IMPORTANT NOTICE

NOT TO BE PUBLISHED OPINION

THIS OPINION IS DESIGNATED "NOT TO BE PUBLISHED." PURSUANT TO THE RULES OF CIVIL PROCEDURE PROMULGATED BY THE SUPREME COURT, CR 76.28 (4) (c), THIS OPINION IS NOT TO BE PUBLISHED AND SHALL NOT BE CITED OR USED AS AUTHORITY IN ANY OTHER CASE IN ANY COURT OF THIS STATE.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: May 19, 2005
NOT TO BE PUBLISHED

Supreme Court of Kentucky

FINAL

2004-SC-0539-WC DATE 6-9-05 ElaGraham D.C.

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF CORRECTIONS — APPELLANT

V.

APPEAL FROM COURT OF APPEALS
2004-CA-0048-WC
WORKERS' COMPENSATION BOARD NO. 02-72289

BEVERLY TRAVIS; HON. DONALD G. SMITH,
ADMINISTRATIVE LAW JUDGE; AND
WORKERS' COMPENSATION BOARD — APPELLEES

MEMORANDUM OPINION OF THE COURT

AFFIRMING

In a two-to-one decision, the Workers' Compensation Board (Board) reversed an Administrative Law Judge's (ALJ's) finding of causation on the ground that the underlying medical opinion was based on an inaccurate medical history. Concluding that the Board exceeded its scope of review and that any inaccuracy was insignificant when all of the evidence was considered, the Court of Appeals reversed and reinstated the award. We affirm.

The claimant testified that she began working for the Department of Corrections on June 3, 2002, as a probation and parole officer. On July 26, 2002, she was sprayed in the face with pepper spray during a training exercise and immediately bent over in pain. She continued with the exercise but later experienced numbness in her lips, a broken tooth, involuntary clenching of her jaws, neck pain, and low back pain that

radiated into her right hip and leg with numbness. She stated that Dr. Renco, her family physician, prescribed pain medication and took her off work. Although she returned to work on July 31, 2002, her pain increased around Labor Day and led her to seek treatment at the emergency room twice within a week. On October 10, 2002, she was terminated for failing to successfully complete her probationary period. She filed an application for workers' compensation benefits on November 13, 2002.

At the hearing, the claimant stated that she continued to experience various symptoms, including constant low back pain with numbness and tingling in her right leg and hip. She continued to take medication for back pain and to help her sleep, but the neck pain had completely resolved. Testifying about her prior medical history, she stated that she had been in an automobile accident in 1997 that led to a cervical fusion by Dr. Petruska in 1998. Although she denied any previous problem with her jaw, back, or right leg on direct examination, she later admitted that she had been using Hydrocodone on a regular basis for neck and back pain before July 26, 2002.

A report and treatment records from Dr. Renco cover the period from September 7, 2001, through October 24, 2002. On September 7, 2001, he noted that the claimant was "using Hydrocodone on a regular basis for severe neck pain." He diagnosed osteoarthritis and previous cervical neck disease for which he recommended continued treatment with Hydrocodone as needed. He also noted fatigue and depression for which the claimant was receiving psychiatric treatment. On December 27, 2001, she came in at Dr. Renco's request to discuss her frequent requests for Hydrocodone refills. At a third visit on June 13, 2002, the claimant was doing well, with no depressive symptoms, and taking only Vicodin as needed for neck and back pain. Dr. Renco noted that he would see her again in six months.

The claimant returned to Dr. Renco on July 29, 2002, three days after the work-related incident. She complained of fatigue, joint aches, slight nausea, and lethargy that had begun the previous Friday when she "got a full face of pepper spray" during a training exercise. She also complained of insomnia and anxiety. At the next visit, on September 13, 2002, she complained of intense neck and low back pain. Dr. Renco noted that x-rays were performed during two emergency room visits and that it appeared she may have "jerked herself hard enough that it irritated her neck." He attributed the pain to an acute exacerbation of her underlying problems. Noting that an appointment with Dr. Petruska was not available until January, Dr. Renco agreed to refer her elsewhere. An October 24, 2002, report indicated that an MRI had been performed and that the claimant was to have been evaluated by Dr. Villanueva on October 17, 2002. Dr. Renco excused the claimant from work from July 29, 2002, until October 18, 2002, noting that the period was subject to revision after he received Dr. Villanueva's report.

On February 3, 2003, Dr. Auerbach evaluated the claimant and reviewed her medical records at the request of counsel. The claimant gave a history of the work-related incident; stated that her initial complaints had included neck pain, which had since subsided; and explained that her current complaint primarily involved her back and right posterior hip, with a radiation of numbness down the entire leg. Dr. Auerbach noted that the 1997 motor vehicle accident was significant and that Dr. Petruska had performed a diskectomy and fusion at C5-6 and C6-7. Noting that he had reviewed Dr. Renco's treatment notes back to 1998, Dr. Auerbach stated that although there was some history of back pain, which might be related to the motor vehicle accident, "she never had complaint of pain in the right hip or numbness of the leg before." After

examining the claimant, he concluded that she sustained a back strain that had become chronic. He noted that although there was some indication of radiculopathy, numbness of the entire leg was not appropriate for a true radiculopathy and sneezing and coughing do not produce leg pain. He was unsure what the best course of treatment might be but expressed concern that continued use of Percocet for back pain might lead to addiction or at least dependence. Also, it appeared to him that an emotional overlay was aggravating the situation. He assigned a 5% AMA impairment to the lumbar spine, attributing none of it to a pre-existing condition.

The employer submitted a report from Dr. Keisler, who evaluated the claimant on April 4, 2003. He received a history of the work-related incident and the symptoms that followed; a history of the 1997 motor vehicle accident and cervical spine surgery; and a history of some low back symptoms that never extended into the right leg. He also reviewed various medical records. Referring to Dr. Renco's treatment records, Dr. Keisler noted that the claimant routinely took narcotic medication for complaints of neck and back pain from September 7, 2001, through June 13, 2002. He noted that the record from July 26, 2002, did not include neck or back complaints and that Dr. Renco's impression at the time was that the other complaints were of unclear etiology. It was not until six weeks later that the reported symptoms included neck and back pain.

Referring to the report from an unnamed "neurosurgeon's workup . . . on July, 17, 2002," Dr. Keisler noted complaints of low back and right leg pain that had been present for three months. According to Dr. Keisler, the report acknowledged the prior surgery and noted that the present neck and right arm symptoms were the same as before. It indicated that there had been right leg pain prior to the cervical spine surgery but that there were no subsequent problems until July 26, 2002. At the time of the workup, the

symptoms included neck and right arm pain and numbness; low back pain; and pain, numbness, and tingling in the right leg. The lumbar symptoms were considered to be the most serious. The report indicated that a 1997 lumbosacral MRI showed no significant problem, clearly indicating to Dr. Keisler that lumbar symptoms must have been present in 1997 to warrant the procedure.

Dr. Keisler noted that the claimant had significant cervical and lumbar symptoms before the July 26, 2002, incident. Although the third day after an injury is the point at which symptoms are at a maximum, she failed to complain of neck, back, arm, or leg symptoms when she saw Dr. Renco on July 29, 2002. Although convinced that the claimant suffered from chronic pain syndrome, he attributed her symptoms to the return of a condition that had been present since 1997 rather than to the 2002 incident.

Noting that the medical evidence was conflicting, the ALJ found Dr. Auerbach's testimony to be the most persuasive regarding causation. As a result, the claimant received an award of temporary total disability benefits and permanent income benefits based on a 5% impairment. The employer appealed.

In reversing the finding of causation, the Board's majority relied on Dr. Keisler's statements regarding an unnamed neurosurgeon's workup which, according to Dr. Keisler, occurred on July 17, 2002. Noting that the date was shortly before the work-related incident and that the report referred to a three-month history of leg pain, the majority determined that the claimant's failure to report that same history to Dr. Auerbach rendered his opinion of causation so flawed that the ALJ could not properly rely upon it. The minority was of the opinion that Dr. Auerbach had sufficient information to support the conclusion he reached and that it was for the ALJ to determine the weight to give his testimony.

The record contains no report of a July 17, 2002, neurosurgical workup; no reference to such a workup; and no evidence that the claimant complained of right leg pain before July 26, 2002, other than what is found in Dr. Keisler's report. Likewise, the record does not contain a report of Dr. Villanueva's neurosurgical evaluation on October 17, 2002, some three months after the work-related incident. Although Dr. Keisler mentions an October, 2002, MRI, he does not mention the October 17, 2002, evaluation.

As the Board's minority opinion pointed out, this case is not akin to Cepero v. Fabricated Metals Corp., 132 S.W.3d 839 (Ky. 2004), wherein the medical opinion at issue was based on a substantially inaccurate and incomplete medical history in which the worker misled a medical evaluator by characterizing as "no big deal" a previous knee injury that had, in fact, caused him to spend two months in a wheel chair. Other medical evidence showed that an injury of that particular type would not have healed without surgery, which the worker did not have. In contrast, there is no indication that the claimant attempted to conceal her previous symptoms of back pain from Dr. Auerbach. He was clearly aware of them and noted them in his report. Under the circumstances, it was within the ALJ's authority to judge the weight and credibility of the conflicting medical opinions regarding causation.

The decision of the Court of Appeals is affirmed.

All concur.

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