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Commonwealth Of Kentucky

Court Of Appeals

NO. 2002-CA-000744-WC

EAGLE CARRIERS — APPELLANT

v. PETITION FOR REVIEW OF A DECISION OF THE WORKERS' COMPENSATION BOARD CLAIM NO. WC-00-58420

TROY GREGORY;
J. KEVIN KING, Administrative Law Judge; and WORKERS' COMPENSATION BOARD — APPELLEES

OPINION

AFFIRMING

** ** ** ** **

BEFORE: BARBER, HUDDLESTON and MILLER, Judges.

HUDDLESTON, Judge: Eagle Carriers appeals from a Workers' Compensation Board opinion which affirmed an administrative law judge's award to Troy Gregory of permanent partial disability benefits as a result of a combination of traumatic and psychological work-related injuries. Our function upon review is to correct the Board only if 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."[1] Because Eagle Carriers has presented the identical arguments in support of the identical claims as it presented to the Board and we do not believe the Board has overlooked or misconstrued controlling statutes or precedent or committed a flagrant error, we adopt the following portions of its opinion as our own.[2]

> On appeal, Eagle contends the ALJ erred in 1) relying on an impairment rating not assessed in conformity with the American Medical Association, Guides to the Evaluation of Permanent Impairment (Guides); 2) awarding benefits based upon psychological and psychiatric factors; and, 3) awarding payment for medications prescribed for conditions that predated the injury.
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> Gregory filed his application for resolution of injury claim on March 9, 2001. Gregory alleged injuries to his neck and low back sustained in a vehicular accident when he was rear-ended by a semi tractor-trailer. The matter was tried before the ALJ on July 24, 2001, and at the hearing Gregory testified, for the first time, as to condition that would support a claim for a psychiatric injury. The ALJ granted a request by Gregory's counsel for additional time to explore that

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[1] Western Baptist Hospital v. Kelly, Ky., 827 S.W.2d 685, 687-688 (1992).

[2] The Board based a part of its analysis on an unpublished opinion of our Court, which we may not do. See Ky. R. Civ. P. (CR) 76.28(4)(c).

issue, and on August 22, 2001, the ALJ allowed Gregory to amend his claim to include a psychological disability.

Gregory testified that in the early 1980s he underwent surgical treatment for scoliosis, in the form of placement of a Harrington Rod. He sated that after the surgery he was allowed to return to work without restrictions, but that he occasionally suffered from pain. Gregory testified he sought relief from Dr. Patton, his family doctor, who prescribed medication in the form of OxyContin, Demerol and Percodan. Gregory stated that the surgery allowed him to carry on a normal life, which included working, hunting, fishing, playing golf and softball and coaching. Gregory stated that on September 27, 2000[,] he was driving a semi tractor-trailer when he was rear-ended by a loaded semi dump truck. Gregory testified that he now has significant pain in his neck, back and shoulder and suffers from daily headaches. Gregory testified that he is depressed and has difficulty sleeping. He stated that Dr. Patton is treating these conditions with increased pain medication and antidepressants.

Medical evidence in this claim comes by way of the reports, records, and/or depositions of Dr. John Patton, Dr. James Templin, Dr. Gregory T. Snider, Dr. James R. Bean, Dr. Scott Mohler and Dr. David Shraberg. Dr. Patton's records were filed on behalf of Gregory. Many of the notes contained within those records are

illegible; however, it appears Dr. Patton treated Gregory for back pain as early as October 3, 1998. Dr. Patton saw Gregory intermittently prior to the work-related event for complaints of back pain. Dr. Patton prescribed various medications including OxyContin and Percodan. In a December 2, 1999[,] office note, Dr. Patton also indicated Gregory was not coping and diagnosed depression. We are unable to decipher from Dr. Patton's office notes exactly what medication, if any, was prescribed for this condition. It is apparent, however, that after the work injury Dr. Patton increased the dosage of the pain medication OxyContin from twenty milligrams to forty milligrams.

Dr. Templin examined Gregory on April 17, 2001. Gregory presented with complaints of constant dull aching pain in the low back and neck pain radiating into the shoulders. Dr. Templin, after receiving an appropriate history, reviewing Gregory's medical records and performing a physical examination, diagnosed the following conditions: 1) chronic low back pain; 2) degenerative disc disease; 3) chronic lumbosacral musculoligamentous strain; 4) S/P Harrington rod placement from T2 through L4; 5) history of severe thoracic scoliosis; 6) history of cervical disc herniation; 7) chronic cervical pain syndrome; 8) chronic musculoligamentous strain; 9) degenerative cervical disc disease; 10) chronic thoracic pain syndrome; and, 11)

chronic headaches. Dr. Templin stated that Gregory did not have an active impairment prior to the injury. Dr. Templin stated that according to the most recent Guides, Gregory's permanent whole body impairment was 15%. He assigned 5% to the lumbar spine injury, 5% to the cervical injury and an additional 6% for pain. Dr. Templin stated that Gregory completed a formal pain related assessment that provided an impairment score of thirty-six, which is equal to a 6% impairment to the whole man. Dr. Templin relied on Table 18-7, contained in Chapter 18 of the Guides and the Combined Value Chart to arrive at the 15% impairment rating.

Dr. Snider evaluated Gregory on June 20, 2001[,] for purposes of a comprehensive independent medical evaluation. Dr. Snider received an appropriate history of the accident, a medical and social history, and he performed a physical examination. Dr. Snider diagnosed: 1) cervical strain; 2) preexisting cervical arthritis; 3) low back pain; 4) scoliosis; 5) status post Harrington rod placement; 6) preexisting breakage of Harrington rod; and, 7) obesity. Dr. Snider believed no further active medical treatment was necessary. He noted that Gregory had chronic back pain and was taking OxyContin prior to the work injury. He also recognized that Gregory had been treated for depression prior to the injury. In addressing Gregory's back condition, Dr. Snider pointed out that Dr. David Stevens, the surgeon

who placed the Harrington rod, assessed a 20% whole person impairment in 1985 based on a thoracolumbar diagnosis. Dr. Snider believed there was no reason to add to this impairment. He assigned Gregory a DRE Cervicthoracic Category II: 5% whole-person impairment. Dr. Snider addressed Gregory's complaints of pain both in his reports and in deposition. Dr. Snider stated:

> In addition, please note that on Page 20 and 570 of the AMA Guides, 5th Edition, it is stated that the chapters and table take into account the effects of pain. In my opinion, Mr. Gregory's case does not warrant additional impairment for the simple fact that but for complaints of pain he would receive no impairment rating whatsoever due to neck or low back problems. Therefore, I think the anatomic impairment determinations should suffice. (Emphasis original.)

Dr. Scott Mohler performed a psychological evaluation on August 30, 2001. Dr. Mohler received an appropriate history and performed a number of standardized tests. Dr. Mohler diagnosed pain disorder associated with both psychological factors and a general medical condition. He also reported a pain related impairment score of forty-nine, using the criteria presented in Chapter 18 of the Guides. Dr. Mohler stated that this finding places Gregory in the moderately severe

range of impairment. Dr. Mohler believed Gregory met the criteria for a Class II mild impairment due to mental and behavioral disorders. He stated:

> Although the current edition of the AMA Guides does not assign a percentage of impairment for mental and behavioral disorders, in my opinion Mr. Gregory has a 10% permanent impairment to the whole man based on psychological factors alone. One-half of this 10% impairment is attributed to his work injury, and the other half is due to pre-existing factors and/or circumstances unrelated to this work injury.

Dr. Shraberg evaluated Gregory on September 7, 2001. Dr. Shraberg received an appropriate background history, which included depression and chronic pain due to "very severe congenital destroscoliosis." Dr. Shraberg stressed that Gregory was receiving powerful pain medication in the form of OxyContin and was also being treated with the anti-depressant Desyrel. He further noted that Gregory was being treated for pain and depression before the work injury. Dr. Shraberg was extremely critical of Dr. Templin's eleven diagnoses and stated that Dr. Templin's impressions can basically be redacted to "progressive chronic pain due to degenerative disc disease with a simple cervical sprain, resolved." Dr. Shraberg found no evidence of any significant depression related to the injury. He believed, according

to the Guides, Gregory was functioning at a Class I level and assessed a 0% impairment.

After a thorough review of the lay and medical testimony of record, the ALJ relied on Dr. Templin's 15% impairment rating and Dr. Mohler's 5% impairment. The ALJ converted this 20% impairment to a total impairment of 19% using the Combined Value Chart in the Guides. The ALJ believed Gregory was not capable of returning to the type of work performed at the time of the injury and calculated Gregory's benefits utilizing the factor contained in [Kentucky Revised Statutes] KRS 342.730(1)(c) 1., i.e., 19% x 3. The ALJ also found as follows:

> KRS 342.020(1) provides that an employer shall pay for the cure and relief from the effects of an injury or occupational disease medical expenses as may reasonably be required at the time of injury and thereafter during disability. The evidence is undisputed that Gregory was actively receiving treatment in the form of prescription medications at the time of the injury. However, the evidence is also undisputed that Gregory's medication use increased following the injury.
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> In support of his position regarding treatment for his physical condition, Gregory

has cited Derr Const. Co. v. Bennett.[3] As pointed out by Gregory a later employer may be liable for medical treatment related to the worsening of a pre-existing active work-related condition. This claim is not similar to Derr, in that Gregory's underlying scoliosis is not work-related. However, that underlying condition was aggravated by a work-injury in the mid-1980's and the Defendant/Employer at the time apparently agreed to pay for medical expenses related to that aggravation.

Furthermore, the contested treatment, primarily prescription pain medication, is not specific to any one body part since the medication provides relief from pain throughout Gregory's body.

Based on these factors, the Administrative law Judge finds that Gregory's prescription pain medication is compensable. However, the administrative Law Judge also finds that any treatment specifically and solely related to Gregory's scoliosis is not related to this injury and therefore, not the responsibility of this Defendant/Employer.

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[3] Ky., 873 S.W.2d 824 (1994).

> The Administrative Law Judge further finds that, but for the work-injury, Gregory's non-work related psychological problems would not have required treatment. Therefore, Eagle is liable for Gregory's psychological treatment pursuant to the Act.

On appeal, Eagle first argues the ALJ erred in relying upon the impairment rating of Dr. Templin, which included pain as a factor. Eagle directs our attention to the testimony of Dr. Snider, which was critical of Dr. Templin's opinion that Gregory's pain produced additional impairment. Eagle relies heavily on the following excerpt from Chapter 18 of the Guides, wherein it is stated:

> Physicians recognize the local and distant pain that commonly accompanies many disorders. Impairment ratings in the Guides already have accounted for pain. For example, when a cervical spine disorder produces radiating pain down the arm, the arm pain, which is commonly seen, has been accounted for in the cervical spine impairment rating.[4]

Thus, Eagle reasons that because Dr. Templin has not explained his findings, the award of additional benefits

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[4] Guides, 5th Edition, p. 570.

for a pain related assessment is error as a matter of law.

> Over the past several years, this Board has been requested to address an increasing number of complaints concerning the appropriate use of the Guides by physicians in their ultimate determination of an impairment rating. We have consistently held that an impairment rating is a medical determination and the assessment of that rating is within the distinct province of physicians. The Guides provides a tool for physicians, and like the mastery of any tool, its proper use rests on the experience, training and skill of the user. We have no doubt in many cases, physicians, in attempting to evaluate impairment, misapply or misinterpret the Guides. Nonetheless, a medical question requires a medical answer. While ALJs may have acquired a significant level of expertise in interpreting the Guide, there remain[s] severe limitations on an ALJ's discretion to apply and calculate impairment ratings.[5]

The process of determining permanent partial disability benefits under KRS 342.730, as amended effective December 12, 1996, begins with an impairment rating under the AMA Guides. Regardless of experience or training, and as exposed as they may be to medical issues, administrative law judges are not trained in performing medical examinations. An impairment rating is a medical

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[5] Compare Newberg v. Garrett, Ky., 858 S.W.2d 181 (1993); Watkins v. Ampak Mining, Inc., Ky. App., 834 S.W.2d 699 (1992).

determination and, as a medical determination, it is not within the ALJ's discretionary authority to arrive at a separate and distinct impairment rating from that which is offered by a physician.

The AMA Guides are written for physicians. The Guides make it clear that their purpose is to provide objective standards for the "estimating" of permanent impairment ratings. In recent years, in an effort to make the Guides more comprehensive, that tome has increased in size from the 339 page volume Fourth Edition to the 613 page Fifth Edition.

We applaud the efforts of the Guides' editors to make that digest more comprehensive. Nonetheless, no matter how thorough the Guides have been in the past, nor how thorough they may become in the future, the fact will remain that they are designed as a tool for the making of impairment "estimates." Page 1 of Chapter 1 of the Fourth Edition states that the Guides provide a standard framework and method of analysis through which "physicians" can evaluate, report on, and communicate information about the impairments of any human organ system. Section 1.2 of the Fourth Edition of the American Medical Association Guidelines to Functional Impairments states that using the Guides requires integrating previously gathered medical information with the results of a current medical evaluation. The editors stress in Section 1.3 of the Fourth Edition that it should be understood that the Guides do not and cannot provide answers about every type and degree of impairment, because of the infinite variety of human medical conditions and because the field of medicine and medical practice is characterized by constant change in understanding

disease and its manifestations, diagnosis and treatment. Furthermore, human functioning in everyday life is a highly dynamic process, one that presents a great challenge to those attempting to evaluate impairment. In this respect, the Guides' authors also provide the following caveat:

> The physicians' judgment and his or her experience, training, skill, and thoroughness in examining the patient and applying the findings to Guides criteria will be factors in estimating the degree of the patient'[s] impairment. These attributes compose part of the 'art' of medicine, which, together with a foundation in science, constitute the essence of medical practice. The evaluator should understand that other considerations will also apply, such as the sensitivity, specificity, accuracy, reproducibility, and interpretation of laboratory tests and clinical procedures, and variability among observers' interpretations of the tests and procedures.

In evaluating an impairment, the Guides note that it is important to obtain enough clinical information to characterize it in accordance with the Guides' requirements. Once this task is accomplished, the evaluator's findings may be compared with the clinical information already available about the individual. If the evaluator's findings are consistent with the results of previous clinical studies, the findings may be compared with the Guides' criteria to estimate the impairment.

Courts, while struggling to ascertain the level of discretionary authority of an administrative law judge and primarily focusing on KRS 342.732, have repeatedly acknowledged that there are limitations on an ALJ's discretion as to the application and recalculation of medical impairment ratings under the AMA Guides.[6] The Courts have permitted ALJs to recalculate the FVC and FEV-1 measurements in occupational lung disease claims only in circumstances where the tables are contained in the AMA Guides and the recalculations of predicted normal values result in nothing more than simple mathematical function. It seems obvious that if the courts would not permit an ALJ to perform the function of personally measuring an individual to determine his height for purposes of recalculation of spirometric test results, a separate analysis of the amount of impairment on a physical examination would clearly be inappropriate.

Continuing its analysis, the Board said:

> In the instant case, the ALJ has resolved conflicting evidence in favor of Gregory and on this issue, we cannot say the ALJ erred as a matter of law. We would also point out to Eagle that the issue is not as clear-cut as it would have us believe. While, as a general matter, pain may already be included in an impairment rating, the Guides also provides an "algorithm for rating pain-related impairment in conditions

[6] See, e.g., Newberg v. Garrett, supra, n. 5; Wright v. Hopgood Mining, Ky., 832 S.W.2d 884 (1992); and Watkins v. Ampak Mining Co., supra, n. 5.

associated with conventionally ratable impairment."[7] This section of the Guides demonstrates that an impairment rating can be increased by 3% if pain-related impairment substantially increases a patient's burden. Dr. Templin's report indicates he performed a formal pain assessment and the results seem to support an increase of 3% for both the cervical and lumbar ratings.

In summary, we hold that questions involving the application or misapplication of the Guides are medical questions to be resolved by the ALJ based on the evidence of record. Traditional rules of analysis including substantial, compelling, and conflicting evidence continue to apply.

Eagle next argues the ALJ erred, as a matter of law, by awarding any impairment based upon psychological factors. Specifically, Eagle argues that Dr. Mohler did not have the benefit of Dr. Patton's medical records, which contained crucial information regarding Gregory's diagnosed preexisting depression. We are cognizant of the general rule [found in Osborne v. Pepsi-Cola Co.,[8]] that if a history given to a physician is sufficiently impeached, the ALJ may disregard opinions based on that history.[ ] In Osborne, the Court stated, "[w]hen a medical opinion is based solely upon history, the trier of fact is not constricted to a myopic view focusing only

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[7] See Guides, Fig. 18-1, p. 574.

[8] Ky., 816 S.W.2d 643 (1991).

on the physician's testimony. Other testimony bearing on the accuracy of the history may be considered."[9]

Dr. Mohler's report reveals that Gregory denied a prior history of psychological or psychiatric problems or treatment. This is in clear opposition to Dr. Patton's diagnosis of depression, which occurred prior to the work-related injury. Nonetheless, Dr. Mohler's evaluation revealed significant preexisting psychological stressors unrelated to the work event. Thus, he did not relate all of Gregory's impairment to the injury. Gregory's prior treatment for depression by Dr. Patton does not render Dr. Mohler's apportionment opinion untrustworthy as a matter of law. As earlier stated in this opinion, issues of weight and credibility are to be resolved by the fact finder. Dr. Mohler's opinion of a 5% psychological impairment as a result of the injury constitutes substantial evidence and we are without authority to hold otherwise.[10]

Eagle finally argues the ALJ erred in requiring payment for OxyContin and for psychiatric/psychological treatment. Initially, we point out to Eagle that we have affirmed the ALJ's award of benefits, which includes an additional 6% impairment for pain as well as a 5% psychological impairment. It is axiomatic that an employer is responsible to pay for the cure and relief

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9 Id. at 647.

10 Ky. Rev. Stat. (KRS) 342.285.

from the effects of a work-related injury.[11] As pointed out by the Court in Derr [ ], "liability for medical expenses requires that only an injury was caused by work and the medical treatment was necessitated by the injury."[12] Further, KRS 342.020 contains no exclusion for prior active disability. We believe the ALJ, relying on the testimony of Dr. Templin and Dr. Mohler, properly determined Eagle was responsible for payment for prescription medication to treat work-related low back, neck and psychiatric conditions.

Because we agree with the Board's decision, we affirm its opinion upholding the ALJ's award of permanent partial disability benefits to Gregory.

ALL CONCUR.

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11 See KRS 342.020.

12 Derr Const. Co., supra, n. 3, at 827.