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Commonwealth Of Kentucky

Court of Appeals

NO. 2006-CA-000318-WC

JOHNEY BALLARD — APPELLANT

v.

PETITION FOR REVIEW OF A DECISION
OF THE WORKERS' COMPENSATION BOARD
ACTION NO. WC-03-81696

GIPSON FARMS TRUCKING, LLC;
HON. JAMES L. KERR, ADMINISTRATIVE
LAW JUDGE; AND WORKERS' COMPENSATION BOARD — APPELLEES

AND

2006-CA-000347-WC

GIPSON FARMS TRUCKING, LLC — CROSS-APPELLANT

v.

CROSS-PETITION FOR REVIEW OF A DECISION
OF THE WORKERS' COMPENSATION BOARD
ACTION NO. WC-03-81696

JOHNEY BALLARD; HON. JAMES L. KERR,
ADMINISTRATIVE LAW JUDGE;
AND WORKERS' COMPENSATION BOARD — CROSS-APPELLEES

OPINION
AFFIRMING AND REMANDING

** ** ** ** **

BEFORE: ABRAMSON AND VANMETER, JUDGES; KNOPF,[1] SENIOR JUDGE.

KNOPF, SENIOR JUDGE: Johney Ballard petitions for review of a January 13, 2006, order by the Workers' Compensation Board (Board) which affirmed in part and reversed in part an award by the administrative law judge (ALJ). His employer, Gipson Farms Trucking, LLC, cross-petitions for a review of the Board's opinion. Finding that the Board's opinion correctly analyzed all of the disputed issues, we affirm and remand this matter to the ALJ for further proceedings as set forth in the Board's opinion.

The Board's opinion fully sets out the relevant facts of this action as follows:

> Ballard was born on December 9, 1966, and resides in Graves County, Kentucky. He completed the ninth grade. Ballard has been certified as an EMT and has held a commercial driver's license. He went to work driving a tractor-trailer for Gipson in 2002. On June 17, 2003, he fell approximately five feet from a truck fracturing the radial head of his left elbow. He was taken to Redi-Care, where he was treated by Dr. John Cecil, and subsequently referred to an orthopedic surgeon, Dr. Thane DeWeese.
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> Ballard first saw Dr. DeWeese on June 19, 2003. In addition to the non-displaced radial head fracture, Dr. DeWeese diagnosed a bony avulsion of about one-by-three centimeters thickness off the lateral aspect

[1] Senior Judge William L. Knopf sitting as Special Judge by assignment of the Chief Justice pursuant to Section 110(5)(b) of the Kentucky Constitution and KRS 21.580.

of the proximal ulna consistent with a lateral collateral ligament avulsion. Dr. DeWeese placed Ballard in a long arm splint and advised he could return to one-handed work as of June 23, 2003. When Dr. DeWeese saw Ballard in follow-up on June 26, 2003, Ballard reported increased pain after removing his splint. Dr. DeWeese placed him in a long arm cast for three weeks. On July 7, 2003, Ballard reported a significant decrease in his pain, even though he had been using his left arm "aggressively," against the doctor's instructions. Dr. DeWeese removed the cast and recommended light activity, including continued work with restricted use of the left arm. He referred Ballard for physical therapy.

Ballard began physical therapy on July 8, 2003, and attended nine sessions through July 30, 2003, with little progress. He reported continued pain and locking during his last session.

Ballard next saw Dr. DeWeese on August 5, 2003. He reported continued discomfort over the posterolateral aspect of the left elbow, particularly after a long day at work. Dr. DeWeese noted once again that Ballard had been "very active with his left arm at work despite instructions otherwise." Ballard reported stiffness, popping and catching of the left elbow with activity, including exercises performed at physical therapy. Dr. DeWeese admonished Ballard regarding overuse of the left arm. He recommended Ballard continue range of motion exercises and light activity.

Ballard's complaints remained unchanged at a follow-up visit on September 29, 2003. Dr. DeWeese ordered a CT scan of the left elbow. The CT scan revealed a small articular fragment in the joint. Dr. DeWeese recommended arthroscopic surgery, which was carried out November 7, 2003. Dr. DeWeese simultaneously performed a lateral arthrotomy to remove bony tissue from the proximal elbow. During the procedure, Ballard was noted to have significant

arthritic changes at the capitellum. Following surgery, Ballard was issued a sling and instructed not to use his left arm for ten days.

On November 18, 2003, Ballard returned to physical therapy. At that time he continued to complain of severe pain and significant loss of range of motion in the left elbow. Ballard attended twelve therapy sessions through December 2003, consistently giving good effort and experiencing slow improvement in range of motion and strength. Thereafter, Ballard maintained, however, that the physical therapy was exacerbating his painful symptoms and stopped attending. In response, Dr. DeWeese administered a left radial capitello-corticosteroid injection. This procedure was reported to have only alleviated Ballard's symptoms for "a day or two."

On January 27, 2004, Dr. DeWeese wrote to a Dr. John Cecil for the purpose of requesting a consultation on Ballard, and copied the letter to Dr. Jeff Watson. Dr. DeWeese noted that, after the November 2003 surgery, Ballard had "struggled post-operatively with continued pain, stiffness and popping of the left elbow." Dr. DeWeese became concerned that Ballard was suffering from posterior lateral instability or some other type of instability that he was unable to discern.

Dr. Watson did not identify instability of the left elbow. Rather, in his office note of February 24, 2004, Dr. Watson diagnosed left radial capitellar post traumatic arthritis as the cause of Ballard's ongoing complaints, which included pain, swelling, stiffness, catching, and popping.

On March 17, 2004, Dr. DeWeese performed a radial head resection, during which he confirmed a moderate amount of arthritis in the left radial capitellum joint. Ballard experienced modest improvement after surgery, though his pain persisted. During April 2004, Ballard

experienced an unexpected and acute worsening of symptoms, documented by his physical therapist. On April 14, 2004, Ballard reported his pain had migrated from the elbow into his upper arm and was also shooting into his wrist. He complained of progressive numbness and tingling in the fourth and fifth digits of his left hand, as well as nocturnal numbness in the second and third digits. The physical therapist reported mottling and moderately impaired sensation in the left forearm, and raised the possibility of reflex sympathetic dystrophy ("RSD").

During Ballard's follow-up visit with Dr. DeWeese on May 11, 2004, he complained of moderate to severe pain in the left elbow, worse since surgery, and accompanied by weakness, numbness, swelling, and popping. Ballard exhibited a positive Tinel's sign and also complained of left forearm pain and tenderness. Dr. DeWeese found no objective signs of RSD, but instead considered the possibility of radial or cubital tunnel syndrome and nerve irritation due to the radial head resection. On the May 11, 2004, Dr. DeWeese wrote a letter to Gipson's workers' compensation carrier in which he related a diagnosis of "left cubital tunnel syndrome of a month's duration." Dr. DeWeese also advised of Ballard's "vague right radial forearm pain which he felt could be representative of a mild radial nerve entrapment syndrome." Dr. DeWeese excused Ballard from work for six weeks pending completion of a home exercise program and a follow-up examination.

On May 26, 2004, Gipson's workers' compensation carrier wrote to Dr. DeWeese seeking clarification of Ballard's diagnosis and medical status. Dr. DeWeese responded by confirming that Ballard's ongoing complaints of numbness and weakness in his left hand were in the doctor's opinion not related to the work injury. Dr. DeWeese further indicated that Ballard was at maximum medical improvement ("MMI") with

respect to his left elbow. Dr. DeWeese noted that Ballard was scheduled for an appointment with Dr. William Gavigan for a work status determination. Dr. DeWeese recommended a Functional Capacity Evaluation ("FCE") to assist in that regard.

On June 22, 2004, Dr. DeWeese again indicated that in his opinion Ballard was at MMI with respect to the left elbow injury. Dr. DeWeese described the fracture as stable and documented full active range of motion of the left elbow. He expressly indicated that the diagnosis of cubital tunnel syndrome was of "recent onset" and "not work related." Because Ballard had come under the care of a pain management specialist, Dr. Gay Richardson, Dr. DeWeese released him to return only as needed.[2]

On December 10, 2004, Dr. DeWeese wrote a letter to Ballard's counsel addressing the issue of causation, in which he again opined that Ballard's cubital tunnel syndrome — first diagnosed May 11, 2004, two months after the radial head resection procedure — was not related to the elbow fracture Ballard sustained at work or the subsequent surgical procedures. Dr. DeWeese clarified that his earlier statement with respect to MMI pertained only to the radial head fracture for which he had been treating Ballard, and not to the cubital tunnel syndrome for which Dr. Richardson undertook care.

Dr. Richardson first saw Ballard on June 8, 2004. On examination, Ballard exhibited: (1) reduced extension at the elbow and the wrist on the left side; and (2) reduced motor strength on abduction of the fingers, with almost no abduction of the fifth digit. Dr. Richardson recorded that Ballard could not close the fourth and fifth digits of the left hand. Ballard had a positive Tinel's on the left with light

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[2] Ballard was referred to Dr. Richardson by his family physician, Dr. Jeffrey Carrico. [footnote in original]

tapping of the elbow over the ulnar nerve. Sensation was decreased in an ulnar nerve distribution below the elbow. Dr. Richardson diagnosed probable left ulnar neuropathy, status post resection of the left radial capitellum joint, myofascial pain syndrome, and disordered sleep. He recommended EMG/NCV testing to evaluate further and that Ballard remain off work in the meantime.

Dr. Gavigan performed an independent medical evaluation on June 30, 2004. Dr. Gavigan's findings on examination were consistent with those of Dr. Richardson. Dr. Gavigan found reduced range of motion in the left elbow, decreased sensation in the radial aspect of the fourth digit and no sensation in the ulnar aspect of the fifth digit. Tinel's was negative. Dr. Gavigan documented atrophy in the left proximal forearm. By contrast, there was no intrinsic muscle atrophy in the left hand, though Ballard exhibited reduced grip strength on active testing. Consequently, Dr. Gavigan agreed that Ballard should undergo an EMG study of the left arm "to find out why he is having the numbness in the fourth and fifth fingers. . . ." Though he reviewed Dr. DeWeese's records, including operative notes, Dr. Gavigan did not conclude that Ballard's persistent neurological deficits were related. Dr. Gavigan offered no opinion with respect to causation. He agreed with Dr. Richardson that Ballard was not yet at MMI. Dr. Gavigan stated, "He is 3 months post surgery for the radial head resection. I think he needs some more therapy or an FCE to see where he is." Dr. Gavigan opined that Ballard could return to light work with occasional use of the left hand, but restricted lifting with the left arm to no more than five pounds.

On July 8, 2004, Dr. Richardson recorded Ballard had been unable to undergo the recommended testing due to a conflict with Gipson's workers' compensation carrier

over compensability of the cubital tunnel syndrome. Dr. Richardson noted that Dr. DeWeese opined the condition was not work-related. Having been advised that Ballard had no history of hand numbness or weakness at prior to the radial head resection, Dr. Richardson concluded that "this nerve problem is likely directly related to his work related injury on 6/17/03." Dr. Richardson also noted that Dr. DeWeese recommended an FCE. Because Dr. Richardson believed Ballard was not yet at MMI with respect to his diagnosis of ulnar neuropathy, he opined an FCE was not appropriate at that time. Dr. Richardson recommended Ballard undergo the recommended testing and appropriate treatment before consideration be given to MMI and a return to work.

On August 12, 2004, Dr. Richardson issued a letter advising that Ballard could not perform any job duties at that time. On September 27, 2004, Ballard reported the nerve testing still had not been authorized. He complained that his symptoms had worsened to include pain radiating into his shoulder blade, making even basic activities of daily living difficult. Ballard informed Dr. Richardson that he was under significant financial stress due to unemployment and child support obligations. He reported that his family physician, Dr. Jeff Carrico, had increased his dose of Xanax and placed him on an anti-depressant, which had improved his mood. He further reported that he had contemplated suicide and been placed under custodial observation.

In December 2004, Dr. Richardson recorded that Ballard was reporting a good level of pain control. By contrast, Ballard also reported continued numbness and tingling and that he was beginning to exhibit a claw hand due to retraction of the digits. Ballard complained of persistent difficulties with activities of daily living. Dr. Richardson continued to keep him off work pending further medical

treatment leading to MMI. In a letter dated February 15, 2005, Dr. Richardson advised that the recommended testing still had not been completed. Nonetheless, Dr. Richardson addressed the issue of permanent impairment, assessing a 21% whole-body impairment rating based on reduced range of motion at the elbow and shoulder, combined with sensory and motor deficits due to ulnar neuropathy. Dr. Richardson opined that these conditions were the result of the post-operative formation of scar tissue and, therefore, were related to the work injury of June 17, 2003.

The only other physician to address permanent impairment was Dr. DeWeese, who issued a Form 107 medical report on March 9, 2005. Dr. DeWeese assessed an 8% rating for impairment related to Ballard's elbow injury and a 5% rating for impairment due to loss of grip strength. These ratings related to two primary diagnoses, status post left radial head resection with residual elbow stiffness and left cubital tunnel syndrome, the latter of which Dr. DeWeese opined was not work-related.

There was no permanent impairment rating introduced into the record with respect to Ballard's psychological condition, although Dr. Carrico issued a letter dated January 17, 2005, in which he opined that Ballard's mental status had declined as a result of his pain and inability to work.

Ballard's final hearing was held on April 26, 2005. At that time, Ballard testified he has been unable to return to work and is drawing social security disability benefits. Ballard stated he has yet to undergo nerve conduction studies and treatment for the numbness in his small and ring fingers, and for the underside of his left forearm, which he described as "dead." His only treatment for several months has been prescription medication for the treatment of his pain, anxiety and depression. Ballard confirmed that Gipson's

> workers' compensation carrier had terminated income and medical benefits following the IME with Dr. Gavigan.
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> Ballard admitted he has been taking Xanax for anxiety since about 1990. He confirmed, however, that the dose has been increased since the work injury at Gipson and that Effexor has been added for the treatment of depression. He also explained that he is seeing a mental health counselor after having a nervous breakdown. Ballard stated he has been so delinquent regarding his child support payments since the injury that he is close to being arrested. Ballard testified he has lost his vehicle and is about to lose his trailer, as well. Ballard stated he has applied for food stamps. He further testified that he attempted suicide in the year before his hearing. Ballard indicated his mental health has improved with medication. He stated that his mother is helping pay for his prescriptions.

After considering the evidence, the ALJ found that Ballard's cubital tunnel syndrome was work-related. Specifically, the ALJ was persuaded by Dr. Richardson that the cubital tunnel syndrome arose as a consequence of the surgery. Gipson did not contest the work-relatedness of the radial head fracture and surgery. The ALJ adopted the 8% impairment rating assessed by Dr. DeWeese, applying that rating to Ballard's whole-body impairment. The ALJ also enhanced Ballard's award by the 3-multiplier pursuant to KRS 342.730(1)(c)1. based on the additional finding that Ballard lacks the physical capacity to return to the type of work he was performing at the time of injury.

Again relying on Dr. DeWeese's opinion, the ALJ found that TTD benefits should have been terminated as of June 22, 2004, and provided for Gipson to take a credit for those benefits paid beyond that date. Finally, the ALJ concluded that Ballard's mental condition had deteriorated as a result of his work-related injuries. Consequently, the ALJ awarded medical benefits related to the psychiatric condition, but no income benefits because there was no permanent impairment rating of record as to the psychiatric condition.

Gipson petitioned for reconsideration of the award of medical benefits based on the psychiatric condition. The ALJ granted the petition and deleted that portion of the award. Thereafter, Ballard appealed to the Board. The Board first found that the ALJ could properly award medical benefits for a work-related psychiatric condition notwithstanding the lack of an associated permanent impairment or disability rating. The Board also found that the ALJ exceeded his authority by deleting that portion of the award on a petition for reconsideration. Consequently, the Board reinstated the award of future medical benefits for Ballard's psychiatric condition.

The Board next found that the ALJ had erred in finding that Ballard's TTD benefits should have been terminated as of June 22, 2004. Although Dr. DeWeese declared Ballard at maximum medical improvement (MMI) as of that date, he repeatedly stated

that his opinion was limited to Ballard’s elbow injury and not the cubital tunnel syndrome. Furthermore, the ALJ rejected Dr. DeWeese’s opinion that Ballard’s cubital tunnel syndrome was not work-related. As a result, the Board found that the ALJ erred by accepting Dr. DeWeese’s opinion that Ballard’s cubital tunnel syndrome had reached MMI as of June 22, 2004. The Board remanded this issue to the ALJ for additional findings as to when Ballard reached MMI.

However, the Board found that the ALJ had not erred in accepting Dr. DeWeese’s assessment of an 8% impairment rating. Although Dr. DeWeese declined to express an opinion as to when the cubital tunnel syndrome reached MMI, he did not specifically exclude it in determining Ballard’s whole-body impairment rating. The Board concluded that the evidence did not compel a finding that Ballard suffered additional whole-body impairment from the cubital tunnel syndrome. Therefore, the Board affirmed the ALJ’s assessment of Ballard’s impairment rating.

In its cross-petition for review, Gipson first argues that the Board improperly substituted its judgment for the fact-finder as to when Ballard reached MMI. We disagree. 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 adversary party's total proof.[3] And, as fact-finder, the ALJ has the sole authority to determine the quality, character and substance of the evidence.[4] Nevertheless, we agree with the Board that the ALJ's discretion to pick and choose from the evidence does not extend so far as to allow the ALJ to make conflicting findings of fact. As the Board correctly explained, "while a witness may be inconsistent, an ALJ may not."

Dr. DeWeese explicitly stated that his opinion regarding MMI was limited to Ballard's elbow injury alone. He did not offer an opinion regarding Ballard's cubital tunnel syndrome, except to say he did not believe the condition was work-related. However, the ALJ rejected Dr. Deweese's opinion and found the cubital tunnel syndrome to be work-related. Consequently, the ALJ clearly erred by relying on Dr. DeWeese's opinion to determine that Ballard's TTD ended as of June 22, 2004.

In his petition for review, Ballard argues that the ALJ also erred by accepting Dr. DeWeese's assessment of an 8% impairment as relating to not only the elbow injury but also as a whole-body impairment. The Board noted that Dr. DeWeese

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

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

included the diagnosis of cubital tunnel syndrome in his Form 107 report. Dr. DeWeese gave a rating for loss of grip strength and included cubital tunnel syndrome as a non-work related condition. Consequently, the Board concluded that the ALJ could reasonably find that the 8% impairment rating accounts for both Ballard's elbow injury and for the cubital tunnel syndrome.

Ballard contends that Dr. DeWeese's impairment rating related only to the elbow injury. Ballard further argues that Dr. DeWeese could not have assessed a whole-body impairment rating because he was not yet at MMI. Although the Board concluded that the ALJ erred in finding that Ballard had reached MMI as of June 22, 2004, the Board also found that the ALJ could reasonably accept Dr. DeWeese's functional impairment rating for Ballard as of that date.

The AMA Guides to the Evaluation of Permanent Impairment (AMA Guides) require that a patient's functional impairment rating may only be measured if the patient being examined has reached MMI. Dr. DeWeese expressly stated that Ballard's cubital tunnel syndrome was not at MMI as of June 22, 2004, when he last saw Ballard. Therefore, he was not in a position to assess a functional impairment rating for that condition.

Nevertheless, we do not agree with Ballard that the evidence compels a finding of a higher impairment rating.

Ballard urges that Dr. DeWeese's 8% rating for the elbow injury should be combined with Dr. Richardson's 10% rating for the cubital tunnel syndrome to arrive at a combined whole-body impairment rating of 17%. But while a fact-finder may not disregard the uncontradicted conclusion of a medical expert, Dr. Richardson's conclusions were not uncontested. The Board noted that Dr. Richardson did not reference the AMA Guides to state how she arrived at the 10% rating. As the claimant, Ballard bore the burden of proof and the risk of nonpersuasion before the fact-finder with regard to every element of his claim.[5] Thus, the ALJ could reasonably reject Dr. Richardson's functional impairment rating of Ballard's cubital tunnel syndrome. Since no other physician assigned a credible rating for that condition, the ALJ could reasonably conclude that Ballard had only proven that he has an 8% functional impairment rating.

Finally, Gipson argues that the Board erred in finding that Ballard is entitled to an award of future medical benefits arising as a result of his work-related psychiatric injury even in the absence of any permanent impairment or disability rating related to that condition. Gipson urges that future medical benefits may only be awarded upon a finding that the condition

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[5] Magic Coal Co. v. Fox, *supra* at 96.

is permanent. However, we find the Board's analysis to be persuasive, and we adopt the following portion of the Board's opinion.

> In this instance, though not cited by the parties, we find the Kentucky Supreme Court's holding in Coleman v. Emily Enterprises, Inc., 58 S.W.2d 459 (Ky. 2001), to be dispositive. In Coleman, *supra*, as in the case sub judice, the record held evidence of a permanent impairment rating related to the claimant's physical injury but not his psychiatric condition. The ALJ awarded income benefits commensurate with a 5.625% permanent disability rating for the claimant's physical injury and awarded past and future medical benefits pursuant to KRS 342.020(2), that included treatment of the related psychiatric condition.
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> The supreme court summarized the contested findings of the ALJ as follows:
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>> Although Dr. Pursley did not consider plaintiff's psychological/psychiatric symptoms work-related, the proof from Dr. Coleman, one of plaintiff's treating physicians, established that such symptoms indeed were associated with the February 18, 1998, work injury and the defendant-employer's failure to promptly provide medical care; therefore, ***while the record otherwise lacks proof that the anxiety and depression [have] produced permanent impairment or disability, an award of medical benefits therefor is warranted.***
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> Id. at 461. (*Emphasis added*). Consequently, the supreme court affirmed the award of medical benefits for the work-related psychiatric condition, notwithstanding the

lack of a permanent impairment or disability rating associated therewith.

We see no reason for a different outcome here. There is substantial evidence to support the ALJ's finding that Ballard's upper extremity injury produced a permanent impairment rating. There is also substantial evidence to support the ALJ's initial inference that Ballard's current psychological problems are substantially work-related and will require future treatment. Ballard's injury caused pain, which in turn caused depression and worsened his anxiety. The depression and anxiety are "effects" of the injury, for which future medical benefits are authorized by statute in accordance with Coleman, *supra*.

Moreover, the ALJ found in favor of Ballard on this issue in his original decision. It was only on reconsideration at the behest of Gipson that the ALJ modified his decision on the merits of this issue and withdrew that portion of the award, stating that Gipson "shall not be responsible for plaintiff's psychological condition ***given the lack of impairment or disability for that condition.***" (*Emphasis added*). KRS 342.281 defines the scope of modification permitted on reconsideration by the fact-finder, as follows: "The administrative law judge shall be limited in the review to the correction of errors patently appearing upon the face of the award, order, or decision and shall overrule the petition for reconsideration or make any correction within ten (10) days after submission."

In reference to this provision, the supreme court in Beth-Elkhorn Corp. v. Nash, 470 S.W.2d 329 (Ky. 1971), wrote, "This statutory limitation is clear and positive. It expresses a legislative policy that the Board shall not have authority to reverse itself on the merits of a claim." Id. at 330. Citing to its prior decision in Nash, supra, the supreme court reiterated, "The petition may not be granted if it appears that the Board has reconsidered the case on

> its merits and/or changed its factual findings." Wells v. Beth-Elkhorn Coal Corp, 708 S.W.2d 104, 106 (Ky. 1985). Most recently, in Garrett Mining Co. v. Nye, 122 S.W.3d 513 (Ky. 2003), the supreme court uniformly held:
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>> KRS 342.281 provides that in considering a petition for reconsideration, "[t]he administrative law judge shall be limited in the review to the correction of errors patently appearing upon the face of the award, order, or decision ...." This language precludes an ALJ (or, formerly, the "old" Board) from reconsidering the case on the merits and/or changing the findings of fact. Wells v. Beth-Elkhom Coal Corp., Ky.App., 708 S.W.2d 104, 106 (1985); see also, Ford Furniture Co. v. Claywell, Ky., 473 S.W.2d 821, 823 (1971) (where record considered by "old" Board supported its decision, KRS 342.281 could not be used to reconsider case on the merits); Beth-Elkhorn Corp. v. Nash, Ky., 470 S.W.2d 329, 330 (1971) (after dismissing employee's claim, "old" Board exceeded its authority by awarding benefits on petition for reconsideration).

We agree with the Board that there was substantial evidence to support the ALJ's initial conclusion that Ballard's current psychological problems are substantially work-related and will require future treatment. Furthermore, the ALJ was not authorized to re-visit this issue in the petition for reconsideration. Therefore, the Board properly reinstated the

ALJ's original award of future medical benefits for the treatment of Ballard's psychiatric condition.

Accordingly, the January 13, 2006 opinion of the Workers' Compensation Board is affirmed and this matter is remanded to the ALJ for additional proceedings as set out in the Board's opinion.

ALL CONCUR.

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