board said, is to either take his deposition or offer the opinion of another physician as to whether that doctor erred in calculating his impairment, leaving the decision as to which opinion is the most persuasive to the ALJ. As neither of those methods was utilized, the Board concluded that Dr. Gilbert's rating constitutes substantial evidence of probative value upon which the ALJ could properly base his decision. Silverado's appeal to this Court challenges that determination.

In a workers' compensation action, the employee bears the burden of proving every essential element of a claim.[5] As the fact-finder, the ALJ has the responsibility to determine the quality, character and substance of the evidence and may draw all reasonable inferences from it.[6] Likewise, the ALJ has the sole authority to determine the weight to be afforded the testimony of

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[4](...continued)
1998, through May 4, 2000, with the exception of the period from July 3, 1998, through September 21, 1998. Permanent partial disability benefits were to begin on May 5, 2000.

[5] Magic Coal Co. v. Fox, Ky., 19 S.W.3d 88, 96 (2000).

[6] Id.; Paramount Foods, Inc. v. Burkhardt, Ky., 695 S.W.2d 418, 419 (1985).

a particular witness.[7] In his role as the fact-finder, the ALJ 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 party's total proof.[8]

When the decision of the fact-finder is in favor of the party with the burden of proof (in this case, Farler), the issue on appeal is whether the ALJ's decision is supported by substantial evidence, that is, evidence of substance and relevant consequence having the fitness to induce conviction in the minds of reasonable people.[9] A party challenging the ALJ's factual findings (in this case, Silverado) must do more than present evidence supporting a contrary conclusion to justify reversal.[10] When reviewing the Board's decision, our function as an appellate court is limited to correcting the Board only where we perceive that 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."[11] Thus, the sole issue on appeal is whether the ALJ's decision is supported by substantial evidence in light of the fact that he relied on Dr. Gilbert's impairment rating and the

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[7] McCloud v. Beth-Elkhorn Corp., Ky., 514 S.W.2d 46 (1974); Magic Coal Co., supra, n. 5, at 96.

[8] Caudill v. Maloney's v. Discount Stores, Ky., 560 S.W.2d 15, 16 (1977); Magic Coal Co., supra, n. 5, at 96.

[9] Special Fund v. Francis, Ky., 708 S.W.2d 641 (1986); Magic Coal Co., supra, n. 5, at 96.

[10] Ira A. Watson Dep't Store v. Hamilton, Ky., 34 S.W.3d 48, 52 (2000).

[11] Western Baptist Hospital v. Kelly, Ky., 827 S.W.2d 685, 687 (1992).

physician failed to document his reasons for using the ROM model or indicate that he complied with its directives.

Pursuant to KRS 342.730, impairment ratings must be determined in accordance with the AMA Guides to the Evaluation of Permanent Impairment, latest edition available. At the time the impairment ratings in the present case were made, the most current edition was the fourth. According to Chapter 3, section 3.3 of that edition, an evaluator assessing the spine should use the Injury Model if the patient's condition is one of those listed in Table 70. If none of the eight categories found in the injury model is applicable, then the evaluator should use the ROM model.

According to the commentary following section 3.3, past editions of the AMA Guides used a system based on assessing the degree of spine motion and assigning impairment percentages based on limitations of motion. However, beginning with the fourth edition, two approaches were adopted. One component, which encompasses patient's traumatic injuries, is called the Injury Model and it involves assigning a patient to one of eight categories, such as minor injury, radiculopathy, etc. on the basis of objective medical findings. The range of motion (ROM) model is the other component, described and recommended in previous editions. If disagreement exists about how a given impairment should be categorized under the injury model, then the ROM may be consulted to provide evidence on the question.

By way of further explanation, the procedures outlined in section 3.3 provide that the physician should use the ROM model as a differentiation if he cannot place the patient into an

impairment category, or if disagreement exists about which of two or three categories is correct for the patient. This preference for the injury or DRE model is reiterated in the "Medical Assessment of Ability to do Work-Related Activities (Physical)," completed by Dr. Gilbert which contains a note indicating that the DRE model should be utilized "unless another method is authorized by the Guides." Beneath that instruction, Dr. Gilbert completed the provided chart indicating that he referenced "Table 75, page 113" in assessing Farler's degree of impairment. Noticeably absent from Dr. Gilbert's report is an explicit justification for his decision to utilize the ROM model in lieu of the DRE model. In the event that Table 75 is used, there are specific instructions to be followed.[12] There is no evidence that Dr. Gilbert met those requirements.

Silverado argues that the ALJ erred in adopting Dr. Gilbert's impairment rating as his failure to specify reasons for preferring the ROM model in this instance and to supply a figure 80 to document his calculations makes it impossible to determine how he arrived at a percentage of impairment for Farler. In further support for its argument that Dr. Gilbert's rating does not

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[12] The instructions are as follows:

> 1) Identify the significant impairment of the primarily involved region.
> 2) The diagnosis-based impairment estimates and percents shown above should be combined with range of motion impairment estimates and with whole-person impairment estimates involving sensation, weakness, and conditions of the musculoskeletal, nervous, or other organ systems.
> 3) List the diagnosis-based, range of motion, and other whole-person impairment estimates on the Spine Impairment Summary Form (Fig. 80, p. 134).

constitute substantial evidence to support the ALJ's findings, Silverado contends that there is no evidence Dr. Gilbert took range of motion measurements after February 24, 1999, and before he assigned a rating to Farler on July 19, 2000, meaning he did so without performing range of motion testing. However, this argument is unpersuasive as Dr. Gilbert's notes explicitly reflect that he reviewed Farler's chart before determining that certain information remained unchanged, including that aspect of Farler's condition. Such a conclusion necessarily requires an evaluation; there is no requirement that a doctor restate his previous findings verbatim in order to substantiate his determination that an earlier finding is still valid. An acknowledgment such as the one here is sufficient.

As a final basis for its contention that Dr. Gilbert's impairment rating is improper, Silverado emphasizes that there is no indication Dr. Gilbert had trouble placing Farler within a DRE category or that he used the ROM model to place him within a DRE category as required by the AMA Guides.

Because we agree with the Board's reasoning as to these arguments and its resolution of the dispositive issue, we adopt the following portion of its opinion as our own:

> [W]hile the DRE model is to be used in most spine related injuries, there are exceptions. The AMA Guides emphasize they are to be used and interpreted by physicians in conjunction with the physician's experience and examination. While it would have been better for Dr. Gilbert to have first attempted to put Farler's condition in a DRE category, we cannot say as a matter of law the

ALJ erred in relying upon Dr. Gilbert's impairment rating because he went directly to the range of motion model without stating his reasons for doing so. Under the 4th Edition of the AMA Guides, in instances where there are multiple diagnoses affecting multiple levels, the range of motion model is an acceptable method. We would also note the 5th Edition of the AMA Guides published shortly before the ALJ rendered his decision specifically states the range of motion model should be used if there is multilevel involvement and/or alteration of motion segment integrity in the same spinal region. While Silverado has offered its arguments as to the propriety of Dr. Gilbert using the range of motion model, there is no medical opinion of record challenging his impairment rating. We believe Dr. Gilbert's impairment rating constitutes substantial evidence of probative value upon which the ALJ could choose to base his determination.

The Board's opinion is affirmed.

ALL CONCUR.

BRIEF FOR APPELLANT:

Amanda A. Young
Joy D. Denton
HARNED, BACHERT & DENTON, LLP
Bowling Green, Kentucky

BRIEF FOR APPELLEES:

Monica Rice Smith
Edmond Collett
John Hunt Morgan
EDMOND COLLETT, P.S.C.
Hyden, Kentucky