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THIS OPINION IS DESIGNATED "NOT TO BE PUBLISHED." PURSUANT TO THE RULES OF CIVIL PROCEDURE PROMULGATED BY THE SUPREME COURT, CR 76.28 (4) (c), THIS OPINION IS NOT TO BE PUBLISHED AND SHALL NOT BE CITED OR USED AS AUTHORITY IN ANY OTHER CASE IN ANY COURT OF THIS STATE.

RENDERED: June 17, 2004
NOT TO BE PUBLISHED

Supreme Court of Kentucky

FINAL

2003-SC-0689-WC DATE 7-8-04 ELA Growth, DC.

WALMART STORES, INC. APPELLANT

V.

APPEAL FROM COURT OF APPEALS
2003-CA-0443-WC
WORKERS' COMPENSATION BOARD NO. 99-66231

LARRY FRENCH; HON. BRUCE COWDEN, JR.,
ADMINISTRATIVE LAW JUDGE; AND
WORKERS' COMPENSATION BOARD APPELLEES

MEMORANDUM OPINION OF THE COURT

AFFIRMING

An Administrative Law Judge (ALJ) determined that the claimant was totally disabled by a work-related injury. The employer later maintained that the ALJ erred by relying upon an impairment that was not determined under the AMA Guides to the Evaluation of Permanent Impairment (Guides). Nonetheless, the Workers' Compensation Board (Board) and the Court of Appeals affirmed findings that the claimant sustained an AMA impairment due to a stroke and that the stroke resulted from his work-related accident. We affirm.

The claimant was born in 1949 and had a twelfth-grade education with no specialized or vocational training. He worked as a plasterer for 14 years, but the occupation resulted in tendonitis, forcing him to quit. After numerous surgeries and a

six-year period of unemployment, the claimant was hired by the defendant-employer in 1998. His duties entailed stocking shelves, mixing paint, and helping customers.

On September 9, 1999, while the claimant was getting a metal shelf bracket from a storage room, heavy items began to fall and hit him on the head. He remembered nothing after that until he arrived at the hospital by ambulance. He was released from the hospital later that day and treated subsequently by his family physician, Dr. Scott. At some point, the employer referred him to Occnet, which recommended physical therapy and also referred him to Dr. Anthony, a neurologist. Approximately 10 months after the injury, he suffered a stroke. He testified that he suffered constant, daily headaches; that the anxiety attacks from which he suffered previously had become worse and had required hospitalization; that he suffered from memory loss and sleeplessness; and that he was required to take a number of medications to control his symptoms.

According to the ALJ's summary of the evidence, Dr. Anthony noted on October 21, 1999, that a set of iron clothes racks had fallen down from a shelf and upon the claimant. He remembered being taken to the hospital by ambulance and being discharged the same day. On July 6, 2000, the claimant was admitted to St. Elizabeth hospital, complaining of dizziness and of numbness on the left side. A brain MRI was unchanged from one performed shortly after the work-related injury. It revealed changes that were characterized as being ischemic and demyelinating or post-traumatic, with the latter thought to be less likely. On July 18, 2000, Dr. Anthony noted the hospitalization and diagnosis of a middle cerebral artery brain infarction. A discharge summary was not available, but MRI, EEG, and CT scans all were normal. A

July 27, 2000, entry indicated that a brain scan revealed evidence of an apparent stroke involving the right parietal and left temporal regions and also showed a probable concussion injury in the temporal and frontal areas of the left side. Dr. Anthony noted that the claimant had a normal cerebral blood flow, which indicated that there was no widespread cerebrovascular disease. He noted that the claimant continued to have significant headaches. An August 17, 2000, note indicated that the claimant expressed feelings of depression and suicidal ideation. On September 11, 2001, Dr. Anthony diagnosed intracranial injury with brief loss of consciousness and noted that the claimant had reported to the hospital again with left-sided weakness and numbness. It appeared that he was worse, with increasing disuse of his left arm, increasing difficulty walking, and increasing facial drop. The final entry, dated September 27, 2001, noted that the claimant lost consciousness after being hit on the head in the work-related incident. It indicated that the initial diagnosis was a simple brain concussion but that the claimant subsequently had more than one episode of apparent brain infarction, with the development and persistence of left-sided weakness and numbness. In his opinion, the claimant did not appear to be improving, and the problem was probably permanent.

The initial Form 107 from Dr. Anthony indicated that the claimant was diagnosed with a brain infarction and noted that a SPECT scan was abnormal. He attributed the condition to the claimant's injury. The form indicated that the claimant had a 100% permanent whole-body impairment and did not retain the physical capacity to return to the type of work he performed when injured. The claimant later filed a supplemental Form 107 report, explaining that the previous one referred to disability rather than AMA impairment. In the supplemental report, Dr. Anthony indicated that the claimant did not

have an active impairment before the injury and that he now had a 15% whole-person impairment under Chapter 3, p. 65 of the Guides.

Dr. Pretoritus performed a diamox brain SPECT scan. On July 20, 2000, Dr. Pretoritus determined that the results of the scan were consistent with the history of prior head trauma rather than multi-focal areas of cerebrovascular disease. Furthermore, the study revealed no evidence of widespread cerebrovascular disease.

Dr. Hartings, a psychiatrist, examined the claimant on October 21, 1999. He found the claimant's IQ, attention, and concentration to be at the level of mental retardation. He stated that attempts to evaluate the claimant's memory produced mixed results due to a lack of effort and significant overlay. He found strong evidence of a conversion disorder but also noted evidence of depression, loss of energy and motivation, and a sense of sadness due to impairment. The MMPI strongly suggested functional overlay. Dr. Hartings recommended psychiatric rehabilitation but thought there was little likelihood that the claimant sustained any irreversible brain damage from the concussion.

Dr. Scott reported to the claimant's counsel that he did not perform AMA impairment evaluations. He noted that the diagnosis of the claimant's injury was a concussion.

When deposed in February, 2001, Dr. Petit testified that he began treating the claimant for anxiety attacks in 1996 by prescribing various medications. In his opinion, the work-related injury neither caused the attacks nor caused them to be more severe. The claimant's first visit after the injury was in December, 1999, at which time his condition had not changed. Dr. Petit stated that, in 1996, he treated the claimant once

every two weeks but presently saw him every four to six weeks. He admitted, however, that the appointments had been more frequent since the injury. He stated that he was called as a consultant after the claimant suffered a transient ischemic attack on July 6, 2000, but he continued to diagnose a severe panic disorder with secondary depression. Dr. Petit saw no indication at the time that the claimant had suffered a stroke.

Dr. Zerga examined the claimant on September 28, 2000, and reviewed the medical records and diagnostic testing. When deposed, he testified that the MRI and EEG were normal. He also testified that the claimant suffered a mild concussion, the effects of which should be temporary because he was able to communicate with the hospital staff about what happened and what his complaints were. In Dr. Zerga's opinion, the claimant had no permanent impairment from the injury, and it would not prevent him from returning to work. He acknowledged, however, that the claimant had suffered a stroke from which he retained some left-sided weakness and loss of coordination. He testified that a SPECT scan is used only for research purposes, is not to be used for a clinical determination of a patient's condition, and does not have any clinical validity in an individual with a history of vascular disease to the brain.

Dr. Shraberg, a psychiatrist, evaluated the claimant in January, 2000. He diagnosed a cervical sprain/strain as well as a concussion and post-concussive symptomology, all of which were resolving. In his opinion, those diagnoses were due to the work-related injury. He thought that the claimant's pre-existing panic disorder was not exacerbated by the injury. Dr. Shraberg recommended six weeks of therapy, followed by temporary light duty. He found no evidence of a neuropsychiatric impairment due to the work-related injury.

The employer asserted that there was no medical evidence of a stroke; that the claimant suffered only a mild concussion from which he reached maximum medical improvement as of July, 2000; that the injury had resolved; and that any further symptoms and medical treatment were not work-related. The employer also asserted that the 15% impairment that Dr. Anthony assigned based upon central nervous system abnormalities was inconsistent with the Guides because Chapter 3, page 65 did not pertain to the central nervous system in either the 4th or 5th Edition of the Guides. The claimant maintained, however, that he was totally disabled and that his disability was due to the effects of the work-related accident.

Relying on the employer's expert, Dr. Zerga, the ALJ determined that the claimant did suffer a stroke in July, 2000. The ALJ noted that the diagnosis was confirmed by Dr. Anthony and by the SPECT scan, the results of which Dr. Pretoritus indicated were more consistent with a history of prior head trauma than with widespread cerebrovascular disease. Based upon Dr. Anthony's testimony, the ALJ determined that the stroke was due to the effects of the work-related accident. Noting that no medical evidence indicated that the impairment rating Dr. Anthony assigned was erroneous and that an ALJ lacked the authority to independently calculate an impairment rating, the ALJ chose to rely upon Dr. Anthony. Furthermore, the ALJ determined that the effects of the work-related accident were totally occupationally disabling by themselves and without regard to the previous nonwork-related anxiety attacks. See Daugherty v. Watts, Ky., 419 S.W.2d 137 (1967).

The employer's argument is two-fold. First, relying upon Caldwell Tanks v. Roark, Ky., 104 S.W.3d 753 (2003), which was rendered during the pendency of its

appeal to the Court of Appeals, the employer maintains that the ALJ was obliged to consult the Guides to determine whether the 15% impairment was consistent with them. Second, it argues that there was no substantial evidence of a work-related impairment because the chapter and page references which Dr. Anthony provided did not conform to the 4th or the 5th Edition of the Guides. The employer asserts that the substantial evidence of record indicates only that the accident may have caused a mild concussion.

The burden was on the claimant to prove every element of his claim, including the extent to which the work-related injury was disabling. An award of permanent total disability requires findings that the worker has an AMA impairment and a complete and permanent inability to work. KRS 342.0011(11)(c) and (36). Although calculating an AMA impairment is a matter for medical experts, determining the weight and character of medical testimony and drawing reasonable inferences from it are matters for the ALJ. We acknowledge that there are instances in which an ALJ may find it helpful to consult the Guides when deciding whether to rely upon medical testimony concerning a worker's impairment and, if so, to what extent. Nonetheless, we are not convinced that an ALJ is required to consult the Guides unless there are exceptional circumstances such as were present in Caldwell Tanks v. Roark, supra.

The ALJ determined that the claimant's stroke and resulting central nervous system abnormalities were work-related, findings that were supported by substantial evidence. To the extent that Dr. Anthony referred to an incorrect chapter and page number in the Guides, his assignment of a 15% AMA impairment under the Guides was open to question. The fact remains, however, that no medical evidence established that the claimant did not have an AMA impairment due to the stroke under the criteria the

Guides set forth for central nervous system abnormalities. For that reason, we are not persuaded that the ALJ was compelled to disregard Dr. Anthony's testimony and conclude that the claimant failed to prove that he had an AMA impairment.

The decision of the Court of Appeals is affirmed.

All concur.

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