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NOT TO BE PUBLISHED OPINION

THIS OPINION IS DESIGNATED "NOT TO BE PUBLISHED." PURSUANT TO THE RULES OF CIVIL PROCEDURE PROMULGATED BY THE SUPREME COURT, CR 76.28 (4) (c), THIS OPINION IS NOT TO BE PUBLISHED AND SHALL NOT BE CITED OR USED AS AUTHORITY IN ANY OTHER CASE IN ANY COURT OF THIS STATE.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: June 16, 2005
NOT TO BE PUBLISHED

Supreme Court of Kentucky

FINAL

2004-SC-0648-WC

DATE 7-7-05 ELW Grow, P.C.

CLARK REGIONAL MEDICAL CENTER — APPELLANT

V.

APPEAL FROM COURT OF APPEALS
2003-CA-2652-WC
WORKERS' COMPENSATION BOARD NO. 99-75897

RITA OSBORNE; HON. BONNIE C. KITTINGER, ADMINISTRATIVE LAW JUDGE; AND WORKERS' COMPENSATION BOARD — APPELLEES

MEMORANDUM OPINION OF THE COURT

AFFIRMING

The Workers' Compensation Board (Board) reversed an Administrative Law Judge's (ALJ's) finding that the claimant had become permanently and totally disabled from her work-related injury at reopening, concluding that there was no substantial evidence of increased impairment from the injury as required by KRS 342.125(1)(d). Convinced that the Board misapplied the law and that the award was supported by substantial evidence, the Court of Appeals reinstated it. Dingo Coal Co. v. Tolliver, 129 S.W.3d 367, 370-71 (Ky. 2004). We affirm.

The claimant was born in 1945, has an eleventh-grade education, and is certified as a patient care technician. She began working for the defendant-employer in 1977. She testified that she provided general care for patients at her employer's facility and that the job required her to lift, push, pull, bend, squat. Her application for benefits alleged that she sustained work-related back injuries while lifting patients on October

28, 1998, and June 1, 1999. When the claims were heard, she had not returned to work and alleged that she was totally disabled. She complained of sharp, burning pain in her low back that ran into her right leg and for which she took Ultram and Flexeril daily. She performed only limited household chores such as making a bed, washing dishes, or cooking and could not run a vacuum cleaner or drive.

The employer submitted reports from Drs. Wood and Sheridan, who were of the opinion that the claimant sustained only soft tissue injuries that had resolved. Dr. Sheridan assigned a 0% impairment, stating that he had consulted the DRE model and the 4th edition of the AMA's Guides to the Evaluation of Permanent Impairment (Guides). Dr. Wood evaluated the claimant and testified that the claimant's symptoms were due to degenerative osteoarthritis in her thoracic and lumbar spine, which existed before the work-related injury. He noted that her treating physician returned her to work within a week of the second injury, albeit with a ten-pound lifting limit.

The claimant introduced testimony from Dr. Vaughan. His report of July 26, 1999, indicated that MRI of the thoracic and lumbar spine revealed disc protrusions/bulges at T11-12, T12-L1, L1-2, and L2-3 but no frank herniations. He attributed her axial thoracic and lower back pain to degenerative spondylosis of the thoracic and lumbar spine. In a December 23, 1999, report Dr. Vaughan indicated that he had seen the claimant twice and had diagnosed thoracolumbar spondylosis. He assigned a "5% [impairment] to the body as a whole" and restricted her from lifting more than 15 pounds and from repetitive twisting and bending of the back.

On October 19, 2000, the claimant was awarded temporary total disability benefits from July 1, 1999, until October 21, 1999. Although the ALJ noted that whether the claimant was permanently and totally disabled was "a close question," he

determined that her permanent disability was only partial and that she retained the ability to perform sedentary work. She received income benefits under KRS 342.730(1)(b) and (c) based on findings that her impairment was 5% and that she did not retain the physical capacity to return to her previous work.

On October 17, 2001, the employer filed a motion to reopen in order to contest the payment of medical expenses for various conditions that it alleged were unrelated to the back injury. In a separate motion, it also moved to join medical providers that had an interest in the medical fee dispute. On October 22, 2001, the claimant moved to reopen her partial disability award under KRS 342.125(1)(d), alleging a worsening of condition and increased disability due to the initial back injuries and complaining that the employer refused to provide medical coverage. Attached to the motion was a letter from her primary care physician, stating that she had developed severe deep vein thrombosis and massive pulmonary embolus. It attributed the conditions to the immobility caused by pain from her back condition. The parties' motions were granted, without objection, and they proceeded to take further proof. After considering the evidence regarding the deep vein thrombosis and pulmonary embolus, the ALJ determined that the conditions were not due to the claimant's back injury. The present appeal concerns only the back condition.

The claimant introduced a medical report from Dr. Kriss, a neurosurgeon, who evaluated her on July 17, 2001, at the request of Dr. Gupta, her pain management specialist. He noted that Dr. Gupta had treated her with medication and injections for low back pain and radicular nerve pain that ran down her right leg. She rated her back pain at 9 out of 10 and her leg pain at 4 out of 10. After taking a history and conducting a physical examination, Dr. Kriss noted that the claimant had been diagnosed with

spondylolisthesis, which could very well account for the radicular pain. A July 24, 2001, report indicates that the claimant brought MRI scans from August, 2000, which showed "some ruptured discs in the proximal lumbar spine, but in the lower lumbar spine at the L3/ L4/ L5 and S1 levels there is no evidence of slippage or spondylolisthesis." He reported that the claimant had convincing nerve pain in the leg but that he found no evidence of a pinched nerve or slippage to provide a structural explanation. For that reason, he did not recommend surgery but did recommend continued pain management therapy because it had helped to alleviate the symptoms from the injury.

A September 23, 2001, report indicated that Dr. Gupta treated the claimant for right L3 radicular pain that was secondary to a disc bulge causing subarticular stenosis and degenerative disc disease. Dr. Gupta stated that the claimant received methadone and that intermittent transforaminal injections helped her significantly. In Dr. Gupta's opinion, she needed aggressive pain control so that she could perform regular exercise, which was the only effective way to prevent further pulmonary emboli. She would not be able to exercise without pain control.

The ALJ to whom the claim was assigned determined that a university medical evaluation of the claimant's conditions would be helpful and directed the claimant to undergo such an evaluation. KRS 342.315(3). Dr. Prince performed the university evaluation on April 15, 2002. His Form 107 report began with a note that the purpose of his evaluation was to address a worsening of the claimant's condition, specifically her back pain. He took a history of the work-related incidents and the course of her treatment and symptoms. His report noted that Dr. Vaughan had conducted a surgical evaluation and found multi-level degenerative changes but did not find any lesions that would be amenable to surgical treatment. The claimant had also undergone a course of

physical therapy and attempted to continue the exercises but found it difficult due to her pain and other medical problems. She eventually began pain management treatment with Dr. Gupta, which was complicated by the pulmonary embolus. Despite various medications, she complained that she continued to have "constant" low back pain, with pain radiating into her posterior right leg. The pain had increased in recent months.

After conducting a physical examination and reviewing June, 1999, MRIs of the lumbar and thoracic spine, Dr. Prince diagnosed chronic low back pain with extensive degenerative changes in the lumbosacral spine. He attributed the claimant's complaints to her injury, stating that there was no history of a prior back injury and that both the findings and clinical course were consistent with the history of a work-related injury and the noted pathology. Dr. Prince assigned a 7% impairment to the lumbosacral spine, none of which was active before the injury, indicating that he used Chapter 15, table 15-7, of the Guides in arriving at the percentage. He indicated that the claimant had described her work as a patient care technician as involving occasional to frequent lifting and carrying while assisting patients and recommended various restrictions due to the injury or its residuals. They included: no frequent or forceful twisting or bending of the trunk; limit lifting or carrying to 20 pounds maximum, 10 pounds regularly; and no lifting below knee level. He did not think that the claimant retained the physical capacity to return to the type of work she performed at the time of injury.

It is undisputed that the employer introduced two reports from Dr. Sheridan, the 1999 report from the initial claim and a May 21, 2002 report. For whatever reason, only the 1999 report is part of the record on appeal. As summarized by the ALJ, the 2002 report indicated that the claimant complained of intermittent thorcolumbar pain and lumbosacral pain that was exacerbated by bending and of intermittent pain that radiated

from her right buttock to her right ankle. He reviewed an April 30, 2002, MRI and indicated that, in addition to the disc bulges at L1-2 and L2-3 that were present in 1999, the 2002 MRI showed bulges at L3-4 and L4-5 and a herniation. He continued to diagnose an acute thoracolumbar strain that had resolved and stated that he was unable to determine if the claimant had radicular pain. In his opinion, the claimant's condition was no different than it had been in 1999. Using the 5th edition of the Guides, he assigned 0% thoracic and lumbar impairments. He thought that the claimant did not need any work restrictions.

Dr. Sheridan also offered an explanation for the reason that there was a difference between the 7% impairment Dr. Prince assigned at reopening and the 5% impairment Dr. Vaughan had assigned in the initial proceeding. According to Dr. Sheridan, Dr. Prince used the 5th edition, Range of Motion model; whereas, Dr. Vaughan had used the 4th edition, DRE model. In his opinion, if both physicians had used the same edition and model, the impairments they assigned would also have been the same.

The ALJ acknowledged that Dr. Shultz had released the claimant to return to work one week after the 1999 injury with a ten-pound lifting restriction but pointed out that the record was silent as to whether he had changed the restriction before the initial award. The ALJ noted that Dr. Sheridan's opinion regarding impairment had been rejected in the initial proceeding and rejected his opinions at reopening. Instead, the ALJ relied upon Dr. Prince, noting that he knew both the basis for Dr. Vaughan's 5% impairment and the purpose of the university evaluation. Although acknowledging that he used the 5th edition of the Guides, which had not been available to Dr. Vaughan, and that he used the Range of Motion model, the ALJ concluded that his report was

evidence of a greater impairment at reopening and entitled to presumptive weight. Convinced that the claimant was no longer capable of even light work, the ALJ determined that the back condition, by itself, rendered her totally disabled at reopening. Dissatisfied with the analysis, the Board remanded the matter for the ALJ to establish that there was sufficient evidence of a change of impairment as shown by objective medical findings. KRS 342.125(1)(d).

Again reviewing the evidence, the ALJ noted that the claimant did not use a wheelchair during the initial proceeding but did use one at the hearing in the reopening. When questioned, she explained was that it was not prescribed by a physician and that she used it for traveling longer distances because of difficulty breathing and because her back "gives out." She stated that Dr. Gupta recommended the use of a cane sometime after October, 2000, and that she now used one almost all the time. Her present medications included Lortab, Midrin, and Neurontin for back pain and Phenergan for stomach upset due to the pain medication. She testified that her pain was significantly worse than in 2000, explaining that Dr. Gupta had increased the dosage of Lortab from 5 milligrams, which she took in 2000, to 7.5 milligrams and then to 10 milligrams. Presently, Dr. Gupta alternated the dose between the 7.5 and 10 milligram strength. Also, she now required injections in her back every four months but did not require them in 2000.

Remaining convinced of a post-award worsening of the claimant's physical condition, the ALJ noted that Dr. Sheridan reported additional disc bulges and a herniation that were not present in 1999. Although he concluded that her condition was no different, the objective findings in his report indicated otherwise. Although Dr. Sheridan could not determine if the claimant had radicular pain, Dr. Gupta characterized

her pain as being radicular. Likewise, Dr. Kriss reported radicular pain. In 1999, Dr. Vaughan restricted the claimant from lifting more than 15 pounds and from repetitive twisting and bending of the back but, at reopening, Dr. Prince restricted her from frequent or forceful twisting or bending of the trunk; from lifting or carrying more than 20 pounds and more than 10 pounds regularly; and from lifting below knee level.

Remaining convinced the claimant had become totally disabled since the initial award, the ALJ found the claimant's testimony regarding the worsening of her back pain to be credible evidence that she had much more back pain than in October, 2000, and that the present pain was throbbing, sharp, and constant. Dr. Gupta had recommended a cane, which she used almost all the time, and she now felt the need to use a wheelchair for traversing longer distances. Furthermore, her ability to perform household duties was now more restricted than it had been.

Again concluding that Dr. Prince's testimony was entitled to presumptive weight, the ALJ determined that Dr. Sheridan's report did not sufficiently explain why there was no actual change of impairment. The ALJ noted that this was not a case where the difference in impairment ratings resulted solely from the use of different editions of the Guides. Although a cross-examination of Dr. Prince could have revealed his rationale for using the Range of Motion model and his opinion of whether there was an actual difference in the claimant's impairment, none was conducted. Furthermore, Section 15.2 of the Guides appeared to support his use of the Range of Motion model.

Under the misapprehension that KRS 342.125(1)(d) required the claimant to prove a post-award increase in her impairment rating due to the effects of her injury and convinced that she failed to do so, the Board again reversed the ALJ's decision. This occurred before our decision in Dingo Coal Co. v. Tolliver, supra, which explained that

KRS 342.125(1)(d) governed only the prima facie showing necessary to warrant further proof-taking. Reversing the Board's decision, the Court of Appeals pointed out that the claimant's motion to reopen was granted without objection; therefore, KRS 342.125(1)(d) was no longer applicable. At issue was whether substantial evidence supported a finding that the claimant became totally disabled due to a post-award worsening of her injury. Convinced that there was, the court reinstated the total disability award. This appeal by the employer followed.

The employer asserts that there was no substantial evidence that a change of condition due to the claimant's back injury caused her to become more disabled during the interval between the initial award and reopening. It emphasizes that she never returned to work after the 1999 accident and acknowledged in the initial proceeding that she had applied for Social Security Disability benefits. Furthermore, her testimony indicated that she thought she was unable to perform even sedentary work at that time. Focusing on Dr. Sheridan's testimony that there was no change in the claimant's condition at reopening, the employer points to his "uncontradicted" opinion that the impairment Dr. Vaughan assigned in the initial proceeding and the impairment Dr. Prince assigned at reopening would have been the same had they used the same standards. The employer also notes that Dr. Kriss found no evidence of a pinched nerve or slippage that would account for the claimant's symptoms at reopening. Although he noted some evidence of a ruptured disc, his report did not specify at what level it was located. Having noted that the claimant acknowledged she had been referred to Dr. Gupta before the initial award, the employer asserts that there was nothing in the physician's report to indicate that a change or worsening of her physical

condition caused her to be more disabled at reopening than she had been in October, 2000.

The amount of disability that the claimant's condition caused was fully litigated in the initial proceeding. As a final determination of the matter, the October, 2000, finding that she was only partially disabled was binding at reopening. As we explained in Dingo Coal Co. v. Tolliver, supra at 370-71, the standard set forth in KRS 342.125(1)(d) governs only the prima facie showing necessary to obtain an order to reopen proof in a claim that has become final. It is inapplicable to the merits of a worker's right to receive additional income benefits in a reopening proceeding. The claimant's motion to reopen was granted without objection. The present dispute concerns whether there was error in the decision on the merits. It is governed by the versions of KRS 342.730 and KRS 342.0011 that were effective on the date of injury. Id.

This is not a reopening in which the injured worker was found to have a greater partial disability, which would have been required to be supported by substantial evidence of increased impairment under KRS 342.730(1)(b). Roberts Brothers Coal Co. v. Robinson, 113 S.W.3d 181, 182-83 (Ky. 2003). In a reopening in which the injured worker is found to have become totally disabled, KRS 342.0011(11)(c) and KRS 342.730(1)(a) require substantial evidence that a worsening of condition due to the injury has caused the worker's present "disability" to be total. Id. The terms "impairment" and "disability" are not synonymous under the 1996 Act. Id.

The initial partial disability award established that the claimant had an AMA impairment at that time, and even Dr. Sheridan did not assert that her impairment had improved; therefore, it is undisputed that the claimant had a disability rating at reopening. KRS 342.0011(35) and (36). In order to receive a total disability award at

reopening, her burden on the merits was to show that a worsening of her condition due to the injury rendered her completely and permanently unable to provide services to another in return for remuneration on a regular and sustained basis in a competitive economy. KRS 342.0011(11)(c) and (34). Even under the 1996 Act, a finding of total disability involves a weighing of the lay and medical evidence and a consideration of some of the Osborne v. Johnson, 432 S.W.2d 800 (Ky. 1968), factors. Ira A. Watson Dept. Store v. Hamilton, 34 S.W.3d 48, 51 (Ky. 2000). Evidence of greater impairment is but one type of evidence of a worsening of condition and but one type of evidence that the worker's disability due to the injury has increased and become total.

KRS 342.285 designates the ALJ as the finder of fact in workers' compensation claims, giving the ALJ the sole discretion to determine the weight, credibility, quality, character, and substance of the evidence and to determine what inferences to draw from it. Paramount Foods, Inc. v. Burkhardt, 695 S.W.2d 418, 419 (Ky. 1985). That discretion extends to the medical evidence as well. Pruitt v. Bugg Brothers, 547 S.W.2d 123, 124 (Ky. 1977). If an ALJ's finding in favor of the party with the burden of proof is supported by substantial evidence in the record, it is reasonable and may not be disturbed on appeal. Special Fund v. Francis, 708 S.W.2d 641, 643 (Ky. 1986). Substantial evidence has been defined as some evidence of substance and relevant consequence, having the fitness to induce conviction in the minds of reasonable people. Smyzer v. B. F. Goodrich Chemical Co., Ky., 474 S.W.2d 367 (1971). The substantiality of evidence must take into account whatever fairly detracts from its weight. Pierce v. Kentucky Galvanizing, Ky.App., 606 S.W.2d 165 (1980).

Dr. Vaughan's report in the initial claim indicated only that he assigned a 5% whole-body impairment. Dr. Sheridan speculated at reopening that it was assigned

under the DRE model of the 4th edition of the Guides. The Form 107 report that Dr. Prince completed specifically required the use of the DRE model for a spinal injury unless another method was authorized in the Guides. Dr. Prince assigned a 7% impairment, using the table for the Range of Motion model. He was not deposed; therefore, he was not examined regarding his reasons for using that model or asked to compare the impairment he assigned with the impairment Dr. Vaughan assigned in the initial proceeding.

The proper interpretation of the Guides with regard to orthopedic injuries is a complex matter that requires medical expertise. This is particularly true when the experts assign impairments using different models. See Thomas v. United Parcel Service, 58 S.W.3d 455 (Ky. 2001). Nonetheless, an ALJ may consult the Guides when necessary in order to weigh the conflicting opinions, to draw reasonable inferences from the available evidence, and to decide which evidence is most reliable. Paramount Foods, Inc. v. Burkhardt, supra; Pruitt v. Bugg Brothers, supra; Pierce v. Kentucky Galvanizing, supra.

Testifying on the employer's behalf, Dr. Sheridan reported that the claimant's condition was no different at reopening than it had been in 1999. He indicated that he thought the DRE model to be appropriate at both points in time and indicated that he thought Drs. Vaughan and Prince would have assigned the same impairment had they used the same guidelines. As the ALJ noted, his objective findings were not entirely consistent with his conclusion that the claimant's condition had not changed. His report did not explain the basis for the opinions he expressed or indicate that Dr. Prince's use of the Range of Motion model was erroneous under the Guides. Furthermore, when rejecting Dr. Sheridan's opinions and deciding to give Dr. Prince's presumptive weight,

the ALJ noted that the Guides appeared to authorize the use of the Range of Motion model where there was multi-level involvement such as Dr. Prince found. Despite the employer's assertions, Dr. Sheridan's opinions were not uncontradicted evidence such as would compel the ALJ to disregard Dr. Prince's opinions and to conclude that the claimant's impairment and physical condition were unchanged.

The medical testimony submitted by the claimant and Dr. Prince's report established that the claimant experienced a change of condition after October, 2000, due to a worsening of the back condition her injury caused. Furthermore, despite his conclusions, Dr. Sheridan noted that a 2002 MRI revealed bulging discs at two levels that were previously unaffected. Dr. Prince imposed physical restrictions at reopening that exceeded the ones Dr. Vaughan imposed in the initial proceeding. Finally, the claimant's own testimony provided competent evidence of a decline in her physical condition due to the back injury and in her ability to perform daily activities. Hush v Abrams, 584 S.W.2d 48 (Ky. 1979). Under the circumstances, there was substantial evidence that a worsening of the work-related back condition, by itself, caused the claimant to be totally disabled at reopening. The Court of Appeals determined correctly that the Board misconstrued the controlling statutes and erred by reversing the award.

The decision of the Court of Appeals is affirmed.

Lambert, C.J., and Cooper, Graves, Johnstone, Scott, and Wintersheimer, JJ. sitting.

All concur.

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