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Commonwealth Of Kentucky

Court of Appeals

NO. 2016-CA-000258-WC

FORD MOTOR COMPANY APPELLANT

v.

PETITION FOR REVIEW OF A DECISION
OF THE WORKERS' COMPENSATION BOARD
ACTION NO. WC-13-00800

DONALD JOBE, JOHN B. COLEMAN,
AND THE WORKERS' COMPENSATION BOARD APPELLEES

OPINION
AFFIRMING

** ** ** ** **

BEFORE: CLAYTON, STUMBO, AND VANMETER, JUDGES.

CLAYTON, JUDGE: This appeal concerns whether workers' compensation benefits should be paid to a Ford Motor Company ("Ford") employee who was injured on the job.

BACKGROUND

Donald Jobe works at a Ford manufacturing plant in Louisville, Kentucky. On January 25, 2012, Jobe was injured when he tripped over a gap between two rubber floor mats that had been placed on the assembly line. He felt a pop in his right hip, and he soon thereafter began experiencing pain in his hip and leg. Jobe denied having previously experienced right hip or leg pain. He had, however, many years prior, been treated for low back pain, though he was not actively being treated for the same when the injurious accident occurred.

It took many doctors many months to diagnose and treat Jobe. When conservative treatments did not resolve Jobe's pain, and when the doctors could not agree on the pain's source, Jobe first underwent spinal surgery in an effort to see if that would resolve the leg and hip pain. When that surgery did not resolve the pain, Jobe ultimately underwent hip surgery, which partially resolved Jobe's complaints. The ALJ summarized the treatment as follows:

> **DR. JOHN GUARNASCHELLI:** The records spanning September 6, 2012 through July 1, 2013 indicate [Jobe] was initially evaluated for complaints of pain in both hips. A history of a work injury occurring on January 22, 2012 was noted wherein [Jobe] experienced a pop in his low back and right hip. He noted that lumbar MRI revealed evidence of a central disc protrusion at L4-5 with significant degenerative change. Dr. Guarnaschelli opined [Jobe] sustained a work related injury resulting in complaints of persistent back pain as well as bilateral hip and upper thigh pain. He felt the L4-5 disc protrusion may be contributing, in part, to [Jobe]'s overall symptom complex. He noted [Jobe] has been examined by three orthopedic specialists who have diagnosed hip bursitis. He concurred with the

recommendations for an ongoing conservative program of both rehabilitation and pain management. However, surgery was subsequently performed on March 12, 2013 consisting of two level decompressive laminectomy and wide bilateral foraminotomy at L4-5 and L5-S1 as well as microsurgical discectomy bilaterally at L4-5. The follow-up notes indicate [Jobe] obtained good relief of his leg pain, but he continued to have low back pain. MRI of the right hip obtained on June 11, 2013 revealed the development of mild to moderate right greater trochanteric bursitis with low grade partial thickness tear of the gluteal medius tendon at the greater trochanter as well as resolution of right femoral head marrow signal abnormality hand mild bilateral sacroiliac arthropathy. Lumbar spine x-rays obtained on July 1, 2013 revealed moderate spondylosis and degenerative disc disease at L5-S1 as well as sacralization of S1, but no subluxation or instability. Dr. Guarnaschelli completed FMLA paperwork on March 21, 2013 indicating [Jobe's] condition commenced on January 23, 2012. He further indicated [Jobe] would remain off work through June 13, 2013 secondary to diagnoses of degenerative disc disease of the lumbar spine as well as status post decompressive laminectomy. He indicated [Jobe's] condition was not due to his occupation. Dr. Christian Abuk also completed FMLA paperwork on November 21, 2012 indicating [Jobe's] condition began in January 2012 and that he anticipated a return to work in February 2013. He did not consider [Jobe's] condition to be related to his occupation.

DR. THOMAS LOEB: Dr. Loeb initially evaluated [Jobe] on July 10, 2013 for right lateral hip pain. He noted that MRI of the right hip demonstrated findings consistent with a low grade partial thickness tendon tear of the gluteus medius as well as mild to moderate right greater trochanteric bursitis. The office note of August 12, 2013 indicates a diagnosis of right hip ligamentum teres tear. He prescribed Mobic and referred [Jobe] for a surgical consultation.

DR. GREGORY NAZAR: Dr. Nazar noted that a right hip MRI performed on March 28, 2012 demonstrated an

area of marrow edema in the region of the posterior right femoral head consistent with a possible diagnosis of a stress fracture or bone contusion. He referred [Jobe] to a hip specialist who felt [Jobe's] problems were stemming from a low back condition. He noted that he saw [Jobe] on May 31, 2012 at which time he reviewed a lumbar MRI showing no evidence of acute herniation although it did show degenerative change involving the lateral recess of L5-S1. He subsequently performed a lumbar myelogram on June 6, 2012 which clearly showed the nerves roots on the right at L4, L5 and S1 descend and exit normally without being compressed or displaced as well as disc protrusion at L4-5. He described the disc protrusion as being chronic and not compressing the nerve root. He suspected [Jobe's] pain was coming from the signal abnormality of the hip area identified on MRI. He noted [Jobe's] neurologic examination was normal and straight leg raising test was negative. He felt it was clear there was no need or role for surgical intervention. He did not feel [Jobe's] pain was being referred or related to his back in any shape, form or fashion. Instead, he felt the pain was likely arising from the hip and recommended a second opinion consultation.

DR. THOMAS BYRD: Dr. Byrd initially evaluated [Jobe] on December 10, 2013 for evaluation of his right hip pain. He noted [Jobe] had imaging evidence of abnormality in his hip, but the hip did not appear to be the primary pain generator on physical examination. He felt it unlikely the plaintiff's complaints of lateral pain were referred from the hip. He noted that MRI revealed modest abductor tendinopathy. Surgery was subsequently performed on February 13, 2014 consisting of a diagnostic arthroscopy of the right hip followed by endoscopy with bursectomy and repair of the gluteus medius. Dr. Byrd completed paperwork for Unicare indicating [Jobe's] disability began on December 10, 2013, but clarified this was the date he first saw [Jobe.]

DR. JAMES FARRAGE: Dr. Farrage performed an independent medical evaluation on June 9, 2014. He noted a history of the work injury, reviewed medical records and conducted a physical examination. He noted

[Jobe] was status post L4-5 and L5-S1 decompressive laminectomy, discectomy and bilateral foraminotomy, but otherwise neurologically stable. He noted he was also status post right hip arthroscopy with greater trochanteric bursectomy and repair of gluteus medius tendon. While there was no hip contracture, he noted there is evidence of residual iliotibial band syndrome. He explained the bone contusion of the right femoral head has a chronic disruption of the right ligamentum teres and hypertrophic ossification of the anterior aspect of the right hip acetabulum. Therefore, he noted [Jobe] was plagued with chronic right lateral hip pain, mildly restricted range of motion, decreased proximal strength, gait abnormality and impaired functional capacity. He opined [Jobe's] overall clinical presentation and historical account are consistent with the proposed mechanism of injury. While he felt [Jobe's] treatment to date had been appropriate, he did not feel he would require further diagnostic studies. He placed [Jobe] at maximum medical improvement and encouraged a home exercise program with follow-up with his primary treating physician. He opined [Jobe] met the criteria for placement in the "light" occupation category from the *Department of Labor Guidelines* wherein he would be capable of lifting and carrying no more than 20 pounds on an occasional basis and up to 10 pounds on a frequent basis. He recommended [Jobe] avoid prolonged standing or walking with allowance for frequent change in position. He further recommended [Jobe] avoid negotiating stairs, climbing ladders or working from unprotected heights. He assessed 14% whole person impairment using the "Combined Values Chart" of the *AMA Guides* which he apportioned as being 11% for the lumbar spine and 3% for the right hip.

Dr. Farrage also testified by deposition on December 11, 2014. He acknowledged [Jobe] reported that his primary complaint at the time of the work injury was right hip pain, but he complained of pain in his right hip and low back at the time of his June 9, 2014 evaluation. It was his belief that the low back and right hip injuries were related to the work incident in January 2012 as [Jobe] did not have any such issues prior to that time. He explained

that during the course of treatment, the focus shifted from the right hip to the low back as being the primary pain generator. He testified that it was entirely possible to have low back pathology that presents as hip pain. While he acknowledged Dr. Guarnaschelli as the treating surgeon may be in the better position to determine causation, he still found it hard to understand how a patient that did not have any major back or hip problems prior to the fall could suddenly develop same absent injury. He understood there could be some degenerative changes in [Jobe's] low back that were dormant prior to the fall, but brought into disabling reality by the work incident. However, he agreed it was possible the pre-existing degenerative changes could have become symptomatic for a completely independent reason. He testified that functional capacity evaluations are used to establish objectively what a patient can do. He acknowledged that he did not perform a functional capacity evaluation, but he did conduct some basic maneuvers during his examination as well as obtaining a history from [Jobe] regarding what he could or could not do. He found [Jobe] had restricted range of motion, decreased grip strength and tenderness over the greater trochanter. He acknowledged examination of the right hip was basically normal except for swelling in the right calf and subjective complaints of pain. On direct examination, he was not surprised to learn [Jobe] was doing the work of an inspector, a position which fell within the restrictions assessed at the time of his evaluation. He noted there is a tendency for physicians to release patients back to work to see how they will do when they return to work, but many of those patients find they are unable to perform the work. He considered [Jobe] to be a credible patient who was frustrated with the fact that he was still having ongoing pain issues despite a lengthy course of treatment. Regardless of causation, Dr. Farrage explained the treating surgeon felt the lumbar surgery was necessary following failure of conservative treatment and there was a reasonable expectation the procedure would address the right hip pain. He explained the 11% impairment assessed for the lumbar spine was based on the lumbar surgery. However, he felt it was entirely possible [Jobe] sustained

low back and right hip injuries at the time of the 2012 incident. He also felt it was possible the fall sustained in 2012 could have exacerbated the underlying degenerative changes in the lumbar spine. He agreed the January 25, 2012 incident was the precipitating event that brought [Jobe] to the doctors who ultimately led him to Dr. Guarnaschelli and the surgery. On recross examination, he acknowledged [Jobe's] initial complaint was right hip pain. He reiterated that he would defer to the opinion of Dr. Guarnaschelli in regards to [Jobe's] low back problems.

DR. GREGORY GLEIS: Dr. Gleis performed an independent medical evaluation on September 17, 2014. He noted a history of the work injury, reviewed medical records and conducted a physical examination. He opined [Jobe's] right hip was injured on January 25, 2012 resulting in a partial tear of the gluteus medius tendon insertion on the greater tronchanter. He assessed 3% whole person impairment under the *AMA Guides* in regards to the right hip. However, he did not feel the lumbar spine condition was related to the work injury. Instead, he felt the lumbar spine condition was caused by pre-existing multiple low back aggravations and the natural aging process. Nevertheless, he felt [Jobe] has a permanent lumbar impairment given his two spinal surgeries. He assessed 11% whole person impairment under the *AMA Guides*. He noted [Jobe] has returned to work at regular duty and reports that he does have pain, but is able to perform his job duties without accommodation. Therefore, he did not recommend any work restrictions. He disagreed with the independent medical evaluation of Dr. Farrage regarding his opinion [Jobe] would be restricted to light occupations. He agreed with Dr. Farrage's opinion regarding impairment for the right hip and low back although he disagreed with Dr. Farrage using the DRE method in assessing impairment for the lumbar spine. He further disagreed with Dr. Farrage's opinion regarding causation. Based on his review of the medical records and history obtained from [Jobe], Dr. Gleis opined the lumbar spine was evaluated only because of the difficulty in making a diagnosis for the causation of his right hip pain. In

> addition, he noted that low back surgery did not improve his pre-operative symptoms. Therefore, he did not feel the lumbar spine was harmfully changed or injured with the January 25, 2012 [incident].

(Opinion, pp. 6-13).

In light of this lengthy medical history, the ALJ was tasked with determining whether Jobe's work-related injury included his lower back condition. The ALJ found the case of *Coleman v. Emily Enterprises, Inc.*, 58 S.W.3d 459 (Ky. 2001), to be most analogous, wherein a plaintiff's work-related injury, and the employer's failure to provide prompt medical treatment, resulted in the development of psychological disorders that were ultimately determined to be a direct result of the injury. In the instant case, the ALJ found the low-back impairment was assigned to Jobe due to the low back surgery he underwent "because the doctors were unable to accurately diagnose his work related condition." (Opinion, p. 14). The lumbar spine was evaluated and treated only because the doctors had difficulty accurately diagnosing the cause of the right hip pain. "In other words, the only reason [Jobe] underwent low back evaluation and subsequent surgery was because of the difficulty in making the work related right hip diagnosis." *Id*. Thus, "the low back impairment resulting from the surgery is related to [Jobe's] work related right hip injury and is therefore compensable." *Id.*

On appeal to the Worker's Compensation Board ("Board"), the Board affirmed the ALJ's opinion. It noted Ford's argument was that it should not be liable for any disability attributable to the lumbar condition. Ford claimed the ALJ

"engaged in unsupported speculation when he concluded the only reason Jobe underwent the lumbar surgery was due to a failure to find the source of his hip pain." (Opinion, p. 8). Ford claimed the back surgery would have been performed at some time in the future regardless of the work-related hip injury.

The Board rejected Ford's argument. It noted that its "sole task on appeal is to determine whether substantial evidence supports the ALJ's decision." (Opinion, p. 11). The Board analyzed the issue as follows:

> In his September 6, 2012, medical note, Dr. Guarnaschelli stated Jobe presented with a chief complaint of "back pain both hips pain." He noted Jobe had been referred by Dr. Hart to Drs. Nazar, Bonnarens, Malkani, and Rennirt. Dr. Guarnaschelli noted as follows:
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> [A]s the patient explains to me service Drs. feels [sic] it is coming from his hips other [sic] so [sic] that is coming from his back. The patient personally feels as if his pain is primarily hip related aggravated by certain activities but is also aggravated at nighttime.
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> Dr. Guarnaschelli noted his examination was at Jobe's request. He provided the following diagnosis:
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> Clinically and radiographically this patient has sustained a work-related injury resulting in complaints of persistent back pain and bilateral hip and upper thigh pain. He does have radiographic evidence of a central disc protrusion at L4-L5 that may be contributing in part are in total to his overall symptom complex. He has had 3 separate orthopedic specialist [sic] examined him. There has been a diagnosis of bursitis. None of the orthopedics feels that he is a candidate for any type of hip surgery and the previous neurologic surgeon did not feel that he is a candidate for spine surgery.

As a result of his examination, Dr. Farrage noted Jobe was status post L4-5, L5-S1 decompressive laminectomy, discectomy, and bilateral foraminotomy. He was also status post right hip arthroscopy at which time a greater trochanteric bursectomy was performed as well as repair of the gluteus medius tendon with two anchors. Dr. Farrage concluded Jobe's clinical presentation and historical account was consistent with the proposed mechanism of injury. . . .

. . .

The September 6, 2012, report of Dr. Guarnaschelli constitutes substantial evidence in support of the ALJ's determination the low back surgery and by extension the 11% whole impairment rating assessed for the surgery is work-related. Moreover, the opinion of Dr. Guarnaschelli expressed in his September 6, 2012, record and Dr. Farrage's opinions support a finding the low back condition is work-related. In his initial report, Dr. Guarnaschelli clearly indicates Jobe sustained work-related hip and back injuries. Jobe's deposition and hearing testimony is consistent with Dr. Guarnaschelli's statement the back injury is work-related as Jobe specifically testified Dr. Guarnaschelli told him hip and leg problems may result from a back injury. As noted in Dr. Guarnaschelli's September 6, 2012, medical note, the doctors could not agree on whether Jobe sustained a hip or back injury as a result of the event of January 25, 2012.

The ALJ has the discretion to give more credence to Dr. Guarnaschelli's September 6, 2012, report. The fact Dr. Guarnaschelli may have changed his opinion as reflected in his response to the questions posed in the FMLA form does not discount the fact that Dr. Guarnaschelli's September 6, 2012, report constitutes substantial evidence in support of a determination Jobe sustained a work-related back injury in addition to a hip injury on January 25, 2012.

Even though Dr. Farrage testified he would defer to Dr. Guarnaschelli's opinions as to the effects of the January

> 25, 2012, event, in his June 9, 2014, report and to a certain extent in his deposition, he expressed the opinion Jobe sustained work-related back and hip injuries on January 25, 2012. Thus, the opinions expressed by Dr. Guarnaschelli in his September 6, 2012, report and the opinions expressed by Dr. Farrage in his report and deposition constitute substantial evidence in support of the ALJ's finding the surgery and the impairment rating assessed pursuant to the AMA *Guides* due to the surgery are work-related.
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> Since our task on appeal is only to determine whether substantial evidence supports the ALJ's determination and substantial evidence supports his decision, the August 6, 2015, Opinion and Award must be affirmed.

(Opinion, pp. 11-15).

Ford now appeals to this Court. Following a recitation of the relevant standard of review, we address Ford's claims.

STANDARD OF REVIEW

Appellate review of a worker's compensation decision regarding questions of law or mixed questions of law and fact are subject to *de novo* review by this Court. *Bowerman v. Black Equipment Co.*, 297 S.W.3d 858, 866 (Ky. App. 2009).

Questions of fact, on the other hand, are subject to substantial discretion under Kentucky Revised Statutes (KRS) 342.285, as that statute "designates the ALJ as finder of fact, and has been construed to mean that the factfinder has the sole discretion to determine the quality, character, weight, credibility, and substance of the evidence, and to draw reasonable inferences from the evidence." *Id*. (citing *Paramount Foods, Inc. v. Burkhardt*, 695 S.W.2d 418,

419 (Ky. 1985); *McCloud v. Beth-Elkhorn Corporation*, 514 S.W.2d 46, 47 (Ky. 1974)). The fact-finder has "the right to believe part of the evidence and disbelieve other parts of the evidence whether it came from the same witness or the same adversary party's total proof." *Caudill v. Maloney's Discount Stores*, 560 S.W.2d 15, 16 (Ky. 1977).

"Where the ALJ determines that a worker has satisfied his burden of proof with regard to a question of fact, the issue on appeal is whether substantial evidence supported the determination." *McNutt Construction/First General Services v. Scott*, 40 S.W.3d 854, 860 (Ky. 2001) (citing *Special Fund v. Francis*, 708 S.W.2d 641, 643 (Ky. 1986)). "The function of further review of the [Board] in the Court of Appeals is to correct the Board only where the . . . Court 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).

With these considerations in mind, we turn to the issues presented by Ford.

ISSUES

Ford first argues that the Board substituted its judgment for the ALJ's judgment by using Dr. Guarnaschelli's medical report and Dr. Farrage's testimony to find a causal relationship between Jobe's lumbar impairment and his work injury. Ford argues that the ALJ did not make an explicit finding that Dr. Guarnaschelli made a causal connection between Jobe's work-related injury and

his lumbar condition. Thus, according to Ford, the Board was without authority to make such a finding.

Ford's argument misses the mark. The ALJ reviewed the evidence and made the factual finding that Jobe had sustained his burden of proving the lumbar condition was due to a work-related injury. Having made this factual finding on causation, the Board was required to examine whether substantial evidence existed to support the ALJ's factual finding. *McNutt Construction*, 40 S.W.3d at 860. It properly performed its function by examining the record *in toto* and noting that there was evidence of substance that supported the trial court's factual decision. Accordingly, we find the Board did not err by denying Ford's appeal on this first issue.

Ford also claims that the ALJ's determination that there was a causal relationship between the lumbar injury and the work accident is a legal issue. Ford maintains the "uncontested" facts support a legal conclusion that the lumbar injury is unrelated to the work accident. That Ford maintains this argument proves the issue is a fact question that the Board properly examined. "Although a party may note evidence which would have supported a different conclusion than that which the ALJ reached, such evidence is not an adequate basis for reversal on appeal." *Id.* (citing *McCloud v. Beth-Elkhorn Corp*., 514 S.W.2d 46 (Ky. 1974)). Ford's argument on appeal is exactly that – Ford believes the evidence supported a different conclusion about the factual question of whether the condition was related to the injury.

Moreover, "[c]ausation is a matter to be decided by the fact-finder." *Coleman*, 58 S.W.3d at 462. *See also Lane v. S&S Tire, Inc., No. 15*, 182 S.W.3d 501, 507 (Ky. 2005); *Williams v. White Castle Systems, Inc.*, 173 S.W.3d 231, 235-36 (Ky. 2005); *Campbell v. Hauler's Inc.*, 320 S.W.3d 707, 711 (Ky. App. 2010) ("In heart attack cases, causation is a factual determination based on a legal concept for the purpose of determining whether or not the work was the legal cause or only the stage on which an inevitable tragedy occurred."). Whether the work-related injury was the proximate cause of Jobe's lumbar condition is thus a fact issue, not a legal issue. The ALJ made the factual finding that there was a causal link. The Board examined the evidence and noted evidence of substance existed to support this finding. Having reviewed the record ourselves, we find no error with either. *Cf. Webster County Coal , LLC (Dotiki Mine) v. Parker*, 2014 WL 3973258 (Ky. App. 2014) (not reported) (finding no error in ALJ's determination that work related slip was proximate cause of both knee injury and back injury, even though worker had extensive history of back conditions and doctors disagreed about whether the back condition was due to the work injury).

Accordingly, Ford's argument fails *in toto*.

ALL CONCUR.

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