2018 Mid-Winter Meeting & CLE Seminar

Majestic Mirage Resort
Punta Cana, Dominican Republic

Presented by the
Kentucky Bar Association
Workers’ Compensation Law Section

Kentucky Bar Association
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The Kentucky Bar Association
Workers’ Compensation Law Section
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2018 Mid-Winter Meeting
&
CLE Seminar

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# 2018 Workers’ Compensation Mid-Winter Meeting & CLE Seminar

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THURSDAY, JANUARY 25

8:15-8:30 a.m. Welcome and Opening Remarks
Ann F. Batterton

8:30-9:30 a.m. Update on Multipliers: 2 x 3 = 1 Year of Updates
(1.00 CLE credit)
Amanda M. Perkins

9:30-10:30 a.m. Facial and Dental Injuries Part 1
(1.00 CLE credit)
Richard A. Pape, DMD, MS

10:30-10:45 a.m. Break

10:45-11:45 a.m. Facial and Dental Injuries Part 2
(1.00 CLE credit)
Richard A. Pape, DMD, MS

11:45 a.m.-12:45 p.m. The Sage from Cow Creek: A Thirty Year Retrospective from Both Sides of the Bench
(1.00 Ethics credit)
Justice David A. Barber

FRIDAY, JANUARY 26

8:30-9:30 a.m. Ethics in the Cloud
(1.00 Ethics credit)
Marcus A. Roland

9:30-10:30 a.m. Coal Workers' Pneumoconiosis
(1.00 CLE credit)
Sara V. A. May
10:30-10:45 a.m.  Break

10:45-11:45 a.m.  TTD While Working: Simplistic Confusion Defined
(1.00 CLE credit)
J. Gregory Allen

11:45 a.m.-12:45 p.m.  Returning the Worker to Work: Light Duty and the Intersection of Workers' Compensation, the FMLA, and the ADA
(1.00 CLE credit)
Stephanie D. Ross

SATURDAY, JANUARY 27

8:30-9:45 a.m.  Case Law Update
(1.25 CLE credits)
Bonnie J. Hoskins

9:45-10:15 a.m.  Using the 5th Edition AMA Guides in Evaluating Impairment Ratings and Conducting Depositions
(0.50 CLE credits)
Robert F. Ferreri

10:15-10:30 a.m.  Break

10:30-11:45 a.m.  Legislative Update
(1.25 CLE credits)
Timothy J. Wilson

11:45 a.m.-12:15 p.m.  Medical Fee Disputes
(0.50 CLE credits)
Lori V. Daniel

12:15-12:45 p.m.  How Did You Get a Work Injury if You Weren't Injured at Work?
(0.50 CLE credits)
William C. O. Reaves
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David A. Barber was appointed by Governor Beshear to serve as Justice on the Supreme Court of Kentucky representing the seventh appellate district and served on the Court until December, 2015. At the time of his appointment, Justice Barber was a member of the firm Richardson, Barber & Williamson. He also served as Senior Legal Counsel and Policy Advisor for the Kentucky House of Representatives from 2014-2015. From 1999-2007, Justice Barber served as Judge on the Kentucky Court of Appeals, District 7, Division II. He was a member of the Judicial Nomination Commission for the Kentucky Department of Workers' Claims from 1995-1999, and a member of the Barber Law Office in Prestonsburg from 1985-1999. Justice Barber also served as an Administrative Law Judge in the Department of Workers' Claims from 1991-1992. He received his A.A. from Alice Lloyd College, his B.A. from Transylvania University, and his J.D. from the University of Kentucky College of Law. Justice Barber also completed post-graduate work on a Judicial L.L.M. at Harvard Law School in 2004. He is a member of the Kentucky Bar Association.

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James Gregory Allen is an associate attorney at Jones & Walters, PLLC in Pikeville, where he represents employers and insurers in administrative proceedings regarding workers' compensation and disability claims. From November 2013 until April 2016, Mr. Allen served as an Administrative Law Judge with the Kentucky Department of Workers' Claims. Prior to that, he was a member and managing partner of Riley and Allen, P.S.C. in Prestonsburg. He received his B.A. from Eastern Kentucky University and his J.D., *cum laude*, from the Northern Kentucky University Salmon P. Chase College of Law. Mr. Allen is a member of the Kentucky and Floyd County Bar Associations.
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Bonnie Hoskins graduated from the University of Kentucky in 1978 with honors and high distinction, and studied at the Centre for Renaissance Studies in Oxford, England before entering the University of Kentucky College of Law in 1979. She was a member of the National Moot Court Team while at the College of Law and received her J.D. in 1979. Since that time, Ms. Hoskins has practiced primarily administrative law specializing in workers' compensation defense. She clerked with Kentucky's Special Fund while in law school and then practiced with the Special Fund for a short time after completing her law degree. Ms. Hoskins then engaged in private practice in Eastern Kentucky representing clients primarily in the coal industry from 1983-1986 before joining Stoll, Keenon & Park in 1987, where she was a member of the firm's Administrative Committee and Strategic Planning Committee. She was also instrumental in developing and upgrading computer software specifically designed for the Workers' Compensation Department. In 2001, Ms. Hoskins founded Hoskins Law Offices PLLC. She is a former Chair of the Kentucky Bar Association Workers' Compensation Law Section and a contributing author to the University of Kentucky Workers' Compensation Desk Book. Ms. Hoskins is a frequent speaker at continuing legal education seminars and has published numerous outlines and articles in continuing legal education publications.
Bobby Ferreri is managing partner at Ferreri Partners, PLLC in Louisville. After gaining distinction as a member of the American Inn of Court at the Brandeis School of Law, Mr. Ferreri was admitted to the Kentucky Bar in 2004. Following his admittance, he has spent his career in workers' compensation litigation, economic development and entrepreneurial advisory roles. His current practice is focused on employer and small business related issues offering both legal expertise and practical solutions. Prior to founding Ferreri Partners, Mr. Ferreri was the Executive Director of Greater Louisville Inc.'s ENTERPRISECORP, a leading economic development organization dedicated to assisting high-potential early-stage companies. He serves on the Boards of the Kentucky Association of Corporate Growth, NUCLEUS, VelocitySI and Old Louisville Meets New Louisville. Mr. Ferreri has been named to Louisville’s 40 Under 40, Who's Who In Louisville Technology, and Young Philanthropist of the Year. In addition to his law degree, Mr. Ferreri holds a B.S. in finance from Miami University, and a Masters of Business Administration from the University of Louisville where he graduated with distinction. He currently serves as Secretary of the KBA Workers' Compensation Law Section.

Tim Wilson is the senior & managing partner at Wilson & McQueen, PLLC, where he practices exclusively in the field of workers' compensation. Mr. Wilson has participated at various levels of the workers' compensation system, including his assistance in drafting proposed legislation and administrative regulations and litigation of cases through the Kentucky system including appeals at the Kentucky Court of Appeals and the Supreme Court of Kentucky. He received his B.A., with distinction, and M.A. from Morehead State University, and his J.D. from the University of Kentucky College of Law. Mr. Wilson has been listed in Best Lawyers in America annually since 2010 and as a Kentucky Super Lawyer annually since 2008. He currently serves as President of the Kentucky Workers' Association (KWA), and is a member of the Kentucky Bar Association and its Workers' Compensation Law Section.
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William Reaves is president of William C.O. Reaves, PSC in Ashland, where he practices in the areas of social security disability, Kentucky workers’ compensation law, and SSI. He received his B.S., cum laude, from Murray State University in 1978 and his J.D. from the Northern Kentucky University Salmon P. Chase College of Law in 1981. Mr. Reaves is a member of the Kentucky Workers’ Association, Kentucky Workers’ Compensation Education Association, and the National Organization of Social Security Claimants’ Representatives. He is also a member of the Kentucky Bar Association and serves as Vice Chair of the KBA Workers’ Compensation Law Section.
I. APPLICATION OF THREE MULTIPLIER

A. Recent Board Opinions

Ford Motor Company (LAP) v. Phyllis Russ, Claim #: 2014-01072, Rendered: 04/15/16, Status: Final

1. Facts.

The Claimant alleged injuries to both of her hands and forearms on May 21, 2013, due to her repetitive work duties. The Claimant began working for her employer, Ford, in June 2012 and performed several different jobs. She was eventually moved to a position where she placed rubber seals around truck doors which required her to push with both hands. She developed symptoms in her left hand after doing that job for a week. On May 1, 2013, she was moved to a job requiring her to push wiring and pins through trucks. She was later returned to the door seal position and her left thumb "locked up" after two days. When she reported her thumb had locked, the Claimant was moved to another position.

The Claimant eventually underwent surgery for her left thumb on September 16, 2013, and was allowed to return to light duty work three days later. The Claimant missed no work after her return to light duty, and continues to work for the Employer. She has received regular pay and some overtime pay while working light duty. She has also received multiple pay raises since the date of injury.

Both parties agreed that the Claimant did not return to the type of work she was doing prior to the injury. However, the parties disagreed on post-injury wages and whether or not she is likely to continue to earn that wage.

The ALJ determined the Claimant sustained permanent work-related cumulative trauma injuries to her left thumb and right third and fourth fingers. He awarded PPD benefits based upon a 10 percent impairment rating. The ALJ also enhanced the award of PPD benefits by the three multiplier, but did not make a determination as to whether the two multiplier applied as well.

Ford filed a Petition for Reconsideration alleging that the ALJ erred in enhancing the PPD award by the three multiplier contained in KRS 342.730(1)(c)1. Ford argued that the ALJ erred
in finding the Claimant would be unable to earn the same or greater wages into the indefinite future, the third prong of the Fawbush analysis, since it was purely speculative and not supported by any concrete evidence. Ford maintained the Claimant had not satisfied the third prong of the Fawbush analysis.

2. Issue.

Is the ALJ required to perform a Fawbush analysis for an award of the three multiplier when the Claimant has returned to work?

3. Holding.

No. The Board determined an analysis pursuant to Fawbush was not required. In the ALJ's opinion, he found the Claimant does not retain the capacity to perform the work she was doing on the date of her injury, thus entitling her to an enhancement of benefits pursuant to KRS 342.730(1)(c)1. However, he did not make the determination that she was also entitled to the application of the two multiplier pursuant to KRS 342.730(1)(c)2. Therefore, the Fawbush analysis was not required. Such analysis is only required when there is a finding that both KRS 342.730(1)(c)1 and KRS 342.730(1)(c)2 are applicable. The ALJ made no such determination and this was not an issue preserved for the ALJ to decide, nor was it addressed in a petition for reconsideration. Therefore, based upon the ALJ's determination, the Board affirmed the enhancement of benefits by the multiplier contained in KRS 342.730(1)(c)1.

B. Recent Court of Appeals Decisions


a. Facts.

Claimant was employed by Heritage Healthcare as a physical therapy assistant when she suffered a work-related injury to her right ankle on January 25, 2013. She underwent two surgeries and eventually returned to Heritage Healthcare in her position as a physical therapy assistant.

Claimant testified that her job requires her to stand, pull, stoop, squat, climb and lift. Claimant explained that she lifted patients, wheelchairs, and equipment in the gym. When Claimant initially returned to work, she was under a restriction of no squatting. Approximately a month after Claimant's return, her doctor released her from all
restrictions. Claimant testified that she experienced difficulty performing her job duties after she returned to work. Specifically, Claimant stated she has difficulty walking patients, squatting, and lifting.

In his opinion and award, the ALJ awarded a three multiplier based on Claimant's testimony regarding her job performance and continued pain. The ALJ performed the Fawbush analysis. At the first prong, he relied on the Claimant's testimony and Dr. Muffly's report in finding that Claimant did not have the physical capacity to return to work. At the second prong, the parties stipulated that the Claimant is still working for the defendant but making lower wages. Therefore, the ALJ found that KRS 342.730(1)(c)2 does not apply. Even though the ALJ determined that (c)2 does not apply, he performed an analysis of the third prong. For the third prong, the ALJ found that based on Claimant's testimony and Dr. Muffly's report, Claimant is unlikely to continue for the indefinite future to do work from which to earn such a wage.

The defendant appealed and argued that the ALJ erred in enhancing Claimant's award of PPD benefits by the three multiplier.

b. Issue.

Did the ALJ err in enhancing Claimant's award of PPD benefits by the three multiplier when Claimant returned to her pre-injury job without restrictions?

c. Holding.

No. On review, the Court of Appeals noted that substantial evidence supported the ALJ's findings that Claimant was not physically able to perform the same daily jobs or tasks of a physical therapy assistant as she performed before the injury. It was well within the ALJ's discretion to rely upon Claimant's testimony as to her inability to lift, transfer, and ambulate heavier patients without assistance after the injury. Also, the Kentucky Supreme Court has concluded that if an employee returns to the same job post-injury but is unable to perform some of the tasks of that job, the employee is entitled to the three-multiplier under KRS 342.730(1)(c)1. Ford Motor Co. v. Forman, 142 S.W.3d 141 (Ky. 2004). As such, the Court of Appeals affirmed, concluding that the Board properly affirmed the ALJ's application of the three multiplier pursuant to KRS 342.730(1)(c)1.

a. Facts.

Claimant sustained a work-related "near amputation" of his right wrist and hand on October 12, 2011. After an initial surgical procedure, Claimant returned to work in February 2012. A second surgery was necessary approximately two months later, following which Claimant again returned to work. At the time of the injury, Claimant was making approximately $20.00 per hour. At the time of his deposition in late 2013, Claimant was still employed by defendant in a modified and somewhat different job than before the injury although his job classification remained constant. Claimant was earning approximately $21.00 per hour. Claimant was not receiving further medical care nor taking prescription medications for his injury.

In his opinion and award, the ALJ assessed a 41 percent whole person impairment rating with a three multiplier. Citing Fawbush, the ALJ determined that the three multiplier was applicable rather than the two multiplier.

The defendant appealed and the Board entered its opinion vacating in part and remanding the matter to the ALJ for further findings. Specifically, the Board concluded that the ALJ failed to adequately address the third prong of the Fawbush analysis – the likelihood of Claimant's ability to continue earning wages exceeding those at the time of his injury for the foreseeable future. The Board believed the ALJ's analysis considered only Claimant's ability to continue in his current job and did not consider any other applicable factors. Because it believed defendant was entitled to specific findings and a complete analysis regarding the appropriate multiplier, the Board vacated the ALJ's decision as to the enhancement and remanded for further findings.

b. Issue.

Did the Board correctly conclude further findings were necessary under Fawbush?

c. Holding.

Yes. In Fawbush, the Kentucky Supreme Court held that an ALJ must determine which multiplier under KRS 342.730(1)(c) is factually most appropriate. When a Claimant meets the criteria for both the two multiplier and
three multiplier, the ALJ is authorized to choose between them as he/she sees fit under the facts of that particular case. Kentucky River Enterprises, Inc. v. Elkins, 107 S.W.3d 206, 211 (Ky. 2003). In the analysis, the ALJ must decide if the injured worker has a "permanent alteration in the claimant's ability to earn money due to his injury." Fawbush, 103 S.W.2d at 12. An award enhanced by the three multiplier is proper only if it is determined a worker is unlikely to continue earning a wage exceeding his wages at the time of the injury for the indefinite future. Fawbush articulated several factors to be considered in the analysis, including the lack of physical capacity to return to the type of work claimant previously performed, whether the post-injury work is done out of necessity, whether the post-injury work requirements are outside medical restrictions, and if completing the post-injury work is only possible when claimant takes more narcotic pain medication than prescribed. Id. In Adkins v. Pike County Bd. of Educ., 141 S.W.3d 387, 390 (Ky. 2004), the Supreme Court clarified:

However, jobs in Kentucky, an employment-at-will state, can and do discontinue at time for various reasons, and wages may or may not remain the same upon the acquisition of a new job. Thus, in determining whether a claimant can continue to earn an equal or greater wage, the ALJ must consider a broad range of factors, only one of which is the ability to perform the current job.

Because the ALJ found both the two and three multipliers were potentially applicable, it triggered the third prong of the Fawbush analysis. Although the ALJ may have reached the correct result in applying the three multiplier, more detailed findings relative to its determination of Claimant's future earning capability are required by Fawbush. On remand, the Court directed the ALJ to analyze the broad array of factors influencing Claimant's ability to earn the same or greater wages for the foreseeable future and subsequently make specific findings as to the evidence supporting the decision of whether application of the two multiplier or three multiplier is appropriate.
C. Supreme Court Decisions


1. Facts.

Claimant was employed by Two Chicks as a sales clerk. Two Chicks is a boutique store which sells gifts, jewelry, purses, silver, pewter, pillows, and furniture. Claimant's job at Two Chicks involved straightening the store, stocking shelves, pricing items, writing up sales tickets, assisting customers, and helping out when needed. Claimant stated that she had to frequently use a step stool or ladder to reach merchandise that was located above her reach. In October 2011, Claimant fell down from the step stool while reaching for a Christmas ornament, fracturing her right tibia. She underwent surgery to repair the fracture but was unable to return to work at Two Chicks.

One of Two Chick's owners testified that climbing the step stool was not an essential part of Claimant's job as she could get assistance, could have the customer retrieve things she could not reach, or find the same item in a different part of the store. Furthermore, the owner testified that the store could accommodate Claimant if she wanted to return.

Claimant's surgeon stated that she has an 8 percent impairment rating and is unable to climb stairs or ladders, is unable to repetitively bend or squat, and is unable to perform heavy lifting. Relying on Claimant's testimony and physician reports, the ALJ found that Claimant could not return to the type of work she performed prior to her injury and awarded Claimant enhanced benefits pursuant to KRS 342.730(1)(c).

Two Chicks appealed arguing that the ALJ did not present adequate findings to support the award of the three multiplier to Claimant. The Board vacated the portion of the ALJ's opinion and award that granted Claimant the three multiplier. The Board found that the ALJ performed the incorrect analysis because he did not determine whether Claimant's restrictions prevent her from being able to perform all of the tasks of a sales clerk.

The Court of Appeals disagreed with the Board and reinstated the application of the three multiplier to Claimant's award. The Court of Appeals held that the ALJ applied the correct legal standard when he found that Claimant could no longer perform many of the tasks associated with her pre-injury job due to her physical restrictions. Additionally, the Court of Appeals found that Claimant's testimony indicating that she did not think she had the ability to perform many of the tasks associated with her pre-injury job was persuasive and that the ALJ could rely upon it.
2. Issue.

Did the ALJ err in finding that Claimant was entitled to a three multiplier when Claimant was able to perform some job duties, but not the duty she was performing when injured?

3. Holding.

No. As used in KRS 342.730(1)(c), the phrase "the type of work that the employee performed at the time of injury" refers to the specific jobs or tasks that the individual performed, rather than the title of the position or the job classification. Ford Motor Co. v. Forman, 142 S.W.3d 141 (Ky. 2004). The ALJ in Forman did not apply the three multiplier to claimant's award because she returned to the same job classification that she had pre-injury. However, the Board reversed, finding that the ALJ erred by using claimant's job classification as the standard for refusing to enhance the award. The Court of Appeals affirmed. This Court, in affirming, found that the ALJ must analyze all of the evidence to determine what jobs claimant performed at the time of her injury and then find whether she retains the physical capacity to return to those jobs. If she did not retain the physical capacity to return to those jobs, even if she returned to the same job classification, she would be entitled to the three multiplier.

Several years after Forman, the Court rendered the decision of Miller v. Square D Co., 254 S.W.3d 810 (Ky. 2008). In Miller, the ALJ found that claimant was not entitled to the three multiplier because he could perform the mold technician job which he was performing when injured. However, pre-injury claimant also did assembly work for the same employer which he no longer performed. The Court ultimately reversed and remanded the matter for the ALJ to consider what claimant's physical capacity was to do assembly work. The Court found that "the phrase 'the type of work that the employee performed at the time of injury' to refer broadly to the various jobs or tasks that the worker performed for the employer at the time of injury rather than to refer narrowly to the job or task being performed when the injury occurred." Id. at 814.

The Supreme Court, applying the law from Forman and Miller, affirmed the Court of Appeals. In doing so, the Court noted that "the type of work that the employee performed at the time of injury" refers to the specific jobs or tasks performed, not to the specific job title or classification or to the specific task the employee was doing when injured. The Court noted that the ALJ analyzed the tasks Claimant was required to perform and her ability to perform those tasks. There was testimony from a Two Chicks owner that Claimant was not required to perform all of those tasks, particularly the climbing and reaching. However,
Claimant testified that she was required to perform those tasks, and the ALJ had the discretion to believe Claimant.

II. APPLICATION OF TWO MULTIPLIER

Recent Board Opinions:


1. Facts.

Claimant alleged on September 18, 2012, he was injured when he fell on his back while building a mold inside the plant. Claimant also alleged that on October 8, 2012, he injured his lower back when he felt a pop while he was working with a wheel barrow. After each injury, Claimant returned to light duty work and missed no work due to his work injuries. At the time of the first and second work injuries, Claimant's AWW was $1,346.00. Subsequently, Claimant's AWW was reduced to $1,201.00 beginning in January, 2013, but then increased to $1,225.00 in January, 2014, due to a raise.

Based on Claimant's testimony and the opinion of Dr. Fadel, the ALJ concluded that Claimant did not retain the capacity to perform the work he was performing on October 8, 2012, and awarded PPD benefits, enhanced by the three multiplier.

KOI contended that the two multiplier was applicable. However, the ALJ concluded the plain language of KRS 342.730(1)(c)2 indicates the possible application is only appropriate if an employee returns to work. Since Claimant did not miss work then there is no work for him to return to; consequently, consideration of the two multiplier was not appropriate.

KOI filed a petition for reconsideration arguing that the ALJ misinterpreted KRS 342.730(1)(c)2 as requiring Claimant to miss work before being applicable.

2. Issue.

Was the ALJ prohibited from considering whether the two multiplier pursuant to KRS 342.730(1)(c)2 is applicable since Claimant did not miss any work following his work injuries?

3. Holding.

No. KRS 342.730(1)(c)2 reads as follows:

If an employee returns to work at a weekly wage equal to or greater than the average weekly wage
at the time of injury, the weekly benefit for permanent partial disability shall be determined under paragraph (b) of this subsection for each week during which that employment is sustained. During any period of cessation of that employment, temporary or permanent, for any reason, with or without cause, payment of weekly benefits for permanent partial disability during the period of cessation shall be two (2) times the amount otherwise payable under paragraph (b) of this subsection. This provision shall not be construed so as to extend the duration of payments.

The Board went on to say that as a general rule, statutes and duly promulgated regulations are open to construction only if the language contained therein is ambiguous and requires interpretation. If, on the other hand, the language of the statute or regulation is clear and unambiguous on its face, statutory construction mandates that it follow the provision's plain meaning. Layne v. Newberg, 841 S.W.2d 181 (Ky. 1992); Overnite Transp. Co. v. Gaddis, 793 S.W.2d 129 (Ky. App. 1990); Claude N. Fannin Wholesale Co. v. Thacker, 661 S.W.2d 477 (Ky. App. 1983). In this instance, the Board found nothing ambiguous within the plain language of KRS 342.730(1)(c)2 as to its intended application.

KRS 342.730(1)(c)2 requires that in order for an employee to be eligible for enhancement of his PPD benefits by the two multiplier, he must return to work at a weekly wage equal to or greater than the AWW at the time of the injury. The statute does not require the employee to have missed work before he returns to work at a wage equal to or greater than his pre-injury AWW in order to be eligible for enhancement by the two multiplier. To apply such an interpretation would penalize a worker who returns to work at the same or greater wages without missing any work but reward an employee who misses days, weeks, months, or even years of work before he returns to work at the same or greater wages. Such an interpretation would produce an absurd result.

In Livingood v. Transfreight, LLC, 467 S.W.3d 249 (Ky. 2015), the Kentucky Supreme Court stated as follows:

In Kentucky Mountain Coal Co. v. Witt, 358 S.W.2d 517 (Ky. 1962), the Court construed the former KRS 342.120(5) [footnote omitted], which provided for awards to be paid from the Subsequent Claim Fund ("SCF") where a claimant was employed by the same employer after an injury at the same or greater wage. At issue was whether the SCF remained liable for payment of the award after the claimant's employment was terminated. There, the award commenced on September 12, 1960. The
claimant was reemployed at wages equal to or exceeding his former wages. The SCF proceeded to pay the award until June, 1961, when it discovered that the reemployment had ended on March 2, 1961. The then Board relieved the SCF from payment and imposed liability upon the employer for future payments during such time as the claimant was not employed at the same or greater wage. The employer appealed. The Court affirmed.

The obvious purpose of the statute is to encourage reemployment of injured workmen at adequate wages by relieving the employer of the requirement of paying disability compensation in addition to full wages ... But the inducement or encouragement the legislature has extended is clearly for continued reemployment. It is not conceivable that the legislature intended to relieve an employer completely of liability for compensation payments if he should reemploy the workman for only one day.

In construing a statute the courts will consider the purpose which the statute is intended to accomplish.

*Id.* at 256-257

The Board noted the Supreme Court emphasized "continued" re-employment which applies in the case herein. As noted by the Supreme Court, continued employment is encouraged and KRS 342.730(1)(c) serves as an inducement to continued employment. The fact that Claimant returned to work without first missing work does not preclude applicability of the two multiplier.

Accordingly, the Board reversed the ALJ's interpretation and remanded for a determination of whether the two multiplier is applicable. If the two multiplier is applicable, the ALJ should perform a *Fawbush* analysis.

B.  **Active Care Chiropractic, Inc. v. Katherine Rudd, Claim #: 2014-81319, Rendered: 02/24/2017, Status: Appealed to Court of Appeals**

1. **Facts.**

Claimant began working for the Employer in June, 2004, as a secretary and receptionist. At the time of her June 2, 2014, accident, Claimant earned $12.00 per hour, and worked sixteen or seventeen hours per week. On June 2, 2014, Claimant slipped and fell, landing on her left side. Claimant eventually underwent three surgeries.
Claimant returned to regular duty with no restrictions in September, 2015. Claimant testified she resumed all of her pre-injury job duties and continued to earn the same rate of pay until she retired on May 2, 2016. Claimant testified that she retired because she wanted to spend more time at home and stated that her left shoulder injury did not factor into her decision to retire.

The ALJ found Claimant was entitled to PPD benefits based on a 22 percent impairment rating. In light of Livingood v. Transfreight, LLC, 467 S.W.3d 249 (Ky. 2015), and the fact Claimant’s cessation from work was due to her voluntary retirement and not misconduct, the ALJ determined she was entitled to the two multiplier.

Active Care appealed and argued that the two multiplier is not applicable in a case where the injured worker successfully returned to work and then subsequently retires.

2. Issue.

Did the ALJ err in awarding the two multiplier since Claimant voluntarily retired?

3. Holding.

No. In Chrysalis House, Inc. Tackett, 283 S.W.3d 671 (Ky. 2009), claimant was discharged from his employment at a residential substance abuse treatment center for theft from a resident. The ALJ determined the criminal activity was irrelevant for the purposes of KRS 342.730(1)(c)2. The Workers' Compensation Board and the Kentucky Court of Appeals affirmed. The Kentucky Supreme Court reversed and narrowed the applicability of KRS 342.730(1)(c)2. The Court stated although subsection c(2) is unambiguous, it must be considered in the context of the entire provision. There, the Court held the section permits double benefit during a period of cessation of employment at the same or greater wage "for any reason, with or without cause, provided that the reason relates to the disabling injury." Id. at 674; see also Hogston v. Bell South Telecommunications, 325 S.W.3d 314 (Ky. 2010).

Subsequently, the Kentucky Supreme Court overruled Chrysalis House, Inc. v. Tackett, supra, through its holding in Livingood v. Transfreight, LLC, supra. In Livingood, claimant sustained a work-related shoulder injury requiring three surgeries. He eventually returned to work without restrictions. Upon his return to work, claimant accidentally bumped into a pole while operating a forklift without causing damage. The employer subsequently terminated his employment in December, 2010. Claimant began subsequent employment in December, 2011, earning less than he did with his previous employer. The ALJ determined claimant's termination was not due to his disabling shoulder injury and declined to award
the two multiplier pursuant to Chrysalis House, Inc. v. Tackett, *supra*. Regarding the two multiplier, the Workers' Compensation Board and the Kentucky Court of Appeals affirmed. The Kentucky Supreme Court provided the following analysis in overruling Chrysalis House, Inc. v. Tackett, *supra*:

Consistent with the foregoing, we conclude that the legislature did not intend to reward an employee's wrongdoing with a double benefit. **We hold that KRS 342.730(1)(c)2 permits a double income benefit during any period that employment at the same or a greater wage ceases "for any reason, with or without cause," except where the reason is the employee's conduct shown to have been an intentional, deliberate action with a reckless disregard of the consequences either to himself or to another.** In the instant case, the substantial evidence of record does not establish that Livingood's conduct was of that nature. Rather, the ALJ concluded that "but for the prior transgressions the pole bumping incident would not have resulted in [Livingood's] termination." (emphasis added)

*Id.* at 256-259

The Supreme Court reiterated its position in Fuertes v. Ford Motor Co., 481 S.W.3d 808, 810 (Ky. 2016), stating:

**KRS 342.730(1)(c)2 permits a double income benefit during any period that employment at the same or a greater wage ceases for any reason, with or without cause, except where the reason is the employee's conduct shown to have been an intentional, deliberate action with a reckless disregard of the consequences either to himself or to another.**

The Court stated the burden of proof rests with the employer to show the cessation was due to conduct noted in Livingood. The Court further noted, "this is a high standard and basic bad behavior will not bar application of the two multiplier. If Fuertes did not engage in such conduct, the two multiplier may be applied to his award." *Id.*

The Board found, based upon the plain language of **KRS 342.730(1)(c)2** stating during any period of cessation of employment, "temporary or permanent, for any reason, with or without cause," and recent holding of Livingood v. Transfreight, LLC, *supra*, and Fuertes v. Ford Motor Co., *supra*, the ALJ did not err in applying the two multiplier. The ALJ noted Claimant
acknowledged, and it appeared undisputed, she voluntarily retired and her cessation was not due to misconduct as contemplated in Livingood. Therefore, the ALJ determined Claimant was entitled to the two multiplier beginning on the date her employment ended. Based upon KRS 342.730(1)(c)2 and the holdings in Livingood v. Transfreight, LLC, supra, and Fuertes v. Ford Motor Co., supra, the ALJ performed the appropriate analysis, and substantial evidence, primarily Claimant's testimony, supported her determination.

4. Court of Appeals.

On appeal, the Court of Appeals affirmed the Board's decision because "[w]e have a duty to accord to words of a statute their literal meaning unless to do so would lead to an absurd or wholly unreasonable conclusion." Livingood v. Transfreight, LLC, 467 S.W.3d 249, 257-258 (Ky. 2015) (citing Bailey v. Reeves, 662 S.W.2d 832, 834 (Ky. 1984). The Court of Appeals stated that the issue of whether "voluntary retirement" is a reason to apply the double benefit, given the purpose of the statute is to encourage workers to remain in the work force, is a consideration for examination by a higher court.
I. **ORAL AND FACIAL ANATOMY**

A. Trigeminal Nerve (Cranial n. V): supplies sensation to most of face and motor control to muscles of jaws

B. Facial Nerve (Cranial n. VII): supplies motor control to muscles of face and, in part, taste to the tongue

C. Temporomandibular Joint (TMJ): joint of lower jaw. Blanket term for dysfunction of TMJ is temporomandibular disorder (TMD) and can range from muscle (myofascial) or joint pain to limited range of motion to noise in the joint. About 25 percent of population has some form of TMD.

D. Maxilla: upper jaw

E. Mandible: lower jaw

F. Salivary Glands: three large glands – parotid, sublingual, submandibular; many small (minor) glands scattered throughout the mouth.

G. Sinus: air-filled cavity in skull lined by thin, mucous-secreting membrane. All connected and drain into the nose. Frontal (forehead), ethmoid (above nose), maxillary (between eyes and back teeth), sphenoid (posterior to nose).

H. Dental Anatomy and Common Terminology

1. Enamel: outer white covering of crown; hardest substance in body.

2. Dentin: yellowish hard tissue lying below enamel and makes up the root.

3. Pulp: blood vessels and nerves of tooth.
4. Crown: the part of tooth you can see in the mouth.

5. Root: part of tooth embedded in the jaw.

6. Impaction: a tooth which has not completely erupted into the mouth (most often a wisdom tooth or cuspid).

8. Calculus (tartar): calcium deposits from saliva which build up on teeth and harbor bacteria.


11. Periodontitis (gum disease, pyorrhea): chronic inflammation of gingiva involving bone loss around the teeth.

12. Alveolus: portion of jaw bone holding the teeth.

13. Crown: ceramic or metal covering which protects teeth when they are weakened by fracture or extensive decay.

14. Fixed partial denture (bridge): used to replace one or more missing teeth by crowning adjacent teeth and suspending a fake crown (pontic) over the area of the missing tooth.

15. Removable partial denture: removable appliance used to replace one or more teeth and has wire clasps which attach to remaining teeth. Those teeth tend to loosen over time.

16. Root canal (endodontic treatment): tooth remains in place but small files are used to remove the pulp of the tooth and the space is filled with a biocompatible material.
17. Dental implant: titanium root-shaped body which is placed into jaw and integrates with the bone. Can be used to replace one tooth or in series to support a bridge or denture.

18. Mini implant: smaller diameter implant useful for replacing small teeth or using in series to hold a removable denture in place. It is a poor choice for replacing large teeth due to chance of fracture.

II. DENTAL INJURIES

A. Avulsion: tooth knocked out. Tooth can be reimplanted, splinted and treated with root canal if reimplantation occurs immediately.

B. Luxation: tooth loosened but doesn’t come out. Tooth can be splinted and treated with root canal.

C. Dental fracture: depending on angle, depth may require extraction or may be able to be saved with crown, root canal.

D. Resorption: idiopathic process whereby an inflammatory process starts to breakdown tooth structure necessitating removal. Can be from impacted tooth resting against root or spontaneous but most often is a tooth which has been traumatized in the past (sometimes years earlier).
III. SKELETAL INJURIES TO THE FACE

A. General Classification of Fractures

1. Simple: bone breaks but not exposed.

2. Compound: fracture plus exposure to the external environment.

3. Greenstick: fractured but segments don’t separate, may not be readily apparent on x-ray.


B. Areas of Face

1. Forehead: frontal sinus fracture, usually only the anterior, superficial part. More rarely, posterior table is fractured requiring neurosurgical management.

2. Nasal fracture: usually treated with simple splinting/packing; however, fracture or flexion of cartilage can make good result difficult due to "memory" of cartilage. More extensive injuries can involve ethmoid sinus and medial of orbits thus requiring extensive surgery.

3. Zygomaticomaxillary complex (cheekbone, ZMC).

4. Orbital fracture: most commonly the floor of the orbit. It is usually not treated unless globe (eyeball) is displaced or entrapped.

5. Upper jaw.

   a. Lefort I, II, III fractures of the upper jaw/midface: much less common today with advent of airbags and increased use of seatbelts.

   b. Mandible fractures: divided into regions.
6. Dentoalveolar fracture: fracture of bone of tooth-bearing portion of jaw. This is different from luxation in that the bone itself is fractured, not just a loose tooth.

7. Open reduction and internal fixation (ORIF): bones are reapproximated and secured using plates and screws.


9. External fixator (Joe Hall Morris): bones are reapproximated and external pins and a bar are placed. Used when fracture is badly comminuted preventing placement of internal plates.

IV. SOFT TISSUE INJURIES

A. Laceration: repaired with sutures.

B. Sectioning of Nerve: can result in decreased sensation (trigeminal nerve) or paralysis of face (facial nerve), treated with suturing under magnification when possible.

V. LONG TERM SEQUELAE OF MAXILLOFACIAL INJURIES

A. Soft Tissue Scarring – potential treatment with resurfacing, microdermabrasion, scar revision

B. Nerve Injury

1. Paresthesia – any altered sensation.
2. Anesthesia – complete lack of sensation (usually transection).

3. Hypoesthesia – decreased sensation.


8. Neuroma – nerve heals in an irregular fashion creating scar tissue and often painful.

9. Neuralgia – painful signals from a nerve. It is often described as stabbing, sharp, burning, or like electric shock. Trigeminal neuralgia (tic douloureux) – a specific condition (not an injury), sometimes caused by blood vessel below brain compressing nerve root.

10. Classification of nerve injuries.
    a. Neuropraxia: nerve stretched or bruised. This is normally a temporary, partial loss of sensation.
    b. Axontemesis: body of nerve is intact but axons within the nerve are disrupted. This is a partial loss of sensation which may be permanent.
    c. Neurotemesis: body of nerve is severed. No sensation. This may be permanent.
    d. Sunderland Classification system grade I (mild) to V (severe) is a more concise scale.

11. Treatment.
    a. Immediately following injury nerve can sometimes be sutured.
    b. In the facial skeleton, oftentimes proper reduction of the bones will allow the nerve to heal. However even when reduction is well-done, there is a real risk of decreased sensation and, less commonly, dysesthesia, which can take months to resolve or be permanent.
    c. Nerve repair can be done later but should be within first several months to have highest chance of success. More
difficult to get good result from repair when patient has dysesthesia due to changes that occur centrally.

C. Malocclusion: occurs when upper or lower jaw fractures are not aligned properly at time of fixation. This can be treated with osteotomies of the maxilla or mandible and/or orthodontics.

D. Missing Teeth: can be replaced with implants, bridges, dentures as indicated. Implants, while usually the ideal treatment, can require multiple procedures, bone and gingival grafting, and long treatment times depending on the circumstance.

E. Altered Speech: if malocclusion is significant or there is paresthesia of the tongue.

F. TMD: to be covered separately.

G. Osteomyelitis: when fractures do not heal completely or are not treated promptly, chronic infection of bone can set in. Treatment can require aggressive surgical debridement and long-term IV antibiotics.

VI. TEMPOROMANDIBULAR JOINT PATHOPHYSIOLOGY AND TREATMENT
A. Anatomy: unique joint in that it translates (slides) and rotates.

B. Bones Involved: condyle of mandible and glenoid fossa of temporal bone.

C. Meniscus: disc of cartilage resting between mandible and temporal bones. In normal function should move along with the condyle.

D. Internal derangement: blanket term for malfunction of disc.

E. Anterior Disc Displacement with Reduction: meniscus sitting in front of condyle. Able to open fully, jaw may deviate on opening, makes popping sound or sensation as meniscus goes back into position.

F. Anterior Disc Displacement without Reduction (closed lock): meniscus sitting in front of condyle but won’t pop back in place. Condyle can rotate but not translate. Jaw usually opens 10-15mm (normal is 35-40mm) and deviates towards locked side. Usually releases spontaneously within minutes to days. If not, it can be treated with arthrocentesis or arthroscopy.

G. Synovitis/Capsulitis: inflammation of soft tissues of the joint causing pain.

H. Chondromalacia: degeneration of cartilage. This results in "grating" or "gravel" sensation/sound in joint. Can be result of long term bruxism (see below), inflammatory disease (e.g. rheumatoid arthritis), or natural arthritic change from aging.

I. Ankylosis: joint fused to skull with fibrous scar tissue which may ossify to varying degrees. Usually result of severe trauma or repeated surgical procedures. This is rare. It is treated with open joint surgery.

J. Myofascial Pain: pain in muscle.
K. Referred (Heterotopic) Pain: painful source from one area of body causes pain in another part. Usually adjacent anatomically or have same input in brain.

L. Trigger Point: localized area of hypersensitive muscle fibers, can result in referred pain and is often focus of patient pain complaints.

M. Bruxism: clenching or grinding of teeth, often associated with sleep disorders, stress, depression.

N. Traumatic Injuries

1. Direct: blow to the joint or chin can cause sudden elongation of ligaments of the joint which may compromise normal condyle-disc mechanism.

2. Indirect (whiplash for example): unlikely to result in injury to TMJ. When pain in TMJ is seen in association with indirect injury, it is likely to be referred pain.

O. Microtrauma: most common source of TMD and usually from bruxism. Repeated small forces applied to joint over extended period of time as seen with clenching or grinding teeth or malocclusion. This leads to instability of disc position and degeneration of cartilage.

P. Remember that a large segment of the population will have preexisting TMD of some sort with no injury history.
Q. TMD can affect anyone but most common in women in their teens and twenties. It is less common in the elderly. It is often remitting and relapsing.

R. Treatments for TMD

1. Biteguard (also called bite/occlusal splint): most common treatment because non-invasive and works for majority of patients. Mechanism of action not entirely clear but protects teeth from forces of bruxism and, by opening the bite, decreases the amount of force generated by muscles and pressure on joint tissues.

2. Arthrocentesis: performed under sedation, joint is flushed with saline and sometimes steroids injected. Ninety percent effective at releasing closed lock and reducing pain.

3. Arthroscopy: performed under general anesthesia, small camera inserted in joint to visualize joint tissues. Joint is flushed, can insert microsurgical instruments and lasers into joint to debride tissue. Specialized procedure performed by relatively small number of surgeons. Ninety percent effective at releasing closed lock and reducing pain.

4. Menisectomy: for severe deterioration of disc. Open joint procedure where disc is removed. Much more invasive but has high rate of success in pain relief.

5. Arthroplasty: open joint procedure where boney surfaces are recontoured and scar tissue debrided. It can sometimes make things worse by creating more scar tissue so it is not done much anymore.

6. Total joint replacement: reserved for joints with advanced arthritic degeneration.

7. Physical therapy: to increase mobility and reduce pain.

8. Trigger point injections: inject muscular trigger points to break up foci of contracting fibers. Botox may be used to temporarily deenerve muscle. Local anesthetic most commonly used for injection although dry "needling" has shown equal efficacy.

9. Occlusal adjustment: Selectively adjusting areas of patient’s bite by reducing enamel. May also adjust occlusion with crowns on teeth to restore biting surface that has worn away or fractured off.

10. Orthodontics and jaw repositioning osteotomies: beneficial for some patients with TMD but relationship between occlusion and the development of TMD is tenuous.
11. In general, non-invasive treatments should be exhausted prior to moving on to surgical procedures.

VII. APPLICATION OF AMA GUIDELINES FOR DENTAL/FACIAL INJURIES

A. In addition to diet, need to consider alterations to speech, physical deformity, mobility of jaws, decreased sensation, and pain.

B. Relationship of Dietary Restrictions on Whole Body Impairment
   1. Diet limited to semi-solid foods: 5-19 percent.
   2. Diet limited to liquid foods: 20-39 percent.
   3. Diet limited to feeding tube: 40-60 percent.

C. Recommendation for loss of olfaction (smell) or taste: 1-5 percent whole body impairment.

D. Speech: assess audibility, intelligibility, and functional efficiency, whole body impairment can be as high as 35 percent in cases of total loss of speech. Evaluation by speech pathologist should be considered.

E. Pain from TMD or neuropathic (nerve) pain and loss of sensation: whole body impairment 1-35 percent depending upon degree.

F. Loss of function of facial muscles from CN VII injury: 5-19 percent whole body impairment.

G. As dental and TMD problems are common and dental reconstruction and TMD treatment can be quite expensive, ideally one should try to find out if condition that client is asking to be fixed is a preexisting condition.

VIII. CONSIDERATIONS IN DEALING WITH DENTISTS VS. PHYSICIANS

While injuries such as fractures are similar in their treatment and cost to what you would encounter when dealing with a general, orthopedic, or neurosurgeon, dentistry is much different in terms of expense. While procedures such as fillings and extractions have relatively low overhead, crowns, implants, bridges and dentures have high fixed overhead costs. In an orthopedic surgery case, there is typically a fee paid to the surgeon and another facility fee paid to the hospital or surgery center. In dentistry, all the overhead (facility, lab fees, etc.) are being born by the dentist. It has been my experience in Kentucky that this is not taken into consideration by those determining reimbursements. In some cases, it has not been financially viable to deliver care because the workman’s compensation reimbursement is lower than the overhead costs.
Everything I need to know about Ethics I learned in Kindergarten.

This was the title of an ethics presentation made by Woodrow Burchett in the late 1980s based upon a novel by Robert Fulghum. Many of you have seen the videotape of that presentation as it has been shown countless times over the years. The Sage's basic theme centered around a few of the points made by Fulghum in that treatise:

1. Share everything.
2. Play fair.
3. Don't hit people.
4. Don't take things that aren't yours.

Former Chief ALJ Landon Overfield and then Commissioner Dwight Lovan quoted these axioms in a presentation they made a while back to workers' compensation practitioners.

Their comment was a query "Too Simple?" My answer then, as it is now, is no. I have set out their work on the nuts and bolts of Ethics as they viewed it in relation to Workers' Compensation Practice because frankly I cannot improve upon it.

COMPETENCE

**SCR 3.130(1.1)**

A lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.

Workers' compensation practice, in past decades, has been seen as a lower echelon practice which did not require a considerable amount of legal skill or legal expertise. This is no longer the case. Workers' compensation practice has now become highly specialized. As hundreds of thousands of dollars may rest on the practice of these claims, the workers' compensation practitioner must stay abreast of the rapidly changing statutory and regulatory authority governing the practice.

One of the most expedient methods by which to keep up with the rapidly changing law is the "the World Wide Web" – the Internet. You can log on to the Department of Workers' Claims' website at [http://www.labor.ky.gov/workersclaims/Pages/Department-of-Workers'-Claims.aspx](http://www.labor.ky.gov/workersclaims/Pages/Department-of-Workers'-Claims.aspx). This website offers invaluable information including up-to-date statutes and regulations [don't forget the regulations!!], and the latest forms, publications, upcoming events, etc. There are also groups such as CompEd, Inc., offering websites and periodic
emails concerning workers' compensation practice in Kentucky. Much of this is free. It is suggested that you avail yourself of this information.

Continuing legal education is not only mandatory for Kentucky lawyers, it is essential in becoming and remaining a COMPETENT practitioner. Keep in mind that the KBA's requirement of 12.00 hours annually is a minimum requirement. You certainly can, and most practitioners, particularly those in the first ten years of their practice, should attend far more than 12.00 hours of CLE.

A wonderful source of knowledge for the young practitioner is the experienced practitioner. Most experienced practitioners will gladly allow younger lawyers to attend workers' compensation depositions, BRCs and/or hearings with them to gain first-hand experience. Most ALJs will welcome the attendance of young practitioners as observers at BRCs and hearings. All of this information and first-hand observation is without cost.

DILIGENCE

SCR 3.130(1.3)

A lawyer shall act with reasonable diligence and promptness in representing a client.

The first question to be asked by the COMPETENT workers' compensation practitioner about to represent a plaintiff is: "Should I take this case?" The answer often is not simple and may require some DILIGENCE. The success of such a practitioner's business is often directly related to the screening of prospective clients. Good cases tend to foster good results and the opposite is also true.

Prior to entering into a contractual relationship with a prospective client, the practitioner and/or his or her paralegal should conduct an in-depth interview with the prospective client and obtain authorization for records checks. After the initial interview, the practitioner should inquire of the Office of Workers' Claims concerning previous work-related injuries and previous filings of workers' compensation claims. A check of the medical facilities in the prospective client's home area should also be conducted to determine the prospective client's medical history in general and, in particular, to check for previous injuries or illnesses which may have an effect on the prospects of recovery in the matter for which representation has been sought. If the prospective plaintiff's story and history check out, an attorney/client contract should be drafted and executed. Keep in mind 803 KAR 25:010 §6(7) requires a motion for attorney's fee be accompanied by a photocopy of the signed and dated contingency fee contract.

The plaintiff's lawyer, after entering into the contractual arrangement for representation, should get the claim ready for presentation. This will require investigation to make sure all of the facts are as the plaintiff has related them to be. The lawyer or her/his staff should have a detailed vocational, medical and litigation history and as much information as the plaintiff can gather concerning his/her wages both prior and subsequent to the work-related injury. The practitioner should also gather all medical records and have a medical report, preferably from the treating physician, which gives an opinion concerning the work-related injury, a specific diagnosis, the causation of the impaired condition, a functional impairment rating, if the plaintiff is at maximum medical improvement, and an opinion concerning restrictions on the plaintiff's physical activities. In short, have the claim
ready for litigation before the initiating pleadings are ever filed. Before filing the initiating pleadings, submit a reasonable demand for settlement with a reasonable timeline for a response. Negotiate in good faith and keep the client informed of all responses to demands.

It is also important that the lawyer know the plaintiff and know how she/he will appear under direct and cross-examination. Educate the plaintiff concerning the litigation process in general and his/her deposition in particular. A plaintiff should never be caught totally by surprise concerning the type of questions that will be propounded at the deposition.

Defense counsel must also exercise diligence. Once the claim has been initiated by the filing of a Form 101, 102 or 103, the ball is in the defendant's court for a period of time. Although the plaintiff still has the burden of proof, the scheduling order calls for immediate action by the defendant. Once a claim has been initiated and a scheduling order issued, the defendant has forty-five days from the date of the scheduling order in which to file a Form 111, Notice of Claim Denial. 803 KAR 25:010 §7(2). If no Form 111 is filed, all of the allegations contained in the Form 101, 102 or 103 shall be deemed admitted. This is a default judgment. If a claim is being denied in whole or in part, the defendant shall state in detail the basis for the denial.

The plaintiff's practitioner should be particularly interested in the proper filing of the Form 111. Although workers' compensation, as a general rule, is somewhat less adversarial than other civil litigation, a complete failure to file a Form 111 will not be excused. If a Form 111 is not filed, the defendant has admitted all the allegations contained in the initiating pleading, such as the occurrence of a work related injury, the plaintiff's statement concerning the giving of notice, etc. Of course, what is admitted is only that which has been properly pleaded. If the Form 101 is not fully and accurately completed, the defendant may have admitted very little or, sometimes, nothing at all.

While a defendant may be given an extension of time within which to file a Form 111, if there are no reasonable grounds for excuse and one has not been filed at the time of the benefit review conference, the plaintiff has what amounts to a default judgment. As with default judgments, there still must be "proof of damages" so to speak and the plaintiff must still submit medical evidence concerning a functional impairment rating, physical capacity, etc.

If a defendant plans to assert a "Special Defense," it must do so within forty-five days from the date of the scheduling order or within ten days after the defense is discovered or should have been discovered. The special defenses are listed in 803 KAR 25:010 §7(2)(d). Defenses which must be raised in a special answer are the unreasonable failure to follow medical advice, failure to comply with safety laws, false statement on an employment application, voluntary rejection of the Workers' Compensation Act, voluntary intoxication or self-infliction of injury, refusal to accept rehabilitation services or the running of periods of limitations or repose. If not timely raised, any available special defenses are waived.

It is IMPERATIVE that workers' compensation lawyers and their offices have an adequate, modern, operational and very active system regarding litigation deadlines ... a tickler system. When does the statute of limitations run? When is the Form 111 due? When does the client's proof time expire? When is the brief due? Should the ALJ have ruled on your motion by now?
The competent and diligent workers' compensation practitioner should be actively involved with each file. Know what must be done by you, opposing counsel and the ALJ and by when it must be done. The ALJs do not mind reasonable requests from counsel. If you are concerned that a motion or some other pleading on which some action should have been taken has "slipped through the cracks," a call to the ALJ's office to inquire about the status is perfectly acceptable. Of course, this does not mean calling the ALJ's office two days after your motion has been filed.

COMMUNICATION

**SCR 3.130(1.4)**

(a) A lawyer shall:

(1) promptly inform the client of any decision or circumstance with respect to which the client's informed consent, as defined in Rule 1.0(e), is required by these Rules;

(2) reasonably consult with the client about the means by which the client's objectives are to be accomplished;

(3) keep the client reasonably informed about the status of a matter;

(4) promptly comply with reasonable requests for information; and

(5) consult with the client about any relevant limitation on the lawyer's conduct when the lawyer knows that the client expects assistance not permitted by the Rules of Professional Conduct or other law.

(b) A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.

"What we've got here ... is FAILURE to communicate!" This famous quote from "Cool Hand Luke" explains a myriad of life's problems in general and problems encountered in the practice of law in particular. Failing to communicate with a client has probably gotten more lawyers fired than any other shortcoming. Lay people, even those experienced in workers' compensation matters but especially injured workers, do not always understand the legal ramifications, requirements and consequences of what is swirling around them during workers' compensation litigation. After gathering all of the necessary information, discuss with your client his, her or its expectations of recovery/liability. At this point, the practitioner should educate the client as to the intricacies and realities of workers' compensation. It is extremely important to HONESTLY and FRANKLY apprise your client of the range of likely outcomes of his, her or its case. DO NOT overstate the merits or value of the perspective claim nor minimize the client's perspective exposure. [These steps also relate to COMPETENCE and DILIGENCE.]
During the course of the litigation it is of paramount importance that counsel for both sides keep their respective clients apprised as to what has transpired in the litigation and the direction in which the litigation is headed. Surprises are not good things. Clients are entitled to timely responses to phone calls, written correspondence and emails. Copies of everything the practitioner files, sends or receives should be forwarded to the client immediately. This is especially true concerning settlement demands and settlement offers. It is wise to document your recommendations to your client in follow-up letters and, likewise, document what your client has represented to you as to the client's wishes to proceed. These types of communication protect the lawyer but, just as importantly, greatly reduce the likelihood of a misunderstanding between a lawyer and his or her client. [This again is also important in COMPETENCE and DILIGENCE.]

Every lawyer enjoys giving good news to her/his client. However, the lawyer must also inform the client when new developments are changing the tenor of the litigation to the client's detriment. Don't wait for the opinion to be rendered before informing the plaintiff that all of his/her coworkers testified against her/him; or the defendant that its supervisory employees have confirmed the plaintiff's version of events; or that the plaintiff's treating physician gave an opinion that was less than supportive of her/his allegations; or that the defendant's IME doctor is one which none of the ALJs find credible; or that the defense has or has not been successful in its statute of limitations or notice defense. No one wants to give (or hear) bad news, but get that unsavory task out of the way as soon as possible. As stated earlier, surprises in workers' compensation litigation are not good things.

CONFLICT OF INTEREST: CURRENT CLIENTS

SCR 3.130(1.7)

(a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

(1) the representation of one client will be directly adverse to another client; or

(2) there is significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer.

(b) Notwithstanding paragraph (a), a lawyer may represent a client if:

(1) The lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;

(2) the representation is not prohibited by law;

(3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and
(4) each affected client gives informed consent, confirmed in writing. The consultation shall include an explanation of the implications of the common representation and the advantages and risks involved.

Both plaintiffs' lawyers and defendants' lawyers must remember who they REPRESENT. The most common problem to which this rule applies is the representation of the INSURED (the defendant employer) when both the cost of the litigation (including that most important cost of litigation, the attorney's fee) and the amount recovered will be paid by a third party, the employer, the workers' compensation insurance carrier or the third-party administrator. A problem can also exist when the injured worker's spouse, parent, treating physician, etc. attempts to control or influence any aspect of the litigation or the relationship between a lawyer and client. The cardinal rule is simply: REMEMBER WHO YOU REPRESENT.

When an insurer and its insured have conflicting interests in a matter arising from any insurance agreement, the insurer should be required to provide separate counsel for the insured and the arrangement should assure the separate counsel's professional independence. It may be difficult for defense counsel who is retained by a third party payer on a regular basis as defense counsel representing employers in workers' compensation litigation to point this out to the insurer but it is his/her ethical duty to do so.

Many claims are filed alleging entitlement to benefits for two separate injuries when the employer is insured at the time of one injury by one insurance carrier and, at the time of the other injury, is either insured by another insurance carrier, is self-insured or is uninsured. The lawyer retained by the insurance carrier to represent the employer (client) on one injury CANNOT attempt to deflect liability onto that client as a result of the other injury. REMEMBER WHO YOU REPRESENT!

Plaintiff's counsel must make no representations or assurances to a spouse or any other third party concerning the litigation and/or possible recovery. The lawyer for the plaintiff cannot assure a medical provider that his, her or its medical expenses will be paid out of the plaintiff's award. The lawyer does owe a duty to the client to advise her/him if third parties are seeking payments and can also attempt to negotiate those obligations on behalf of the client within the context of the workers' compensation litigation while a plaintiff may have more bargaining power.

**MERITORIOUS CLAIMS AND CONTENTIONS**

*SCR 3.130(3.1)*

A lawyer shall not knowingly bring or defend a proceeding, or assert or controvert an issue therein, unless there is a basis in law and fact for doing so that is not frivolous, which includes a good faith argument for an extension, modification or reversal of existing law....

Some initiating pleadings and some responsive pleadings should never have seen the light of day (or the glow of a photocopy machine). Frivolous claims and frivolous defenses sometimes occur in today's workers' compensation arena. Some alleged injuries did not in fact occur but also some claimed defenses have been manufactured. Frivolous claims and defenses take a great toll on the workers' compensation system and the frayed nerves of
ALJs. Previously discussed matters relating to COMPETENCE and DILIGENCE should but do not always prevent non-meritorious claims and/or contentions.

This rule, if followed properly, mandates against a lawyer initiating a claim on behalf of a plaintiff if the claim has no basis in fact. The rule also mandates against denying a meritorious claim without a factual basis to do so. Failure to heed the mandates of this rule, in time, will affect not only the lawyer's practice but can result in significant statutory changes that are not in the best interest of the workers' compensation system.

Always remember, and help your client to understand, the fact the other side is not honorable, caring, generous, industrious, and heterosexual does not determine the merits of the claim or defense. An alcoholic who is sober when injured (or drunk but functioning properly when hit by a falling object) is still entitled to recover. An employer who expects more work than that for which it pays or that did not come to the hospital to see the injured worker does not have to pay more for a work-related injury than is statutorily mandated. Pain and suffering is not an element of damages under the workers' compensation act.

If you're practicing workers' compensation claims in any volume, you're going to lose a few. If the ALJ has truly made a mistake, you should feel free to take the necessary appellate steps. However, don't continue to fight just because you lost. This is particularly applicable to defendants. There is always the temptation to drag out the payment of benefits, unreasonably contest medical expenses, etc. This type of conduct can also affect the lawyer's practice and move the general assembly to make statutory changes that may or may not be beneficial.

CANDOR TOWARD THE TRIBUNAL

**SCR 3.130(3.3)**

(a) A lawyer shall not knowingly:

1. Make a false statement of material fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to a tribunal by the lawyer;

2. Fail to disclose to the tribunal published legal authority in the controlling jurisdiction known to the lawyer to be directly adverse to the position of the client and not disclosed by opposing counsel; or

3. Offer evidence that the lawyer knows to be false. If a lawyer, the lawyer's client, or a witness called by the lawyer, has offered material evidence and the lawyer comes to know of its falsity, the lawyer shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal. A lawyer may refuse to offer evidence, other than the testimony of a defendant in a criminal matter that the lawyer reasonably believes is false.

(b) A lawyer who represents a client in an adjudicative proceeding and who knows that a person intends to engage, is engaging or has
engaged in criminal or fraudulent conduct related to the proceeding shall take reasonable remedial measures, including, if necessary, disclosure to the tribunal.

(c) The duties stated in paragraphs (a) and (b) continue to the conclusion of the proceeding, and apply even if compliance requires disclosure of information otherwise protected by Rule 1.6.

(c) A lawyer may refuse to offer evidence that the lawyer reasonably believes is false.

(d) In an ex parte proceeding, a lawyer shall inform the tribunal of all material facts known to the lawyer which will enable the tribunal to make an informed decision, whether or not the facts are adverse.

This rule really should need no explanation. Regardless of what is seen and heard in political campaigns, the truth should be important. NEVER misrepresent the facts or law in discussions, pleadings, motions, briefs or any other communication with or before an ALJ. It is not mandatory that the lawyer point out all the facts which are adverse to his/her client's interest. The workers' compensation lawyer does not have to make the opposing party's argument for her, him or it. However, whatever is represented as a fact must be a fact, not the lawyer's interpretation of what the fact may mean.

The presentation of misleading or fallacious statements concerning the proceedings, compliance with discovery requests, settlement negotiations, a client's position concerning the litigation, etc. violates this rule. A legal argument based on a knowingly false representation of the law constitutes dishonesty toward the ALJ (the 'tribunal”) as does presenting knowingly false evidence. The fact that the lawyer's lack of candor toward the ALJ is merely suspected and not substantiated will still, if it occurs repeatedly, affect the lawyer's credibility with the ALJ.

FINALLY

What I would like to devote my time to talking about now is not a rehash of their words, but rather about Woodrow's Prophecy as I see it from the perspective of a Practicing Attorney and Appellate Judge. Feel free to ask questions as this discussion progresses.
I. INTRODUCTION

With the age of cloud computing squarely upon us, the use of software as a service (SaaS) and other cloud-based applications such as Windows Office 365, Dropbox, Carbonite and others, is virtually mandatory in our legal practices. With the initiation of the online filing requirements of the DWC, working in the cloud is a crucial part of our everyday practice of workers’ compensation law; and, as with any big change in the practice of law, ethical considerations abound. The primary concerns focus on competence and confidentiality.

II. PRIMARY CONSIDERATIONS

In "Breaking Down Cloud Computing" by Nicole Black and Matt Spiegel,¹ the authors give an overview of the ethical considerations of cloud computing. They note that it is generally accepted that use of cloud computing by lawyers is ethical. A chart produced by the ABA compared all of the cloud-computing ethics opinions (as of 2014) that have been issued throughout the United States.²

Black and Spiegel highlight a September 2013 ethics opinion, issued by the Iowa Committee on Practice Ethics and Guidelines, which concluded:

> When transmitting a communication that includes information relating to the representation of a client, the lawyer must take reasonable precautions to prevent the information from coming into the hands of unintended recipients. This duty, however, does not require that the lawyer use special security measures if the method of communication affords a reasonable expectation of privacy. Special circumstances, however, may warrant special precautions. Factors to be considered in determining the reasonableness of the lawyer’s expectation of confidentiality include the sensitivity of the information and the extent to which the privacy of the communication is protected by law or by a confidentiality agreement.

Black and Spiegel also set forth the Iowa committee’s checklist of questions to ask of technology and cloud-computing vendors.

- Will I have unrestricted access to the stored data?


• Have I stored the data elsewhere so that if access to my data is denied I can acquire the data via another source?

• Have I performed due diligence regarding the company that will be storing my data?

• Are they a solid company with a good operating record and is their service recommended by others in the field?

• In what country and state are they located and do business?

• Does their end user’s licensing agreement (EULA) contain legal restrictions regarding their responsibility or liability, choice of law or forum, or limitation on damages?

• Likewise does their EULA grant them proprietary or user rights over my data?

• What is the cost of the service, how is it paid and what happens in the event of non-payment?

• In the event of a financial default, will I lose access to the data; does it become the property of the company or is the data destroyed?

• How do I terminate the relationship with the company?

• What type of notice does the EULA require?

• How do I retrieve my data and does the company retain copies?

• Are passwords required to access the program that contains my data?

• Who has access to the passwords?

• Will the public have access to my data?

• If I allow non-clients access to a portion of the data, will they have access to other data that I want protected?

• Recognizing that some data will require a higher degree of protection than others, will I have the ability to encrypt certain data using higher level encryption tools of my choosing?

The primary ethical considerations lawyers must consider are competency and confidentiality.

III. THE MODEL RULES ON CLOUD COMPUTING – COMPETENCY

The Model Rules of Professional Conduct (Rule 1.1(8)) address cloud-computing under the heading of competency.
[8] To maintain the requisite knowledge and skill, a lawyer should keep abreast of changes in the law and its practice, including the benefits and risks associated with relevant technology, engage in continuing study and education and comply with all continuing legal education requirements to which the lawyer is subject.

(Emphasis added)

In a recent article by Sarah Andropoulos, the author notes that a majority of jurisdictions have enacted rules requiring attorneys to become and remain familiar with technologies that affect their practices. These changes stemmed from Model Rule 1.1 enacted by the ABA in 2012, specifically Comment 8.

While the Model Rules are not binding, some states have adopted Rule 1.1 and Comment 8. But what does Comment 8's vague wording implicate?

Andropoulos says "the primary reason for the technology rule’s broad wording is that technology is constantly changing and the legal industry is slow to catch up with such advances to begin with, making enforcement of highly particularized requirements somewhat unrealistic."

Other states, including Kentucky, provide more guidance reaching beyond competency into the areas of confidentiality.

IV. KENTUCKY ETHICS OPINION – CONFIDENTIALITY

In Ethics Opinion KBA E-437 issued March 21, 2014, the KBA addressed the ethics of cloud computing. It determined lawyers may utilize cloud computing services with clients’ confidential information.

Following a lengthy discussion of the issue, the KBA concluded:

A lawyer may use cloud-based services with regard to confidential client information. In using cloud-based services, a lawyer must use reasonable care to assure that client confidentiality is protected and client property is safeguarded. See SCR 3.130(1.6(a)) & (1.15(a)). A lawyer must act consistent with his or her duty of competence in selecting and monitoring the providers of cloud-based services. See SCR 3.130(1.1). A lawyer must use "reasonable efforts" to ensure that the conduct of providers of cloud-based services assisting him or her is compatible with ethical obligations of the lawyer, and, if the lawyer is a partner or otherwise has managerial authority in a law


firm, the lawyer must use "reasonable efforts" to make sure that the firm has measures in place to assure that providers of cloud-based services engage in conduct compatible with ethical obligations of the lawyer. See 3.130(5.3(a) & (b)). Finally, a lawyer must consult with the client about the use of the cloud if the matter is sufficiently sensitive such that the duty to "reasonably consult with the client about the means by which the client’s objectives are to be accomplished" is implicated. See SCR 3.130(1.4(b)).

How should lawyers address these concerns? First, the consistent use of password protection and password management (routine changing of passwords) is a must. Second, a lawyer should exercise her due diligence in researching and implementing cloud-based services, including close perusal of user agreements and inquiries as set forth above. Third, the client should be involved in the discussion of the use of cloud-based services. Preferably the retention letter and client agreement should include a discussion of the attorney's use of cloud-based applications and consent should be given by the client for this use.

In his Louisiana Legal Ethics blog, Professor Dane S. Ciolino discusses the issue in an article entitled "Cloud Computing Ethics." He notes that there is little difference between the ethics issues presented by the use of cloud technology and those that arise with regard to the traditional methods of data storage and communication. Regardless of the technology, he notes the duties of confidentiality and competence remain steadfast.

He also observes that a lawyer must supervise non-lawyer assistants and staff, including contractors and vendors, to assure that they "act in a manner that is consistent with the professional obligations of a lawyer."

He recommends the following due diligence before utilizing a cloud-based service for storing client data:

- Obtain the cloud storage vendor's service agreement. For example, the "terms of service" for Dropbox and SugarSync are posted on those vendors' websites.
- Assure that the service agreement requires the vendor to preserve the confidentiality and security of materials.
- Consider whether the vendor requires password access to the data, and whether the data will be encrypted.
- Consider whether the vendor must inform the lawyer of unauthorized access events.
- Investigate how the vendor stores and backs up data, and whether the lawyer will have unrestricted and reliable access to data.

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• Investigate how the lawyer can obtain data upon terminating the vendor.
• Become fully competent in the use of the vendor’s interface and technology.
• Reevaluate the vendor’s contractual obligations and capabilities periodically.
• Respect the client’s contrary wishes about cloud storage.
• Save paper copies of wills, notes and other documents when a paper “original” is typically necessary.

The American Bar Association also addresses these concerns in "Cloud Computing/Software as a Service for Lawyers." The article points out:

[G]iven that one of an attorney's foremost duties is to safeguard client confidentiality, attorneys are understandably wary about placing client files on a vendor's servers. Indeed, the issue extends beyond just confidentiality: attorneys must be sure that the files will be secure from destruction or degradation (whether from system failure, natural disaster, or dissolution of the vendor's business), and they must be able to retrieve the data in a form that's usable outside of the vendor's product.

The ABA also notes that files stored on a vendor's servers "are more secure than those located on a typical attorney's PC, as the vendors often employ elaborate security measures and multiple redundant backups in their data centers."

The ABA article sets forth additional questions to consider:

• How does the vendor safeguard the privacy/confidentiality of stored data?
• How often is the user's data backed up? Does the vendor back up data in multiple data centers in different geographic locations to safeguard against natural disaster?
• What is the history of the vendor? Where do they derive their funding? How stable are they financially?
• Can I get my data "off" their servers for my own offline use/backup? If I decide to cancel my subscription to the software, will I get my data? Is data supplied in a non-proprietary format that is compatible with other software?
• Does the vendor's Terms of Service or Service Level Agreement address confidentiality and security? If not, would the vendor be willing to sign a confidentiality agreement in keeping with your professional responsibilities?

V. OTHER STATES

Ciolino, *supra*, provides an overview of other states’ ethics opinions relating to cloud storage: 7

- Massachusetts Bar Association, **Ethics Op. 12-03** (2012) (lawyer may store electronic files in cloud if lawyer makes “reasonable efforts to assure that the provider’s policies and practices are compatible with the lawyer’s professional obligation of confidentiality).


- Oregon State Bar Formal **Opinion No. 2011-188** (2011) ("Lawyer may store client materials on a third-party server so long as lawyer complies with the duties of competence and confidentiality to reasonably keep the client’s information secure within a given situation. To do so, the lawyer must take reasonable steps to ensure that the storage company will reliably secure client data and keep information confidential.").


- Pennsylvania Bar Association Committee on Legal Ethics and Professional Responsibility, **Formal Opinion No. 2011-200** (2011).

- Iowa Committee on Practice Ethics and Guidelines, **Ethics Opinion No. 11-01** (2011) (lawyer may store client data with cloud provider, but must perform due diligence to evaluate whether provider will protect and competently store data).


- New Jersey Supreme Court, Advisory Committee on Professional Ethics, **Ethics Op. 701** (2006).

- Nevada Bar Association, Standing Comm. on Ethics, **Formal Op. No. 33** (2006) (lawyer may store client data in cloud if lawyer competently and reasonably ensures data will be kept secure and confidential).

- Alabama State Bar Association, **Ethics Opinion No. 2010-02** (2010) (lawyer may store client data with cloud provider provided the lawyer undertakes reasonable efforts to ensure confidentiality).

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7 See also https://www.americanbar.org/groups/departments_offices/legal_technology_resources/resources/charts_fyis/cloud-ethics-chart.html.


VI. RELATED CONCERNS AND RESOURCES

A. Encryption

Some attorneys may prefer additional encryption for their cloud-based applications. Software exists to allow for this. Boxcryptor is a free application that encrypts sensitive files and folders in Dropbox, Google Drive, OneDrive and other cloud storage applications. AxCrypt, Folder Lock and 7Zip are other options.

B. File Retention

Cloud storage also helps maintain an effective and long-term file retention policy. While Ethics Opinion KBA E-436 issued May 17, 2013, sets out no specific time a lawyer must retain a closed file, it notes:

As a matter of good practice, a lawyer should retain a paper or electronic file for at least five years after the file has been closed. Even then, a lawyer should carefully evaluate whether the file contains items that the lawyer should retain for a longer time or whether special circumstances exist such that the file should be retained for a longer time.

Online or offline paperless storage allows a lawyer to maintain files even longer, eliminates physical storage concerns and allows for quick retrieval of a file.

C. Resources

1. Casefleet.com offers an overview of security best practices.8

2. The Delaware Courts Commission on Law & Technology provides a discussion on a wide variety of topics ranging from cloud computing to data security to courtroom technology and social media.9


3. The ABA's legal technology resources page covers cloud computing, social media, paperless practices, and time and billing concerns.\textsuperscript{10}

VII. CONCLUSION

While the legal profession is often slow in adopting new technologies, the present technological climate makes it virtually imperative for attorneys to become familiar with paperless and cloud-based technologies. This raises a variety of ethical concerns, primarily competence and confidentiality. It is widely accepted that storing client data in the cloud meets confidentiality requirements, provided the appropriate safeguards are observed.

Further, it is imperative that attorneys stay abreast of new technology to maintain competence in their profession. Adopting best practices in implementation of your paperless/cloud-based data management and exercising due diligence in selecting and monitoring cloud-computing vendors can help you meet these ethical goals.

\textsuperscript{10} \url{https://www.americanbar.org/groups/departments_offices/legal_technology_resources/resources.html}
I. FEDERAL BLACK LUNG

A. Approval Rates


B. Chart from the DOL Website


This is the initial awarded rate and does not consider ALJ Opinions.

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</tbody>
</table>

TF - Black Lung Disability Trust Fund liability
RO - Responsible coal mine operator liability

¹ Approvals do not include conversions of miner to survivor benefits under 422(l) of the Act.
² Merit denials: claims that received a Proposed Decision & Order after all evidence is considered.
³ Non-merit denials: claims that are abandoned or withdrawn prior to a PDO.
⁴ Merit/non-merit categories were not quantified until FY 2008.
⁵ Approval rate calculated using approved and denied claims and does not include withdrawn and abandoned claims (non-merit decisions).
II. LEGAL PNEUMOCONIOSIS AND THE PREAMBLE

A. Definition – 20 CFR §718.201(2) – Legal pneumoconiosis. "Legal pneumoconiosis’ includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment."

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease, which may first become detectable only after the cessation of coal mine dust exposure.

B. The ALJ may find clinical coal workers’ pneumoconiosis (objective) and no legal pneumoconiosis or legal pneumoconiosis and no clinical pneumoconiosis.

C. Applies to new claims filed even though four or five denials in the past.

D. Once ALJ finds legal pneumoconiosis, causation of disability is almost automatic.

E. Scope

1. COPD – catch all;
2. Emphysema;
3. Asthma;
4. Chronic bronchitis – by history alone; and
5. Basically any obstructive or restrictive lung disease.

F. Total Disability

1. 20 CFR §718.204 was amended and liberalized the definition of total disability due to pneumoconiosis to include an aggravation of a totally disabling pulmonary impairment caused by exposure unrelated to coal mine employment.

2. Total disability due to pneumoconiosis defined. A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in §718.201, is a substantially contributing cause of the miner’s totally disabling respiratory or
pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner’s disability if it:

a. Has a material effect on the miner’s respiratory or pulmonary condition; or,

b. Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

c. Where the miner’s usual coal mine work required significant physical exertion, a relatively small respiratory impairment may be totally disabling. Accordingly, the miner’s respiratory impairment may continue to deteriorate even after it reaches the point where it would be considered totally disabling under the Act. (Federal Register, p. 3352). (See Crabtree v. Southern Ohio Coal.).

III. PPACA

Fifteen-year presumption – underground or equivalent – changes burden of proof to the employer. Automatic widow entitlement if miner’s claim awarded. (See Byrd vs. AEP Kentucky Coal, LLC.).

IV. WITHDRAWAL OF CASE

A. If the initial evidence does not meet the disability criteria, the Claimant withdraws the case and waits three (3) months to one (1) year to file a new one. The Claimant picks a new doctor and qualifies.

B. If a claim is withdrawn, it’s like it never happened.

V. MODIFICATION

We have had a claim that has been modified twelve times.

VI. NEW REGULATIONS AND POLICIES

A. More Claims being Paid

B. Digital X-rays

C. New Pilot Program – The DOL gets an exam tentatively awarding claim and D/Employer gets an exam to rebut. The DOL writes back to their doctor asking why their opinion is correct or if the D/Employer's doctor’s report changes their opinion.

- We've seen the DOL request several "supplemental" reports this way.

D. New Evidence Exchange Rules – must disclose any information dealing with the "disease."
VII. PROCEDURE FOR CLAIMS

A. Application is filed.

1. Miner selects physician from DOL approved physician list.

2. Miners traveling from Pikeville to western Kentucky for exam, although the D/Employer has a 100 mile limitation.

B. DOL issues Notice of Claim putting Employer (R/O) on notice that we have thirty days to respond. Independent contractors will be imputed as employee of coal company even though not employed.

C. Employer files Controversion.

D. Department receives medical information and issues a Schedule for the Submission of Additional Evidence tentatively denying or awarding claim.

E. If Employer didn’t get an exam before, now entitled to exam.

F. All medical evidence gathered within evidentiary limitations, and DOL issues Proposed Decision and Order denying or awarding claim.

G. All parties have thirty (30) days to appeal to the Office of Administrative Law Judges.

H. Case assigned to Regional ALJ Office, which could be in Washington, Cincinnati, Newport News, Pittsburgh, or Cherry Hill.

I. Case set for Formal Hearing before specific ALJ.

J. Formal hearing.

K. Briefs filed.

L. ALJ Opinion. Reversal of District Director.

M. Appeal to BRB.

N. Appeal to Sixth Circuit.

VIII. KENTUCKY BLACK LUNG


1. Pending claims went into abeyance. According to ALJ Case, approximately 750 claims were pending at that time.

2. Claims continued to be filed at a rate of 400 per year while awaiting the decision from the Kentucky Supreme Court.
3. According to ALJ Case, claims have continued to be filed at the same rate.
   a. Fifty-one claims were filed in November, 2017.
   b. Thirty-nine claims were filed in December, 2017.

B. Back to University Evaluations, however, the only true .315 evaluator we have at this time is Dr. Folz at the University of Louisville.
   • Plaintiffs can now also be seen by .315/.316 evaluators, Dr. Westerfield or Dr. Chavda. Dr. Crum interprets Dr. Chavda’s studies.

C. Offset of Claims – The Employer/Carrier gets a dollar for dollar offset from the state claim on any federal award. Reminder: The Coal Fund pays half (1/2) of any state indemnity award.

D. IMPORTANT QUESTION: Will Parker v. Webster Co. Coal, LLC (Dotiki Mine), 529 S.W.3d 759 (Ky. 2017), apply to CWP cases?
KRS 342.0011(11)(a) defines temporary total disability as follows:

"Temporary total disability" means the condition of an employee who has not reached maximum medical improvement from an injury and has not reached a level of improvement that would permit a return to employment.

The above definition has been determined by our courts of justice to be a codification of the principles originally espoused in W.L. Harper Const. Co., Inc. v. Baker, 858 S.W.2d 202, 205 (Ky. App. 1993), wherein the Court of Appeals stated generally:

TTD is payable until the medical evidence establishes the recovery process, including any treatment reasonably rendered in an effort to improve the claimant's condition, is over, or the underlying condition has stabilized such that the claimant is capable of returning to his job, or some other employment, of which he is capable, which is available in the local labor market. Moreover, . . . the question presented is one of fact no matter how TTD is defined.

In Central Kentucky Steel v. Wise, 19 S.W.3d 657 (Ky. 2000), the Supreme Court further explained that

[i]t would not be reasonable to terminate the benefits of an employee when he is released to perform minimal work but not the type that is customary or that he was performing at the time of his injury.

Id. at 659.

In other words, where a claimant has not reached MMI, TTD benefits are payable until such time as the claimant's level of improvement permits a return to the type of work she was customarily performing at the time of the traumatic event.

In Magellan Behavioral Health v. Helms, 140 S.W.3d 579 (Ky. App. 2004), the Court of Appeals instructed that until MMI is achieved, an employee is entitled to a continuation of TTD benefits so long as she remains disabled from her customary work or the work she was performing at the time of the injury. The court in Helms, supra, stated:

In order to be entitled to temporary total disability benefits, the claimant must not have reached maximum medical improvement and not have improved enough to return to work.

. . .

The second prong of KRS 342.0011(11)(a) operates to deny eligibility to TTD to individuals who, though not at maximum medical improvement, have improved enough following an injury that they can return to work despite not yet being fully recovered. In Central Kentucky Steel v. Wise, [footnote omitted] the statutory phrase "return to employment" was
interpreted to mean a return to the type of work which is customary for the
injured employee or that which the employee had been performing prior
to being injured.

Id. at 580-581.

In Double L Const., Inc. v. Mitchell, 182 S.W.3d 509, 513-514 (Ky. 2005), the Supreme
Court further elaborated with regard to the standard for awarding TTD as follows:

As defined by KRS 342.0011(11)(a), there are two requirements for TTD: 1.) that the worker must not have reached MMI; and 2.) that the worker
must not have reached a level of improvement that would permit a return
to employment. See Magellan Behavioral Health v. Helms, 140 S.W.3d
579, 581 (Ky. App. 2004). In the present case, the employer has made an
"all or nothing" argument that is based entirely on the second
requirement. Yet, implicit in the Central Kentucky Steel v. Wise, supra,
decision is that, unlike the definition of permanent total disability, the
definition of TTD does not require a temporary inability to perform "any
type of work." See KRS 342.0011(11)(c).

Central Kentucky Steel v. Wise, supra, stands for the principle that if a
worker has not reached MMI, a release to perform minimal work rather
than "the type that is customary or that he was performing at the time of
his injury" does not constitute "a level of improvement that would permit a
return to employment" for the purposes of KRS 342.0011(11)(a).

19 S.W.3d at 659.

Next, the Court of Appeals rendered unpublished cases on the issue: Nesco Resource v.

In Nesco, former ALJ Jones wrote for the Court of Appeals stating:

Having reviewed Wise and its progeny, we are confident that the law in
Kentucky is well-settled with regard to determining eligibility for TTD. To
demonstrate that he is entitled to receive TTD, an injured worker must
prove both that he is unable to return to his customary, pre-injury
employment and that he has not reached MMI from his work-related
injury.


In Zappos.com v. Mull, supra, the ALJ awarded TTD benefits during a period Mull had
not returned to her regular employment but worked light duty. TTD benefits were
awarded during the period Mull had not attained MMI and had not reached a level
of improvement which would permit her to return to her regular customary employment.
Zappos.com appealed to the Board, and we reversed the award of TTD benefits. The
Court of Appeals reversed the Board and reinstated the award of TTD benefits finding,
due to her work-related injury, Mull no longer retained the physical ability to perform any activities requiring gripping and grabbing with her right hand or both hands. Her pre-injury employment was undisputedly and largely comprised of such activities. And, her post-injury light duty work was not.

2014 WL 3406684 at *11.

Coincidently, the Court cited to the Livingood v. Transfreight, LLC decision that had been rendered by the Court of Appeals on January 31, 2014 (but not yet reviewed by the Supreme Court) in support of its position.

Then, the Supreme Court decided Livingood on appeal from the Court of Appeals. In Livingood v. Transfreight, LLC, 467 S.W.3d 249, 254 (Ky. 2015), the Supreme Court declined to hold a claimant is entitled to TTD benefits so long as he or she is unable to perform the work performed at the time of the injury stating as follows:

As the Court explained in Advance Auto Parts v. Mathis, No. 2004-SC0146-WC, 2005 WL 119750, at *3 (Ky. Jan. 20, 2005), and we reiterate today, Wise does not "stand for the principle that workers who are unable to perform their customary work after an injury are always entitled to TTD."

467 S.W.3d at 254.

Two months after rendering Livingood v. Transfreight, LLC, supra, the Supreme Court took up Mull, 2015 WL 6590024 (Ky. Oct. 29, 2015) (Ordered not to be published), specifically rejecting the Court of Appeals' interpretation of "a return to employment" as set forth in KRS 342.0011(11)(a). In reversing the Court of Appeals, the Supreme Court stated:

The Board held:

Here, Zappos accommodated Mull's restrictions with a scanning position, which she testified was a normal part of her employment prior to the injury. Zappos correctly notes Mull acknowledges she was capable of continuing to perform the light duty work but ceased her employment with Zappos for personal reasons completely unrelated to the work injury. Nothing in the record establishes the light duty work constituted "minimal" work and she worked regular shifts while under restrictions. She was also capable of performing, and continued to perform for more than one year post-injury, her primary fulltime employment with Travelex. Given Mull was capable of performing work for which she had training and experience, and voluntarily ceased her employment for reasons unrelated to her injury or the job duties, substantial evidence does not support the award of TTD benefits and we therefore reverse.
Mull subsequently appealed to the Court of Appeals, which reversed the Board and reinstated the award of TTD benefits. The Court of Appeals held that the phrase "return to employment," as found in KRS 342.0011(11)(a), "was only achieved if the employee can perform the entirety of her pre-injury employment duties within the confines of the post-injury medical restrictions." Thus, since Mull no longer retained the physical ability to perform any activities requiring gripping and grabbing with her right hand, and her pre-injury employment required such tasks, the Court of Appeals held she was entitled to TTD benefits. We disagree, and reverse the Court of Appeals.

The Board's review in this matter was limited to determining whether the evidence is sufficient to support the ALJ's findings, or if the evidence compels a different result. Western Baptist Hosp. v. Kelly, 827 S.W.2d 685, 687 (Ky. 1992). Further, the function of 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." Id. at 687-88. Finally, review by this Court "is to address new or novel questions of statutory construction, or to reconsider precedent when such appears necessary, or to review a question of constitutional magnitude." Id. The ALJ, as fact-finder, has the sole discretion to judge the credibility of testimony and weight of evidence. Paramount Foods, Inc. v. Burkhardt, 695 S.W.2d 418 (Ky. 1985).

As stated above, pursuant to KRS 342.0011(11)(a), in order for a claimant to be entitled to TTD benefits, she must satisfy a two-prong test: (1) she must not have reached MMI; and (2) she must not have reached a level of improvement that would permit her return to employment. Double L Constr., Inc. v. Mitchell, 182 S.W.3d 509, 513 (Ky. 2005). Wise stands for the proposition that TTD benefits for a claimant should not be terminated just because she is released to perform minimal work if it is not the type of work that was customary or that she was performing at the time of his injury. 19 S.W.3d at 657. However, "Wise does not 'stand for the principle that workers who are unable to perform their customary work after an injury are always entitled to TTD.'" Livingood v. Transfreight, LLC, __ S.W.3d __ (Ky. 2015). Accordingly, the ALJ must analyze the evidence in the record and determine whether the light duty work assigned to the claimant is not minimal and is work that she would have performed before the work-related injury.

In Livingood, the claimant, a forklift driver, could not drive a forklift due to his light duty work restrictions. Instead, while on light duty restrictions he changed forklift batteries, monitored bathrooms for vandalism, and checked to make sure freight was correctly placed around the facility. The ALJ determined that since Livingood had performed those tasks before, and the work was not a make-work project, he had returned to employment and was not entitled to TTD benefits. Id. at __. The ALJ's findings were affirmed by this Court.
In this matter, Mull satisfied the first prong of the TTD benefit test because she had not reached MMI. But, the ALJ did not perform an in depth analysis of the second requirement, whether the light duty work Mull performed was a return to her regular and customary employment. However, despite the lack of an in depth analysis, the facts of this matter are relatively clear, and we must agree with the Board that substantial evidence does not support the ALJ's award of TTD.

Prior to her injury, Mull's job tasks included retrieving a product, scanning it, and placing it in a shipping box. Mull was trained in all of these tasks. After the injury, Mull was restricted to scanning items. Mull testified that scanning was a normal part of her pre-injury employment. The light duty work is not a significant diversion from her original employment and there is no indication the work was minimal. Mull also received the same hourly wage. Mull returned to her regular and customary employment at Zappos and she does not satisfy the second requirement to receive TTD benefits.


The Supreme Court noted although the ALJ may not have performed an "in depth analysis" of the facts, it was "relatively clear" that Mull's "light duty work is not a significant diversion from her original employment and there is no indication the work was minimal." The Court went on to determine that "the purpose of TTD benefits is to cover a period of time in which an employee cannot work or can only perform minimal work."

More recently, in Trane Commercial Systems v. Tipton, 481 S.W.3d 800 (Ky. 2016), the Supreme Court reinforced its decision in Zappos.com v. Mull, supra, and again rejected the Court of Appeals' definition of "a return to employment" stating as follows:

The Court of Appeals in this case held that Tipton was entitled to TTD while she was working full-time for Trane and earning the same hourly rate. This holding by the Court of Appeals was based on a misunderstanding of Bowerman and an understandable misinterpretation of what "return to employment" means.

Tipton at 806.

The Supreme Court also differentiated the holding in Bowerman v. Black Equipment Co., 297 S.W.3d 858 (Ky. App. 2009). The ALJ had relied upon this case in reaching his initial determination. The Court explained,

the Court of Appeals only held that Bowerman was entitled to additional TTD for part of the period his claim was in abeyance, a period when he was not working. It did not hold that he was entitled to TTD for the period before his claim was placed in abeyance and during which he had worked."

Tipton at 806.
The Supreme Court provided the following clarification regarding the standard to be applied in determining when an employee has not reached a level of employment that would permit "a return to employment":

We take this opportunity to further delineate our holding in Livingood, and to clarify what standards the ALJs should apply to determine if an employee "has not reached a level of improvement that would permit a return to employment." KRS 342.0011(11)(a). Initially, we reiterate that "[t]he purpose for awarding income benefits such as TTD is to compensate workers for income that is lost due to an injury, thereby enabling them to provide the necessities of life for themselves and their dependents." Double L Const., Inc., 182 S.W.3d at 514. Next, we note that, once an injured employee reaches MMI that employee is no longer entitled to TTD benefits. Therefore, the following only applies to those employees who have not reached MMI but who have reached a level of improvement sufficient to permit a return to employment.

As we have previously held, "[i]t would not be reasonable to terminate the benefits of an employee when he is released to perform minimal work but not the type [of work] that is customary or that he was performing at the time of his injury." Central Kentucky Steel v. Wise, 19 S.W.3d at 659. However, it is also not reasonable, and it does not further the purpose for paying income benefits, to pay TTD benefits to an injured employee who has returned to employment simply because the work differs from what she performed at the time of injury. Therefore, absent extraordinary circumstances, an award of TTD benefits is inappropriate if an injured employee has been released to return to customary employment, i.e. work within her physical restrictions and for which she has the experience, training, and education; and the employee has actually returned to employment. We do not attempt to foresee what extraordinary circumstances might justify an award of TTD benefits to an employee who has returned to employment under those circumstances; however, in making any such award, an ALJ must take into consideration the purpose for paying income benefits and set forth specific evidence-based reasons why an award of TTD benefits in addition to the employee’s wages would forward that purpose.

Tipton at 807.

Based on this standard, the Supreme Court determined the ALJ and this Board had correctly decided Tipton was not entitled to additional TTD benefits reasoning as follows:

Applying the preceding to this case, we must agree with the ALJ that Tipton was not entitled to TTD during the period in question. Tipton’s physician released her to perform light and sedentary work, which Trane provided for her. Additionally, although Tipton had not previously assembled circuit boards, she had assembled the air conditioning units and had tested them. Furthermore, she did not produce any evidence that assembling circuit boards required significant additional training or that it was beyond her intellectual abilities. In fact, it appears that Tipton was certainly capable of and wanted to perform the circuit board assembly job.
because she bid on and was awarded the job after her release to full-duty work. Thus, there was ample evidence of substance to support the ALJ's denial of Tipton's request for additional TTD benefits, and we reverse the Court of Appeals.

Tipton at 807.
I. FAMILY MEDICAL LEAVE ACT

A. General

The Family and Medical Leave Act (FMLA) provides eligible employees up to twelve workweeks of unpaid leave a year, and requires group health benefits to be maintained during the leave as if employees continued to work instead of taking leave. Employees are also entitled to return to their same or an equivalent job at the end of their FMLA leave.

B. Coverage

The FMLA applies to all:

- public agencies, including local, state and federal employers, and local education agencies (schools); and

- private sector employers who employ fifty or more employees for at least twenty workweeks in the current or preceding calendar year, including joint employers and successors of covered employers.

C. Eligibility

In order to be eligible to take leave under the FMLA, an employee must:

- work for a covered employer;

- have worked 1,250 hours during the twelve months prior to the start of leave; (special hours of service rules apply to airline flight crew members)

- work at a location where the employer has fifty or more employees within seventy-five miles; and

- have worked for the employer for twelve months. The twelve months of employment are not required to be consecutive in order for the employee to qualify for FMLA leave. In general, only employment within seven years is counted unless the break in service is (1) due to an employee's fulfillment of military obligations, or (2) governed by a collective bargaining agreement or other written agreement.
The 1,250 hours include only those hours actually worked for the employer. Paid leave and unpaid leave, including FMLA leave, are not included.

D. Unpaid Leave

The FMLA only requires unpaid leave. However, the law permits an employee to elect, or the employer to require the employee, to use accrued paid vacation leave, paid sick or family leave for some or all of the FMLA leave period. An employee must follow the employer's normal leave rules in order to substitute paid leave. When paid leave is used for an FMLA-covered reason, the leave is FMLA-protected.

E. Qualifying Conditions

A covered employer must grant an eligible employee up to a total of twelve workweeks of unpaid, job-protected leave in a twelve month period to take medical leave when the employee is unable to work because of a "serious health condition."

F. Employer Notice Obligations under the FMLA

When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA purpose, the employer must notify the employee of his or her eligibility to take leave, and inform the employee of his or her rights and responsibilities under the FMLA. When the employer has enough information to determine that leave is being taken for a FMLA-qualifying reason, the employer must notify the employee that the leave is designated and will be counted as FMLA leave.

Absent extenuating circumstances, the regulations require an employer to notify an employee of whether the employee is eligible to take FMLA leave (and, if not, at least one reason why the employee is ineligible) within five business days of the employee requesting leave or the employer learning that an employee's leave may be for a FMLA-qualifying reason.

At the same time an employer provides an employee notice of the employee's eligibility to take FMLA leave, the employer must also notify the employee of the specific expectations and obligations associated with the leave. Among other information included in this notice, the employer must inform the employee whether the employee will be required to provide certification of the FMLA-qualifying reason for leave and the employee's right to substitute paid leave (including any conditions related to such substitution, and the employee's entitlement to unpaid FMLA leave if those conditions are not met).
G. Leave Time under the FMLA

An employee must comply with an employer's call-in procedures unless unusual circumstances prevent the employee from doing so (in which case the employee must provide notice as soon as he or she can practicably do so). The regulations make clear that, if the employee fails to provide timely notice, he may have the FMLA leave request delayed or denied and may be subject to whatever discipline the employer's rules provide.

The regulations allow recertification no more often than every thirty days in connection with an absence by the employee unless the condition will last for more than thirty days. For conditions that are certified as having a minimum duration of more than thirty days, the employer must wait to request a recertification until the specified period has passed, except that in all cases the employer may request recertification every six months in connection with an absence by the employee. The regulations also allow an employer to request recertification in less than thirty days if the employee requests an extension of leave, the circumstances described in the previous certification have changed significantly, or if the employer receives information that casts doubt upon the employee's stated reason for the absence or the continuing validity of the certification.

Additionally, employers may request a new medical certification each leave year for medical conditions that last longer than one year. Such new medical certifications are subject to second and third opinions.

H. Job Restoration under the FMLA

As a condition of restoring an employee who was absent on FMLA leave due to the employee's own serious health condition, an employer may have a uniformly applied policy or practice that requires all similarly situated employees who take leave for such conditions to submit a certification from the employee's own health care provider that the employee is able to resume work. Under the regulations, an employer may require that the fitness-for-duty certification address the employee's ability to perform the essential functions of the position if the employer has appropriately notified the employee that this information will be required and has provided a list of essential functions. Additionally, an employer may require a fitness-for-duty certification up to once every thirty days for an employee taking intermittent or reduced schedule FMLA leave if reasonable safety concerns exist regarding the employee's ability to perform his or her duties based on the condition for which leave was taken.

If an employee fails to timely submit a properly requested medical certification (absent sufficient explanation of the delay), FMLA protection for the leave may be delayed or denied. If the employee never provides a medical certification, then the leave is not FMLA leave.
If an employee fails to submit a properly requested fitness-for-duty certification, the employer may delay job restoration until the employee provides the certification. If the employee never provides the certification, he or she may be denied reinstatement.

On return from FMLA leave (whether after a block of leave or an instance of intermittent leave), the FMLA requires that the employer return the employee to the same job, or one that is nearly identical (equivalent).

If not returned to the same job, a nearly identical job must:

- offer the same shift or general work schedule, and be at a geographically proximate worksite (i.e., one that does not involve a significant increase in commuting time or distance);
- involve the same or substantially similar duties, responsibilities, and status;
- include the same general level of skill, effort, responsibility and authority;
- offer identical pay, including equivalent premium pay, overtime and bonus opportunities, profit-sharing, or other payments, and any unconditional pay increases that occurred during FMLA leave; and
- offer identical benefits (such as life insurance, health insurance, disability insurance, sick leave, vacation, educational benefits, pensions, etc.).

II. AMERICANS WITH DISABILITIES ACT

A. General

Title I of the Americans with Disabilities Act of 1990 prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment.

B. Coverage

The ADA covers employers with fifteen or more employees, including state and local governments. It also applies to employment agencies and to labor organizations. The ADA's nondiscrimination standards also apply to federal sector employees under section 501 of the Rehabilitation Act, as amended, and its implementing rules.
C. Eligibility

An individual with a disability is a person who:

- has a physical or mental impairment that substantially limits one or more major life activities;
- has a record of such an impairment; or
- is regarded as having such an impairment.

A qualified employee or applicant with a disability is an individual who, with or without reasonable accommodation, can perform the essential functions of the job in question.

D. Reasonable Accommodation

Reasonable accommodation may include, but is not limited to:

- making existing facilities used by employees readily accessible to and usable by persons with disabilities;
- job restructuring, modifying work schedules, reassignment to a vacant position;
- acquiring or modifying equipment or devices, adjusting or modifying examinations, training materials, or policies, and providing qualified readers or interpreters.

An employer is required to make a reasonable accommodation to the known disability of a qualified employee if it would not impose an "undue hardship" on the operation of the employer's business. Reasonable accommodations are adjustments or modifications provided by an employer to enable people with disabilities to enjoy equal employment opportunities.

Accommodations vary depending upon the needs of the individual employee. Not all people with disabilities (or even all people with the same disability) will require the same accommodation. An employer does not have to provide a reasonable accommodation if it imposes an "undue hardship."

E. Undue Hardship

"Undue hardship" is defined as an action requiring significant difficulty or expense when considered in light of factors such as an employer's size, financial resources, and the nature and structure of its operation.
An employer is not required to lower quality or production standards to make an accommodation; nor is an employer obligated to provide personal use items such as glasses or hearing aids.

F. Interactive Process

An employer generally does not have to provide a reasonable accommodation unless an individual with a disability has asked for one. If an employer believes that a medical condition is causing a performance or conduct problem, it may ask the employee how to solve the problem and if the employee needs a reasonable accommodation. Once a reasonable accommodation is requested, the employer and the individual should discuss the individual's needs and identify the appropriate reasonable accommodation. Where more than one accommodation would work, the employer may choose the one that is less costly or that is easier to provide.

III. KENTUCKY WORKERS’ COMPENSATION LAW

A. General

Kentucky's Workers' Compensation Act, KRS Chapter 342 et.seq. provides certain statutory benefits, primarily income and medical benefits, for workers injured in the course and scope of their employment.

B. Coverage

Employers mandatorily subject to, and required to comply with, the provisions of KRS Chapter 342 include:

- Any person, other than one engaged solely in agriculture, that has in the state one or more employees subject to the Act.

- The state, any agency thereof, and each county, city of any class, school district, sewer district, drainage district, tax district, public or quasipublic corporation, or any other political subdivision or political entity of the state that has one or more employees subject to the Act.

C. Eligibility

Employees covered under KRS Chapter 342 include:

- Anyone working under contract for hire, expressed or implied;

- Executive officers of corporations;

- State, county or city employees;

- Volunteer firefighters;
Those who sell and deliver newspapers; and

Any person performing services in a trade profession or business.

Employees exempted from coverage under KRS Chapter 342 include:

- Agriculture employers/employees;
- Domestic worker in private home if less than two (must work less than forty hours per week);
- Working for sustenance only, with charitable or religious organization;
- Covered by Federal Act;
- Employees who elect to reject coverage;
- Employees coming or going in voluntary carpool/vanpool; and
- Certain religious organizations.

An employer who employs an exempt employee may elect to be subject to the Act.

D. Anti-discrimination Statute

KRS 342.197 prohibits discrimination against employees who file or pursue a workers' compensation claim.

(1) No employee shall be harassed, coerced, discharged, or discriminated against in any manner whatsoever for filing and pursuing a lawful claim under this chapter.

* * * *

(3) Any individual injured by any act in violation of the provisions of subsection (1) or (2) of this section shall have a civil cause of action in Circuit Court to enjoin further violations, and to recover the actual damages sustained by him, together with the costs of the law suit, including a reasonable fee for his attorney of record.

The landmark case establishing a cause of action for workers' compensation retaliation, Firestone Textile Company Div., Firestone Tire and Rubber Co. v. Meadows, 666 S.W.2d 730 (Ky. 1983), held:

The only effective way to prevent an employer from interfering with his employees' rights to seek compensation is to recognize that the latter has a cause of action for retaliatory discharge when the discharge is motivated by
the desire to punish the employee for seeking the benefits to which he is entitled by law. *Id.* at 732-734.

The Act does not require an employer to offer light duty to an injured worker. Nevertheless, there are statutory provisions that encourage the employer to bring injured employees back to work at light duty and govern the treatment of employees on light duty.

E. Light Duty Not a "Benefit"

To prevail under *KRS 342.197*, a plaintiff is required to prove the alleged retaliation was based upon his collection of compensation or benefits provided under the Act. The assignment of an employee to a light duty position after a work-related injury is not a "benefit" provided under the Act. *KRS 342.001(14)* defines "compensation" as "all payments made under the provisions of this chapter representing the sum of income benefits and medical and related benefits." Income benefits under Kentucky's Workers' Compensation Act are defined as "payments made under the provisions of this chapter to the disabled worker or his dependents in case of death, excluding medical and related benefits." *KRS 342.001(12)*.

Thus, it can be seen that assignment to a light duty position after a work-related injury is not a "benefit" within the scope of Kentucky's Workers' Compensation Act. Indeed, in the typical light duty situation, the workers' compensation carrier is not paying the employee "income benefits;" rather, the employer is paying the employee wages.

F. Temporary Total Disability

Returning an injured employee to work at light duty may help ensure an employer's compliance with the ADA, and also avoid a period of temporary total disability. . . maybe. "Temporary total disability" means the condition of an employee who has not reached maximum medical improvement from an injury and has not reached a level of improvement that would permit a return to employment.

But what is meant by "return to employment?" The statute provides no further guidance, and so it has been left to the judges, the Board and the appellate courts to interpret this phrase. The seminal case on point was issued by the Supreme Court in 2000, *Central Kentucky Steel v. Wise*.

*Central Kentucky Steel v. Wise*, 19 S.W.3d 657 (Ky. 2000)

The claimant was an iron worker released to work with a five-pound lifting restriction on 7/11/97. He did not in fact return to work until 9/30/97, when he moved out of state and took a job with a different employer. TTD benefits were awarded during the period from 7/11/97–9/30/97, on the rationale "It would not be reasonable to terminate the benefits of an employee when he is released to perform minimal work but not the type that is customary or that he was performing at the time of injury."
The decision in *Wise* was applied in the context of concurrent employment in another oft-cited published opinion of the Supreme Court, *Double L Const., Inc. v. Mitchell*.

*Double L Const., Inc. v. Mitchell*, 182 S.W.3d 509 (Ky. 2005)

The claimant was a carpenter who sustained an eye injury. He was released to light duty on 3/3/03 and released to full duty on 8/18/03. During this time period, the claimant was able to go back to his concurrent employment as a janitor, and the employer argued it owed no TTD since the claimant was able to perform this other work within his restrictions. The Supreme Court held "a worker whose injury renders him temporarily unable to perform the work in which the injury occurred should not be penalized for performing what work he is able to do." He was awarded TTD benefits calculated from an AWW that included wages from his carpentry job alone, however.


The claimant was a quality control inspector on a labeling line. Her job involved inspecting various sized bottles, including half-pint and quart bottles, on an assembly line. She filed a claim for injuries to her back, shoulder, neck, and wrists, among other things. She was awarded TTD during a period in which she was restricted from lifting quart bottles, but could have RTW at light duty lifting half-pint bottles. Applying the narrowest conceivable interpretation of "customary," the Court of Appeals in this unpublished opinion affirmed the award of TTD during that period in which claimant was restricted from lifting quart bottles, which was one of her pre-injury employment duties.


The Court of Appeals reversed the ALJ's denial of TTD during a period of return to work at light duty where the claimant's pre-injury work as a forklift operator was physically laborious and his light duty work was in the parts room, cleaning the office, taking out the garbage, filling parts orders, and pulling parts for customers. Claimant had difficulty performing this light duty work, due to the amount of reaching involved, and required help from his supervisor. This light duty work was deemed "minimal work" under *Wise* and, therefore, did not preclude an award of TTD.


This decision addressed the employee's entitlement to TTD during a period of light duty return to work and also the employer's entitlement to a credit for wages paid. The claimant's job at the time of his shoulder injury involved heavy labor. The light duty position he returned to was primarily administrative in nature. Describing his light duty job as "entirely different" from his pre-injury work, the Court of Appeals affirmed an award of TTD.
from the date of injury through MMI, including periods of light duty accommodation. "An employee does not forego his right to receive TTD even if he continues performing some work prior to MMI so long as he remains unable to return to the type of work he was performing at the time of injury."

Regarding the employer's claim of a credit against TTD for wages paid, the Court of Appeals noted that the statute does not provide for a credit against TTD for wages paid. The statute provides for a credit in only two situations, unemployment benefits and payments made under an employer-funded disability or sickness and accident plan that does not contain its own internal offset provision. The Court of Appeals noted that the Supreme Court's holding in Millersburg Military Institute v. Puckett, 260 S.W.3d 339 (Ky. 2008) supported this outcome. In Puckett, the Supreme Court held that the employer was confusing "wages" with "benefits." The employer was not entitled to a credit against TTD for bona fide wages paid for work performed, noting there was no evidence introduced to indicate the employer intended the wages to be paid in lieu of workers' compensation benefits.


The tip of the claimant's finger was severed by a machine, but successfully reattached by surgery. The claimant was released to "one handed duty" and returned to work the next day. The employer's safety coordinator testified that the light duty work performed by claimant would not have been assigned to an employee under normal conditions. She stated the jobs were assigned to claimant in an attempt to find work which he could complete within the constraints of his physical restrictions. The employer contended for this reason that the wages paid to claimant were not bona fide, but were paid as a benefit to him and should be treated as benefits paid in lieu of TTD. The ALJ awarded TTD benefits for a period that overlapped with the period the claimant returned to light duty work and was paid actual wages. The ALJ found that claimant had not reached MMI and that he was not able to physically perform his customary work during that time period. The ALJ did not allow the employer a credit for the wages paid during the period of TTD because those payments constituted neither unemployment benefits nor benefits payable under an exclusively employer-funded sickness and accident or disability plan, which are the only two categories of wage replacement benefits for which the statute provides for a credit. The ALJ was affirmed all the way up.


The claimant never missed work following his back injury, but had two periods of light duty in which he claimed he just showed up for work and stood around. He was paid his usual wages. His supervisor testified
employees were never permitted simply to stand around, and that the claimant was put at the end of a trim line for inspection purposes. The supervisor acknowledged he had to "create a job function" for the claimant on a daily basis, and admitted that quality checks were not a "regular job." The ALJ awarded TTD benefits during these periods in which the claimant was assigned to perform "menial tasks" while on restricted duty.

Having concluded TTD benefits were due during the claimant's return to work at light duty, and because the employer failed to report its non-payment of TTD to the DWC (since it was paying the claimant his regular wages), the Court of Appeals held that the employer would be estopped from raising limitations as an affirmative defense.

Moreover, the Court of Appeals rejected the employer's argument it was entitled to a credit against TTD for wages paid, stating, "Furthermore, Toyota waived any potential credit against its workers' compensation liability for these wages because it failed to claim that these wages were paid in lieu of compensation as required by Triangle Insulation & Sheet Metal Co. v. Stratemeyer."1 Thus, we see again a court suggesting that a credit might be had if the employer produces evidence the wages were paid in lieu of TTD and asserts its claim to a credit.

In a blessed moment of equanimity, the Supreme Court issued a published opinion on 8/20/15 affirming the ALJ's denial of TTD to an employee who returned to work at light duty substantially similar to the work he customarily performed for the employer, Livingood v. Transfreight, LLC, and elaborated on that opinion in Trane Commercial Systems v. Tipton. The Supreme Court in Tudor vacated and remanded the case to the ALJ for reconsideration of the TTD issue in light of its opinion in Tipton.

Livingood v. Transfreight, LLC, 467 S.W.3d 249 (Ky. 2015)

The Supreme Court affirmed the ALJ's denial of TTD during a period of return to work at light duty. The claimant's job at the time of injury was as a forklift operator. He also marked freight. On light duty, he spent 50 percent of his time changing batteries (a job he had previously performed for this employer), 25 percent of his time marking freight, and 25 percent of his time monitoring bathrooms for workers writing on walls. Thus, 75 percent of his light duty assignments comprised of tasks previously performed by the claimant for the defendant/employer. He was paid his usual wages and worked his usual hours. Significant factors cited by the Supreme Court: (a) usual wages, (b) significant work, not makeshift work, and (c) primarily work previously performed by the employee. While the Supreme Court might simply have held that the work performed by the claimant constituted "customary" employment, it instead went so far

1 Triangle Insulation and Sheet Metal Co., a Div. of Triangle Enterprises, Inc. v. Stratemeyer, 782 S.W.2d 628 (Ky. 1990).
as to "reiterate today, Wise does not stand for the principle that workers who are unable to perform their customary work after an injury are always entitled to TTD." (citing Advance Auto Parts v. Mathis, 2004-SC-0146-WC, 2005 WL 119750 (Ky. Jan. 20, 2005)).

Trane Commercial Systems v. Tipton, 481 S.W.3d 800 (Ky. 2016)

Tipton sustained a knee injury while working in the control department testing AC units. This job involved frequent bending, squatting, crawling, and kneeling. She had previously performed work for the company assembling AC units. After her injury of 5/6/10, she was off work entirely until 3/22/11, when she was released by her treating physician to return to sedentary work with no overtime. She returned to work at a job assembling circuit boards and earning her same hourly rate. On 7/7/11, she was released to her pre-injury job, but still no overtime. Tipton felt she could not perform her prior job without significant problems, so she bid on and was permanently placed in the circuit board assembly job. She eventually began working overtime again, and her hourly pay rate increased.

Trane stopped paying TTD when Tipton returned to work on 3/22/11. Tipton argued she was entitled to TTD until 7/7/11, when she was released to her pre-injury job (though not released to her usual hours, which included overtime). The ALJ denied her claim for additional TTD, on grounds that her return to the circuit board assembly job was customary, non-minimal work. This decision was affirmed by the Board, but reversed by the Court of Appeals. The Supreme Court reversed the Court of Appeals, and took the opportunity to elaborate on its decision in Livingood regarding what constitutes "employment" for purposes of terminating TTD.

However, it is also not reasonable, and it does not further the purpose for paying income benefits, to pay TTD benefits to an injured employee who has returned to employment simply because the work differs from what she performed at the time of injury. Therefore, absent extraordinary circumstances, an award of TTD benefits is inappropriate if an injured employee has been released to return to customary employment, i.e. work within her physical restrictions and for which she has the experience, training, and education; and the employee has actually returned to employment. We do not attempt to foresee what extraordinary circumstances might justify an award of TTD benefits to an employee who has returned to employment under those circumstances; however, in making any such award, an ALJ must take into consideration the purpose for paying income benefits and set forth specific evidence-based reasons why an award of TTD benefits in addition to the employee’s wages would forward that purpose.
In other words, the Supreme Court has essentially indicated that the default in cases involving an actual return to work at light duty in a job for which the claimant has the necessary experience, training and education is no TTD. In Livingood, the Court had compared the claimant's light duty job tasks to his pre-injury work and concluded that there was sufficient overlap between those job duties for the light duty work to be considered "customary." This Trane decision seems to loosen that standard. There is no comparison of the pre-injury job duties to the light duty position.

Rather, so long as the light duty job is within the claimant's restrictions and she has the "experience, training, and education" to perform the work, it will be deemed customary. Presumably, she couldn't perform the light duty job if she didn't have the necessary experience, training and education, so this seems to be a low bar.

It is worth noting that the Supreme Court specifically limits this rule to cases in which the claimant has in fact returned to employment. Clearly, the courts are going to take a much harder look at the light duty job where the employee did not in fact return to work. The more the light duty job offer resembles the claimant's pre-injury job, the stronger the argument it constitutes "customary employment."

IV. PUTTING IT ALL TOGETHER: INTERACTION BETWEEN WORKERS' COMPENSATION, ADA AND FMLA

A. Disability Standards

1. Does everyone with an occupational injury have a disability within the meaning of the ADA?

No. Even if an employee with an occupational injury has a "disability" as defined by a workers' compensation statute, she may not have a "disability" for ADA purposes.

The ADA defines "disability" as: (1) a physical or mental impairment that substantially limits a major life activity, (2) a record of such an impairment, or (3) being regarded as having such an impairment. Impairments resulting from occupational injury may not be severe enough to substantially limit a major life activity, or they may be only temporary, non-chronic, and have little or no long term impact.

2. Does every person who has filed a workers' compensation claim have a disability under the "record of" portion of the ADA definition?

No. A person has a disability under the "record of" portion of the ADA definition only if he has a history of, or has been misclassified as having, a mental or physical impairment that substantially limits one or more major life activities.
3. When does a person with an occupational injury have a disability under the "regarded as" portion of the ADA definition?

A person with an occupational injury has a disability under the "regarded as" portion of the ADA definition if she: (1) has an impairment that does not substantially limit a major life activity but is treated by an employer as if it were substantially limiting, (2) has an impairment that substantially limits a major life activity because of the attitude of others towards the impairment, or (3) has no impairment but is treated as having a substantially limiting impairment.

B. Return to Work

4. May an employer require that an employee with a disability-related occupational injury be able to return to "full duty" before allowing him to return to work?

No. The term "full duty" may include marginal as well as essential job functions or may mean performing job functions without any accommodation. An employer may not require that an employee with a disability-related occupational injury who can perform essential functions be able to return to "full duty" if, because of the disability, he is unable to perform marginal functions of the position or requires a reasonable accommodation that would not impose an undue hardship.

5. May an employer refuse to return to work an employee with a disability-related occupational injury simply because it assumes, correctly or incorrectly, that she poses some increased risk of reinjury and increased workers' compensation costs?

No, unless an employer can show that employment of the person in the position poses a "direct threat." Where an employer refuses to return an employee to work because it assumes, correctly or incorrectly, that her disability-related occupational injury creates merely some increased risk of further occupational injury and increased workers' compensation costs, it discriminates on the basis of disability. The employer may not refuse to return an employee who is able to perform the essential functions of the job, with or without a reasonable accommodation, unless it can show that returning the person to the position poses a "direct threat."

The fact that an employee has had a disability-related occupational injury does not, by itself, indicate that she is unable to perform the essential functions of the job or that returning her to work poses a direct threat. In some circumstances, evidence about an employee's disability-related occupational injury may be relevant to whether she can perform the essential functions of the job, with or without a reasonable accommodation, or it may be relevant to the direct threat analysis.
6. May an employer refuse to return to work an employee with a disability-related occupational injury simply because of a workers' compensation determination that s/he has a "permanent disability" or is "totally disabled"?

No. Workers' compensation laws are different in purpose from the ADA and may utilize different standards for evaluating whether an individual has a "disability" or whether he is capable of working. For example, under a workers' compensation statute, a person who loses vision in both eyes or has loss of use of both arms or both legs may have a "permanent total disability," although he may be able to work. A workers' compensation determination also may relate to a different time period. Such a determination is never dispositive regarding an individual's ability to return to work, although it may provide relevant evidence regarding an employee's ability to perform the essential functions of the position in question or to return to work without posing a direct threat.

7. Under the ADA, is a rehabilitation counselor, physician, or other specialist responsible for deciding whether an employee with a disability-related occupational injury is ready to return to work?

No. The employer bears the ultimate responsibility for deciding whether an employee with a disability-related occupational injury is ready to return to work. Therefore, the employer, rather than a rehabilitation counselor, physician, or other specialist, must determine whether the employee can perform the essential functions of the job, with or without reasonable accommodation, or can work without posing a direct threat.

On the other hand, the employer may find it helpful to seek information from the rehabilitation counselor, physician, or other specialist regarding the employee's specific functional limitations, abilities, and possible reasonable accommodations.

In order to obtain useful and accurate information from a rehabilitation counselor, physician, or other specialist in making a return to work decision, an employer may wish to provide him/her with specific information about the following:

- the essential functions of the employee's position and the nature of the work to be performed;
- the work environment and the employer's operations, including any unavoidable health or safety hazards which may exist; and
- possible reasonable accommodations.

C. Reasonable Accommodations

8. Does the ADA require an employer to provide reasonable accommodation for an employee with an occupational injury who does not have a disability as defined by the ADA?
No. The ADA does not require an employer to provide a reasonable accommodation for an employee with an occupational injury who does not have a disability as defined by the ADA.

9. **May an employer discharge an employee who is temporarily unable to work because of a disability-related occupational injury?**

No. An employer may not discharge an employee who is temporarily unable to work because of a disability-related occupational injury where it would not impose an undue hardship to provide leave as a reasonable accommodation.

10. **What are the reinstatement rights of an employee with a disability-related occupational injury?**

An employee with a disability-related occupational injury is entitled to return to his same position unless the employer demonstrates that holding open the position would impose an undue hardship.

In some instances, an employee may request more leave even after the employer has communicated that it would impose an undue hardship to hold open the employee's position any longer. In this situation, the employer must consider whether it has a vacant, equivalent position for which the employee is qualified and to which the employee can be reassigned without undue hardship to continue his leave for a specific period of time.

11. **Must an employer, as a reasonable accommodation, reallocate job duties of an employee with a disability-related occupational injury?**

Yes, if the duties to be reallocated are marginal functions of the position that the employee cannot perform because of the disability. Reasonable accommodation includes restructuring a position by reallocating or redistributing the marginal functions that the employee cannot perform because of the disability. However, an employer need not eliminate essential functions of the position.

12. **May an employer unilaterally reassign an employee with a disability-related occupational injury to a different position instead of first trying to accommodate the employee in the position he held at the time the injury occurred?**

No. An employer must first assess whether the employee can perform the essential functions of his original position, with or without a reasonable accommodation. Examples of reasonable accommodation include job restructuring, modification of equipment, or a part-time work schedule. Reassignment should be considered only when accommodation within the employee's original position is not possible or would impose an undue hardship.
13. Must an employer reassign an employee who is no longer able to perform the essential functions of her original position, with or without a reasonable accommodation, because of a disability-related occupational injury?

Yes. Where an employee can no longer perform the essential functions of her original position, with or without a reasonable accommodation, because of a disability-related occupational injury, an employer must reassign her to an equivalent vacant position for which she is qualified, absent undue hardship. If no equivalent vacant position (in terms of pay, status, etc.) exists, then the employee must be reassigned to a lower graded position for which she is qualified, absent undue hardship.

14. If there is no vacancy for an employee who can no longer perform her original position because of a disability-related occupational injury, must an employer create a new position or "bump" another employee from his position?

No. The ADA does not require an employer to create a new position or to bump another employee from his position in order to reassign an employee who can no longer perform the essential functions of her original position, with or without a reasonable accommodation.

15. When an employee requests leave as a reasonable accommodation under the ADA because of a disability-related occupational injury, may an employer provide an accommodation that requires him to remain on the job instead?

Yes. An employer need not provide an employee's preferred accommodation as long as the employer provides an effective accommodation – one that is sufficient to meet the employee's job-related needs.

Accordingly, an employer may provide a reasonable accommodation that requires an employee to remain on the job, in lieu of providing leave (e.g., reallocating marginal functions, or providing temporary reassignment).

The employer is obligated, however, to restore the employee's full duties or to return the employee to his original position once he has recovered sufficiently to perform his essential functions, with or without a reasonable accommodation.

However, if an employee with a disability-related occupational injury does not request a reasonable accommodation, but simply requests leave that is routinely granted to other employees (e.g., accrued paid leave or leave without pay), an employer may not require him to remain on the job with some type of adjustment unless it also requires employees without disabilities who request such leave to remain on the job with some type of adjustment.
16. May an employer satisfy its ADA obligation to provide reasonable accommodation for an employee with a disability-related occupational injury by placing her in a workers' compensation vocational rehabilitation program?

No. An employer cannot substitute vocational rehabilitation services in place of a reasonable accommodation required by the ADA for an employee with a disability-related occupational injury. An employee's rights under the ADA are separate from her entitlements under a workers' compensation law. The ADA requires employers to accommodate an employee in her current position through job restructuring or some other modification, absent undue hardship. If it would impose an undue hardship to accommodate an employee in her current position, then the ADA requires that an employer reassign the employee to a vacant position she can perform, absent undue hardship.

17. May an employer make a workplace modification that is not a required form of reasonable accommodation under the ADA in order to offset workers' compensation costs?

Yes. Nothing in the ADA prohibits an employer from making a workplace modification that is not a required form of reasonable accommodation under the ADA for an employee with an occupational injury in order to offset workers' compensation costs. For example, the ADA does not require employers to lower production standards to accommodate individuals with disabilities. However, an employer is clearly permitted to lower production standards for an occupationally injured employee as a way of returning him to work more quickly.

D. "Light Duty"

The term "light duty" has a number of different meanings in the employment setting. Generally, "light duty" refers to temporary or permanent work that is physically or mentally less demanding than normal job duties. Some employers use the term "light duty" to mean simply excusing an employee from performing those job functions that s/he is unable to perform because of an impairment. "Light duty" also may consist of particular positions with duties that are less physically or mentally demanding created specifically for the purpose of providing alternative work for employees who are unable to perform some or all of their normal duties. Further, an employer may refer to any position that is sedentary or is less physically or mentally demanding as "light duty."
In the following questions and answers, the term “light duty” refers only to particular positions created specifically for the purpose of providing work for employees who are unable to perform some or all of their normal duties.

18. Does the ADA prohibit an employer from creating a light duty position for an employee when she is injured on the job?

No, in most instances. An employer may recognize a special obligation arising out of the employment relationship to create a light duty position for an employee when she has been injured while performing work for the employer and, as a consequence, is unable to perform her regular job duties. Such a policy, on its face, does not treat an individual with a disability less favorably than an individual without a disability; nor does it screen out an individual on the basis of disability.

Of course, an employer must apply its policy of creating a light duty position for an employee when she is occupationally injured on a non-discriminatory basis. In other words, an employer may not use disability as a reason to refuse to create a light duty position when an employee is occupationally injured.

An employer need not create a light duty position for a non-occupationally injured employee with a disability as a reasonable accommodation. The principle that the ADA does not require employers to create positions as a form of reasonable accommodation applies equally to the creation of light duty positions. However, an employer must provide other forms of reasonable accommodation required under the ADA. For example, subject to undue hardship, an employer must: (1) restructure a position by redistributing marginal functions which an individual cannot perform because of a disability, (2) provide modified scheduling (including part time work), or (3) reassign a non-occupationally injured employee with a disability to an equivalent existing vacancy for which she is qualified. Accordingly, an employer may not avoid its obligation to accommodate an individual with a disability simply by asserting that the disability did not derive from an occupational injury.

In some cases, the only effective reasonable accommodation available for an individual with a disability may be similar or equivalent to a light duty position. The employer would have to provide that reasonable accommodation unless the employer can demonstrate that doing so would impose an undue hardship.

19. If an employer reserves light duty positions for employees with occupational injuries, does the ADA require it to consider reassigning an employee with a disability who is not occupationally injured to such positions as a reasonable accommodation?

Yes. If an employee with a disability who is not occupationally injured becomes unable to perform the essential functions of his/her job, and there is no other effective accommodation available, the employer must
reassign him/her to a vacant reserved light duty position as a reasonable accommodation if (1) s/he can perform its essential functions, with or without a reasonable accommodation; and (2) the reassignment would not impose an undue hardship. This is because reassignment to a vacant position and appropriate modification of an employer’s policy are forms of reasonable accommodation required by the ADA, absent undue hardship.

An employer cannot establish that the reassignment to a vacant reserved light duty position imposes an undue hardship simply by showing that it would have no other vacant light duty positions available if an employee became injured on the job and needed light duty.

20. If an employer has only temporary light duty positions, must it still provide a permanent light duty position for an employee with a disability-related occupational injury?

No. The ADA typically does not limit an employer’s ability to establish or change the content, nature, or functions of its positions. So, for example, an employer is free to determine that a light duty position will be temporary rather than permanent. Thus, if an employer provides light duty positions only on a temporary basis, it need only provide a temporary light duty position for an employee with a disability-related occupational injury.

21. Must employers pay an exempt employee the same wages when she is on light duty?

No. An exempt employee must be paid the same agreed-upon salary every week, without regard to the number of days or hours worked. However, the employer may change the amount of that salary based on expected future absences for partial disability. As long as the salary is adjusted in advance based on expected duties, rather than being changed "after the fact" based on the hours worked, it may be treated much like any other salary adjustment imposed for a change in expected duties (such as an exempt employee who changes to part-time status). An alternate option is a temporary conversion to nonexempt status for the duration of recovery. If the employee’s graduated return to full duty will involve increasing hours (e.g., twenty hours the first week, then twenty-five hours, then thirty hours, then thirty-five hours), or if there is a potential for unexpected absences (for follow-up appointments, possible regression, etc.), then it may be easier for the employer to pay the employee by the hour. The employee could then be returned to exempt status upon resuming full duties.

22. Must employers pay a non-exempt employee the same wages when he is on light duty?

No. Nothing in the ADA prevents the employer from reducing the employee's pay to reflect the new, lighter-duty position. Moreover, it is clear from the case of Trane v. Tipton that an employee need not be employed at 100 percent of his AWW in order to be disqualified from
receiving TTD benefits. It remains unsettled how much less than his AWW an employee may earn while working light duty and still be deemed ineligible for TTD benefits.

23. Is there a limit to how long an employee may work on light duty?

No. The ADA does not require an employer to create a light duty position for an injured worker, and does not set a maximum time limit on an employee's work in a light duty capacity. Similarly, there is no maximum length of time an employee may qualify as temporarily totally disabled under the workers' compensation statute. It is common for employers dealing with workers' compensation claimants to impose a fixed limit, for example, a ninety-day limit, on the length of light-duty transitional work. When the fixed light-duty period ends, just as when an employee's leave is exhausted, the employer is required to reengage in the interactive process to try to discover those reasonable conditions under which the employee can return to his former position and perform at full productivity.

24. Are there consequences for an employee who refuses a light duty job offer?

Under FMLA, the employee has the right to decline work for up to twelve weeks. An employee who cannot return to his original work after FMLA leave expires, however, is not entitled to an alternate position.

Under the ADA, while an employer cannot require an employee to do something that is inconsistent with restrictions assigned by the employee's doctor, an employer can require an employee to return to work if the employee can perform the work required with or without a reasonable accommodation. In this respect, the ADA does not provide an employee with a legal tool allowing the employee to escape work that he is capable of performing.

Under Kentucky workers' compensation law, this question usually arises in the context of eligibility for TTD benefits. A worker is eligible for TTD benefits when he has not reached MMI and has not reached a level of improvement that would permit a return to employment, meaning the work he was performing at the time of injury or that is customary.
Fact Sheet #28: The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons. This fact sheet provides general information about which employers are covered by the FMLA, when employees are eligible and entitled to take FMLA leave, and what rules apply when employees take FMLA leave.

COVERED EMPLOYERS

The FMLA only applies to employers that meet certain criteria. A covered employer is a:
- Private-sector employer, with 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including a joint employer or successor in interest to a covered employer;
- Public agency, including a local, state, or Federal government agency, regardless of the number of employees it employs; or
- Public or private elementary or secondary school, regardless of the number of employees it employs.

ELIGIBLE EMPLOYEES

Only eligible employees are entitled to take FMLA leave. An eligible employee is one who:
- Works for a covered employer;
- Has worked for the employer for at least 12 months;
- Has at least 1,250 hours of service for the employer during the 12 month period immediately preceding the leave*; and
- Works at a location where the employer has at least 50 employees within 75 miles.

* Special hours of service eligibility requirements apply to airline flight crew employees. See Fact Sheet 28J: Special Rules for Airline Flight Crew Employees under the Family and Medical Leave Act.

The 12 months of employment do not have to be consecutive. That means any time previously worked for the same employer (including seasonal work) could, in most cases, be used to meet the 12-month requirement. If the employee has a break in service that lasted seven years or more, the time worked prior to the break will not count unless the break is due to service covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA), or there is a written agreement, including a collective bargaining agreement, outlining the employer’s intention to rehire the employee after the break in service. See "FMLA Special Rules for Returning Reservists".

LEAVE ENTITLEMENT

Eligible employees may take up to 12 workweeks of leave in a 12-month period for one or more of the following reasons:
• The birth of a son or daughter or placement of a son or daughter with the employee for adoption or foster care;
• To care for a spouse, son, daughter, or parent who has a serious health condition;
• For a serious health condition that makes the employee unable to perform the essential functions of his or her job; or
• For any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.

An eligible employee may also take up to 26 workweeks of leave during a "single 12-month period" to care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember. The "single 12-month period" for military caregiver leave is different from the 12-month period used for other FMLA leave reasons. See Fact Sheets 28F: Qualifying Reasons under the FMLA and 28M: The Military Family Leave Provisions under the FMLA.

Under some circumstances, employees may take FMLA leave on an intermittent or reduced schedule basis. That means an employee may take leave in separate blocks of time or by reducing the time he or she works each day or week for a single qualifying reason. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operations. If FMLA leave is for the birth, adoption, or foster placement of a child, use of intermittent or reduced schedule leave requires the employer’s approval.

Under certain conditions, employees may choose, or employers may require employees, to "substitute" (run concurrently) accrued paid leave, such as sick or vacation leave, to cover some or all of the FMLA leave period. An employee’s ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

NOTICE

Employees must comply with their employer’s usual and customary requirements for requesting leave and provide enough information for their employer to reasonably determine whether the FMLA may apply to the leave request. Employees generally must request leave 30 days in advance when the need for leave is foreseeable. When the need for leave is foreseeable less than 30 days in advance or is unforeseeable, employees must provide notice as soon as possible and practicable under the circumstances.

When an employee seeks leave for a FMLA-qualifying reason for the first time, the employee need not expressly assert FMLA rights or even mention the FMLA. If an employee later requests additional leave for the same qualifying condition, the employee must specifically reference either the qualifying reason for leave or the need for FMLA leave. See Fact Sheet 28E: Employee Notice Requirements under the FMLA.

Covered employers must:

(1) Post a notice explaining rights and responsibilities under the FMLA. Covered employers may be subject to a civil money penalty for willful failure to post. For current penalty amounts, see www.dol.gov/whd/fmla/applicable_laws.htm;

(2) Include information about the FMLA in their employee handbooks or provide information to new employees upon hire;
(3) When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA-qualifying reason, provide the employee with notice concerning his or her eligibility for FMLA leave and his or her rights and responsibilities under the FMLA; and

(4) Notify employees whether leave is designated as FMLA leave and the amount of leave that will be deducted from the employee’s FMLA entitlement.

See Fact Sheet 28D: Employer Notice Requirements under the FMLA.

CERTIFICATION

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member’s serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer’s expense) and periodic recertification of a serious health condition. See Fact Sheet 28G: Certification of a Serious Health Condition under the FMLA. For information on certification requirements for military family leave, See Fact Sheet 28M(c): Qualifying Exigency Leave under the FMLA; Fact Sheet 28M(a): Military Caregiver Leave for a Current Servicemember under the FMLA; and Fact Sheet 28M(b): Military Caregiver Leave for a Veteran under the FMLA.

JOB RESTORATION AND HEALTH BENEFITS

Upon return from FMLA leave, an employee must be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee’s use of FMLA leave cannot be counted against the employee under a “no-fault” attendance policy. Employers are also required to continue group health insurance coverage for an employee on FMLA leave under the same terms and conditions as if the employee had not taken leave. See Fact Sheet 28A: Employee Protections under the Family and Medical Leave Act.

OTHER PROVISIONS

Special rules apply to employees of local education agencies. Generally, these rules apply to intermittent or reduced schedule FMLA leave or the taking of FMLA leave near the end of a school term.

Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under the FLSA regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave. This special exception to the “salary basis” requirements for FLSA’s exemption extends only to an eligible employee’s use of FMLA leave.

ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any
proceeding, related to the FMLA. See Fact Sheet 77B: Protections for Individuals under the FMLA. The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

For additional information, visit our Wage and Hour Division Website: http://www.wagehour.dol.gov and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4-USWAGE (1-866-487-9243).

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Fact Sheet #28G: Certification of a Serious Health Condition under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees who work for covered employers to take unpaid, job-protected leave for specified family and medical reasons, with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

The employer may require the employee to submit a certification from a health care provider to support the employee’s need for FMLA leave to care for a covered family member with a serious health condition or for the employee’s own serious health condition. The employer may not request a certification for leave to bond with a newborn child or a child placed for adoption or foster care. For information about certification requirements for military family leave, see Fact Sheet 28M(c): Qualifying Exigency Leave under the Family and Medical Leave Act; Fact Sheet 28M(a): Military Caregiver Leave for a Current Servicemember under the Family and Medical Leave Act; and Fact Sheet 28M(b): Military Caregiver Leave for a Veteran under the Family and Medical Leave Act.

The employer must notify the employee each time a certification is required. The employer’s notice must be included in the written notice of FMLA rights and responsibilities given to the employee when leave is first requested. The employer may request certification at a later date if it questions the appropriateness of the leave or its duration.

MEDICAL CERTIFICATION

If the employer requests medical certification, the employee is responsible for providing a complete and sufficient certification, generally within 15 calendar days after the employer’s request. The employee is responsible for paying for the cost of the medical certification and for making sure the certification is provided to the employer. If the certification is incomplete or insufficient, the employer must give the employee a written notice stating what additional information is necessary to make the certification complete and sufficient. The employee must provide the additional information to the employer within seven calendar days, in most circumstances.

- A certification is considered “incomplete” if one or more of the applicable entries on the form have not been completed.

- A certification is considered “insufficient” if the information provided is vague, unclear, or non-responsive.

Content of the certification - Information on the certification may include: contact information for the health care provider; the date the serious health condition began and how long it will last; appropriate medical facts about the condition; for leave for the employee’s own serious health condition, information showing that the employee cannot perform the essential functions of the job; for leave to care for a family member, a statement of the care needed; for intermittent leave, information showing the medical necessity for intermittent or reduced
schedule leave and either the dates of any planned leave or the estimated frequency and duration of expected incapacity due to the condition.

**Consequences** - If the employee does not provide the requested certification within the time required or fails to provide a complete and sufficient certification despite the opportunity to cure any deficiencies, the employer may deny the employee’s request for FMLA leave.

**Annual certification** - If the employee’s need for FMLA leave lasts beyond a single FMLA leave year, the employer may require the employee to provide a new medical certification in each new FMLA leave year.

**Certification forms** - The FMLA does not require the use of any specific certification form. The Department has developed optional forms that can be used for leave for an employee’s own serious health condition (WH-380-E) or to care for a family member’s serious health condition (WH-380-F), or the employer may use its own forms. If the employer chooses to use its own forms, it may not require any additional information beyond what is specified in the FMLA and its regulations. Employers must accept a complete and sufficient medical certification, regardless of the format. In all instances, the information requested on the certification form must relate only to the serious health condition for which the employee is seeking leave. The Department’s forms are available for free at [www.dol.gov/whd/fmla](http://www.dol.gov/whd/fmla).

**AUTHENTICATION AND CLARIFICATION**

Once the employer has received a complete and sufficient certification, the employer may not request additional information from the health care provider. However, the employer may use a human resources professional, a leave administrator, another health care provider, or a management official to contact the health care provider to authenticate or to clarify the certification. For example, the employer’s appropriate representative could ask the health care provider if the information contained on the form was completed or authorized by him or her, or ask questions to clarify the handwriting on the form or the meaning of a response. Under no circumstances may the employee’s direct supervisor contact the employee’s health care provider.

**SECOND AND THIRD OPINIONS**

If the employer has received a complete and sufficient certification but has a reason to doubt that it is valid, the employer may require the employee to obtain a second medical certification. The employer can choose the health care provider to provide the second opinion, but generally may not select a health care provider who it employs on a regular or routine basis. If the second opinion differs from the original certification, the employer may require the employee to obtain a third certification from a healthcare provider selected by both the employee and employer. The opinion of the third health care provider is final and must be used by the employer. The employer is responsible for paying for the second and third opinions, including any reasonable travel expenses for the employee or family member. While waiting for the second (or third) opinion, the employee is provisionally entitled to FMLA leave.

**RECERTIFICATION**

In general, the employer may request the employee to provide a recertification no more often than every 30 days and only in connection with an absence by the employee. If a certification indicates that the minimum duration of the serious health condition is more than 30 days, the employer must generally wait until that minimum duration expires before requesting recertification. However, in all cases, including cases where the
condition is of an indefinite duration, the employer may request a recertification for absences every six months.
The employer may request a recertification in less than 30 days only if:

- the employee requests an extension of leave,
- the circumstances described by the previous certification have changed significantly, or
- the employer receives information that causes it to doubt the employee’s stated reason for the absence or
  the continuing validity of the existing medical certification.

In general, the employer may ask for the same information in a recertification as that permitted in the original
medical certification. However, an employer may provide the health care provider with a record of the
employee’s absences and ask if the serious health condition and need for leave is consistent with the leave
pattern. The employee is responsible for paying for the cost of a recertification. The employer cannot require a
second or third opinion for a recertification. In most circumstances, the employer must allow the employee at
least 15 calendar days to provide the recertification after the employer’s request.

FOREIGN MEDICAL CERTIFICATION

If the employee or the employee’s family member is visiting another country, or a family member resides in
another country, and a serious health condition develops, the employer must accept a medical certification, as
well as second and third opinions, from a health care provider who practices in that country. If a medical
certification by a foreign health care provider is not in English, the employer may require the employee to
provide a written translation of the certification.

FITNESS-FOR-DUTY

The employer may have a policy or practice that requires employees in similar job positions who take leave for
similar health conditions to provide a return to work, or “fitness-for-duty,” certification from the employee’s
health care provider showing that the employee is able to resume work. The employer may request a fitness-
for-duty certification only with regard to the particular health condition that caused the employee’s need for
FMLA leave. If the employer will require a fitness-for-duty certification, it must provide notice of that
requirement and whether the certification must address the employee’s ability to perform the essential functions
of his or her job with the FMLA designation notice.

In general, a fitness-for-duty certification may not be required for each absence taken on an intermittent or
reduced leave schedule. However, if the employer has a reasonable belief that the employee’s return to work
presents a significant risk of harm to the employee or to others, the employer may require a fitness-for-duty
certification up to once every 30 days.

As long as the employer has provided the required notice regarding any fitness-for-duty certification
requirement, the employee’s return to work may be delayed until the fitness-for-duty certification is provided.
An employer may contact an employee’s health care provider to clarify or authenticate a fitness-for-duty
certification, but cannot delay the employee’s return to work while making that contact. An employer may not
require second or third opinions for a fitness-for-duty certification. The employee is responsible for paying any
cost of obtaining the fitness-for-duty certification. If State or local law or collective bargaining agreement
governs an employee’s return to work, those provisions must be applied.
ENFORCEMENT

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any proceeding, related to the FMLA. See Fact Sheet 77B: Protections for Individuals under the FMLA. The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

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The duty to provide a reasonable accommodation to a qualified individual with a disability is considered one of the most important statutory requirements of the Americans with Disabilities Act of 1990 (ADA). Under the ADA, an employer with fifteen or more employees is required to provide a covered job applicant or employee with a reasonable accommodation, unless doing so would pose an undue hardship (i.e., significant difficulty or expense) or direct threat. A reasonable accommodation requires that steps be taken to enable a qualified individual with a disability to perform the essential functions of the position. Reasonable accommodation further includes the employer's reasonable efforts to assist the employee and to communicate with the employee in good faith. In the reasonable-accommodation context, the ADA envisions an interactive process by which employers and employees work together to assess whether an employee’s disability can be reasonably accommodated. The interactive process is an informal practice in which the covered individual and the employer determine the precise limitations created by the disability and how best to respond to the need for accommodation.

Employee’s Duty to Request an Accommodation

Generally, courts have recognized that an employee must request an accommodation to trigger the interactive process. The request may be either oral or written. The Equal Employment Opportunity Commission (EEOC) takes the position that requests for accommodation do not need to be in writing. The employer may request, however, that the employee complete a written accommodation request. The ADA does not require employers to speculate about the accommodation needs of employees and applicants; rather, the individual requesting the accommodation has an obligation to provide the employer with enough information about the disability to determine a reasonable accommodation. To state an adequate accommodation request, an employee must at a minimum request some change or adjustment in the workplace and must link that request to his or her disability, rather than simply present the request in a vacuum. Although courts endorse the view that an employer should not require an employee to use “magic” language, or even use the term "accommodation" in the request, an employee must be clear in indicating the need for an accommodation because of a medical condition.

Duty to Provide an Accommodation without an Express Request

Although the general rule places the burden to request an accommodation on the employee or applicant, there are circumstances under which employers may have an obligation to provide an accommodation without a request to do so. Employers should be aware that some courts have suggested that if the employer knows both about the disability and the need for accommodation, it may have an obligation to provide the accommodation – even without an express request that a modification is needed because of a disability. This often occurs in circumstances where the employee’s disability is obvious and it is clear that the disability is interfering with the employer’s performance expectations.
Further, the EEOC’s guidance suggests that accommodation should be provided without request if the employer

- knows that the employee has a disability,
- knows or should know that the employee is experiencing workplace problems because of the disability, or
- knows or should know that the disability prevents the employee from requesting a reasonable accommodation.


The EEOC clarifies that, under the latter circumstances, if the individual declines the offer of an accommodation, the employer will have fulfilled the accommodation requirement under the ADA.

**Employer’s Duty to Engage in the Interactive Process**

Once an accommodation has been requested or the need for an accommodation is obvious, the employer should initiate an interactive process with the individual. Courts generally have held that the interactive process requires employers to

- analyze job functions to establish the essential and nonessential job tasks,
- identify the barriers to job performance by consulting with the employee to learn the employee’s precise limitations, and
- explore the types of accommodations that would be most effective.

Employers can demonstrate a good-faith attempt to accommodate by meeting with the employee, requesting information about the limitations, considering the employee’s requests, and discussing alternatives if a request is burdensome.

Because the interactive process imposes mutual obligations on employers and employees, an employer cannot be liable for failure to accommodate if a breakdown in that process is attributable to the employee. Courts have consistently attributed the breakdown in the interactive process to the employee where the employee refuses to allow the employer to discuss the employee’s alleged disability with the employee’s doctor after attempts to accommodate the employee are unsuccessful. Further, courts have attributed the breakdown of the interactive process to the employee where the employee did not respond to the employer’s request for information about the employee’s abilities and the nature and extent of the restrictions. Finally, courts have held employees responsible for the breakdown in the interactive process when an employee uncompromisingly insists on a single accommodation that is unreasonable as a matter of law.

To the contrary, if the breakdown in the interactive process is attributable to the employer, courts have generally held this to be an adverse employment action.
However, an employer’s failure to initiate the interactive process is not itself a "per se" violation of the ADA, where no accommodation is possible. The ADA requires the parties to engage in an informal, interactive process, to explore possible accommodations, but an employer’s failure to participate in the interactive process is not actionable unless the employee can demonstrate that the employee could have been reasonably accommodated but for the employer’s lack of good faith. If no accommodation would allow the employee to perform his or her job, the employer is not obligated to participate in the interactive process of accommodation required by the ADA.

The Employer Is Not Required to Provide the Specific Accommodation Requested

Finally, employers are not obligated to provide the specific accommodation requested by the employee; rather, employers are required to provide a reasonable accommodation. Although the ADA provides a right to a reasonable accommodation, it does not provide a right to any specific requested or preferred accommodation. Thus, an employee is not entitled to his or her "choice" accommodation but rather a "reasonable" accommodation. For example, an employer may choose to let an employee call off work without penalty as a reasonable accommodation, rather than provide the employee’s requested accommodation of working from home.

An employee may refuse an accommodation offered by the employer; however, if the employee cannot perform the job without the accommodation, the employee will not be considered "qualified" under the ADA. For instance, a court held that an employee was not "qualified" where she could not be around workplace fumes, and she refused the potential accommodation – use of a respirator – which was proposed by the employer.

Can an Employer Lawfully Deny an Accommodation Request?

Employers may be able to deny accommodation requests or defend against legal claims of failure to accommodate by citing to undue hardship or direct threat.

Undue hardship. Under the ADA, an employer is not required to make reasonable accommodations that would impose an "undue hardship" on the employer. The burden is on the employer to prove an undue hardship. Whether an accommodation will impose an undue hardship is determined on a case-by-case basis. For example, while an employer with thirty employees may legitimately claim that an extended period of disability leave for one of its employees would create an undue hardship, an employer with 25,000 employees, that employs hundreds of employees in the same position as the employee requesting leave, will have difficulty arguing undue hardship as a defense. Undue hardship includes any action that is

- unduly costly,
- extensive,
- substantial,
- disruptive, or
- fundamentally alters the nature or operation of the business.
The ADA and EEOC regulations identify several factors to consider when determining whether an accommodation would impose an undue hardship. See 42 U.S.C. §12111(10)(B) (2013); 29 C.F.R. §1630.2(p) (2013). For example, employers may consider the nature and net cost of the accommodation, the overall financial resources of the covered entity, and the number of employees employed by the covered entity. Employers asserting "cost" as the reason for undue hardship should note that the EEOC has routinely said that the cost that must be spent on an accommodation depends on the employer’s resources, not on the employee’s salary, position, or status within the company. See EEOC Enforcement Guidance: Reasonable Accommodation and Undue Hardship, supra, at Question 45.

Some general principles may be gleaned from cases evaluating whether an accommodation is an undue hardship:

- An accommodation that would result in other employees having to work harder or longer is not required under the ADA.

- Where an employer has waived certain requirements for other employees, the employer cannot claim that it would cause an undue hardship to waive those same requirements for an individual with a disability.

- An employer may assert that a modified schedule for an employee would be an undue hardship because of the significant cost of keeping the facility open, which may include additional hours for other personnel such as security personnel.

- An accommodation to one employee that violates the seniority rights of other employees in a collective-bargaining agreement is not reasonable because it would expose the employer to potential union grievances and costly remedies.

Direct threat. Some disabilities pose a "direct threat" to the health and safety of individuals in the workplace. Where there is no reasonable accommodation available to negate that threat, employers may cite the direct-threat defense.

Employers can assert the direct-threat defense only if the individual poses a significant risk that cannot be reduced or eliminated by accommodation. A speculative or remote risk is insufficient. The assessment of whether an individual poses a direct threat is based on reasonable medical judgment that may be based on current medical knowledge or the best available objective evidence. Factors considered in assessing whether an individual poses a direct threat include

- the duration of the risk,

- the nature and severity of the potential harm,

- the likelihood that the potential harm will occur, or

- how soon the potential harm may occur.
See 29 C.F.R. §1630.2(r) (2013).

For example, consider a heavy-machinery worker with epilepsy. The worker who operates heavy machinery and who has been suffering from seizures might pose a direct threat to his or her or someone else’s safety. If no reasonable accommodation is available (i.e., an open position to which the employee could be reassigned), the employer would not violate the ADA by terminating the employee.

**Best Practices**

As part of employer best practices regarding the interactive process, and for each accommodation request, the employer should do the following:

- Document in writing its receipt of the request for accommodation, providing a copy to the individual and retaining a copy for the employer’s records. This allows the employer to show that it took the request seriously and responded promptly.

- Ask the individual for information about the extent of the impairment, including notes from doctors or other health-care providers, and request medical testing relevant to the accommodation at issue.

The EEOC has specifically issued policy to this effect in its ADA Enforcement Guidance: Preemployment Disability-Related Questions and Medical Examinations (Oct. 10, 1995). Specifically, the EEOC policy states that if someone requests a reasonable accommodation, and the disability and/or the need for accommodation is not obvious, an employer may ask for reasonable documentation about the individual’s disability and functional limitations. In its Enforcement Guidance on Reasonable Accommodation and Undue Hardship, No. 915.002 (Oct. 17, 2002) at Question 6, the EEOC reiterated that an employer may require documentation to establish that a person has an ADA disability and that the disability necessitates a reasonable accommodation.

- Confer with the individual to discuss accommodation alternatives, which includes listening to the individual’s preference and the option to suggest alternatives.

- Document in writing the discussion about the accommodation and the final determination about how the accommodation request is resolved, including any undue-hardship analysis.

The obligation to provide a reasonable accommodation is ongoing. An employer may be required to provide more than one accommodation to a covered individual, and the employer may be required to provide a different accommodation if the disability or other circumstances change. Because unique and challenging situations can arise with respect to disabilities in the workplace, employers must understand their obligations to engage in the interactive process and reasonably accommodate individuals with disabilities.

I. PUBLISHED COURT DECISIONS


Plaintiff worked as a waitress and earned $2.10/hour plus tips. A year later, the owner gave her increased job duties and changed her pay to $100 per week plus tips. Plaintiff continued reporting tips to the IRS but unbeknownst to Plaintiff, owner stopped reporting her tips to IRS. Plaintiff did not realize this oversight until she received her W-2. Plaintiff did not report her tips to the IRS after learning that owner had not reported tips. She was injured and ALJ found that the AWW to be $259.22 based on the highest of four quarters prior to the date of injury. This highest quarter occurred prior to her change in pay structure.

ISSUE: Did the ALJ calculate the Plaintiff's AWW correctly?

HOLDING: Yes. The UEF argued that Plaintiff's wages were fixed by the week. The Supreme Court disagreed noting that unreported tips do not alter the reality that Plaintiff is an employee with variable income derived from gratuities; it does not convert her to an employee earning a fixed wage. The correct calculation of AWW is based upon the highest of her four quarters of wages prior to the date of injury even if during that highest quarter tips are included because they were reported.

FINAL: Yes


Plaintiff alleged he sustained a left shoulder injury on 4/27/15. Plaintiff acknowledged that he injured his left arm and shoulder in 2009 and underwent two surgeries between 2010 and 2011 and has since experienced ongoing pain. Plaintiff acknowledged that any claim arising from the 2009 injury was time barred. Plaintiff pointed out that after the 2009 injuries and subsequent surgeries, he was able to resume work on the assembly line with no restrictions or limitations. Therefore, Plaintiff asserted his 2009 injury had not caused him any impairment whatsoever. He argued that the new injury had culminated in additional, permanent pain in his left arm and shoulder separate and apart from his ongoing pain in that region of the body. Plaintiff sought TTD and medical benefits from

* With Special Thanks to Hon. Michael W. Alvey, Chairman, Kentucky Workers’ Compensation Board, Hon. Wayne Daub, and Hon. James Fogle.
the date of injury (4/27/15) to the date of MMI (10/30/15, the date Dr. Barefoot placed Plaintiff at MMI) and PPD and medical benefits thereafter. The ALJ dismissed the claim.

ISSUES: Did the ALJ err in dismissing the claim?

HOLDING: Partially yes. The Kentucky Supreme Court has explained that if work-related trauma exacerbates a pre-existing condition, causing it to require medical treatment but results in no permanent impairment rating, the worker has sustained a compensable injury and is entitled to what medical and TTD benefits the evidence permits. In other words, a worker with a work-related exacerbation of a pre-existing condition sustains a new and separate "injury" and is entitled to medical benefits at least until he returns to her pre-exacerbation, baseline state of health. The Court of Appeals affirmed that the ALJ did not err in finding Plaintiff had no entitlement to TTD or PPD income benefits. However, the Court of Appeals ruled that the ALJ did not decide whether Plaintiff did or did not suffer from an exacerbation nor was there a definitive adjudication regarding an alleged temporary exacerbation injury. The case was remanded to the ALJ to make such findings.

FINAL: Yes


ALJ found Plaintiff had classification of category 1/1 CWP with spirometric testing values that exceed 80 percent. Based on these findings, the ALJ awarded RIB benefits. Due to Plaintiff's advanced age, the ALJ found that Plaintiff could not receive those benefits unless he participated in an approved retraining or education program. The Plaintiff challenged the constitutionality of the RIB statute's age classifications.

ISSUE: Are the RIB statute's age classifications constitutional?

HOLDING: Yes. The Supreme Court held those age classifications are constitutional. The purpose of RIB is to encourage coal employees who have early signs of CWP to leave the coal industry before the disease results in significant impairment. Thus, in order to receive RIB benefits, employees who have radiographic evidence of the disease but no significant breathing impairment must stop working in the mining industry. Encouraging susceptible employees to leave the industry provides a rational basis for any perceived discrimination. Finally, KRS 342.732(1)(a)7 must fall or stand in its entirety and declaring it unconstitutional would leave Plaintiff in the same position: entitled to RIB benefits but only so long as he enrolls in and participates in an approved retraining or education program.

FINAL: Yes.

Plaintiff was injured and entered into a Form 110 which was approved by the CALJ. The settlement included PPD benefits awarded at a weekly rate of $218.89 for 425 weeks. Following approval of settlement, Plaintiff's attorney moved for attorney fee. The motion was sustained and counsel was awarded $9,401.41. Plaintiff elected to have this lump sum fee paid in a single payment with her weekly benefits reduced *pro rata*. Plaintiff anticipated her reduced weekly rate would be $193.69. CCMSI indicated her reduced weekly benefits were actually $191.36 reasoning that her reduced benefits must recoup the present day value of the lump sum attorney's fee to account for the time value of money. Plaintiff filed a Motion for Determination disputing CCMSI calculations and arguing that this $2.33 per week reduction which totals $869.09 allows CCMSI unilaterally to take extra money from her benefits without ALJ approval and thereby breaches the terms of the settlement agreement.

**ISSUE:** Did CCMSI's calculation take extra money from the Plaintiff and thereby breach the settlement agreement?

**HOLDING:** No. [KRS 342.320](#) provides that a claimant is responsible for payment of her attorney fees and lists possible options. Although CCMSI physically pays the lump sum fee, Plaintiff is the one actually paying the attorney. The use of the phrase "commuting sufficient sums to pay the fee" authorizes the present value discount. The lump sum is equal to the present value of future periodic payments. In this context, the statute is in fact contemplating a present value discount of a lump sum payment made through deductions from future periodic payments. The plain text of the statute clearly includes the ability to deduct present value discounts for lump sum payments effectuated by discounting future benefits.

**FINAL:** Yes.


Plaintiff, a janitor, was assigned to clean the paint shop facility at an automobile manufacturing plant. While cleaning the paint room, he inhaled chemical fumes and was ultimately diagnosed with GERD symptoms and cough possibly related to inhalation injury and reactive airway dysfunction syndrome (RADS). Pulmonary functional testing indicated moderately severe restriction. Physician recommended that Plaintiff return to work but avoid exposure to paint room chemicals. Plaintiff returned to work and was relocated to the main building to avoid exposure to paint chemical fumes. Plaintiff was capable of performing his janitorial duties in the main building but didn't believe he could work in the paint room because of the chemical fumes. The ALJ found that Plaintiff had lost the physical capacity to return to his pre-injury job and that he returned to work at equal or greater wages. The ALJ performed a Fawbush v. Gwinn analysis and concluded that Plaintiff's ongoing
pulmonary limitations made it unlikely he could continue earning a wage equal to or greater than his pre-injury wage for the indefinite future and applied the 3X multiplier.

ISSUE: Did the ALJ err in applying the 3x multiplier?

HOLDING: No. Although Plaintiff was able to perform janitorial tasks after his injury, he was no longer able to tolerate the presence of the chemical solvent as he had pre-injury. The ALJ's decision was supported by substantial evidence in the record. The ALJ weighed the medical and lay evidence, including the Plaintiff's own testimony regarding his ability to work, and the ALJ was persuaded by Plaintiff's testimony as to his pulmonary limitations. A review of the record indicates the ALJ's determination that Plaintiff was unlikely to earn the same or greater wage indefinitely was supported by substantial evidence.

FINAL: Yes.

F. Roach v. Owensboro Health Regional Hospital, 2015-CA-001696-WC, 518 S.W.3d 786 (Ky. App. 2017)

Plaintiff was injured on 12/28/12 while employed as a CNA. She was diagnosed with post-traumatic right cubital tunnel syndrome and underwent an ulnar nerve decompression of the right elbow. Plaintiff did not identify as exhibits any unpaid or out-of-pocket medical bills, and did not list "unpaid or contested medical expenses" as a contested issue in her pre-conference notice. "Unpaid or contested medical expenses" was not marked as a contested issue nor were unpaid or contested medical expenses listed at the hearing. The issue of unpaid medical expenses was not addressed during Plaintiff's direct and cross-examination and only raised for the first time on redirect examination. The ALJ admitted the bills into evidence over objection. The ALJ granted Employer two weeks to submit rebuttal evidence, and no rebuttal evidence was filed. The ALJ awarded PPD benefits and future reasonable and necessary medical expenses. Employer filed a petition for reconsideration asking that the ALJ deny Plaintiff's request for reimbursement and payment of the medical expenses at issue. The ALJ denied this petition stating the issue of unpaid or contested medical was not raised and as such the decision regarding the work relatedness of Plaintiff's injury is dispositive.

ISSUE: Did the ALJ err in denying the Employer's Petition of Reconsideration?

HOLDING: Yes. Plaintiff's complete failure to comply with any of the regulation's provisions regarding the introduction of exhibits and the identification of contested issues prevented the ALJ from resolving the compensability of the unpaid and out-of-pocket paid medical bills. § 13(9) provides the plaintiff/employee "shall bring to the BRC copies of known unpaid medical bills not previously provided and documentation of out-of-pocket expenses." The BRC's purpose is to expedite the processing of workers' compensation claims, to avoid the
need for a formal hearing by resolving controversies, and, if a hearing is unavoidable, to narrow and define the contested issues. Plaintiff thwarted these purposes by utterly failing to comply with the regulation's mandates. To compound the problem, Plaintiff made no mention of the bills during her direct examination. Not a word was said about her unpaid and out-of-pocket medical expenses until re-direct examination. This was Employer's first notice of the bills. As noted, Plaintiff admitted she never submitted the bills to Employer prior to the BRC or formal hearing. The ALJ abused its discretion when it admitted the bills into evidence.

FINAL: Yes.


Plaintiff was seriously injured on 10/8/12 while working with a crew constructing a concrete retaining wall next to a highway. Two VanMeter employees were also injured in the incident; one other employee was killed. The incident triggered an investigation by KOSHA. KOSHA issued three citations: one for improper fall protection at the job site; one for inadequate trenching at the job site; and one for improper support or bracing of formwork to protect against the failure of vertical and lateral loads. The proposed penalty for each violation was $5,600. VanMeter conceded liability on the first two citations. It further maintained that those citations did not contribute to the failure of the wall. VanMeter, however, contested the third citation relating to the alleged failure to properly secure the form. VanMeter and KOSHA entered into a Settlement Agreement. The ALJ awarded PTD benefits. However, the ALJ found that Plaintiff had not met her burden for proving a violation of a safety statute or regulation and was not entitled to an enhanced award.

ISSUE: Did the ALJ err in not awarding an enhanced award due to a safety violation?

HOLDING: No. Although the WCB reversed the findings of the ALJ, the Court of Appeals reversed the findings of the WCB. The fact that the employer settled the KOSHA citation without admitting a violation is immaterial. In the context of a workers' compensation claim, it is the responsibility of the ALJ to determine whether a violation of a statute or administrative regulation has occurred. The ALJ's opinion was supported by evidence of substance. The ALJ articulated what evidence and testimony was and was not persuasive and specified its reasoning. The ALJ, not WCB, is empowered to determine the quality, character and substance of the evidence. Additionally, it is the ALJ who makes the determination of whether a violation of a safety statute or administrative regulation has occurred. A settlement agreement for KOSHA citations and resulting fine is not evidence sufficient to compel a finding of an intentional safety violation.

FINAL: No (appealed to Kentucky Supreme Court).
H. **Parker v. Webster County Coal, LLC (Dotiki Mine), 2014-SC-000526-WC, 529 S.W.3d 759 (Ky. 2017)**

The Kentucky Supreme Court declared **KRS 342.730(4)** to be unconstitutional. That provision provided for the termination of all income benefits when the employee became eligible for normal old age Social Security retirement benefits. The Court ruled that this violated the Equal Protection provisions of the Constitution, and further that it constituted "Special Legislation," which is prohibited by the Kentucky Constitution. Webster County Coal, LLC filed a Petition for Certiorari which is still pending.


Plaintiff began working for Ford in 1993 and was transferred to the paint department in 2011. She described the job as strenuous and repetitious. Her right arm and elbow began to hurt in 2012. This pain became constant and severe by Feb 2013. She initially did not report her right upper extremity pain as work related. At some point, she changed her mind and sought workers’ compensation benefits. She sought compensation for cumulative trauma/repetitive motion injuries to her right arm, right wrist, and neck. The ALJ determined Plaintiff failed to prove her diagnoses were causally related to her work and dismissed the claim.

**ISSUE:** Did the ALJ err in dismissing the claim?

**HOLDING:** Yes. Although the WCB affirmed the ALJ, the CA reversed. Plaintiff argued that four doctors diagnosed her with work-related thoracic outlet syndrome but two did not link that diagnosis to Plaintiff's work activities. The ALJ found that Plaintiff had been actively treated for right arm, elbow, and neck pain since 2003 and stated that Dr. Bilkey failed to explain how or why Plaintiff's work activities caused her pain. However, upon review, Dr. Bilkey's report did indeed explain how Plaintiff's work activities caused her to experience pain. There must be proof in the record causally connecting the diagnosis to the work injury in order for the ALJ to make a finding of work-relatedness. "While the ALJ was certainly at liberty to pick and choose what evidence she found persuasive, we hold that she flagrantly erred in her discounted assessment of Dr. Bilkey's evaluation in reaching the decision to dismiss Plaintiff's claim and that this caused a gross injustice to Plaintiff." This matter was remanded to permit the ALJ to properly examine Dr. Bilkey's report along with the rest of the medical proof and make an appropriate decision as to whether Plaintiff met her burden to establish that her condition was work related.

**FINAL:** No. (This has been appealed to Kentucky Supreme Court).
Ray Thomas settled a workers' compensation claim with his employers and its insurers. The parties agreed that Thomas would receive periodic payments through the purchase of an annuity. His employer's insurer assigned its obligation to make those payments to American General Annuity Service Corporation (AGASC) via qualified assignment. AGASC then purchased the annuity from American General Life Insurance Company (AGLIC) to fulfill the obligation. Following these events, Thomas sought to transfer his rights in the periodic payments to a third party in exchange for one lump-sum payment. Thomas contracted with DRB for this purpose. DRB in turn filed an application to approve the transaction, which AGASC and AGLIC (collectively "American General") contested. In opposition, American General argued that the language of the settlement agreement, the qualified assignment to AGASC, and the annuity contract each proscribed an assignment of Thomas' payment rights. They also argued that the provisions of Kentucky's Structured Settlement Protection Act (SSPA), found at KRS 454.430, do not apply to structured settlements resulting from workers' compensation claims. The circuit court approved Thomas' assignment to DRB. The circuit court concluded the SSPA applies to workers' compensation settlements and further found that the assignment was in Thomas' best interest.

ISSUES: Did the circuit court err in approving Thomas' assignment to DRB? Do the provisions of Kentucky's Structured Settlement Protection Act at KRS 454.430 apply to workers compensation claim?

HOLDING: No, the circuit court did not err in approving Thomas' assignment to DRB. KRS 454.430 to 454.435 sets forth the procedure one must follow when seeking to transfer payment rights under a structured settlement. Namely, he or she must petition and receive approval from a circuit court of competent jurisdiction. Another panel of the Court considered whether KRS 454.435 conferred jurisdiction on circuit courts to approve the factoring of a workers' compensation award. That panel construed the statutory language in light of the entire SSPA and answered in the affirmative. In this case, as the payee under the structured settlement agreement, Mr. Thomas had a legitimate claim to his periodic payments just like any creditor in a debtor-creditor relationship. That claim is the hallmark of a personal property interest and under Wehr Constructors, Inc. v. Assurance Co. of America, 384 S.W.3d 680, 688 (Ky. 2012) may not, ordinarily, be restrained from alienability. The anti-assignment provisions in this case were accordingly unenforceable, and Mr. Thomas was able to avail himself of the SSPA procedures.
Dr. Grossfeld performed an IME on the Plaintiff and assigned an 8 percent impairment rating. The ALJ used this rating in calculating Plaintiff's award. Plaintiff asserted that Dr. Grossfeld utilized passive range of motion measurements rather than active range of motion measurements of his right shoulder. He argued the AMA Guides required the evaluation of his right shoulder to be based only upon active range of motion measurements. As such, he reasoned Dr. Grossfeld effectively disregarded the AMA Guides, and, consequently, the ALJ had no right to rely upon her opinion in determining his award. An ALJ may not give credence to a physician's impairment rating if the rating is not based on the AMA Guides. Any assessment that disregards the express terms of the AMA Guides cannot constitute substantial evidence to support an award of workers' compensation benefits.

ISSUE: Did the ALJ err in relying upon the opinion of Dr. Grossfeld in calculating the Plaintiff's award?

HOLDING: No. The ALJ considered Dr. Grossfeld's opinion and accompanying direct testimony. The ALJ and the WCB both concluded that this case was not one where a physician directly disregarded the AMA Guides in arriving at an impairment rating. Both concluded this case concerned a medical expert's permissible interpretation and application of the AMA Guides. The AMA Guides acknowledge that the effectiveness and accuracy of these kinds of tests are subject to the conscious or subconscious processes of the individual being evaluated. The physician must use the entire range of clinical skill and judgment when assessing whether or not the measurements or tests results are plausible and consistent with the impairment being evaluated. If, in spite of an observation or test result, the medical evidence appears insufficient to verify that an impairment of a certain magnitude exists, the physician may modify the impairment rating accordingly and then describe and explain the reason for the modification in writing.

If Dr. Grossfeld believed, in light of other medical evidence and in the exercise of her entire range of clinical skill and judgment, that Plaintiff's measurements were implausible, indicative of poor effort, and insufficient to verify that an impairment of a certain magnitude existed, then Dr. Grossfeld was permitted to discount the active range of motion measurements she obtained from Plaintiff and modify his impairment rating which was what happened in this case. This reflected Dr. Grossfeld's interpretation of the AMA Guides and her assessment of Plaintiff's impairment both of which are medical questions. The ALJ, as fact finder, is vested with sole authority to judge the credibility of conflicting medical evidence and in this case properly exercised his authority as fact finder in relying upon the expert opinion of Dr. Grossfeld.

FINAL: No. (This case has been appealed to Kentucky Supreme Court.)
Plaintiff injured his back on 10/22/07 while working as a youth director for a community action agency. He underwent a lumbar fusion, and returned to work. He continued to have low back pain, irritability and depression. In 2010, the ALJ found 13 percent impairment for the physical injury and 5 percent for the psychological injury, which combined to 17 percent impairment. The ALJ found Plaintiff was capable of performing his pre-injury job. Plaintiff filed a motion to reopen in March 2014. He testified his back and leg pain increased, and he was no longer able to work. He had undergone implantation of a spinal cord stimulator, which partially relieved his leg symptoms, but his physician had to remove it within a year because of a malfunction. Dr. Brackett assessed 47 percent impairment of which 15 percent was cervical spine, 6 percent was thoracic spine, and 28 percent was lumbar spine. Dr. Guberman assessed 28 percent impairment for the lumbar spine. Dr. Vaughn assessed 23 percent impairment. Dr. Vaughan stated he would have assessed the same impairment rating and imposed the same restrictions if he had seen Plaintiff following his lumbar fusion. The ALJ found Plaintiff was not PTD but chose to believe Dr. Vaughan and found an increase in physical impairment from 13 percent to 23 percent. He also found a 12 percent psychological impairment, which combined to 32 percent impairment. The ALJ further found Plaintiff had lost the capacity to return to his pre-injury job, and awarded PPD benefits with the 3x multiplier.

ISSUE: Did the ALJ err in choosing to believe Dr. Vaughn, who concluded that Plaintiff had sustained no change in impairment rating or worsening of disability since the original award?

HOLDING: No. KRS 342.125 requires the claimant to prove a worsening of impairment. On reopening, the ALJ's finding regarding the claimant's permanent impairment rating at the time of the initial award is non-reviewable once final. The first ALJ's finding that Plaintiff had a 13 percent impairment rating is res judicata and cannot be revised on reopening. The initial permanent impairment rating is the baseline which the ALJ must use on reopening to determine if there has been any increase. It is the fact finder's opinion regarding a claimant's permanent impairment rating that controls, not the opinion of a physician. The ALJ was free to choose what evidence to believe.

FINAL: Yes.

The CALJ ruled that a pharmacy is a "medical provider," and that the claimant has the statutory right to choose which pharmacy will fill his prescriptions. The CALJ further resolved the medical fee dispute over pharmaceutical pricing in favor of IWP, and imposed sanctions on the
Defendant for bringing or defending the reopening without reasonable grounds.

ISSUE: Did the CALJ err in determining that a pharmacy is a medical provider and that the claimant has the statutory right to choose which pharmacy will fill his prescriptions?

HOLDING: No. The Supreme Court ruled that a pharmacy is a medical provider, and, absent the employer's participation in a managed care organization, claimants are free to choose which pharmacy to use. Pharmacy reimbursement rate disputes should be resolved the same way all other disputes under KRS 342 are resolved: the parties present their proof, and the ALJ makes a determination. The ALJ may, but is not required to, take into consideration the published average wholesale price. The ALJ may also take into consideration the wholesale acquisition price, which has some connection to what a wholesaler would charge a retailer. The ALJ, by exercising the discretion granted to him or her, must determine what the appropriate reimbursement rate is under the regulation. As to this case, the CALJ did not order KESA to reimburse IWP based on the published average wholesale price that IWP charged. He ordered KESA to reimburse IWP pursuant to the statute and regulations, which he correctly interpreted to be the actual average wholesale price IWP paid. However, the CALJ did not make any specific findings regarding the actual average wholesale price IWP paid for the medications it dispenses. Therefore, this matter must be remanded to the DWC for assignment to an ALJ with instructions to make findings regarding what IWP's actual average wholesale price was for the medications at issue. KESA is not liable for interest on any past due medical benefits it may owe IWP. WCB correctly reversed the CALJ's assessment of costs against KESA.

FINAL: No. (Case still pending on Petition for Rehearing.)


Mamie Baytos' husband, Stephen, sustained a serious work-related injury (a torn thoracic aorta) on 2/9/06, and died on 12/3/09. Before Stephen passed away, he entered into a settlement with Family Dollar. He accepted a lump-sum payment and agreed not to pursue any future claims. The settlement was not signed by Mamie, and it did not include references to any future rights that she might have. On 8/31/11, Mamie filed a motion to reopen Stephen's claim in order to seek death benefits. The ALJ determined that Stephen's death was a result of the injury, and he awarded death benefits to Mamie.

ISSUE: Did the ALJ err in awarding death benefits or were death benefits barred by the settlement agreement?

HOLDING: No, the ALJ did not err in awarding death benefits. The text of KRS 342.750 is inescapable. The plain meaning is unmistakably clear.
that if a worker dies because of a workplace injury, the worker's surviving spouse is entitled to income benefits in the form of 50 percent of his AWW. The Kentucky Supreme Court has previously interpreted this provision, in a manner academically favored and consistent with a majority of other jurisdictions, to create a separate cause of action for surviving spouses independent of the injured worker's claim. The Court understands the implications this ruling may have on the settlement negotiation process and the possibility that this holding may undercut the ability of employers and injured employees to come to an agreement with binding finality. But those problems belong to the legislature to resolve and are beyond our constitutional prerogative of interpreting the law as presented by the case before us.


On 6/26/07, Cheryl Blaine, the Executive Director for the Authority injured her lower back and eventually had surgery on her back. Following her surgery, she returned to work for the Authority on 1/28/08. In 12/09, Blaine filed a claim for her 2007 injury. Blaine's claim was placed in abeyance pending additional treatment and settlement discussions. On 4/28/11, while Blaine's first claim was still pending, Blaine again injured her back at work, and underwent surgery for this injury as well. She did not return to work. Blaine filed a claim for this second injury. The ALJ determined that Blaine was entitled to PPD benefits for the 6/26/07 injury based upon a 26 percent impairment rating with no multipliers. The ALJ determined that the second injury rendered Blaine PTD. On appeal, the WCB concluded that the ALJ failed to address whether Blaine's first injury rendered her PTD. Additionally, WCB concluded that the ALJ failed to conduct a proper analysis under Fawbush v. Gwinn.

ISSUE: Were the WCB's findings correct?

HOLDING: Yes. Blaine urged the Court to revisit Fawbush and limit its analytical framework to those circumstances where the injured worker returns to work and is competitive with non-injured employees without any job modifications, concessions or accommodations. The Court disagreed. Blaine argued that she did not return to work at equal or greater wages. The Court noted that Blaine stipulated to an AWW of $1,202.80 on 6/26/07 and an AWW of $1,287.50 on 4/28/11, and stipulated that she returned to work on 1/28/08 at equal or greater wages. The ALJ was not required to and, indeed, not authorized to look beyond this stipulation by the parties but had he done so, it would not change the fact that Blaine's compensation was "equal to or greater" at the time of her January, 2008, return to work. Ultimately, a triple benefit may be permissible depending on the ALJ's findings, but it is not required as Blaine argued on appeal.

FINAL: Yes.
Plaintiff filed a Form 101 alleging that he suffered work-related injuries to his back, neck, left hip, and left knee from tripping while exiting a bulldozer and falling onto the track. The ALJ conducted a hearing on 12/18/14. Following that hearing, Plaintiff's attorney engaged in settlement discussions with the adjustor for Crossrock's insurer. Neither the ALJ nor Crossrock's counsel were advised of these negotiations. In the final email, dated 2/24/15, the adjustor indicated that Crossrock would agree to a settlement involving a lump-sum payment of $55,000 with a waiver of vocational rehabilitation benefits. The adjustor also asked Plaintiff's attorney to prepare the appropriate settlement documents. But on 2/20/15, the ALJ issued an Opinion and Award concluding that Plaintiff was not entitled to TTD benefits or future medical benefits. Plaintiff's attorney received the opinion on 2/25/15. On 3/3/15, Plaintiff filed a Petition for Reconsideration, asserting that the parties reached a settlement prior to receipt of the Opinion. Plaintiff attached copies of the emails as an exhibit to the petition. In its response, Crossrock argued that any negotiations between Plaintiff's counsel and the adjustor were improper because SCR 3.130(4.2) prohibits a lawyer from communicating with a client who he knows to be represented by counsel. In the alternative, Crossrock argued the alleged settlement failed to resolve all material terms and was therefore unenforceable. The ALJ denied the Petition for Reconsideration and concluded that Plaintiff failed to properly raise a motion to adopt the settlement by filing a Form 110 or by presenting verified motion to adopt the settlement agreement.

ISSUE: Did the ALJ err in denying the Plaintiff's Petition for Reconsideration?

HOLDING: No. The issue was not whether the terms of the alleged settlement between Plaintiff and Crossrock's insurance adjuster were complete, but rather whether the settlement was properly introduced into the record for the ALJ to consider at all. By statute, in order for a settlement agreement to be enforced, it must be filed with and approved by the ALJ. Although the omission of a Form 110 is not fatal to Plaintiff's claim, in its absence, Plaintiff was required to file a verified motion with the correspondence and sufficient documentation, which taken together, comprise a complete memorandum of agreement. Plaintiff, however, never filed a verified motion; instead, he attempted to bring the correspondence into the records via his petition for reconsideration. As a result, the alleged terms of the settlement were never properly brought before the ALJ.

FINAL: Yes.
On 4/11/12, Silva-Lamas was working as a brick mason’s helper when he fell from a ladder and suffered multiple injuries. In his initial Application, Silva-Lamas named Jose Acahua as his employer. Acahua did not have workers' compensation insurance. During the course of discovery, the parties determined that, at the time of his injury, Silva-Lamas was working on a house owned by Barry Chaney. Chaney and his wife decided to put a brick and wood porch on the back of their house. Chaney hired a contractor named Timberwolf to perform the framing and carpentry, and he intended to hire his brother-in-law, Stonie Newsome, to perform the masonry work. However, by the time Timberwolf completed its part of the construction, Newsome was too busy with other projects to do the masonry work. Therefore, Newsome had one of his employees, Jose Acahua, contact Luis Lopez to see if Lopez could do the masonry work. Lopez agreed to do the work, and he enlisted Silva-Lamas and two others to assist him. Acahua did not perform any work on the job but acted as an interpreter among Lopez, his helpers, and Chaney, and Acahua apparently handled some of the monetary transactions between Chaney and Lopez, who acted as the "boss" on the job. Silva-Lamas moved to join Newsome and Lopez as defendant/employers. The ALJ denied Silva-Lamas' motion as to Newsome but granted it as to Lopez and sent a copy of the joinder order to Lopez by first-class mail. Following the ALJ's joinder order, Silva-Lamas filed a second Application naming Lopez as his employer. The Commissioner of the DWC sent a copy of that Application to Lopez via first class mail. The postal service returned that mailing stamped "undeliverable." Because it appeared that Lopez never received notice of the claim, the UEF contested the DWC's jurisdiction to proceed against him, and by extension, against the UEF. The ALJ rejected the UEF's argument.

ISSUE: Did the ALJ err in rejecting the UEF argument?

HOLDING: No. KRS 342.270 states that if the parties fail to reach an agreement as to compensation, either party may make written application for resolution of claim. Once an application is filed, the Commissioner is required to issue notice of the filing to all parties. Pursuant to 803 KAR 25:010, Section 3(2), the Commissioner then serves the application by first class mail. As the UEF noted, the service provision of the regulation appears to be at odds with KRS 342.135. However, in looking at KRS 342.135 as a whole, it is clear that the General Assembly intended to provide two methods for notices to be given or served. The first is by registered mail, and the second is pursuant to whatever method the civil rules deem adequate. The Commissioner's mailing of Notice of Silva-Lamas' claim to Lopez complied with the service requirements of the Civil Rules.

FINAL: Yes.

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Plaintiff sustained injuries in a motor vehicle accident on 11/15/12, while employed as an over-the-road truck driver. Plaintiff kept his truck at home at all times except when he was driving, or when he took it to the terminal at Lewisport for service. He called the dispatcher from his home to receive assignments, and left on his route from his home. When his route was finished, he returned home with the truck. His home was near the interstate. Plaintiff stated keeping a truck at home provided a benefit to First Class by reducing fuel cost, wear and tear on the vehicle, and maintenance costs. This testimony was corroborated by other employees. The day before the accident, Plaintiff became ill while returning to Kentucky from a delivery in Illinois. Plaintiff took his truck to Derby City Tank Wash in Louisville, where he was to have the tank cleaned before proceeding to Frankfort to pick up a load. It was determined Plaintiff should not complete his dispatch and another driver was sent to the tank wash to pick up Plaintiff's trailer to finish the dispatch. Plaintiff was on his way home from the tank wash in his truck without the trailer, when his truck left the road and crashed into trees. The ALJ dismissed the claim based on the going and coming rule.

ISSUE: Did the ALJ err in dismissing the case based on the going and coming rule?

HOLDING: Yes. The sole issue before the Court of Appeals was whether the WCB properly ruled in Plaintiff's favor in its determination that Plaintiff was providing a service to Employer and was entitled to traveling employee status at the time of the accident. The WCB ruled that Employer had failed to meet the burden of demonstrating overwhelming favorable evidence in support of its position that Plaintiff was not providing a service to it or that Plaintiff was not a traveling employee. Plaintiff had been employed since 1998 and had routinely driven the Employer's rig (with or without a trailer or tanker) to and from his home. As he and three other employees testified, keeping a truck at home provided a benefit by reducing fuel cost, wear and tear on the vehicle, and maintenance costs. Because Plaintiff's route began and ended at home, returning home early because of illness did not introduce a significant departure from that routine. Plaintiff was merely returning home, albeit earlier in the day than usual, from work; there was no "distinct departure from the normal course of his employer's business."

FINAL: Yes.

Miner was killed in a mining accident. The Mine Safety and Review Commission issued citations to McCoy Elkhorn for violating safety regulations relating to its roof safety plan. The ALJ determined McCoy
Elkhorn committed intentional safety violations that caused Miner's death and awarded enhanced benefits. The ALJ found AIG/AIU Ins. Co. v. South Akers Mining Co., LLC, 192 S.W.3d 687 (Ky. 2006), to be applicable. In AIG/AIU, the Court ruled that the employer's insurance company was liable for enhanced benefits awarded under KRS 342.165(1).

ISSUE: Did the ALJ err in awarding enhanced benefits per the findings of AIG/AIU?

HOLDING: No. KCESIF argues AIG/AIU is inapplicable here because it is a guaranty fund rather than an insurance carrier; consequently, the assessment of the 30 percent enhanced benefit unfairly penalizes KCESIF because the employer is insolvent. However, the Court of Appeals stated that AIG/AIU clearly established that an award of benefits pursuant to KRS 342.165(1) is increased compensation owed to the worker, not a penalty against the employer. Further, because AIG/AIU established KRS 342.165(1) does not impose a "penalty," KCESIF cannot rely on the language of KRS 342.910(2) exempting guaranty funds from liability for assessed penalties. In this case, Miner's award included the 30 percent benefit enhancement pursuant to KRS 342.165(1). Miner's employer, McCoy Elkhorn, would have been liable for payment of the entire award but for its insolvency; accordingly, KRS 342.900 and KRS 342.906(9) support the conclusion that KCESIF is obligated to pay Miner's entire award.

FINAL: Yes.

II. UNPUBLISHED COURT DECISIONS


Plaintiff sustained four separate work related injuries to his back. Plaintiff settled the first injury and filed a claim for benefits for the 2006, 2009 and 2011 injuries. Dr. Burke assigned 34 percent impairment rating, and Dr. Snider assigned 22 percent impairment rating. ALJ found Dr. Snider's report to be more credible and calculated the award based on three separate and distinct injuries rather than aggregating them as if they were one injury. Plumley argued that the methodology utilized by Dr. Snider's impairment rating did not conform to the AMA Guides. However, what Plumley characterizes as multiple instances of disregard from the AMA Guides is just as easily characterized as a differing interpretation and application of the Guides by a medical professional. Plumley also contended that his multiple specific traumatic injuries, which were separated by a period of years, should be treated as a single cumulative stress injury for the purpose of determining benefits as they had a cumulative effect on his condition. This assertion goes against the principle of Lewis v. Ford Motor Co., 363 S.W.3d 340 (Ky. 2012), where the Supreme Court ruled that partial disability awards rendered for specific injuries to the same body part occurring at different times should
not be aggregated to allow the claimant to receive payments that exceed the maximum for permanent total disability. The Lewis holding should be extended to this case as to rule that Plumley's distinct and specific traumatic injuries somehow related to a cumulative trauma injury would be to ignore the delineation between the two types of injury. The record contains ample evidence of specific instances of workplace trauma causing injuries of appreciable proportion.

**HOLDING:** Singular, but repeated, injury events created by gradual injury do not amount to cumulative trauma per existing case law.

**FINAL:** Yes (not appealed to Supreme Court).


Plaintiff filed a claim for pneumoconiosis in 1993 while working for Ikerd & Bandy. Plaintiff settled his claim in 1994 where he agreed to resolve his pneumoconiosis claim in exchange for a lump sum RIB payment. In the present case, the ALJ found that Plaintiff had established the presence of CWP, category 1/1 and no pulmonary impairment based on pulmonary function studies above 80 percent. Plaintiff will only be entitled to a RIB benefit. Due to Plaintiff's age (sixty) at the time of last exposure, he has the option to elect to receive a 25 percent PPD rating from the date of last exposure until age sixty-five. The ALJ denied James River any credit for the prior RIB settlement between Plaintiff and Ikerd & Bandy.

**ISSUE:** Did the 1994 settlement constitute a RIB award?

**HOLDING:** The 1994 settlement did constitute a RIB award as Plaintiff entered into a settlement agreement whereby he agreed to resolve his pneumoconiosis claim in exchange for a lump sum RIB payment. The Court of Appeals acknowledged that the 1994 settlement was ambiguous but as the 1994 settlement explicitly recited its basis as a RIB claim, and Plaintiff received a lump sum payment as a RIB award, then the Court of Appeals concluded Plaintiff contracted for and received a RIB award in 1994. As Plaintiff had previously received a RIB award in 1994, the ALJ erred in awarding additional retraining incentive benefits.

**FINAL:** No (appealed to Kentucky Supreme Court).


Plaintiff and his wife operated Kay Trucking. Plaintiff repaired and operated several trucks owned by the company, and his wife handled business operations. Plaintiff fell from a ladder while working on a truck in November, 2013. Plaintiff told his wife about the fall but did not seek medical attention until January, 2014. On 1/23/14, Plaintiff injured his back and right shoulder while lifting a hood on a coal truck. This incident was witnessed by his wife, and she called the workers' compensation
insurance carrier and reported the November, 2013, and January, 2014, incidents. Plaintiff also injured himself while lifting a 100 pound tire in February, 2014. Plaintiff had significant prior medical history which was submitted by the Defendant-Employer. Dr. Nadar assessed 5 percent impairment for cervical spine, 8 percent for lumbar spine, 6 percent for right shoulder and 4 percent for left shoulder. Dr. Nadar attributed 30 percent of the overall impairment rating to pre-existing conditions. Dr. Jenkinson assigned 0 percent impairment from the three work incidents. The ALJ assigned impairment based on Dr. Nadar's rating and determined Plaintiff was PTD. Defendant asserted Dr. Nadar was not provided prior medical records which would potentially affect his findings of causation. The ALJ articulated her reasoning why Dr. Nadar's report constitutes substantial evidence.

ISSUE: Did the ALJ err in finding Dr. Nadar's report constituted substantial evidence due to the failure of Dr. Nadar not being provided prior medical records?

HOLDING: No. The Court of Appeals held that any deficiency in Dr. Nadar's report due to the medical history provided to him goes to the weight of the evidence and is a subject which might have been addressed via cross examination had Dr. Nadar been deposed. The ALJ stated she considered the total evidence in this claim, which included Plaintiff's testimony regarding which incidents caused his current conditions. Her conclusions were well supported by Plaintiff's testimony. Therefore, there was no error in the ALJ's reliance upon Dr. Nadar's impairment ratings.

FINAL: Yes (not appealed to Kentucky Supreme Court).


Plaintiff alleged he sustained injury to both upper extremities as a result of repetitive job duties. Dr. Byrd diagnosed status post pronator teres syndrome, status post carpal tunnel syndrome with release and ulnar nerve transposition. Dr. Byrd assigned 7 percent impairment attributable to the right upper extremity. In contrast, Dr. Dubou opined the cubital tunnel syndrome had nothing to do with work and assigned 2 percent impairment rating based upon persistent carpal tunnel findings. The ALJ concluded that Plaintiff sustained compensable injuries including the cubital tunnel syndrome. The ALJ awarded PPD benefits based on Dr. Byrd's 7 percent rating and awarded TTD benefits from 3/8/13 to 7/15/13, the time when Plaintiff was performing the light duty inspector position, which the ALJ concluded was not sufficiently similar to his pre-injury work activities.

ISSUES: 1) Was the ALJ's finding that the cubital tunnel syndrome is work related supported by the medical evidence? 2) Did the ALJ err in awarding TTD from 3/8/13 to 7/15/13?
HOLDING: 1) Yes. The ALJ based his decision on the opinion of Dr. Byrd, who believed that Plaintiff was having problems associated with an ulnar neuropathy of his right elbow from repetitive work. Records from Dr. Tsai also indicated symptoms associated with work activity, which the ALJ believed supported Dr. Byrd’s opinion that there was a causal connection. 2) Yes. The Defendant cites *Trane Commercial Systems v. Tipton*, 481 S.W.3d 800 (Ky. 2016) which was decided after the ALJ rendered his decision. Defendant contends that Plaintiff's light duty inspector job was a legitimate job which benefited Employer and did not require additional training to perform. Plaintiff was paid his regular wages while on light duty. Defendant argued that Plaintiff was not entitled to TTD during this time because his situation did not constitute the "extraordinary circumstance" contemplated by *Tipton*. The matter was remanded to the ALJ to consider the *Tipton* factors.

FINAL: Yes (appealed to Supreme Court which affirmed on 9/28/17).


Plaintiff injured her right leg on 1/4/12, and alleged she developed PTSD from the incident. She was off work from 1/4/12 to 8/15/12, and was paid TTD benefits. She returned to work at UPS on 8/15/12 with accommodations. She was not able to completely perform her duties as she had prior to her injury. She was under no work restrictions, and the crew members and her supervisor performed all her work involving dollies. She was being paid a wage that was greater than her pre-injury AWW, and had not missed any time from work. The ALJ awarded PPD benefits with the 3x enhancement multiplier, after performing a Fawbush analysis. He also awarded TTD benefits for the period she worked at greater wages from 8/15/12 until she reached MMI on 1/4/13. UPS asserted that the ALJ's findings went to whether Helms was entitled to the 3x multiplier pursuant to *KRS 342.730(1)(c)* (whether she retained the physical capacity to perform the same job as when she was injured) rather than whether she returned to her usual and customary work for purposes of the TTD analysis.

ISSUE: Did the ALJ err in awarding TTD benefits to Plaintiff from the time she returned to work on 8/15/12 through 1/4/13?

HOLDING: Yes. The question before the ALJ was whether she had returned to her usual and customary work, which the record reflected she had on 8/15/12. The record also reflected that Plaintiff had taken a second job with Delta doing the same job she performed at UPS.

FINAL: Yes.

McKinnley Morgan, an attorney, represented Stanley McQueen in a workers’ compensation claim against Memorial. McQueen ultimately agreed to the terms of a settlement agreement. According to the agreement, McQueen would receive a lump sum payment for past due benefits from 1/21/13 through 7/15/13. In May 2013, the ALJ approved the settlement and rendered an order awarding Morgan an attorney fee of $10,837.41. On 6/6/13, Memorial forwarded a check to Morgan's office in the amount of $15,414.41. The check stub included the notation "past due benefits." Days later, after deducting litigation expenses of $1,203.00, Morgan disbursed the remaining $14,211.41 to McQueen. In 4/15, Morgan filed a complaint against Memorial in Clay Circuit Court to enforce the attorney fee award. Memorial filed an answer and counterclaim denying the allegation and asserting Morgan's claim was fraudulent. Memorial argued Morgan had erroneously disbursed the check to McQueen and was attempting to recoup the money from Memorial. In an order rendered 9/7/15, the circuit court concluded no issues of fact existed and granted summary judgment in Morgan’s favor.

ISSUE: Did the circuit court err in granting summary judgment to Morgan?

HOLDING: Yes. It was undisputed that Memorial submitted a check for $15,414.41 to Morgan and that Morgan subsequently disbursed $14,211.41 to McQueen. Memorial presented documentary evidence and affidavits indicating the check included funds for both Morgan's attorney fee and McQueen's past due benefits. Viewing the record most favorably to Memorial, clearly it presented affirmative evidence that material issues of fact exist as to whether Morgan's attorney fee was included in the check for "past due benefits."

FINAL: Yes.


Plaintiff sustained multiple injuries in a fall from a roof on 5/31/11. Plaintiff named Absolute Metal Building Systems as the employer and the Commissioner certified that Absolute did not have coverage. The UEF then filed a motion to join additional defendants. Chris Caldwell hired Plaintiff to perform this construction work. Caldwell is the owner of Absolute. Caldwell was also an independent, commission-based salesman for Tin Man. The construction site is owned by Chris Campbell. The ALJ determined Caldwell was acting as a general contractor in retaining the services of Plaintiff and a few other men who helped erect the building for Campbell. However, the ALJ concluded Plaintiff was an employee of Tin Man under the up-the-ladder theory of liability. The ALJ next concluded Tin Man was responsible under the joint venture or joint enterprise theory of liability. The ALJ found Plaintiff was an employee of both Caldwell and Tin Man. The WCB determined that Tin Man could not
be liable simultaneously as an employer, an up-the-ladder employer, and a member of a joint venture. Thus, WCB vacated and remanded with the instruction that the ALJ "clarify his holdings and identify a single theory of Tin Man's liability, if any." On remand, the ALJ determined that the members of the joint venture and/or their insurance carrier were jointly and severally liable for payment of the workers' compensation benefits awarded.

ISSUE: Did the ALJ err in determining that members of the joint venture were jointly and severally liable for payment of workers' compensation benefits awarded?

HOLDING: Yes. A specific agreement to share profits must constitute an essential element of every partnership. The absence of such an agreement to share profits is conclusive proof that a partnership does not exist. The evidence did not support the ALJ's finding of a joint venture with respect to Tin Man because it was only paid for the materials it supplied and did not share in profits.

FINAL: Yes.


Plaintiff worked thirty years in the coal industry. He filed a cumulative trauma claim. The employer submitted evidence of a long history of prior problems to the body parts involved. The medical evidence was conflicting as to whether Anderson had sustained cumulative trauma. The ALJ denied the claim.

ISSUE: Did the ALJ err in denying the cumulative trauma claim?

HOLDING: No. In the instant case, the ALJ articulated his reasoning for finding the opinions of certain doctors more persuasive over conflicting medical evidence. The ALJ was free to weigh the evidence and reasonably relied on certain doctors over others.

FINAL: Yes.


Plaintiff had worked in underground coal mining for forty years. He filed a claim for both a shoulder injury and hearing loss. At the BRC, the contested issues included the work-relatedness of the shoulder injury and the possible award of PTD benefits. An audiologist evaluated Plaintiff's hearing and assigned him a 21 percent impairment rating. Plaintiff testified that his employer provided hearing protection but wearing such devices was unsafe and impractical. The devices prevented miners from hearing the tell-tale audible indications of an imminent ceiling collapse,
and also hindered or prevented communications and instruction between co-workers. The ALJ awarded PTD benefits for the hearing loss.

ISSUE: Did the ALJ err in awarding PTD benefits for hearing loss?

HOLDING: No. The ALJ noted in his Opinion that Employer acknowledged awareness of Plaintiff's audiology report and findings, and that Employer's brief to the ALJ discussed the extent of Plaintiff's impairment due to hearing loss. Employer clearly had opportunity to present a defense to Plaintiff's claim, and in fact did attempt to present a defense. The ALJ did not abuse his discretion in adjudicating the issue of PTD benefits as it related to hearing loss. The ALJ applied the Ira A Watson factors to assess Plaintiff's circumstances. His physical condition was such that even given reasonable accommodations (hearing aids), he would still be required to wear hearing protection per restrictions, which were both unsafe and impractical in the noisy underground environment. His advanced age (sixty-one years) and his limited education (his highest level of scholastic completion was eleventh grade) coupled to significantly limit Plaintiff's ability to find gainful employment and perform duties required by such employment. The ALJ also specifically found that Plaintiff's skills as a miner would not transfer to any occupation outside of the mine setting. Plaintiff is, due to a work-related occupational disease or injury, unable to find or maintain employment.

FINAL: Yes.


Plaintiff began working for Speedway starting in August 2013. He was transferred to a store in Southpoint, OH, and then transferred to a store in Huntington, WV, in May, 2014. Plaintiff allegedly injured his right shoulder while working at the WV store. He was transferred back to Kentucky and began working at Speedway in Louisville in June, 2014. Plaintiff filed his claim for the injuries to his right shoulder in May, 2014. The ALJ concluded that Plaintiff was covered for workers' compensation benefits under the extraterritorial provisions of KRS 342.670.

ISSUE: Did the ALJ err in his conclusion that Plaintiff was covered for workers' compensation benefits under the extraterritorial provisions of KRS 342.670?

HOLDING: Yes. There was no dispute Plaintiff's contract of hire was made in Kentucky and he was injured while working at the West Virginia store. The ALJ was faced with determining whether KRS 340.670 subsection 1(a) or 1(b) was applicable to the facts of this case. The ALJ did not engage in any discussion or analysis of the potential applicability of KRS 342.670(1)(a) or (b). The ALJ's failure to engage in fact-finding was compounded by his failure to cite to the specific subsection of KRS 342.670(1) he found applicable in determining Plaintiff was "covered for workers' compensation benefits under the extraterritorial provisions of
The issue is whether at the time of Plaintiff's injury his employment was principally localized in West Virginia or was not principally localized in any state. If Plaintiff's employment was not principally localized in any state, since he was working under a contract of hire made in Kentucky, Kentucky had jurisdiction. However, if Plaintiff's employment at the time of the injury was principally localized in West Virginia, West Virginia had jurisdiction. The failure of the ALJ to support his determination of extraterritorial coverage with any analysis about whether Rose's employment was principally located in Kentucky or in any other state rendered the ALJ's opinion not in conformity with KRS Chapter 342. And, WCB may sua sponte review a question of law even though it is unpreserved. The WCB properly determined that the ALJ must reconsider the issue of extraterritorial coverage under the provisions of KRS 342.670 so that the ALJ can make the appropriate conclusions and analysis concerning whether Plaintiff's employment was principally located in Kentucky or any other state.

FINAL: Yes.


HBC Leasing, a corporation engaged in the leasing of property, hired and paid Brent Owen of O & O Builders to build a metal building on the Livingston County property. The owners of HBC also owned MPD, an engine repair corporation. Owen hired a second construction company to assist with the job and also employed Brock. Brock was injured while working at the construction site in September, 2007. Between MPD, O & O Builders, and HBC Leasing, only MPD held workers' compensation insurance. The ALJ identified Owen as the party responsible for payment of Brock's benefit; however, Owen did not have workers' compensation insurance. Accordingly, the burden of compensating Brock fell to the UEF. The UEF argued that, via the "up-the-ladder" provisions MPD was responsible for Brock's benefit due to its close ties to HBC Leasing and its agreement with Owen for construction of the metal building. The ALJ concluded that neither MPD nor HBC Leasing were "contractors engaged in the business of construction" as required to prove "up-the-ladder" liability.

ISSUE: Did the ALJ err in not applying the up-the-ladder provisions?

HOLDING: No. To be adjudged liable, an entity must fit the statutory descriptions of a "contractor," and for that to occur it must be regularly engaged in the same or similar type of work as the work the subcontractor was hired to perform. To determine this, a series of factors are taken into consideration, which was done by the ALJ in this case. The ALJ made a factual finding that none of the entities to which UEF would assign liability qualified as a contractor based upon the applicable factors. Entering into a contract with a building contractor does not convert one into a "contractor" for purposes of up-the-ladder liability.

FINAL: Yes.

Whitlock suffered an injury to her low back on March, 2013. Dr. Barlow assigned 6 percent impairment and diagnosed bulging disc and bilateral radiculopathy. This pain would increase if Whitlock returned to mining work. Dr. Huhn concluded that Whitlock did not sustain an impairment-ratable injury. In his opinion, Whitlock was physically able to return to her former employment as an underground miner without restrictions. The ALJ awarded benefits for PTD. River View argued that Whitlock's employment at her sister's restaurant indicated that she was able to perform work as defined by the Act. Also, due to Whitlock's age (forty) and the fact that she had a certificate in early childhood development, she was not totally disabled and could do some work.

**ISSUE:** Did the ALJ err in awarding PTD benefits?

**HOLDING:** No. Whitlock testified that she had no regular schedule at the restaurant and worked only when she needed assistance paying a bill or when her sister needed help. Whitlock only worked a few hours each shift and could leave whenever she felt the need. She did not work on a full time or regular basis. The fact that Whitlock may have performed less than regular work at her sister's restaurant in exchange for help paying her bills does not, as a matter of law, negate Whitlock's entitlement to a PTD award. Second, although age and education are significant factors that an ALJ must consider, these factors are not dispositive and the Employer's argument was not persuasive.

**FINAL:** Yes.


Milliron began working for Ford in Minnesota in 1992. In 1997, he sustained a neck injury and underwent surgery. Dr. Kim assigned 23.5 percent impairment rating not based on the AMA Guidelines. Milliron settled his claim based on a 24 percent rating. Thereafter, Milliron returned to full-duty employment with no restrictions. Over the years that followed, Milliron treated residual neck pain with over-the-counter medications and chiropractic treatments. He transferred to Kentucky in 2011. Milliron experienced neck pain in May, 2013, when he yanked on a cable to release a part off a rack. Milliron was placed on light duty and worked sporadically over the following eighteen months. Dr. Bilkey assigned 28 percent impairment and acknowledged that a portion of the current rating was attributable to the 1997 neck injury but had difficulty in asserting exactly what percentage as Dr. Kim did not use the AMA Guides for the prior rating. Dr. Bilkey attributed one third or 9 percent to the 2013 injury. Dr. Banerjee concluded that the 2013 injury was merely a temporary aggravation of a pre-existing active condition. Accordingly, he assigned no impairment rating for the 2013 injury, and opined that Dr. Bilkey's report was not sufficient to apportion one-third of the current...
impairment to the 2013 injury. The ALJ concluded that the 2013 injury aggravated Milliron's cervical condition resulting in a permanent injury. The ALJ found Dr. Bilkey's report persuasive and adopted the 9 percent impairment rating.

ISSUE: Did the ALJ err in using Dr. Bilkey's findings for the award?

HOLDING: No. The proper interpretation of the AMA Guides is a medical question which must be left to medical experts. Because the AMA Guides do not provide guidance under the facts at bar, Dr. Bilkey assigned an impairment rating for Milliron's prior injury which he subtracted from the current impairment rating. Dr. Bilkey's conclusion was reasonably supported by the record and the law. The issue was not whether Dr. Bilkey could have reached a different conclusion. Rather, the question was whether his opinion constituted substantial evidence upon which the ALJ was free to rely in the exercise of his discretion. Dr. Bilkey's opinion constituted substantial evidence, and the Court found no error on this issue.

FINAL: Yes.


Jones began working for Ford in July, 2012, as a moon roof assembler. His job required climbing into a vehicle and putting screws into a roof panel. He would climb in and out of vehicles seventy-five times an hour. He began experiencing right foot pain in April, 2013. He was diagnosed with a stress fracture, and surgery was performed on his right foot on 5/20/14. Jones was off work for six weeks. He did not receive TTD payments during the six-week period. When he returned to work on 7/7/14, Jones had restricted work duties until 9/14. As Jones was in a walking boot and was unable to perform his previous job, he was made a "floater" and would perform different jobs as needed. Jones began developing problems with his left foot. Jones had surgery on his left foot on 12/24/14. Jones attempted to return to work in 2/15. He was given "no work available" status due to his restrictions. He was able to work a couple of weeks in 3/15, but was again placed on "no work available" status on 4/5/15. Jones then had another surgery on his right foot on 4/15/15, which placed him out of work until 6/15. Jones continued to work brief periods of time between being placed on "no work available" status for the following months until his third surgery on his right foot on 9/13/15. Jones returned to work again on 11/20/15. Jones remained a floater and has since requested that his doctor forego assigning work restrictions as he knows he will be given "no work available" status if he has restrictions. The ALJ found Jones suffered injuries to his feet, awarded medical, TTD and PPD benefits based upon a 4 percent impairment rating with the 3x multiplier. WCB affirmed except for part of one TTD time period. The Court of Appeals affirmed.

ISSUE: Did the ALJ err in awarding benefits?
HOLDING: No. A worker's testimony is competent evidence of his physical condition and of his ability to perform various activities both before and after being injured. In the instant case, the finding of TTD was supported both by Jones' testimony and the report from Dr. Fadel, who performed an IME for Ford. The ALJ made the three necessary factual findings to award the 3x multiplier: (1) Jones cannot return to the same work he performed pre-injury; (2) Jones's AWW is equal to or greater than his pre-injury AWW; and (3) Jones cannot continue to earn those wages for the indefinite future because he is only currently working as a floater due to financial necessity. The WCB reversed the ALJ's finding that Jones should receive TTD from 9/13/15 to 12/16/15 as Jones returned to work on 11/20/15.

FINAL: Yes.


Mills claimed to have injured his back, right leg and right foot. At the Hearing, Mills and Nally agreed to a $40,000 lump-sum agreement that included interest, attorney's fees, vocational rehabilitation, TTD, PTD, PPD, a waiver of the right to reopen, and a waiver of medical expenses. The agreement recited that $8,000 was paid for the waiver of the right to reopen. The agreement also recognized that Mills was apprised of the terms and conditions and fully understood he was dismissing future benefits with prejudice. In the time leading up to approving the agreement, Mills had received an MRI of his lumbar spine and was referred to Dr. Bean for surgical intervention on 8/26/13 – the day before the CALJ approved the settlement. On 9/6/13, Mills filed a "Motion to Set Aside Proposed Settlement," asserting his need for surgery as the basis for setting aside the agreement. The ALJ granted Mills' motion. WCB dismissed the appeal because the order was not final and appealable. On remand, the ALJ then ordered that the settlement agreement was valid and denied Mills' motion to set aside the agreement. Mills' referral to Dr. Bean occurred before the agreement, so the ALJ concluded his new need for surgery did not amount to newly-discovered evidence.

ISSUE: Did the first order issued by the ALJ setting aside the settlement agreement constitute res judicata?

HOLDING: No. Once the settlement was approved, Mills' only avenue for relief was a motion to re-open the claim. However, Mills received valued consideration in the form of $8,000 in exchange for his right to re-open. Mills' settlement agreement expressly contracted away his right to reopen this claim. There are no allegations of fraud or bad faith in entering the settlement agreement. Mills received a lump sum of $8,000 in exchange for vacating his statutory right to reopen his claim.

FINAL: Yes.

Crayne injured his back while working for Piper Logging. Crayne contended that he worked for Piper six days a week for $100 dollars a day. He was paid in cash and by check. Edward "Frankie" Piper claimed that Crayne worked only three days per week. The ALJ discussed the testimony of Crayne's doctor, Dr. Davies, and Dr. Best, who was the doctor selected by the UEF to perform an IME. Based on this evidence, the ALJ specifically stated that "Dr. Best and Davies have both indicated the work event on 4/17/13 is what caused Plaintiff's back condition that eventually required surgery." The ALJ specifically determined that Crayne worked an average of three to four days per week and that he received $100 per day in compensation.

ISSUE: Did the ALJ err in calculating the Plaintiff's AWW?

HOLDING: No. KRS 342.140(1)(d) sets forth the method for determining a worker's AWW if the claimant's wages are fixed by the day. It is not disputed that Crayne's wages were set in this manner, and he was paid $100 per day. Furthermore, given that the employer did not provide the required paperwork, the ALJ only had the testimony of the owner, Crayne, and another employee, McCaslin, plus copies of Crayne's checks. Based on this information, the ALJ opined that Crayne worked an average three to four days per week in the thirteen-week quarter preceding the work accident, and he earned $350 per week. This constituted substantial evidence that the ALJ's AWW calculation was reasonable.

FINAL: Yes.


Caldwell was an employee of J. Turner Trucking. J. Turner Trucking entered into a coal hauling contract with Xinergy Corporation, which sold the mine site to Straight Creek. The record reflected that the mine is owned by Straight Creek and JW Resources (JWR). Xinergy assigned the J. Turner hauling service contract to Straight Creek simultaneously with transfer of ownership of the mine to Straight Creek. Caldwell was injured when the truck he was driving rolled backward and overturned. Caldwell alleged that, due to the negligence of Straight Creek and JWR in designing, constructing and/or maintaining the private coal road, he was unable to traverse the grade of a hill in the road thus leading to his accident. Straight Creek and JWR contended that a mechanical failure of the truck acted as both proximate and legal cause of the accident. Caldwell sought and received workers' compensation benefits through his employer, J. Turner Trucking. Caldwell initiated a civil action, alleging negligence against Straight Creek and JWR.

ISSUES: 1) Whether the record showed Caldwell had received workers' compensation benefits; and 2) whether the record presented adequate
proof on the issue of fact that Caldwell was engaged in work that was a regular or recurrent part of Straight Creek or JWR’s business.

HOLDING: Though Straight Creek and JWR treated themselves as a singular entity, they are in fact, legally distinct corporations with differing roles in the mine operation. Consequently, the Court examined them as separate entities, taking into account their respective roles. The truly operative question, as it relates to JWR, is whether a holding company, with no actual ownership interest in any of the mine’s assets, engages in the coal mining business. Straight Creek operates the mine, while JWR merely owns Straight Creek. Evidence introduced by Straight Creek indicated Straight Creek’s activities include the mining of coal, placing it in coal pits, and transporting the coal elsewhere from the coal pits (which is the activity contracted out to J. Turner Trucking). Such activities not only fall within the activities of coal mining as an industry, but also the regular and recurrent activity of Straight Creek in particular. As the entity which operates the mine, Straight Creek unquestionably falls within the definition of "contractor" found in KRS 342.610(2)(b). As a participant in the coal mining industry, which contracted out some of its regular and recurrent tasks, Straight Creek is entitled to rely on the exclusive remedy provisions of KRS 342.690 and is, as a matter of law, immune from this claim.

FINAL: Yes.


Underwood’s job involved removal and installation of windows and doors. A single window weighs seventy-five pounds or more and the doors more than 300 pounds. He would have to load his truck himself. On 6/3/09, he injured his head, neck, back and hands when he fell off a ladder. On 4/21/10, he became aware of the manifestation of injury to his wrists due to repetitive lifting (cumulative trauma). Underwood continued to work at Pella until 8/4/10. The ALJ found a 29 percent impairment rating due to the 6/3/09 cervical injury and a 30 percent impairment rating due to his 4/21/10 injury. The ALJ found that he continued to work in pain after 6/3/09, that he returned to his same job, but did not, in reality, retain the physical ability to return to that job. As such, the ALJ applied the 3x multiplier to the PPD benefits for the 6/3/09 injury. The ALJ further found Underwood was PTD as a result of the combined effects of the two injuries, and began the PTD award as of the date of the 4/21/10 injury. Employer asserted that Underwood continued to work up until 8/4/10, and thus, any award of PTD should not begin until at least 8/4/10.

ISSUE: When does the PTD award begin?

HOLDING: "The statute defines permanent total disability as 'the condition of an employee who, due to an injury, has a permanent disability rating and has a complete and permanent inability to perform any type of work as a result of an injury.' The statute affords us no
latitude. We are compelled to agree that "as a matter of law, a worker cannot be considered totally permanently disabled during a period he continues to work at his regular job, with no accommodations, at full wages." Id. at *3.

FINAL: Yes (case appealed to Supreme Court but ultimately settled).


On the morning of 4/26/13, Mary Ann Quinn was going to her job as a school bus monitor. She parked her car in the parking lot on the school board's property. As she was walking toward the bus garage office at approximately 6:15 a.m., Quinn was struck by a car driven by Sylvia Ogden, who was also employed by the school board as a bus monitor and was also going to work. The carrier paid workers compensation benefits to Quinn following the accident. On February 12, 2015, Quinn filed a complaint in Jessamine Circuit Court alleging that she was injured as a direct and proximate result of Ogden's negligence. In her answer, Ogden raised the exclusive remedy of the Workers' Compensation Act as a defense. Ogden subsequently moved for summary judgment. The trial court entered Summary Judgment for Ogden.

ISSUE: Did the trial court err in granting summary judgment to Ogden?

HOLDING: No. An injured worker is barred from filing an action at law against a fellow employee unless the fellow employee, i.e., the alleged tortfeasor, committed a willful and unprovoked act of physical aggression against the injured worker. Thus, barring the narrow exceptions for deliberate wrongdoing, the test for fellow employee immunity is whether each of the employees involved would have been entitled to Workers' Compensation benefits for an injury suffered in the incident. Kentucky law does not require that an employee first park and exit her personal vehicle in order to trigger application of the operating premises exception.

FINAL: Yes.


Branham underwent laparoscopic surgery in 1999 to remove his kidney. In 12/12, Branham complained of abdominal pain. The CT scan on 12/12/12 revealed a small fat-containing umbilical hernia. However, the radiologist interpreting the scan did not mention the hernia in his impressions. On 7/8/13, Branham was wielding a wrench to change a mat on a press machine when he felt a tearing sensation in his abdominal area around his navel. He felt immediate excruciating pain. Branham further aggravated his abdominal pain on 7/31/13 when lifting computer monitors at work. Dr. Rafson performed hernia repair surgery in 12/13. Branham returned to work. On 4/1/14, he was tightening a bolt on a press
machine when he again felt a ripping sensation in his abdomen. Dr. Pokorny performed a hernia repair surgery on 10/7/14.

Dr. Bilkey opined that Branham sustained a work-related injury abdominal strain, umbilical, incisional hernia on 7/8/13, and a work-related recurrent strain and umbilical hernia on 4/1/14. Dr. Bilkey assigned a 2 percent impairment rating for the 4/14 abdominal injury. Dr. Bilkey concluded by noting the hernias occurred at the site of the prior laparoscopic surgery. That surgery caused a weak spot to occur in the abdominal wall making the hernia more likely. However, the hernia did not exist as a symptomatic concern until 7/8/13 and then there was surgery to repair it. The second work injury on 4/1/14 caused a recurrence of symptomatic hernia. Dr. Ballard's opinion was consistent with that offered by Dr. Bilkey. She opined that both hernias were work-related as they were caused by twisting and heavy work. Dr. Ballard noted it was possible that Branham's prior laparoscopic surgery in 1999 may have led to his hernia, but that his work appeared to have aggravated it and caused him to need to have surgery. She rated the impairment as 0 percent. Dr. Ballard later changed her mind. She submitted an addendum report on 8/6/15, stating that on further review of the records, he was symptomatic from his umbilical hernia on 4/23/13. The umbilical hernia is likely related to the fact that he had a laparoscopic procedure performed to remove his kidney when he donated a kidney to his brother. His subsequent complaints are related to nonwork-related problems rather than to a work-related cause of his umbilical hernia. The note from 4/13/13 clearly indicates that it was recommended that he have an umbilical hernia repair prior to the date of his reported work injury on 7/8/13.

Employer contended that Dr. Bilkey's opinion was so unreliable and against the weight of the medical evidence it could not possibly amount to substantial evidence to support the ALJ's finding of work-relatedness. Employer contended the medical records as a whole reveal the hernia was symptomatic, identifiable, diagnosed, and surgical before the first alleged work-related hernia date. Employer maintained that it was patent error for the ALJ to rely on medical causation opinions that are in direct contradiction to the undisputed medical facts. The ALJ found Branham's abdominal injuries to be work-related and awarded medical expenses but not PPD or TTD.

ISSUE: Was the ALJ's finding of work relatedness supported by substantial evidence?

HOLDING: Yes. Medical records, like all documentary evidence, are subject to some degree of interpretation. Dr. Bilkey did not share the Employer's view on the medical evidence and neither did the ALJ. The Court of Appeals saw nothing in the medical records directly linking the umbilical hernia to Branham's abdominal pain prior to the work injury in 7/13. Further, the Court of Appeals could not say Dr. Bilkey's medical opinion was unreasonable or against the weight of the evidence such that it was error for the ALJ to rely on it as evidence to support his finding that Branham sustained a work-related injury on 7/8/13.
Boling has been employed by OMU since 1996. He repairs auxiliary equipment associated with power generation. This work is physically demanding. Boling was injured at work in 2007, underwent surgery at L4-L5 by Dr. Trofkin, and was released to work in 2009. He settled on 9/23/08 based on a 13 percent impairment rating. Boling was injured again on 12/26/13 while carrying a piece of equipment. Dr. Trofkin performed a second surgery at L4-L5 on 7/16/14. Boling returned to full duty on 9/8/14. Dr. Loeb believed that Boling did not suffer a new injury in 2013; rather it was Dr. Loeb's opinion that Boling was suffering from the recurrence of a prior medical condition. Dr. Rhodes believed that Boling's symptoms were a temporary exacerbation of the 2007 injury. Dr. Trofkin believed that Boling was suffering from a new injury. The ALJ denied the claim for PPD benefits. The ALJ held that the evidence supported a finding that Boling suffered a temporary exacerbation of his 2007 injury.

ISSUE: Did the ALJ err in finding a temporary exacerbation?

HOLDING: No. "A review court must give great deference to the ALJ as the finder of fact, Boling has not convinced us that the evidence compels a different result. We fail to find any compelling evidence which would permit us to overturn the ALJ's decision. The ALJ acted within his authority in exercising his discretion and finding the testimony of Drs. Loeb and Rhodes more persuasive. There is no indication that the ALJ was derelict in his examination of the evidence." Id. at *2.


Attebury began to experience headaches, dizziness, short-term memory loss, and confusion six months after he started working as an underground coal miner. He attributed his symptoms to the paint he was using at work and stated that his symptoms improved when he was off work for any length of time. Attebury had previously suffered from seasonal affective disorder, for which he took an anti-depressant, and from panic attacks, anxiety, and headaches. Dr. Mayron diagnosed toxic encephalopathy, which he attributed to Attebury's exposure to the chemical toluene, a component of the Krylon spray paint Attebury used at work. Dr. Mayron assigned him a 49 percent impairment rating, and referred to an article from the Annals of Neurology from 6/88 to support his conclusions that Attebury's condition was related to exposure to toluene. Dr. Mayron provided copies of other articles to the court reporter after his deposition. Dr. O'Keefe concluded that Attebury's symptoms were not related to exposure to chemicals in Krylon but to Attebury's
depression, which Dr. O'Keefe attributed to claustrophobia associated with working in an underground coal mine. The ALJ awarded benefits.

ISSUE: Did the opinions of Dr. Mayron meet the Daubert requirements as adopted in City of Owensboro v. Adams?

HOLDING: Yes. Other articles relied on by Dr. Mayron indicate that chronic non-intentional exposure to toluene can occur in workers in the painting industry. Furthermore, the articles indicate that exposure at less than 200 ppm is associated with headache, fatigue, and nausea, while exposure at 200 to 500 ppm is associated with loss of coordination, memory loss, and loss of appetite. While Dr. Mayron may have referred only to the Annals of Neurology article in his written report, he testified that he relied on a number of other articles and provided those articles for review. The test of reliability is flexible and the Daubert factors neither necessarily nor exclusively apply to all experts in every case. Here, Dr. Mayron did have a history that Attebury was repeatedly exposed to toluene while performing his job in a confined space. Furthermore, the ALJ found that Attebury testified and related to Dr. Mayron his exposure, which was not challenged by the Employer. The record contained sufficient evidence to support the ALJ's finding that Dr. Mayron had an adequate understanding of Attebury's exposure to toluene and the impact of that exposure.

FINAL: Yes.

Wilson installed and serviced commercial signs. His job duties included heavy lifting, climbing extension ladders, and loading and unloading heavy materials. In 8/11, Wilson was treated by Dr. Brown for a bone spur in his left foot. Dr. Brown diagnosed left foot pain related to plantar fasciitis and heal pain syndrome. Wilson was instructed to return for follow-up treatment in three weeks. On 11/14/11, Wilson was working on a sign. He descended the ladder and when he stepped off the ladder onto the ground, he rolled his left ankle. Three days later, on 11/17/11, Wilson returned to see Dr. Brown, but the doctor was unavailable. Wilson was treated by Dr. Hubbard. That same day, 11/17/11, Dr. Dunn took a history from Wilson stating the patient is a forty-nine-year-old male with lateral sided foot pain for three months, worsening over last six weeks. On 12/2/11, Dr. Hubbard's notes stated for the first time that Wilson was reporting a work related injury of which his employer was aware. On 2/1/12, Dr. Hubbard amended his 11/17/11 notes to reflect Wilson was reporting a work injury. On 2/7/12, and notwithstanding Dr. Hubbard's 11/11 note in Wilson's medical history that "Patient denies a previous history of trauma," the doctor corrected that history to say "at that time he

stated that he had slipped off a ladder at work and hurt his left foot." The letter also mentioned that Wilson reported he had been treated previously by Dr. Brown for pain in both feet. Dr. Hubbard testified within reasonable medical probability that the patient's condition was a natural progression of the symptoms that he complained of in 8/11. He admitted it was possible that the event on 11/14 could possibly have caused the problems that led to the surgery. Dr. Farrage stated that Wilson's "clinical presentation and historical account are consistent with the proposed mechanism of injury" justifying surgery. Dr. Myrick opined that Wilson's torn tendons were unrelated to the 11/14/11 work injury based upon the 11/17/11 treatment note. Dr. Loeb found it difficult to believe, based on Dr. Hubbard's history, that this is related to the work injury of 11/14/11. The ALJ awarded TTD benefits, PPD benefits upon a 2 percent impairment rating with the 3x multiplier, and medical benefits. WCB affirmed.

ISSUE: Was the ALJ's finding of causation proper?

HOLDING: No. The [ALJ] is not justified in disregarding the medical evidence where the causal relationship is not apparent to the layman. "The causal relationship in this case is not apparent to the layman. In fact, none of the half dozen or so medical practitioners involved could unequivocally identify a cause. Therefore, it was improper for the ALJ to decide this claim without relying on the testimony of the medical experts and, instead, relying only on (1) the believability of Wilson's testimony regarding his changing symptoms, and (2) notes Wilson asked Dr. Hubbard to add to his medical record, as determinative of medical causation. Nevertheless, we still can affirm if we find in the record substantial evidence in the form of medical proof, within a reasonable degree of medical certainty, that the cause of Wilson's injury was rolling his ankle while at work on November 14, 2011. We have examined the record and fail to find such evidence." Id. at *6.

FINAL: Yes.


Ramey claimed that while mopping a floor, she began to fall, tried to catch herself and in the process injured both shoulders, her back, left hip and both knees. Ramey also alleged an emotional or psychological injury.

ALJ Justice rendered an Opinion, Award and Order imposing the 3x multiplier to the PPD award. WCB found that the ALJ did not fully explicate the basis for his decision to award the 3x multiplier. The Court of Appeals rendered an Opinion sustaining WCB's Opinion, and remanded to ALJ Bolton. ALJ Bolton rendered an Order on Remand finding that Ramey was entitled to the 3x multiplier. WCB again remanded the matter to ALJ Bolton with directions to consider the extent to which Ramey is capable of working in a sedentary capacity each week. ALJ Bolton rendered a Second Order on Remand finding that Ramey is entitled to the
3x multiplier. Employer appealed asserting that the ALJ's analysis pursuant to Fawbush v. Gwinn, 103 S.W.3d 5 (Ky. 2003), was not supported by substantial evidence, and he sought a remand to the ALJ with instructions to enter an award based on the 2x multiplier.

ISSUE: Was ALJ's Bolton's Fawbush analysis supported by substantial evidence?

HOLDING: Yes. ALJ Bolton went on to state, "My analysis is limited to whether she would qualify for a statutory 2 or 3 multiplier. Based upon her inability to perform the work duties of her position at Dr. Lynn's office without significant and ongoing accommodation of her restrictions, I did not believe, based upon the evidence, that she retained the physical capacity to return to the type of employment performed at the time of injury. As I clearly stated, I also believe from the evidence that the Plaintiff could not continue to earn a wage that equaled or exceeded her pre-injury wages." In concluding that Ramey did not possess the physical and emotional capacity to return to the type of employment performed at the time of injury, ALJ Bolton relied on several witnesses of record. Because the ALJ's findings of fact and conclusions of law amply support the record from both the lay and expert medical testimony, and as Lynn has not established that the evidence was so overwhelming as to demand a ruling in his favor, the Court of Appeals found no error.

FINAL: No (Case has been appealed to Kentucky Supreme Court).


Laney Utilities erects utility poles. Laney had a service contract agreement with Employee Staff, LLC, to provide payroll services and workers' compensation coverage for its "assigned employees." Laney did not have workers' compensation coverage independent of its agreement with ES. Sunz is ES's workers' compensation insurance carrier. A&C Communications had a contract with Mountain Rural Telephone to perform work on a communication line. A&C subcontracted that work to Laney. Henry Decker was injured while working for Laney on A&C's job. A&C has workers' compensation coverage through KEMI.

On 3/28/11, Decker filed a Form 101 naming Laney as the employer and UEF as Laney's "insurance carrier." Decker also named A & C and KEMI as "other defendants." On 3/28/11, the Commissioner certified that Laney had insurance coverage under ES, and that the carrier was Sunz. On 3/30/11, the Commissioner issued notice of the filing of the Form 101 addressed to Sunz. On 4/20/11, the DWC issued a scheduling order addressed to Sunz. On 6/2/11, A&C filed a motion to join ES and Sunz as parties on grounds that the Commissioner had certified that Laney had workers' compensation coverage through ES and Sunz. By Order of 6/27/11, the ALJ granted A&C's motion to join ES and Sunz and further ordered ES and Sunz to file a Form 111 within forty-five days. However, neither ES nor Sunz timely filed a Form 111 within forty-five days. On
8/19/11, ES filed an entry of appearance and a Form 111 denying the
claim. On 8/29/11, Sunz filed an entry of appearance and a Form 111
denying the claim. Sunz also filed a motion to continue the hearing and
for extension of time, reflecting that its counsel was newly hired, having
been contacted by Sunz for representation on 8/23/11.

Neither ES nor Sunz filed a motion for leave to file a late Form 111. The
ALJ dismissed ES and Sunz and found A&C liable as an up-the-ladder
employer. WCB reversed and concluded that the question of whether the
Forms 111 filed by ES and Sunz were properly admitted is determinative
of all issues. On remand, the ALJ must determine whether ES/Sunz
established good cause for the delay and specifically state the basis for
that finding. If ES failed to establish good cause, it must be deemed
Decker's employer and, because ES was insured by Sunz at the time of
Decker's injury, A&C would not have liability for the award. If ES is
deemed the employer, KRS 342.610 is inapplicable. On remand, the ALJ
found that ES and Sunz did not establish good cause for the delay in filing
a Form 111 Consequently, the ALJ held that ES and its insurer, Sunz,
were liable for the award.

ISSUE: Was there good cause to excuse the delayed filing of the Forms
111?

HOLDING: No. Sunz's first argued there was good cause to excuse the
delayed filing of the Forms 111; i.e., that neither it nor ES was provided
copies of the claim file as required by 803 KAR 25:010§2(3)6 and that this
"insufficient joinder" deprived them of procedural due process rights.
However, the Court of Appeals found no reason to believe that Sunz had
not received the notification of the filing of the Form 101 or the scheduling
order and Sunz did nothing in response. When Sunz finally did file the
form, it did so without filing a motion for leave. The only input to explain
the late filing was contained in Sunz's motion to continue the hearing/motion for extension of time. Thus, by its own admission, Sunz
waited four months after the scheduling order had been issued and
nearly two months after the ALJ's Order to attempt to comply.
Inattentiveness or lack of diligence by the carrier or defense counsel is
not good cause to excuse its delay in filing the Form 111. Sunz waived
any defenses that it might have had by failing to timely file the Form 111.

FINAL: No (This case has been appealed to the Kentucky Supreme
Court).

2211072 (Ky. App. May 19, 2017)

Klimko injured his low back while working as a HVAC technician. He
returned to light-duty work in 9/13 at equal or greater wages. On 6/19/14,
Klimko left his employment with Middletown. While servicing an air
conditioner at a customer's house, Klimko found that the coil was leaking
refrigerant. He called his manager to get a price on a replacement coil.
During that call, he had a disagreement with his manager about
Middletown's down-payment policies. The argument became heated, and Klimko told his manager that he was quitting. The manager asked Klimko to return to the office to discuss the matter, but Klimko again stated that he was going home. The customer called Middletown later to say that she had asked Klimko to leave because of his behavior. Middletown had to send another HVAC technician to the house because the customer's air conditioner was not functioning. Middletown retrieved Klimko's work truck later that day, and he returned his tools the following day. Shortly thereafter, he began working for AirStream Technologies with an AWW that was not equal or greater than his pre-injury AWW. The ALJ awarded PPD benefits based on an 11 percent impairment rating, and found that Klimko was entitled to the 2x multiplier from 9/20/13 through 3/20/14 and from 6/20/14 forward. WCB ruled that the ALJ erred by awarding the 2x multiplier for the former period because Klimko returned to work at equal or greater wages. However, WCB found that the ALJ properly awarded the 2x multiplier for the period after 6/20/14 because Klimko ceased to earn equal or greater wages and because his actions did not amount to an intentional, deliberate action with a reckless disregard of the consequences either to himself or to another.

ISSUE: Did Klimko's actions amount to intentional, deliberate action with a reckless disregard of the consequences either to himself or to another?

HOLDING: No. Although Klimko's behavior was "reprehensible," the ALJ, as fact-finder, has the sole discretion to determine the quality, character, and substance of the evidence. Since Klimko, the party with the burden of proof before the ALJ, was successful, the question on appeal to WCB was whether the ALJ's finding was supported by substantial evidence. WCB concluded that there was substantial evidence to support the ALJ's finding that Klimko's behavior on 6/19/14 did not meet the standard for "intentional, deliberate action" set out in Livingood. The Court concluded the ALJ and WCB correctly applied Livingood to the facts of this case. Here, the ALJ found that Klimko merely resigned out of frustration, and not with any subjective intention to deliberately disregard the consequences of his action. Klimko's conduct was clearly unacceptable and would have been grounds for termination if he had not resigned first.

FINAL: No (This case has been appealed to the Kentucky Supreme Court).


Roof was employed by Mickey's Towing & Garage. Johnson, the owner of Mickey's Towing, directed Roof to work beneath a tow truck to perform maintenance. The tow truck was titled to Mickey's Used Cars, an unincorporated entity also owned by Johnson. While Roof was under the tow truck, it fell off its blocks and crushed Roof, resulting in his death. His widow pursued a workers' compensation claim against Mickey's Towing. On 9/2/14, the Estate entered into a settlement agreement with Mickey's Towing and its workers' compensation carrier. In pertinent part, the
agreement provided as follows: "In consideration of the payments set forth above, the Plaintiffs, Mickey's Towing and Garage and its carrier, KEMI, hereby agree that the Plaintiffs completely release and forever discharge Mickey's Towing & Garage and its carrier, KEMI from any liability for benefits pursuant to KRS 342 based on any theory of recovery, which the Plaintiffs now have, or which may hereafter accrue or otherwise be acquired, on account of, or which may in any way grow out of the work-related injury..." On 4/15/15, Danielle Roof filed a civil action against Johnson. The Estate asserted claims for negligence and wrongful death, and sought compensatory and punitive damages, including damages for loss of parental consortium. Johnson responded with a motion to dismiss, arguing that the action was precluded under the exclusive remedy provisions of the Workers' Compensation Act and under the express terms of the settlement agreement. The trial court dismissed the action.

ISSUE: Was the Estate's action precluded by the exclusive remedy provisions of the Workers' Compensation Act, and under the terms of the settlement agreement?

HOLDING: Yes. KRS 342.690(1) states that if an employer secures workers' compensation coverage as required by the Act, then: "[T]he liability of such employer under this chapter shall be exclusive and in place of all other liability of such employer to the employee, his legal representative, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to recover damages from such employer at law or in admiralty on account of such injury or death." The Estate argued that because the tow truck was owned by Mickey's Used Cars, an unincorporated entity operated by Johnson, Johnson may be responsible for Roof's injuries and death separately from Mickey's Towing. The trial court pointed out that the settlement agreement applied not only to Mickey's Towing, but also to any "officers, directors, stockholders, agents, servants, representatives, employees, and other persons, firms, or corporations with whom Mickey's Towing and KEMI have been, or now, or may hereafter be affiliated." The trial court concluded that the settlement agreement and release clearly applied to Johnson.

FINAL: Yes.


Scharringhausen, a commercial electrician, was injured on 7/25/11 while repairing a six-foot exhaust fan on the roof of a two-story building. His supervisor, Mike Phillips, a journeyman electrician, failed to properly secure the lock-out/tag-out device on the electrical circuit that would disconnect the fan from electricity so that it could be repaired. Jeffrey Callam, the safety director at Ready, investigated the incident and determined that it was caused by not placing the lock-out/tag-out materials on the motor's switch prior to beginning work. Callam further determined that this violated the company's rules and an OSHA regulation. Callam testified that as the supervisor on the scene, Phillips...
was responsible for engaging the lock-out/tag-out mechanism, and that he failed to do so in this instance. The ALJ awarded TTD and PPD benefits with the 30 percent penalty.

ISSUE: May Phillips' failure to comply with lock out/tag out mechanism be imputed to the Employer even though Employer specifically trained its employees on proper lock out/tag out procedures?

HOLDING: Yes. KRS 342.165(1) is not penal in nature. Instead, KRS 342.165(1) gives employers and workers a financial incentive to follow safety rules without thwarting the purposes of the Act by removing them from its coverage. The court was not without sympathy for an employer who is penalized despite making every good faith effort to ensure the safety of its employees through policy, regulation, safety meetings, and safety equipment. It is undisputed that Phillips failed to comply with the lock-out/tag-out procedures, and this failure caused Thomas' injury.

FINAL: Yes.


Neeley, a machine operator, was bending a piece of wood when the wood slipped and hit him in the right eye. Both parties stipulated a 17 percent impairment rating. The ALJ awarded PTD benefits. WCB remanded specifically instructing the ALJ to provide an adequate analysis of how he reached his determination of PTD. On remand, the ALJ revised his original order but did not alter the type and amount of compensation awarded.

ISSUE: Did the ALJ flagrantly misconstrue the evidence in awarding PTD benefits?

HOLDING: No. Several physicians provided reports contesting the severity of Neeley's injury and how that impacted his ability to return to work. However, they all agreed that Neeley had suffered a significant injury to his right eye. Both parties also stipulated a 17 percent impairment rating. Furthermore, it is clear from the ALJ's opinion that he afforded great weight to Neeley's live testimony. The ALJ has the sole discretion to determine the quality, character, and substance of the evidence and may reject any testimony and believe or disbelieve various parts of the evidence. Therefore, the ALJ's reliance on the above cited evidence was proper and constitutes substantial evidence supporting an award of PTD benefits.

FINAL: Yes.

Rudd worked for Active Care part-time, sixteen to seventeen hours per week, as a secretary and receptionist. In 6/14, Rudd received an hourly wage of $12. On 6/2/14, while taking trash to a dumpster, Rudd fell and landed on her left shoulder. Treatment required three surgeries on her left shoulder. In 9/15, Rudd returned to her regular work duties for Active Care at the same hourly rate of payment. On 5/2/16, Rudd chose to retire. ALJ awarded PPD benefits, which were increased by the 2x multiplier.

ISSUE: Is voluntary retirement an exception to the application of the double income benefit in KRS 342.730(1)(c)2 because the purpose of the multiplier, return to work by an employee, is not fulfilled?

HOLDING: No. KRS 342.730(1)(c)2 permits a double income benefit, for any reason, after an employee returns to work and then stops working at that job. The statutory subsection provides for a double benefit when there is a cessation of employment "for any reason, with or without cause." In Livingood, the Court concluded that KRS 342.730(1)(c)2 permits a double income benefit during any period that employment at the same or a greater wage ceases "for any reason, with or without cause," except where the reason for the reduction in income is shown to be the employee's intentional, deliberate action with a reckless disregard of the consequences either to himself or to another.

FINAL: No (This has been appealed to the Kentucky Supreme Court).


O'Connor began working as an auditor at UPS around 6/06. His duties included opening boxes to ensure the contents were in good condition, and then sealing them for shipment. At some point when UPS was understaffed, he was required to put the boxes away himself, using high lift equipment. On 3/31/14, while he was moving boxes he described as weighing more than seventy pounds, he felt a pop in his chest and a painful sensation that wrapped around his left side and back to his shoulder. Dr. Grossfeld diagnosed a cervical disc bulge which she attributed to the work he performed in 3/14. Dr. Grossfeld also determined that O'Connor's lower back pain, difficulty standing and the numbness and tingling in his legs were due to a lumbar spine impairment, a pars defect, which is a congenital condition occurring when a spinal growth plate does not fully close. O'Connor's pars defect was bilateral and had worsened to the point that he had Grade 1 spondylolisthesis. Dr. Grossfeld explained that there were no active symptoms the first two times she saw him because the process was ongoing. She did not believe that O'Connor's work activities caused his low back pain, which she attributed to the pars defect exacerbated by morbid obesity. O'Connor argued his pars defect was dormant and then became symptomatic, active, and impairment ratable following an extended period of heavy
lifting at work, and contended that Dr. Grossfeld's testimony supports his claim. The ALJ concluded that O'Connor suffered a compensable, work-related cervical injury, and awarded TTD, PPD and medical benefits. As to O'Connor's lower back condition, however, the ALJ held that it was not caused, aggravated or aroused into disabling reality by any work injury or by any cumulative trauma sustained at work.

ISSUE: Was there a causal connection between the Plaintiff's workplace injury and his pars defect condition?

HOLDING: No. A party may argue evidence which would have supported a conclusion contrary to the ALJ's decision; such evidence is not an adequate basis for reversal on appeal. Simply because his lumbar condition became symptomatic several months after the workplace lifting incident does not mean that there was a causal connection between the two. The ALJ has the sole authority to judge the weight, credibility, substance, and inferences to be drawn from the evidence. As fact-finder, an 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 party's total proof. Because O'Connor bore the burden of proof and he was unsuccessful in persuading the ALJ the only question on appeal is whether the evidence in his favor was so overwhelming that it compelled a different result. The ALJ's decision was supported by the evidence presented and there was no reason to overturn that decision.

FINAL: Yes.


On 2/3/04, Steve Price injured his left foot/ankle and right knee. A knee surgery was performed by Dr. Vincent Samarco, and two ankle surgeries were performed by Dr. James Samarco. The parties entered into a Form 110 settlement agreement that was approved on 8/21/06. Price said he thought the settlement agreement only covered the left ankle. On the Form 110, the "left ankle/foot and right knee" are identified as the "injury" involved. Under the "medical information" section, left foot/ankle right knee surgeries are listed. The "diagnosis" section specifies left foot and right knee. Price argued that the settlement was based on the 4 percent impairment for the left ankle/foot injury, and since no consideration was paid for settlement of the right knee injury he is not bound to the agreement. Price filed his Form 110 on 9/2/16. The ALJ dismissed the claim ruling that Price's remedy for asserting a dispute over the Form 110, or seeking an increase in PPD benefits for the knee, is restricted to a motion to reopen.

ISSUE: Did the ALJ err in dismissing this claim?

HOLDING: No. KRS 342.265(4) states: "If the parties have previously filed an agreement which has been approved by the ALJ, and compensation has been paid or is due in accordance therewith and the
parties thereafter disagree, either party may invoke the provisions of KRS 342.125, which remedy shall be exclusive." As the ALJ observed, the subject matter of the settlement agreement was a singular event of injury. Whenever the settlement agreement described this injury, it described this injury as collectively involving Price’s "left ankle/foot and right knee." The settlement agreement explained the injury had been treated through various surgeries to Price’s left ankle and right knee.

FINAL: Yes.


Roby worked as an assembler, which required her to use her hands constantly and lift up to twenty pounds. She sustained a repetitive trauma injury to her right upper extremity on 4/22/11. She was thirty-three years of age, had a high school education with no specialized or vocational training, and had worked as a retail and fast food cashier and as an assembler for another manufacturer. Dr. Gabriel performed surgery, and advised her to refrain from repetitive use of her right upper extremity and to avoid lifting more than ten pounds. She has not returned to work. During the litigation, Roby enrolled as a full-time student in the nursing program at St. Catherine College, with the intent of becoming a pediatric nurse.

ALJ awarded benefits for PTD. WCB vacated and remanded for the ALJ to undertake additional analysis regarding his finding of PTD. ALJ rendered an Opinion on remand, again finding PTD. The ALJ stated it was reasonably probable that if Roby received vocational rehabilitation and completed her degree, she could find gainful employment, which would operate as grounds for Trim Master to reopen. WCB again vacated, finding he had again failed to adequately support his finding of PTD. WCB stated that the ALJ had failed to factor into his opinion Roby's testimony that a number of people had advised her she would be able to work as a pediatric nurse within her restrictions. ALJ rendered a third Opinion, again finding PTD with additional discussion of the claimant's age and education. WCB again vacated, and remanded ruling the ALJ had failed to adequately address Roby's pursuit of a nursing degree, and had not adequately addressed how he factored Roby's age, which he described as "early middle age" into his conclusion. ALJ rendered a fourth Opinion, again finding PTD. WCB reversed and ordered the ALJ to make an award of PPD benefits. The Court of Appeals reversed the WCB, and the Supreme Court affirmed the Court of Appeals.

ISSUE: Was the WCB finding for PPD benefits improper?

HOLDING: Yes. The Supreme Court noted that although it might not have reached the same conclusion, it could not say that the ALJ's conclusion was, as a matter of law, unsupported by the evidence. The ALJ could have concluded that Roby is only PPD based on Roby's age, continuing
education efforts, and belief that she could perform work in the future as a pediatric nurse. However, the evidence did not compel that finding.

FINAL: Yes.


Stacy, sixty-three, worked in the coal mining industry until 4/16/12. On 11/1/12, Stacy filed an injury claim, indicating that on 4/16/12, he had injured his low back due to cumulative trauma, a hearing loss claim indicating that he became aware of this condition on his last day of work on 4/16/12, and a black lung claim. He later amended the injury claim to allege a cumulative trauma claim to both wrists. The ALJ awarded PTD benefits for the injury claim. The ALJ also awarded medical benefits for his injury and hearing loss claims.

ISSUE: Did the ALJ err in relying on Dr. Hughes' opinion because it was not in accordance with the AMA Guidelines?

HOLDING: No. The Supreme Court rejected Employer's arguments and upheld the ALJ's ruling.

FINAL: Yes.


Gray filed a claim alleging he had contracted CWP, chronic bronchitis and COPD as a result of working as a coal miner. The ALJ dismissed the claim as barred by limitations.

ISSUE: Did the ALJ err in dismissing the claim as barred by limitations?

HOLDING: No. Gray retired on 8/24/09. He filed his claim almost five years later on 8/22/14. He filed a claim for federal black lung benefits in 2011. X-rays were taken by Dr. Baker, who found the presence of both clinical and legal pneumoconiosis, category 1/1, COPD and chronic bronchitis. Pulmonary function studies showed a mild obstructive deficit. ABGs were normal. Gray attached the report from Dr. Baker to his claim.

Gray was informed of these changes to his lungs (symptoms) and his mild pulmonary impairment (also symptoms) by Dr. Baker in 2/11, and he filed a federal black lung claim at that time. Under KRS 342.316(4)(a), there was a "distinct manifestation" of CWP as of that date, and Gray's three-year statute of limitations began to run.

FINAL: Yes.
On 6/10/12, Rife tripped over a hose and fell face-first on a steel beam sustaining facial lacerations, a closed head injury, a cervical strain, and a knee contusion. On 12/7/12, Dr. Abel surgically extended a cervical fusion that had been performed in 2008. Rife developed a complication from this surgery in the form of a hematoma on his neck. Rife returned to surgery the next day to remove the hematoma. Rife eventually recovered after spending a week in a coma. While recovering in ICU, a nurse transferred Rife from his hospital bed to a nearby chair and left him without further supervision. When Rife attempted to return to his bed, he fell to the ground and injured his back. Rife underwent surgery for his back injury in 6/13. Employer argued that there is a clear difference between an injury that occurs during treatment and an injury that is caused by the treatment. The ALJ found that Rife sustained work-related injuries to his neck, back, and brain as a result of the 6/10/12 incident and that Rife had suffered a compensable injury during treatment of a work-related injury that was a natural consequence of the treatment, and that Slater failed to carry its burden of proving a pre-existing active disability. The ALJ then awarded Rife PTD benefits.

ISSUE: Was the ALJ correct in rejecting the Employer's assertion that Rife suffered from a pre-existing active disability?

HOLDING: Yes. The Court found that Rife may well have had a pre-existing impairment of his neck and lower back, but that did not equate to a pre-existing disability. He was never deemed disabled and he continued to work without restrictions up to the date of his accident.

FINAL: Yes.

Tungett was a concrete truck driver who delivered to construction sites. He testified that he injured his back on Saturday, 5/31/14, when he was using a 2x4 to clean "shotcrete" out of the chute of his truck after it had hardened. The ALJ dismissed the claim, finding that claimant failed to meet his burden of proof that he gave due and timely notice of a work-related injury. The ALJ weighed the evidence and made a finding that was supported by substantial evidence. The Court of Appeals reversed and found that "as a matter of law" the employer had notice on 6/5/14 when it was contacted by the immediate care center about Tungett having presented and alleged a workplace injury. In the Court of Appeals' opinion, Tungett was not required to give further notice.

ISSUE: Were the Court of Appeals' findings in error?

HOLDING: Yes. The Court of Appeals' opinion was in error for two reasons. First, it is not the province of the Court of Appeals to substitute its factual findings regarding notice for those of the ALJ. Second, even if
the notice from the immediate care center could be shoe-horned into KRS 342.200, which excuses a worker's delay in giving notice if the employer "had knowledge of the injury," it would still be insufficient because Irving received information about an alleged 5/2/14 injury, not the 5/31/14 injury that Tungett relied on when he filed his claim.

FINAL: Yes.


Turner was tasked with running wires through various parts of Ford vehicles which required the use of his hands and upper body. On 9/27/12, he suffered upper extremity injuries as a result of repetitive work activities. The ALJ awarded TTD benefits from 3/8/13 to 7/15/13, plus PPD benefits based upon a 7 percent impairment rating. Ford argued that Turner's light-duty inspector job was a legitimate job that benefited Ford and did not require additional training to perform. Ford also contended that Turner was not entitled to TTD benefits because his situation did not constitute an "extraordinary circumstance." In contrast, Turner argued that because the ALJ's findings and conclusions were consistent with the requirements of Tipton, it was error for the Court of Appeals to reverse and remand on the issue of entitlement to TTD benefits.

ISSUE: Should Turner receive TTD benefits during this time period as he was working as a light duty inspector and paid his regular wages?

HOLDING: As the ALJ could not have considered the Tipton factors, the Court remanded to the ALJ for that consideration.

FINAL: No (as case was remanded to ALJ for additional findings).


On 10/19/15, Fryman sustained an injury to her low back and bladder when lifting a patient while working as a CNA. She was fifty-five years of age at the time, and she has not worked since the injury date. Laurel Creek paid TTD benefits from 10/20/15 through 11/20/15. Medical records reflected a history of genito-urinary problems. About a month after the injury date, Fryman underwent a hysterectomy. The ALJ concluded that Fryman's uterine prolapse was not work-related. The ALJ found that Fryman was entitled to TTD benefits for her lumbar injury and that she reached MMI on 5/3/16, the date of Dr. Ballard's IME. The ALJ found that Fryman was unable to perform her customary work before reaching MMI, and awarded TTD benefits from 10/20/15 through 5/3/16. The ALJ also awarded PPD benefits based upon Dr. Ballard's 5 percent impairment rating. Upon concluding that Fryman does not retain the physical capacity to return to her pre-injury job duties, the ALJ enhanced the PPD award by the 3.4 multiplier.
ISSUES: Did the ALJ select the correct MMI date? Was the ALJ's award of TTD benefits and the 3.4 multiplier supported by substantial evidence?

HOLDING: Yes to both issues. Employer disagreed with the ALJ's finding that Fryman reached MMI on 5/3/16 – the date of Dr. Ballard's IME – and contended that it is not supported by treatment records or IME reports. Employer contended that the last treatment Fryman received for her back was on 10/22/15. However, Dr. Ballard noted that she had reviewed Dr. Lester's records, which reflected that Fryman was treated for her back in 11/15 and 12/15, although it is not apparent that Dr. Lester's records were filed as evidence. Dr. Ballard also reviewed the report of a 3/21/16 lumbar MRI, which was ordered by Fryman's PCP. Dr. Ballard did not express an opinion MMI occurred prior to the date of her report. Thus, the ALJ was free to conclude Dr. Ballard believed Fryman attained MMI as of the date she saw her. At the hearing, Fryman testified that she was still seeing Ms. Roberts monthly and that she continues to prescribe Tramadol. Fryman also testified that she continues to experience pain and discomfort in her low back, which is worse with activity, including lifting, and that her job as a CNA required lifting throughout the day. Fryman testified that she could not go back to work at Laurel Creek because she cannot lift as she did. Both prongs of the TTD test have been met and the ALJ's award of TTD benefits and the award of the 3.4 multiplier are supported by substantial evidence.

FINAL: Yes.


Richie worked as a heavy equipment operator for thirty-eight years and was hired by CDR Minerals on 11/19/09. On 3/23/13, Richie filed a claim for injuries to his lower back, right hip, and right leg due to cumulative trauma. CDR asserted that no objective evidence existed demonstrating a cumulative trauma injury to Richie's right knee, right shoulder, right hip, or lower back. The ALJ relied upon the medical testimony of Dr. Hughes to support the findings of a work-related injury to Richie's right knee, right shoulder, right hip, and lower back. In his medical testimony, it is apparent that Dr. Hughes considered Richie's complaints of pain, physical restrictions, and work history. Dr. Hughes additionally considered medical records from Daniel Williams, D.C., who reported that Richie suffered from "lower back pain with radiculitis into the right hip and leg." Dr. Hughes also performed a physical examination. It was Dr. Hughes' expert opinion that "within a reasonable medical probability, Richie's multiple pains and restricted motions of the joints is a consequence of his forty years as a heavy equipment operator causing repetitive injury to multiple areas of the body." And, while Dr. Hughes' depositional testimony was ambiguous, it is within the sole province of the ALJ to judge the weight and credibility of the evidence. An ALJ may accept certain portions of an expert's opinion and disregard other portions of the same expert opinion.
ISSUE: Was there substantial evidence to support the ALJ's findings?

HOLDING: Yes. The Court noted that while Dr. Hughes' depositional testimony was ambiguous, it was within the sole province of the ALJ to judge the weight and credibility of the evidence. An ALJ may accept certain portions of an expert's opinion and disregard other portions of the same expert opinion. Sufficient evidence supported the ALJ's findings.

FINAL: Yes.


Rogers suffered an injury to his left shoulder on 9/25/12. He was later diagnosed with a torn rotator cuff, which required two surgeries. Rogers is currently employed at Ford as a sit-down forklift truck operator. Rogers stated the sit-down job is much easier because all he has to do is turn, there is no pressure on his arm, and it is more like driving a car. Rogers testified that based on his limitations, he could not go back to being a standup forklift operator because he could not perform the balancing of driving and pulling. He can no longer return to being a standup forklift operator because Ford no longer operates its standup forklifts.

Dr. Farrage opined Rogers should avoid above shoulder level activity but did retain the physical capacity to return to operating a standup forklift. Pursuant to the AMA Guides, Dr. Farrage assessed a 5 percent impairment rating. According to Dr. Farrage's letter dated 7/7/14, after Rogers's second surgery, Dr. Farrage opined: "Based upon the more specific information regarding Mr. Rogers' job description prior to his work-related injury and his currently established permanent work restrictions, it would be medically inadvisable for him to return to the competitive physical demands of his previous description without undue potential for symptom exacerbation and placing the surgical repair at significant risk of re-injury." Dr. Sallay performed Rogers's surgeries. He opined that on 9/6/13, after Rogers's first surgery, Rogers reached MMI and had a 5 percent impairment rating and no formal restrictions. Dr. Sallay opined that on 6/20/14, after Rogers's second surgery, Rogers reached MMI and had a 2 percent impairment rating, with a permanent restriction of no lifting or repetitive reaching above shoulder level. However, Dr. Sallay did not state he was relying on the AMA Guides.

Dr. Ballard conducted an IME on 1/7/15. She found Rogers reached MMI in June, 2014, and under the AMA Guides had a 3 percent impairment rating. His permanent work restriction with the left arm is no overhead work. She opined Rogers retained the physical capacity to return to the same kind of work as that performed at the time of his injury. Dr. Ballard reviewed the impairment ratings assigned by Dr. Sallay and Dr. Farrage, and opined: "Dr. Sallay previously assigned a 5 percent impairment. This would appear to be the correct impairment. It has not changed since his second surgery. This is not substantively different from the impairment assigned by Dr. Farrage. Although the motions are slightly different, the
total is not." The ALJ found that Rogers sustained a 5 percent impairment rating and did not retain the physical capacity to work as a standup forklift operator.

ISSUE: Did the ALJ err in determining that Rogers did not retain the physical capacity to work as a standup forklift operator?

HOLDING: No. The evidence provided by Dr. Farrage and Dr. Ballard provided sufficient evidence for the ALJ to determine that Rogers had a 5 percent whole person impairment. Rogers' testimony following the second surgery also supported this conclusion as the only improvement Rogers noted was a decrease in his pain. Therefore, the ALJ's finding was supported by sufficient evidence. The ALJ found that Rogers did not retain the physical capacity to return to his work as a standup forklift driver. The finding was properly supported by substantial evidence in the form of Dr. Farrage's letter and Rogers' testimony. A claimant's testimony that he is unable to perform the duties of his former job is competent evidence.

FINAL: Yes.

III. BOARD DECISIONS

A. George Springate v. Four Roses Distillery, Claim #: 2014-87092, Rendered: 10/07/2016, Status: Final

FACTS: The Claimant injured his low back and left hip as he was lifting a panel box on March 31, 2014, while working for the Employer. At the time of the accident, the Claimant was concurrently employed part-time at a home improvement store. It was undisputed the Employer was aware of the Claimant's concurrent employment. The Claimant never returned to work for the home improvement store after the accident. The Claimant was off work from his Employer until September 2, 2014, when he returned to the same job he performed before the accident. In a September 25, 2015, opinion, the ALJ awarded temporary total disability ("TTD") benefits, permanent partial disability ("PPD") benefits and medical benefits. The Board issued an opinion vacating in part and remanded for the ALJ to calculate the Claimant's pre-injury average weekly wage ("AWW") based upon his earnings at both his Employer and his part-time concurrent employment. Once this was determined, the Board directed the ALJ to make a determination of entitlement to any enhancement pursuant to KRS 342.730(1)(c)2. On remand, the ALJ determined the Claimant's pre-injury AWW based upon his wages from both the Employer and his concurrent employment pursuant to KRS 342.140(5). The ALJ then determined the Claimant had returned to work, but not to a wage equal to or greater than his pre-injury AWW. The ALJ additionally determined if the Claimant ever returned to a wage equal to or greater than his pre-injury AWW, he would be entitled to have his weekly PPD benefits "doubled" pursuant to KRS 342.730(1)(c)2 if indeed he subsequently ceased earning such wage, except for, "conduct that is shown to be an intentional deliberate action with a reckless disregard of
the consequences either to himself or another” pursuant to Livingood v.
Transfreight, LLC, 467 S.W.3d 249 (Ky. 2015).

ISSUE: Should the Claimant's concurrent wages be excluded for
purposes of the application of the double benefits pursuant to KRS
342.730(1)(c)2, even though they were included to calculate the
Claimant's AWW for determining TTD and PPD benefits?

HOLDING: No. Pursuant to KRS 342.730(1)(c)2, in order to qualify for
the two multiplier, an employee must return to work at equal or greater
wages than his pre-injury AWW, and that work must cease in accordance
with the standards set forth in Livingood v. Transfreight, LLC, supra. On
remand, the ALJ determined the Claimant's pre-injury AWW consisted of
a combination of his earnings from his Employer and his concurrent
earnings from the home improvement store. After the pre-injury AWW
was established, it became determinative for whether the two-multiplier
pursuant to KRS 342.730(1)(c)2 was applicable. The Board stated the
Claimant returned to his primary employment where he sustained his
injury, without restrictions or limitations. The fact the Claimant is no
longer employed at his concurrent part-time employment is not
determinative. The Board affirmed the ALJ's opinion on remand since he
performed the correct analysis of the Claimant's pre-injury AWW, and
appropriately considered his return to work earnings, with the contingent
award of benefits pursuant to KRS 342.730(1)(c)2.

B. Hazard Community College v. Wayne Melton, Claim #: 2010-77219,
Rendered: 10/07/2016, Status: Appealed to Court of Appeals

FACTS: The Claimant was injured on September 20, 2010, while working
for his Employer. The claim was settled for a lump sum, with the
Claimant waiving his right to future medical benefits except for those
related to his lumbar spine, which would remain open. Subsequently, the
Employer filed a motion to reopen, a Form 112, and a motion to join the
Claimant's treating physician. The Employer attached a utilization review
report, wherein the evaluator found Gabapentin medically necessary, but
treatment with Butrans, Hydrocodone, and Duloxetine was neither work-
related, necessary, nor appropriate. The dispute was assigned to the ALJ
for consideration. On February 26, 2016, the ALJ entered an order
sustaining the motion to reopen and setting a telephonic conference for
March 14, 2016. The ALJ then sent a letter to the treating physician
advising her of the medical dispute, and the telephonic conference set for
March 14, 2016. At the telephonic conference held March 14, 2016, the
ALJ listed the reasonableness, necessity and work-relatedness of
prescription medications consisting of Butrans, Hydrocodone/APAP and
Duloxetine as the contested issues. A telephonic benefit review
conference ("BRC")/Hearing was scheduled for April 12, 2016. The ALJ
also provided thirty days for the parties to introduce evidence.

In the order dated April 12, 2016, the ALJ noted the same issues as listed
at the previous conference and the parties waived a hearing. The ALJ
stated, “The matter is submitted as of April 12, 2016,” despite the fact the
thirty days to submit evidence set forth in the previous order had not yet expired. On April 12, 2016, the treating physician sent a letter to the ALJ setting forth the Claimant's treatment, and the reasons in support of her prescriptions for the contested medication. In an order dated April 18, 2016, the ALJ issued an order stating she had received the correspondence from the treating physician on April 15, 2016, and she was notifying all parties of the notice to ensure "proper filing into the record". On April 28, 2016, the Employer filed an objection and motion to strike the treating physician's correspondence as untimely filed. It noted this was not received until three days after the claim was submitted, and was both untimely and prejudicial. The ALJ overruled this motion in an order issued May 24, 2016. The ALJ then issued a decision on June 10, 2016, resolving the medical dispute in favor of the Claimant based upon the treating physician's correspondence.

ISSUE: Did the ALJ abuse her discretion in admitting the treating physician's correspondence?

HOLDING: No. The Board began by noting the proceedings in a post-award medical dispute in a reopening pursuant to 803 KAR 25:012 differ from the filing of an initial claim pursuant to 803 KAR 25:010, and afford greater latitude or discretion to an ALJ. In a reopening for a medical dispute, the claim is assigned to the Frankfort motion docket pursuant to 803 KAR 25:012 §1(4)(d) for "further proceedings" before an administrative law judge. 803 KAR 25:012 §1(6)(c) states, "This dispute shall be assigned to the Frankfort motion docket, where it shall be either summarily decided upon the pleadings or assigned to an administrative law judge for further proof time and final resolution."

Reopening of a claim pursuant to KRS 342.125 is a two-step process. Stambaugh v. Cedar Creek Mining Co., 488 S.W.2d 681 (Ky. App. 1972). The first step is the filing of a motion, which places the burden on the moving party to provide prima facie or sufficient information to demonstrate a substantial possibility of success in the event evidence is permitted to be taken. AAA Mine Services v. Wooten, 959 S.W.2d 440 (Ky. 1998). "Prima facie evidence" is evidence which "if unrebutted or unexplained is sufficient to maintain the proposition, and warrant the conclusion [in] support [of] which it has been introduced . . . but it does not shift the general burden . . . " Prudential Ins. Co. of America v. Tuggle's Adm'r., 72 S.W.2d 440, 443 (Ky. 1934). Only if the moving party prevails in making a prima facie showing as to all essential elements of the grounds alleged for reopening will the adversary party be put to the expense of further litigation. Big Elk Creek Coal Co. v. Miller, 47 S.W.3d 330 (Ky. 2001). Documentation sufficient for reopening is not necessarily sufficient to support a decision in the movant's favor. Step two of the reopening process then commences, with additional proof time being afforded to allow the merits of the reopening to be finally adjudicated. Campbell v. Universal Mines, 963 S.W.2d 623 (Ky. 1998).

The ALJ determined the Employer made a prima facie showing for reopening, set a telephonic conference, and established a time period for
the introduction of evidence. The ALJ held two telephonic conferences, and set the proof schedule. It is noted the time for introducing evidence set forth in the March 14, 2016, order did not expire until the day after the case was taken under submission. The ALJ received the correspondence from the treating physician two days after the thirty day period for introduction of evidence had expired, although it was dated April 12, 2016. The Board noted the facts of T. J. Maxx v. Blagg, 274 S.W.3d 436 (Ky. 2008) differ greatly from the case sub judice. In T. J. Maxx v. Blagg, a hearing was held, and the claim had been submitted for decision. In this claim, there was no hearing. In T. J. Maxx v. Blagg, the Kentucky Supreme Court held the ALJ erred in ordering a university evaluation after the claim was taken under submission. In the present case, although not forwarded to the ALJ until April 15, 2016, the report itself bore the date of April 12, 2016, which was within the thirty days the ALJ had provided in the order dated March 14, 2016. The Board also noted that case was an original proceeding governed by 803 KAR 25:010, not a medical dispute reopening governed by 803 KAR 25:012. The Board also noted after the ALJ overruled the Employer's objection to the admission of the treating physician's correspondence, it did not move to reopen proof time, nor did it request leave to rebut the correspondence. The introduction of evidence in re-openings for medical disputes does not fall within the restrictive timelines set forth in 803 KAR 25:010, thereby leaving the taking of proof to the ALJ's discretion. The Board did not believe the ALJ abused her discretion or committed reversible error in allowing the treating physician's correspondence into evidence, or that the Employer was unduly prejudiced by the allowance.


FACTS: The Claimant alleged cumulative trauma injuries to his right upper extremity caused by the repetitive work he performed as a welder. He sought treatment and eventually underwent surgery. His treating physician assessed a 6 percent impairment rating pursuant to the American Medical Association, Guides to the Evaluation of Permanent Impairment ("AMA Guides"), and imposed permanent restrictions, which prevented the Claimant from returning to work for the Employer. The Claimant was evaluated by a physician, who diagnosed right lateral epicondylitis, status post right elbow surgery, and chronic right elbow pain and dysfunction. He stated these conditions were caused by the Claimant's repetitive forceful grasping in an awkward position. He determined the Claimant had reached maximum medical improvement ("MMI") and assessed a 12 percent impairment rating pursuant to the AMA Guides. In a subsequent report, he disagreed with the Employer's evaluating physician's methodology he utilized in arriving at an impairment rating. He then amended his impairment assessment to 5 percent pursuant to the AMA Guides.

The Claimant was also evaluated by another physician at his Employer's request. He diagnosed right lateral epicondylitis of the humerus and status post epicondylar release. He determined the Claimant's condition
was work-related and had reached MMI. The physician assessed a 2 percent impairment rating pursuant to the AMA Guides and explained his methodology. He did not impose restrictions and opined the Claimant could return to his job. He critiqued the methodology employed by the Claimant's evaluating physician in determining an impairment rating. The ALJ awarded TTD benefits, PPD benefits based upon the 2 percent impairment rating assessed by the Employer's evaluating physician, and medical benefits. The ALJ determined the methodology employed by Employer's evaluating physician in arriving at the 2 percent impairment rating, the range of motion method, was the most appropriate pursuant to the AMA Guides.

ISSUE: Did the ALJ err in relying upon the impairment rating assessed by the Employer's evaluating physician?

HOLDING: No. The Board found this case dealt with the ALJ's authority to choose among the opinions of physicians who assess impairment differently. In Kentucky River Enterprises, Inc. v. Elkins, 107 S.W.3d 206 (Ky. 2003), the Kentucky Supreme Court instructed the proper interpretation of the AMA Guides is a medical question solely within the province of the medical experts. In George Humfleet Mobile Homes v. Christman, 125 S.W.3d 288 (Ky. 2004), the Court further held, while an ALJ is not authorized to independently interpret the AMA Guides, he may as fact-finder consult the Guides in the process of assigning weight and credibility to evidence. Although assigning a permanent impairment rating is a matter for medical experts, determining the weight and character of medical testimony and drawing reasonable inferences therefrom are matters for the ALJ. Knott County Nursing Home v. Wallen, 74 S.W.3d 706 (Ky. 2002). Moreover, authority to select an impairment rating assigned by an expert medical witness rests with the ALJ. See KRS 342.0011 (35) and (36); Staples, Inc. v. Konvelski, 56 S.W.3d 412 (Ky. 2001). In this instance, the ALJ was free to adopt either physician's opinion and the Board found he properly exercised his discretion. The Board noted while the Claimant's evaluating physician included documentation from the AMA Guides outlining additional items which could have been considered in assessing the impairment rating, nothing established their mandatory inclusion. Specifically, the Claimant's evaluating physician noted the AMA Guides stated grip strength "can" be included in calculating an impairment rating. However, the specific provision cited by the Claimant does not state this shall be included, nor does it use any other such mandating language. The Board found the Employer's evaluating physician's report constituted substantial evidence upon which the ALJ could rely in determining the appropriate impairment rating, and no contrary result was compelled.


FACTS: The Claimant alleged on September 18, 2012, he was injured when he fell on his back while building a mold inside the plant. The Claimant also alleged on October 8, 2012, he injured his lower back when
he felt a pop while working with a wheelbarrow. After each injury, the Claimant returned to light duty and missed no work due to the work injuries. At the time of the first and second work injuries, the Claimant's AWW was $1,346.00. Subsequently, the Claimant's AWW was reduced to $1,201.00 beginning in January, 2013, but then increased to $1,225.00 in January, 2014, due to a raise. The ALJ adopted a 13 percent impairment rating as a result of the October 8, 2012, work incident. The ALJ determined the Claimant did not retain the capacity to perform the work he was performing on October 8, 2012, and awarded PPD benefits, enhanced by the three multiplier, commencing on October 8, 2012. The ALJ stated he could not consider whether the two multiplier was more appropriate because the Claimant did not miss any work. Since the Claimant did not miss any work, he did not "return to work" pursuant to KRS 342.730(1)(c)2.

ISSUE: Was the ALJ prohibited from considering whether the two multiplier pursuant to KRS 342.730(1)(c)2 is applicable since the Claimant did not miss any work following his work injuries?

HOLDING: No. KRS 342.730(1)(c)2 reads as follows:

If an employee returns to work at a weekly wage equal to or greater than the average weekly wage at the time of injury, the weekly benefit for permanent partial disability shall be determined under paragraph (b) of this subsection for each week during which that employment is sustained. During any period of cessation of that employment, temporary or permanent, for any reason, with or without cause, payment of weekly benefits for permanent partial disability during the period of cessation shall be two (2) times the amount otherwise payable under paragraph (b) of this subsection. This provision shall not be construed so as to extend the duration of payments.

The Board stated as a general rule, statutes and duly promulgated regulations are open to construction only if the language contained therein is ambiguous and requires interpretation. If, on the other hand, the language of the statute or regulation is clear and unambiguous on its face, statutory construction mandates that we follow the provision's plain meaning. Layne v. Newberg, 841 S.W.2d 181 (Ky. 1992). In this instance, the Board found nothing ambiguous within the plain language of KRS 342.730(1)(c)2 as to its intended application. KRS 342.730(1)(c)2 requires in order for an employee to be eligible for enhancement of his PPD benefits by the two multiplier, he or she must return to work at a weekly wage equal to or greater than the AWW at the time of the injury. The statute does not require the employee to have missed work before he returns to work at a wage equal to or greater than his pre-injury AWW in order to be eligible for enhancement by the two multiplier. To apply such an interpretation would penalize a worker who returns to work at the same or greater wages without missing any work but reward an employee who misses days, weeks, months, or even years of work before he
returns to work at the same or greater wages. Such an interpretation would produce an absurd result.

In Livingood v. Transfreight, LLC, 467 S.W.3d 249, 256-257 (Ky. 2015), the Kentucky Supreme Court stated as follows:

The obvious purpose of the statute is to encourage reemployment of injured workmen at adequate wages by relieving the employer of the requirement of paying disability compensation in addition to full wages ... But the inducement or encouragement the legislature has extended is clearly for continued reemployment. It is not conceivable that the legislature intended to relieve an employer completely of liability for compensation payments if he should reemploy the workman for only one day.

In construing a statute the courts will consider the purpose which the statute is intended to accomplish.

The Board noted the Supreme Court emphasized "continued" reemployment which applies in the case sub judice. Continued employment is encouraged and KRS 342.730(1)(c)2 serves as an inducement to continued employment. The mere fact the Claimant returned to work without first missing work does not preclude applicability of the two multiplier set forth in KRS 342.730(1)(c)2. The Board reversed the ALJ's interpretation and remanded for a determination whether the two multiplier is applicable, and if so, performed an analysis pursuant to Fawbush v. Gwinn, 103 S.W.3d 5 (Ky. 2003).


FACTS: The Claimant, a diesel mechanic, had worked for his Employer since 2007. Previously, the Claimant was involved in a motor vehicle accident ("MVA") resulting in back pain, which resolved after treatment at the emergency room and a chiropractor. Approximately six to seven years prior to May, 2014, the Claimant injured his back while working for his Employer for which he treated at the emergency room and then with his chiropractor. The Claimant's injury eventually resolved. The Claimant alleged he reported the work injury to his employer, but no accident report was completed, and he used his personal health insurance to pay for his medical treatment. The Claimant stated he occasionally pulled muscles while working for his Employer, but always felt better the following day and was able to resume his normal work activities.

On May 2, 2014, the Claimant was exiting the maintenance pit when he felt a catch in his back. The owner and operations manager were in their offices. The Claimant testified as he was leaving for the day, he went into the hallway and said "hey, you all, I pulled a muscle or something, I'm just letting you all know, like that. I'll see you all Monday, like that, and I went on home." The Claimant alleged he told the owner on several occasions
thereafter he sustained an injury at work. No injury or accident report was ever completed. The Claimant's symptoms worsened over the weekend. On Monday, he called his Employer and advised he could not come in due to his pain, and he was going to see a physician. He initially went to his chiropractor, and then to his family physician. Surgery was ultimately performed on June 6, 2014. The Claimant used his personal health insurance to pay for his medical treatment.

The Claimant was off work until August or September, 2014. He then returned to light duty until he was terminated in February, 2015. The Claimant did not receive workers' compensation benefits during the period he was off work. Instead, he applied for short-term disability ("STD") benefits through an Aflac policy, which he subsequently received on a weekly basis. The Claimant testified he talked to an Aflac representative prior to surgery, and told him he had a work-related injury. For unknown reasons, the representative allegedly told the Claimant he needed to report the injury as unrelated in order to get benefits. Under the assumption he could return to work quickly after surgery, the Claimant told the owner he was not going to file a workers' compensation claim, and was applying for STD benefits. The Claimant stated he first requested workers' compensation benefits sometime in 2015 when he was let go.

The owner disputed the Claimant's testimony regarding reporting the injury to he and the operations manager. The owner stated he was only told the Claimant's back hurt and he was going home. The owner was not notified the Claimant hurt his back while working. The following Monday, the owner claimed the Claimant called in and reported he was going to see a doctor because his back still hurt. Again, he was not told the Claimant hurt his back at work. The owner met with the Claimant on May 19, 2014. The Claimant informed him surgery was being considered, he was not filing a workers' compensation claim, and would be filing a disability claim. During the meeting, the Claimant did not report he injured his back at work. The Claimant was let go in March, 2015, since he was unable to perform his job duties. The owner did not know the Claimant was claiming he hurt his back at work until around the time the Form 101 was filed on October 16, 2015. Both parties filed medical records and evaluation reports. The ALJ ultimately dismissed the Claimant's claim primarily due to untimely notice.

ISSUE: Did the ALJ err in finding the Claimant did not provide notice of the accident as soon as practicable pursuant to KRS 342.185?

HOLDING: No. KRS 342.185 requires notice of a work-related accident be given to the employer, "as soon as practicable after the happening thereof." While notice is mandatory, the Court of Appeals has indicated, "The statute should be liberally construed in favor of the employee to effectuate the beneficent purposes of the Compensation Act." Marc Blackburn Brick Co. v. Yates, 424 S.W.2d 814, 816 (Ky. 1968). Whether notice has been given as "soon as practicable" depends upon the circumstances of the particular case. Id. Notice to an employer of a
physical injury carries with it notice of all conditions that may reasonably be anticipated to result from that injury. See Dawkins Lumber Co. v. Hale, 299 S.W. 991 (Ky. 1927). See also Reliance Diecasting Co. v. Freeman, 471 S.W.2d 311 (Ky. 1971). Additionally, the statute does not necessarily require an injured worker to be aware of, and report each injury resulting from an accident, but must report the accident itself. Reliance Diecasting Co. v. Freeman, supra.

The Kentucky Supreme Court held in Granger v. Louis Trauth Dairy, 329 S.W.3d 296 (Ky. 2010), the ALJ was correct in dismissing a claim based upon inadequate notice, and affirmed the ALJ's refusal to find an excusable delay in reporting the injury pursuant to KRS 342.200. The Court noted the purpose of the notice requirement is threefold: to enable an employer to provide prompt medical treatment in an attempt to minimize the worker's ultimate disability and the employer's liability; to enable the employer to investigate the circumstances of the accident promptly; and to prevent the filing of fictitious claims. The Court additionally noted that although a lack of prejudice to the employer excuses an inaccuracy in complying with KRS 342.190, it does not excuse a delay in giving notice. Having failed to convince the ALJ that he gave notice of the accident and resulting injury "as soon as practicable," his burden on appeal was to show the decision to be unreasonable under the circumstances because overwhelming evidence compelled a favorable finding.

The Board noted while the Claimant identified evidence supporting a different conclusion, primarily his own testimony, substantial evidence was presented to the contrary. Testimony was conflicting as to whether the Claimant informed his Employer he sustained a work-related back injury. While the Claimant insisted he told the owner and/or the operations manager he hurt his back at work, the owner testified had only been told the Claimant hurt his back. The owner insisted at no time after May 2, 2014, did the Claimant tell him his injury occurred at work when he was leaving the pit. The owner testified it was only after the claimant filed his workers' compensation claim that he learned of the alleged work accident.

The ALJ heavily relied on the Claimant's and the owner's testimony regarding their conversation on May 19, 2014. In essence, both testified the Claimant reported he was not going to file a workers' compensation claim, but was going to apply for STD benefits. The Board found the ALJ acted within her discretion to determine which evidence to rely upon, and it cannot be said her conclusions are so unreasonable as to compel a different result. Ira A. Watson Det. Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000). The ALJ determined the Employer was not provided notice of the work-related accident until the filing of the Form 101 on October 16, 2015, over one year after the alleged May 2, 2014 event. The ALJ determined this was not "as soon as practicable." The Board found substantial evidence supported the finding that the Claimant's notice was not reasonable or timely, and no contrary result is compelled.

FACTS: The Claimant alleged work-related neck injuries while working as a groundskeeper for the Employer on July 20, 2013. The Claimant began working for the Employer in February, 2013. In a decision rendered March 17, 2015, the ALJ determined the Claimant sustained a work-related cervical injury on July 20, 2013, warranting a 5 percent impairment rating pursuant to the AMA Guides. He additionally enhanced the award of PPD benefits by the three multiplier. The ALJ found the Claimant was not entitled to an award of TTD benefits. The ALJ did not address the issue of whether the Claimant was a seasonal employee. Based upon records submitted by the Employer, the ALJ determined the Claimant had been paid a total of $5,391.56 during his employment period which he divided by fourteen to arrive at an AWW. He then determined the Claimant was a maximum wage earner, and awarded PPD benefits at the rate of $66.05 per week.

The Board rendered a decision on August 21, 2015, vacating in part, and remanding the ALJ's decision. The Board found the ALJ had failed to make a finding as to whether the Claimant was a seasonal employee. The Board then stated, "Thus, on remand, the ALJ must enter specific findings of fact as to [the Claimant's] employment status at the time of the work injury." On remand, the ALJ was directed to determine the Claimant's AWW based upon his earnings through July 13, 2013. He was also directed to determine if the Claimant was a seasonal employee, and, if so, to determine the AWW pursuant to KRS 342.140(2). No appeal was taken from this Board's decision. On remand, the ALJ issued a decision on November 18, 2015. The ALJ struck information submitted in the original proceeding by the Employer from responses to a request for production of documents as inadmissible, and stated this information could not be considered in his determination. The ALJ specifically stated, "I find that even accepting that some employees, including the plaintiff, were laid off in the winter that nonetheless the work was capable of being done year round. As such, the plaintiff was not a seasonal employee." The ALJ determined the Claimant's AWW was $386.39 and amended his PPD benefits accordingly.

In a decision entered June 6, 2016, the Board reversed, vacated and remanded the ALJ's decision. This Board reversed the finding of the Claimant's employment status since the ALJ's analysis failed to demonstrate he was not a seasonal employee. The Board also vacated the determination of the AWW and award of PPD benefits. The Board found the ALJ's exclusion of evidence ambiguous, dilatory and erroneous, and came far too late especially in light of the notation contained in the January 20, 2015 Hearing Order indicating this information would be considered as evidence. The Board stated "As a matter of law, the evidence filed in this litigation, . . . indicates [the Claimant] was a seasonal employee. . .." The Board noted the Claimant's testimony he was laid off in the winter months by the Employer due to lack of work is prima facie evidence supporting the conclusion he was a seasonal employee.
employee. A "realistic estimation" of the compensation the Claimant "would have expected to earn" but for his injury must be based upon the evidence in this case, and the evidence in this case indicated he worked on a seasonal basis from March or April through October or November. No appeal was taken from this Board's June 6, 2016, decision. On August 2, 2016, the ALJ entered an Order on Reconsideration which was actually a decision on remand. The ALJ found the Claimant was a seasonal employee, and his entire earnings for the applicable period preceding his date of injury was $5,291.50. The ALJ determined the Claimant's AWW is $107.83 and amended his award of PPD benefits accordingly.

ISSUE: Did the Board force the ALJ to re-decide the case after two previous determinations the Claimant was not considered a seasonal employee?

HOLDING: No. In Inman v. Inman, 648 S.W.2d 847, 849 (Ky. 1982), the Court stated:

The law-of-the-case doctrine is a rule under which an appellate court, on a subsequent appeal, is bound by a prior decision on a former appeal in the same court and applies to the determination of questions and law and not questions of fact. "As the term 'law of the case' is most commonly used, and as used in the present discussion unless otherwise indicated, it designates the principle that if an appellate court has passed on a legal question and remanded the case to the court below for further proceedings, the legal questions thus determined by the appellate court will not be differently determined on a subsequent appeal in the same case. Thus, if, on a retrial after remand, there was no change in the issues or evidence, on a new appeal the questions are limited to whether the trial court properly construed and applied the mandate. The term 'law of the case' is also sometimes used more broadly to indicate the principle that a decision of the appellate court, unless properly set aside, is controlling at all subsequent stages of the litigation, which includes the rule that on remand the trial court must strictly follow the mandate of the appellate court." 5 Am. Jur. 2d, Appeal and Error, Sec. 744.

In McGuire v. Coal Ventures Holding Co., Inc., 2009-SC-000114-WC, rendered October 29, 2009, designated not to be published, the Kentucky Supreme Court described the law of the case doctrine as follows:

The law of the case doctrine concerns the preclusive effect of judicial determinations in the course of a single litigation before a final judgment. [footnote omitted] As applied to

workers' compensation cases, a final decision of law by an appellate court [footnote omitted] or the Board [footnote omitted] establishes the law of the case and must be followed in all later proceedings in the same case. Slip Op. at 6.

On June 6, 2016, the Board rendered a decision remanding this claim to the ALJ, and he was directed to find the Claimant was a seasonal employee. No appeal was taken from that decision. The ALJ did as directed and we find his decision was not erroneous. The ALJ was further directed to make the appropriate calculations based upon this determination. He did so, and again, the Board found no error. Based upon the direction of the Board, the ALJ appropriately determined the Claimant was a seasonal employee and amended the award of benefits appropriately. The Board affirmed since the ALJ's decision is in accordance with the directives of this Board.


FACTS: The Claimant alleged injuries to his cervical and lumbar spine due to the repetitive nature of his work as a surface coal miner. He also alleged occupational hearing loss due to daily exposure to loud machinery while working for his Employer. He alleged August 21, 2014, as the date of injury for both claims. At the time, the Claimant was over the age of fifty-five. The Claimant worked in surface coal mining for approximately forty years where he primarily operated bulldozers. He began working for the Employer in 1994. He testified as to the daily vibration and jarring his body was subject to due to his work with the Employer. The Claimant stated he was exposed to loud noise while operating a bulldozer and ripper on a daily basis. The Claimant had hearing difficulty when he last performed his job. The Claimant had difficulty hearing his boss on the two-way radio. Therefore, the Claimant would have to exit the bulldozer and talk to his boss instead. The Claimant stated his ability to hear was an important aspect of his job. Medical records were filed, including a university evaluation related to the Claimant's hearing loss. The evaluator concluded the Claimant had occupationally related and noise induced hearing loss. He assessed an 11 percent impairment rating and recommended hearing protection. The university evaluator did not offer an opinion on the Claimant's ability to return to his job.

The ALJ found the Claimant did not meet his burden of proof regarding whether he sustained any ratable cumulative trauma injuries to his cervical or lumbar spine. The ALJ found the Claimant sustained occupational hearing loss, and adopted the 11 percent impairment rating assessed by the university evaluator. The ALJ found the Claimant was not entitled to the three multiplier for his work-related hearing loss pursuant to KRS 342.730(1)(c)1. The ALJ awarded PPD and medical benefits for the Claimant's occupational hearing loss. He calculated the
PPD award as follows: $1,021.77 (AWW) x 2/3 = 576.80 (max) x .11 = $63.45 x 1.4 (AMA impairment factor + age 55+) = $88.83 per week.

ISSUE: Did the ALJ err in including the age factor in the award of PPD benefits?

HOLDING: Yes. The Board found the medical records constituted substantial evidence supporting the ALJ's determination regarding the alleged cumulative trauma injuries, and no contrary result was compelled. Likewise, the Board found substantial evidence supported the ALJ's determination the Claimant retained the physical capacity to return to the type of work he performed at the time of his injury in light of his occupational hearing loss. However, the Board held the ALJ erred in including the age factor in his award of PPD benefits. The ALJ determined the three multiplier pursuant to KRS 342.730(1)(c)1 is not applicable. KRS 342.730(1)(c)3 clearly states, "[r]ecognizing that limited education and advancing age impact an employee's post-injury earning capacity, an education and age factor, when applicable, shall be added to the income benefit multiplier set forth in paragraph (c)1." Because the ALJ determined the Claimant was not entitled to an enhancement of his PPD award by the three-multiplier, the Board found the ALJ erred in including the age factor of 0.4 in calculating the award of PPD benefits. The Board vacated in part and remanded for recalculation of the award of PPD benefits after excluding the age factor contained in KRS 342.730(1)(c)3.


FACTS: The ALJ found compensable contested medications prescribed to the Claimant and referred the claim to the Commissioner of the Department of Workers' Claims ("Commissioner") for consideration of sanctions pursuant to KRS 342.267 and KRS 342.310 in an April 19, 2016, opinion. The Employer filed a notice of appeal on June 24, 2016, naming the Claimant and the ALJ as parties. However, the notice of appeal failed to name medical providers as parties.

ISSUES: 1) Was the notice of appeal proper? 2) Can an ALJ refer a claim to the Commissioner for consideration of sanctions pursuant to KRS 342.310?

HOLDING: No for both. The failure to name an indispensable party is a jurisdictional defect fatal to an appeal. Com., Dept. of Finance, Div. of Printing v. Drury, 846 S.W.2d 702 (Ky. 1992). As medical providers whose treatment regimens formed the basis of the underlying medical dispute, the Claimant's treating physicians, who were not named in the notice of appeal, were indispensable parties. Consequently, the Board found it was without jurisdiction to rule on the merits of the arguments raised by the Employer. An indispensable party to an appeal is one whose absence prevents the tribunal from granting complete relief among those already listed as parties. See CR 19.01; CR 19.02; Braden v.
Republic-Vanguard Life Ins. Co., 657 S.W.2d 241 (Ky. 1983); Milligan v. Schenley Distillers, Inc., 584 S.W.2d 751 (Ky. App. 1979). As a matter of law, the failure to name an indispensable party is a jurisdictional defect fatal to an appeal – even one to this Board. Id.

803 KAR 25:010 §21(2)(c), as it existed at the time of the filing of the appeal, expressly mandated the notice of appeal shall: 1. Denote the appealing party as the petitioner; 2. Denote all parties against whom the appeal is taken as respondents; 3. Name the ALJ who rendered the award, order, or decision appealed from as a respondent; 4. If appropriate name the director of the Division of Workers’ Compensation Funds as a respondent; and 5. Include a claim number. 803 KAR 25:010 §21(2), as it existed at the time the appeal was filed. This regulation has been replaced by 803 KAR 25:010 §22(2) which contains the same language, and is the administrative counterpart to CR 73.02(1)(a) and CR 73.03(1). Those rules provide respectively:

(1)(a) The notice of appeal shall be filed within 30 days after the date of notation of service of the judgment or order under Rule 77.04(2).

The notice of appeal shall specify by name all appellants and all appellees ("et al." and "etc." are not proper designation of parties) and shall identify the judgment, order or part thereof appealed from. It shall contain a certificate that a copy of the notice has been served upon all opposing counsel, or parties, if unrepresented, at their last known address.

The notice of appeal, when properly filed, transfers jurisdiction of a case from the ALJ to the Board and places all parties named therein under the Board's jurisdiction. Both this Board and the Kentucky courts of justice have repeatedly held failure to name a party in the notice of appeal to the Board is a jurisdictional defect fatal to the appeal. Com. of Kentucky, Dept. of Finance, Div. of Printing v. Drury, supra; Peabody Coal Co. v. Goforth, 857 S.W.2d 167 (Ky. 1993). The case law clearly establishes strict, not substantial compliance is the rule for failure to name parties. Johnson v. Smith, 885 S.W.2d 944, 950 (Ky. 1994); City of Devondale v. Stallings, 795 S.W.2d 954 (Ky. 1990); Stewart v. Kentucky Lottery Corp., 986 S.W.2d 918, 921 (Ky. App. 1998). Therefore, dismissal is the result mandated for failure to name an indispensable party. City of Devondale v. Stallings, supra.

The Board found the Claimant's treating physicians rendering the disputed treatment were indispensable parties, but were not named in the notice of appeal, nor joined as a party. The Board concluded their absence from this appeal prevented the granting of complete relief. Consequently, regarding the ALJ's determination regarding the treatment regimen of the Claimant's treating physicians, the Board dismissed the appeal, in part, for lack of jurisdiction. Because the issue of referral to the Commissioner for the consideration of sanctions does not affect the rights
of the medical providers, the Board found it retained jurisdiction to review this issue. The assessment of sanctions pursuant to KRS 342.310 is discretionary. Section (1) of that statute states if any, “[ALJ], the board, or any court before whom any proceedings are brought under this chapter” determines such proceedings have been brought, prosecuted, or defended without reasonable ground, he or it may assess the whole cost of the proceedings. This discretion is afforded only to an ALJ, this Board, or a court, not the Commissioner. The Board found it was incumbent upon the ALJ to make a determination regarding the application of KRS 342.310, and she was not permitted to defer such determination to the Commissioner. Because the ALJ erred in referring the matter to the Commissioner for consideration of sanctions pursuant to KRS 342.310, the Board vacated the decision, in part, and remanded for additional determination.

However, the ALJ could properly refer the claim to the Commissioner for a determination of penalties against the insurer pursuant to KRS 342.267. That statute provides:

If an insurance carrier, self-insured group, or self-insured employer providing workers’ compensation coverage engages in claims settlement practices in violation of this chapter, or the provisions of KRS 304.12-230, the commissioner of the Department of Workers' Claims shall fine the insurance company, self-insured group, or self-insured employer the sum of one thousand dollars ($1,000) to five thousand dollars ($5,000) for each violation and if they have a pattern of violations, the commissioner may revoke the certificate of self-insurance or request the commissioner of insurance to revoke the certificate of authority of the insurance carrier or the self-insured group.

The Board noted whether an insurer's actions constitute an unfair claims settlement practice pursuant to KRS 342.267 is a determination left exclusively to the Commissioner. There is no statutory provision by which an ALJ may sanction an employer pursuant to KRS 342.267. Therefore, the Board found the ALJ properly referred the claim to the Commissioner for consideration of penalties pursuant to KRS 342.267.


FACTS: The Claimant injured his left shoulder on August 26, 2013, when he fell while chasing a subject in the course and scope of his duties as a peace officer. The Claimant had worked as a corrections officer with the Employer since 2009. He began working secondary employment in 2010. The Claimant was familiar with his Employer’s off duty and secondary employment policies. At the time of the accident, the Claimant worked on the third shift for his Employer. After he completed his shift, he frequently worked at secondary jobs.
On the date of the accident, the Claimant completed his shift with his Employer, and then went to his second job where he performed security work with another officer. He wore his corrections officer uniform and equipment, including handcuffs and his service weapon while performing the security work. He made rounds and patrolled the premises. As the Claimant was preparing to leave his second job, the officer he was working with received a radio call indicating there was a disturbance in one of the buildings. When he and the other officer arrived at the scene, two employees were engaged in a fight with several other employees watching. When the officers broke up the fight, one of the involved individuals fled the scene. The Claimant and the other officer pursued, and the individual left the company's property. The Claimant ultimately caught the individual, and they fell to the ground, at which time he injured his left shoulder. The fall did not occur on the premises of the Claimant's secondary employment.

The Claimant stated that although he was not on the clock at the time of the accident, as a sworn peace officer he was on duty twenty-four hours per day, seven days per week. He stated he had previously exercised his peace officer powers, including the power of arrest, while he was off duty. The Claimant's supervisor agreed with the Claimant that correction officers are sworn peace officers, with twenty-four hour arrest powers. The ALJ found the Claimant was acting within the course and scope of his duty as a peace officer when he pursued the fighter, and was not acting for the benefit of his secondary employer. Rather, the Claimant pursued the fighter as a public safety matter. The ALJ then awarded income and medical benefits.

ISSUE: Was the Claimant acting within the course of his employment at the time of his injury?

HOLDING: Yes. The primary issue on appeal was whether the Claimant was in the course of his employment when injured. "[T]he language 'in the course of... employment' refers to the time, place, and circumstances of the accident, and the words 'arising out of... employment' relate to the cause or source of the accident." Masonic Widows and Orphans Home v. Lewis, 330 S.W.2d 103, 104 (Ky. 1959). There the Court explained, "The cause must have had its origin in a risk connected with the employment and the injury have flowed from that source as a rational consequence." ld. In this instance, the Claimant was hired by his secondary Employer to essentially walk a beat or patrol the premises. As he was leaving from work, he responded to a situation. As he broke up the fight, one of the individuals fled the scene, and left the premises. The Claimant pursued and was injured while apprehending the individual. The Board stated this far exceeded his job duties with the secondary Employer, and fell in line with his duties as a peace officer and its inherent arrest powers. The Board found persuasive the recent case of Smith v. Norton Hospitals, Inc., 488 S.W.3d 23 (Ky. 2016), where the Kentucky Court of Appeals held an off-duty corrections officer working as a security guard for a private hospital was entitled to qualified immunity from a lawsuit. The Court noted the officer's arrest and citation authority
extended beyond his primary worksite. It was determined at the time of the event, although working at his secondary job, he was acting as a peace officer. The Court additionally noted the hospital could not have granted the officer the authority to arrest or issue citations. Likewise, the Court noted the hospital could not interfere with or relieve him of his authority to do so. The Court noted the fact he was privately employed did not diminish his authority to keep the peace. The Court additionally noted as follows:

Similarly, nothing in either statute limits a peace officer’s arrest or citation authority to on-duty hours. To the contrary, the Kentucky Supreme Court has explained that one reason the General Assembly regulates the off-duty employment of peace officers is

[i]n the event a police officer observes an altercation or other possible criminal activity, a decision must be made whether a criminal violation has occurred and whether an arrest is warranted. Frequently, the decision is not clear-cut and requires the exercise of considerable discretion. In such circumstances, an off-duty officer employed by the proprietor of the business establishment would face a dilemma as to the extent, if any, the officer’s duties should be influenced by the command of the off-duty employer. It is a virtual fait accompli that official conduct would be influenced by the wishes of the employer. Puckett v. Miller, 821 S.W.2d 791, 795 (Ky. 1991).

Id. at 30.

The Court in Smith noted the officer’s actions fell within the scope of his role as a peace officer, regardless of his status at the time of a security officer for a private employer. The Court additionally stated, "to illustrate this point, had Phillips simply been visiting a friend or family member in the hospital and heard Smith say 'What if I had a gun in my purse’ or 'I have a gun in my purse,' as a peace officer, he could exercise his authority to keep the peace of the Commonwealth under the color of law." Id. at 32. The Board stated although addressing the issue of qualified immunity, the underlying logic in Smith was applicable in this instance. The fact the Claimant was privately employed on the inside of the operating premises did not diminish his ability to keep the peace. The Claimant was acting within the course and scope of his peace officer powers. Although the chase began at his secondary employment, the accident did not occur until the Claimant and the fleeing individual were off the premises. There was no evidence the Claimant was hired by his secondary employer to arrest or exert peace officer powers. His job was to maintain security. The Board stated when he witnessed the fight and
an individual fleeing, he gave chase, not as a security guard, but as a peace officer. The Claimant had arrest powers, which he could exercise twenty-four hours a day, seven days a week. The Board stated that whether he was authorized for secondary employment was not dispositive. The Board noted if the Claimant was merely driving down the road and observed an altercation, there is no question he would be authorized to break it up and exercise his arrest powers as necessary to keep the peace. Likewise, if he was injured in that activity, the Board believed his injury would be compensable. This situation is no different. Therefore, the Board affirmed.

J. Safelite Auto Glass v. John Dickerson, Claim #: 2015-01699, Rendered: 01/13/2017, Status: Final

FACTS: The Claimant alleged he injured his low back and right hip on March 11, 2015, when he slipped while exiting a work van at a car wash in Hazard, Kentucky, where he met a customer to replace a windshield. He treated with several physicians, and surgery was ultimately recommended. The Claimant had previously experienced low back and left hip pain due to arthritis. At the time of the accident, he treated for multiple conditions unrelated to the work injury. The Claimant filed voluminous records from over ten treating facilities and physicians. The Employer filed a motion for the Claimant to designate two physicians upon whose opinions he would rely pursuant to KRS 342.033. The ALJ granted the motion, providing the Claimant fifteen days to identify the names of the physicians, per KRS 342.033, upon which he intended to rely. In the December 3, 2015, order, the ALJ also stated, "Records of all other physicians and providers will be removed from the official evidentiary record to be considered by the [ALJ]."

The Claimant filed a notice indicating he would rely upon the records, reports and opinions of his treating physician who recommended surgery and an evaluating physician. His treating physician ultimately diagnosed a right-sided disc herniation at L4-5 and recommended surgery. The evaluating physician determined the March 11, 2015, work accident caused the Claimant's complaints. He determined the Claimant reached MMI on August 28, 2015, and assessed a 13 percent impairment rating pursuant to the AMA Guides. He attributed the entirety of the impairment rating to the work injury and determined the Claimant does not retain the physical capacity to return to the type of work performed at the time of the injury. The evaluating physician also assigned restrictions. The Employer filed the report of its evaluating physician who did not believe an acute lumbar herniation would occur as a result of simply stepping out of a truck with no other trauma, and opined the Claimant's current symptoms are not due to the alleged work accident.

In his decision, despite the December 3, 2015, order limiting the medical evidence, the ALJ summarized the records which he had previously excluded, in addition to those specifically designated by the Claimant and the Employer's evaluating physician's report. However, the ALJ relied upon the opinions of the physicians designated by the Claimant and
determined he sustained a work-related injury warranting a 13 percent impairment rating. Based upon the restrictions imposed by the Claimant's evaluating physician, the ALJ found the Claimant was disqualified from doing his former job and enhanced the PPD award by the three multiplier contained in KRS 342.730(1)(c)1.

ISSUES:  1) Did the ALJ err in summarizing the medical evidence he had previously excluded in the December 3, 2015, order? 2) Did the Employer properly preserve the issue of failure to follow reasonable medical advice pursuant to KRS 342.035? 3) Did the ALJ err in failing to rely upon evidence previously excluded?

HOLDING: Yes to the first issue, but the error was harmless. The Board found although the ALJ summarized medical documentation that he had previously excluded from the evidentiary record in the opinion, it constituted harmless error. The Board noted the ALJ ultimately relied solely upon the opinions of the Claimant's treating physician and his evaluating physician, who were the two medical providers the Claimant certified he would rely upon. The Board found their opinions constituted substantial evidence, and the ALJ acted within the discretion afforded him in determining the Claimant sustained a compensable work-related injury. The Board further held substantial evidence supported the ALJ's determination that the Claimant was entitled to have his award of PPD benefits enhanced by the three multiplier pursuant to KRS 342.730(1)(c)1. The reliance upon the Claimant's evaluating physician's restrictions, along with the Claimant's self-assessment of his ability to labor, falls squarely within the discretion afforded to an ALJ. Hush v. Abrams, 584 S.W.2d 48 (Ky. 1979).

No, to the second issue. The Board rejected the Employer's argument the Claimant's failure to submit to surgery constitutes a failure to follow reasonable medical advice pursuant to KRS 342.035. The Board noted the assertion of failure to follow reasonable medical advice is a special defense which requires the filing of a Special Answer pursuant to 803 KAR 25:010 §5(2)(d)4a, which was in effect at the time the claim was decided and when the Form 111 was filed by the Employer. This regulation contains the same requirements as the provisions of the current practice regulations found at 803 KAR 25:010 §7(2)(d)4a. No Special Answer was filed by the Employer, and this was not an issue preserved at the BRC or Hearing for determination. The Board additionally noted the Claimant had indicated a desire to undergo back surgery; however there is no evidence this treatment was authorized by the Employer. In fact, the Employer's own expert clearly opined such surgery was not due to a work-related injury. The Board found the determination of whether the Claimant failed to follow reasonable medical advice, and whether such refusal amounts to unreasonableness is a question of fact which was not properly preserved for determination. Even if it were, the Board noted the Employer failed to submit evidence supporting its position.
Finally, the Board found the ALJ did not err by failing to rely upon evidence previously excluded from the record. The Employer argued the ALJ should have relied upon records previously excluded from the record. The Employer made no attempt to refile this evidence. As such, the ALJ did not err in refusing to rely upon it. The Board held it would have been erroneous for the ALJ to rely upon excluded evidence.

FACTS: The Claimant is a union pipefitter who lived in Mount Sterling, Kentucky. He was assigned to the Employer in November, 2014, and worked in Louisville, Kentucky. On February 2, 2015, the Claimant stepped with his right foot into a hole covered by heavy tarp and fell. He experienced immediate, severe pain in his low back and right knee and sought treatment. MRIs demonstrated a possible patella fracture in the right knee and disc protrusion at L5-S1. His treating physicians placed restrictions on his work activities. The Claimant also testified he attempted to return to work performing light duty but was unsuccessful. The long drive from Mount Sterling to Louisville caused knee problems. He also stated the Employer wanted him to sit in a chair for eight to ten hours a day, which aggravated his back and knee conditions.

The ALJ primarily relied upon the report of Claimant’s evaluating physician. In his report, the evaluating physician diagnosed knee pain; lumbago; fractured patella, right; protruding herniated lumbar disc; bulging disc at L4-L5; radiculitis right leg; and myospasm. Using the "most recent" or 6th Edition of the AMA Guides, the evaluating physician assessed a 17 percent impairment rating for the lumbar spine and 18 percent for the left knee, combining for a total 35 percent impairment rating. He found the Claimant had not yet attained MMI. He opined the Claimant does not retain the physical capacity to return to work, and assigned restrictions. The evaluating physician was deposed in March, 2016. When questioned on his methodology, he could not confirm, remember or explain how he arrived at the impairment ratings for both the lumbar and right knee conditions. He acknowledged he may have looked in the wrong place in assessing the Claimant’s impairment ratings, and requested time to review his report. He also confirmed he is restricted from prescribing narcotic medication. The December 4, 2013, Amended Agreed Order of Permanent Restriction from the Board of Medical Licensure was filed into evidence, which reflects the evaluating physician’s license to practice medicine was permanently restricted in that he "shall not prescribe, dispense, or otherwise utilize controlled substances for the remainder of his medical practice." Subsequent to the deposition, the evaluating physician prepared an April, 2016, report to correct his assessment of impairment. He assessed an 8 percent impairment rating for the lumbar spine, and 5 percent for the right knee, combining for a total 13 percent impairment rating, and cited to portions of the AMA Guides he used in arriving at his impairment ratings. He explained, "Please forgive my error in the initial submission of this
information, as I used the wrong edition of the [AMA Guides]; and the error was thoroughly unintentional and in no way intended to deceive."

The ALJ determined the Claimant’s lumbar condition was pre-existing, and the event of February 2, 2015, caused a temporary flare-up, which returned to baseline as of April 27, 2015. The ALJ awarded TTD benefits and temporary medical expenses for the low back condition between February 2, 2015, and April 27, 2015. Regarding the right knee, the ALJ adopted the 5 percent impairment rating assessed by the Claimant’s evaluating physician. The ALJ also relied upon the evaluating physician’s opinion and the Claimant’s testimony in determining he lacks the physical capacity to perform his prior job. The ALJ then determined the Claimant was entitled to TTD benefits from February 3, 2015, through May 27, 2015.

ISSUES: 1) Did the ALJ err in relying upon the 5 percent impairment assessed by the Claimant’s evaluating physician? 2) Was the ALJ required to determine whether the physician acted within the scope of his restricted license in rendering his opinion?

HOLDING: No to both. In Kentucky River Enterprises, Inc. v. Elkins, 107 S.W.3d 206 (Ky. 2003), the Kentucky Supreme Court held the proper interpretation of the AMA Guides is a medical question solely within the province of the medical experts. Where there are conflicting opinions from medical experts as to the appropriate percentage, it is the ALJ’s function as fact-finder to weigh the evidence and select the rating upon which permanent disability benefits, if any, will be awarded. Knott County Nursing Home v. Wallen, 74 S.W.3d 706, 710 (Ky. 2002). In George Humfleet Mobile Homes v. Christman, 125 S.W.3d 288 (Ky. 2004), the Court further held that while an ALJ is not authorized to independently interpret the AMA Guides, he may as fact-finder consult them in the process of assigning weight and credibility to evidence. Although assigning a permanent impairment rating is a matter for medical experts, determining the weight and character of medical testimony and drawing reasonable inferences therefrom are matters for the ALJ. Knott County Nursing Home, supra.

In this instance, the Board noted the ALJ summarized the reports and testimony of all the physicians who rendered an opinion on impairment. The Board found it was clear the ALJ reviewed the impairment ratings assessed by each physician, and as fact-finder, consulted the AMA Guides in finding the Claimant’s evaluating physician’s 5 percent impairment rating more credible. The Board also noted the Employer did not argue his corrected assessment of impairment was not in conformity with the 5th Edition of the AMA Guides. The Board found the Employer’s critiques of the evaluating physician’s credibility went to the weight of the evidence to be considered by the ALJ and did not render it unsubstantial. The Board specifically noted the restriction of the evaluating physician regarding the prescription of certain medications had no bearing upon his ability to assess an impairment rating. The Board concluded the ALJ exercised his discretion in choosing to rely upon the Claimant’s evaluating
physician's impairment rating. Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993).

For the first time, on appeal to the Board, the Employer argued the ALJ was required to determine whether the evaluating physician acted within the scope of his restricted license in rendering his opinion. Kentucky law mandates an impairment rating must be assessed by a licensed physician. Physician is defined by KRS 342.0011(32) as follows: "Physician' means physicians and surgeons, psychologists, optometrists, dentists, podiatrists, and osteopathic and chiropractic practitioners acting within the scope of their license issued by the Commonwealth." The Board first noted the argument was not properly preserved on appeal. 803 KAR 25:010 §13(14) provides as follows regarding BRCs: "Only contested issues shall be the subject of further proceedings." The Board also noted the Employer did not request additional findings of fact on this issue in its petition for reconsideration. Even if it had done so, the Board found there was no evidence that the physician was not licensed. The Board ultimately found no error in the ALJ's reliance upon his opinion. After finding substantial evidence also supported the ALJ's determination regarding the Claimant's entitlement to TTD benefits, the Board affirmed.


FACTS: The Claimant had been working for the Employer since 2000 in various positions. Of relevance, the Claimant installed wiring harnesses when he initially developed symptoms in his right hand and wrist. He then moved to another position consisting of seating parts around the vehicle's fuel cap. He had worked on that job for two to three months at the time he went to the Employer's medical department on July 28, 2014. The Claimant filed a Form 101 alleging cumulative trauma injuries to his right hand and wrist due to the repetitive nature of his assembly work with his Employer. The Claimant alleged July 28, 2014, as the date of injury. The Claimant was eventually referred to Kutz Kleinert Clinic for injections. His treating physician ultimately performed surgery on the right middle and ring fingers on November 27, 2014. The Claimant missed no work, but was placed on light duty. He was released to unrestricted work by Dr. Moreno on April 13, 2015. Despite his release to work with no restrictions, the Claimant continued to have some pain in his right wrist when working, and stiffness in the right middle and ring fingers, which had been operated on. He returned to his treating physician in September, 2015, due to his right wrist complaints. His treating physician injected the right wrist in September or October, 2015, and recommended surgery for DeQuervain's tendonitis. He eventually performed surgery on the right wrist for that condition.

The Claimant was evaluated by a physician at his request on May 6, 2015, who diagnosed a work injury occurring on July 28, 2014, and bilateral wrist strain which had resolved. He noted the Claimant had undergone surgical treatment for fingers on his right hand. He noted the Claimant had residual grip strength weakness. He stated the Claimant's
wrists were reportedly doing fine, and opined that whatever problem he had with them had resolved. He did not impose any restrictions upon Claimant's activities. The evaluating physician assessed a 12 percent impairment rating pursuant to the AMA Guides due to loss of grip strength. He opined the Claimant had reached MMI. In a subsequent note dated October 12, 2015, the evaluating physician stated the Claimant had not reached MMI as he had previously opined, and the previous impairment rating he had imposed could not be applied. The Claimant was also evaluated by a physician at the Employer's request on July 20, 2015. He noted the surgery to the two fingers of the right hand due to triggering had resolved after the surgical release. He also noted the wrist problems had resolved. He opined the Claimant reached MMI three months after his surgery, with no residual impairment. He stated the Claimant could work unrestricted full-duty, and anticipated no further treatment. In a subsequent report filed September 25, 2015, the physician assessed a 0 percent impairment rating pursuant to the AMA Guides. In a note dated October 12, 2015, the physician stated DeQuervain's was neither observed by the Claimant's evaluating physician on May 6, 2015, nor by him on July 20, 2015. The Claimant exhibited no signs of DeQuervain's during his examination. He stated if the Claimant has this condition, it was not due to the July 28, 2014, injury. On November 3, 2015, the physician again opined if the Claimant has developed right wrist tendonitis or DeQuervain's tenosynovitis, it is not due to the July 28, 2014, work injury. He stated the Claimant's DeQuervain's symptoms were not noted until after the July 20, 2015, examination, and therefore were unrelated to the July 28, 2014, injury. The ALJ determined the DeQuervain's condition was not work-related. The ALJ also determined the Claimant is not entitled to TTD benefits. She awarded medical benefits pursuant to KRS 342.020 for treatment of the right middle, ring and little fingers, but not for DeQuervain's. The ALJ adopted the assessment of impairment of the Employer's evaluating physician, and found the Claimant not entitled to an award of PPD benefits.

ISSUES: 1) Did the ALJ err in finding the DeQuervain's tendonitis unrelated to the work injury? 2) Did the ALJ err in adopting the assessment of impairment by the Employer's evaluating physician?

HOLDING: No to both. The Board noted it was clear the ALJ primarily relied upon the opinions of the Employer's evaluating physician, and to a lesser extent those of the Claimant's. The ALJ noted the Claimant's treating physician released the Claimant to return to work without restrictions on April 13, 2015. The Claimant exhibited no symptoms of DeQuervain's when he was seen by his evaluating physician in May, 2015, or by the Employer's evaluating physician in July, 2015. The Employer's evaluating physician opined if the Claimant subsequently developed this condition, it was not due to the July 28, 2014, injury. Other than the Claimant's evaluating physician, no physician set forth an opinion the DeQuervain's was work-related. The Board also found no error in the ALJ's reliance upon the Employer's evaluating physician's assessment of a 0 percent impairment rating. In Kentucky River
Enterprises, Inc. v. Elkins, 107 S.W.3d 206 (Ky. 2003), the Kentucky Supreme Court instructed the proper interpretation of the AMA Guides is a medical question solely within the province of the medical experts. In George Humfleet Mobile Homes v. Christman, 125 S.W.3d 288 (Ky. 2004), the Court additionally held, while an ALJ is not authorized to independently interpret the AMA Guides, he may as fact-finder consult the Guides in the process of assigning weight and credibility to evidence. Although assigning a permanent impairment rating is a matter for medical experts, determining the weight and character of medical testimony and drawing reasonable inferences therefrom are matters for the ALJ. Knott County Nursing Home v. Wallen, 74 S.W.3d 706 (Ky. 2002). Moreover, authority to select an impairment rating assessed by an expert medical witness rests with the ALJ. See KRS 342.0011(35) and (36); Staples, Inc. v. Konvelski, 56 S.W.3d 412 (Ky. 2001). The Employer's evaluating physician articulated why he assessed a 0 percent impairment rating for the July 28, 2014, injury. The ALJ was free to rely upon his opinions, which constitute substantial evidence. The Board also noted the Claimant's evaluating physician had withdrawn his opinion that the Claimant had reached MMI, and therefore specifically withdrew the 12 percent impairment rating he had previously assessed. He did so without having seen the Claimant again. The Board held the Employer's evaluating physician's opinion, in conjunction with the medical records, constituted substantial evidence supporting the ALJ's determination regarding the impairment rating, when the Claimant reached MMI, and whether the DeQuervain's condition was due to the work injury.

Ibrahim Mohammed, Administrator of the Estate of Sayel Mohommed, et al. v. Maverick Transportation, LLC, Claim #: 2015-63904, Rendered: 02/10/2017, Status: Final

FACTS: The Claimant was a resident of Mt. Washington, Bullitt County, Kentucky. He was employed as an over-the-road truck driver for the Employer. The Employer is an irregular route over-the-road trucking company, with its headquarters located in Little Rock, Arkansas. It has no offices or other physical locations in Kentucky. The Employer provides notices of job openings through various outlets. All aspects of the application and hiring processes are carried out in Little Rock, Arkansas, including the signing of an employment agreement. The Claimant signed an employment agreement in Little Rock, Arkansas, on August 7, 2014. That agreement outlined that the Claimant was offered employment in Little Rock, Arkansas, and he agreed his principal state of employment was Arkansas. After the Claimant was hired, he attended training, and was then assigned to drive with an over-the-road trucker for four to six weeks. Once the training was completed, he returned to Little Rock for a final evaluation. The Claimant was then assigned to a truck. Commercial Driver's Licenses are required and must be obtained through the driver's state of residence. The Claimant was expected to drive in any of the forty-eight continental states. He drove an over-the-road sleeper unit. He received assignments through an onboard computer system. The dispatches were generated from Little Rock, and sent to the Claimant via a satellite communication system. The Employer neither owns nor leases
any property in Kentucky. At the time of his fatal accident, the Claimant was hauling a load from Rogers, Arkansas, to Danville, Illinois. On September 9, 2016, the Claimant was fatally struck by a car in Boone County, Indiana while working.

ISSUE: Did the ALJ err in finding Kentucky did not have jurisdiction over the claim?

HOLDING: No. KRS 342.670(5)(e), which the ALJ relied upon in dismissing this claim, states as follows:

(e) An employee whose duties require him or her to travel regularly in the service of his or her employer in this and one (1) or more other states may, by written agreement with his or her employer, provide that his or her employment is principally localized in this or another state, and, unless the other state refuses jurisdiction, the agreement shall be given effect under this chapter;

The Board first noted the Claimant did not meet any of the necessary requirements set forth in KRS 342.670(1), which would extend jurisdiction to Kentucky. In order for that to apply, his employment would be required to be principally located in Kentucky, or not in any state. In the alternative, the contract for hire must have been reached in Kentucky. Neither of those conditions is applicable to this situation. The ALJ reviewed the holding in Davis v. Wilson, 619 S.W.2d 709 (Ky. App. 1980), but found the provisions of KRS 342.670(5)(e) to be more applicable.

In this instance, the Board found extraterritorial coverage is not available to confer jurisdiction on Kentucky pursuant to KRS Chapter 342, and the ALJ correctly dismissed the claim. KRS 342.670(5)(e) acknowledges an agreement, such as the one signed by the Claimant, shall be given effect. It was undisputed the Claimant was hired and signed his employment agreement in Little Rock, Arkansas. It was also undisputed the Employer had no physical location in Kentucky. The fatal accident occurred in Indiana while traveling from Arkansas to Illinois. The Claimant was required to participate in training, orientation, and testing, and was hired while he was in Little Rock. Testimony established the Claimant did not become the Employer's employee until he completed the orientation process and signed the employment agreement while he was in Little Rock. The contract for hire between the Claimant and the Employer was entered into in Arkansas and not in Kentucky. Arkansas was listed as the principal place of employment in the contract. When taken as a whole, the Board found the ALJ's determination Kentucky had no jurisdiction was supported by both the law and facts applicable to this case. The Board rejected the Claimant's argument the employment contract was an adhesion contract finding the ALJ provided a sufficient analysis and determined there was no evidence of record to support this assertion. The ALJ provided an analysis which outlined the assertion was not supported by the facts or evidence which was introduced into the record. The ALJ determined that without such evidence he was constrained from
making such finding. The ALJ then noted the language contained in KRS 342.670(5)(e) and determined there was no basis to either invalidate the statute, or transfer the burden of proof to the Employer. Therefore, the Board affirmed.

N. Doyle Whitaker v. James River Coal Company, Claim #: 2009-97597, Rendered: 03/03/2017, Status: Appeal to Court of Appeals

FACTS: The Claimant settled a claim for multiple injuries and was deemed permanently totally disabled. His benefit was increased due to the Employer's failure to follow several safety regulations. For two years, the Employer paid the Claimant bi-weekly until 2014, when it filed for bankruptcy. Payments were then taken over by the Kentucky Coal Workers' Self-Insurance Fund. The Fund moved to reopen the Claimant's claim. It argued it should not be liable for the payment of the safety penalty.

ISSUE: Is the Self-Insurance Fund liable for the payment of enhanced benefits due to the violation of a safety regulation?

HOLDING: Yes. KRS 342.910(2) provides that the Self-Insurance Fund is not liable for the payment of penalties. In AIG/AIU Ins. Co. v. South Akers Mining Co., LLC, 192 S.W.3d 687, 689 (Ky. 2006), the Kentucky Supreme Court determined the increased compensation benefit due to a safety violation is not a "penalty" within the meaning of KRS 342.910(2). The Board applied that holding to the current claim, and determined the Self-Insurance Fund may not relieve itself of payment of the Claimant's increased benefit under the rationale that it is paying a penalty. The dissent raised valid public policy arguments: to wit, the increase or decrease in income benefits due to safety violations is meant to encourage safe work practices. This goal is not furthered by requiring the Self-Insurance Fund, which has no control over workplace safety, to pay increased benefits. Though a valid point, the majority felt restrained by the plain language of the statute and the current Supreme Court cases.


FACTS: The Claimant filed a Form 101 alleging multiple injuries sustained in a MVA in the course and scope of her employment. The BRC order and memorandum indicated the claim was bifurcated for a determination regarding extraterritorial jurisdiction. A Hearing on this issue was held on December 7, 2016. In the "Interlocutory Opinion" issued on January 9, 2017, the ALJ determined the Claimant, "sustained her burden of proof that her claim for an out-of-state injury is encompassed by Kentucky's extraterritorial jurisdiction statute." The ALJ issued a standard proof schedule regarding the remaining issues, and scheduled a telephonic BRC in March, 2017. The ALJ noted the decision was interlocutory and not final and appealable. The ALJ denied the Employer's petition for reconsideration. The Employer appealed the January 9, 2017 Interlocutory opinion.
ISSUE: Did the Employer file an appeal from a final award, order or decision?

HOLDING: No. 803 KAR 25:010 §22(2)(a) provides that within thirty days of the date a final award, order, or decision rendered by an ALJ is filed, any aggrieved party may file a notice of appeal to the Workers' Compensation Board. 803 KAR 25:010 §22(2)(b) defines a final award, order or decision as follows: "[a]s used in this section, a final award, order or decision shall be determined in accordance with Civil Rule 54.02(1) and (2)." Civil Rule 54.02(1) and (2) states as follows:

(1) When more than one claim for relief is presented in an action . . . the court may grant a final judgment upon one or more but less than all of the claims or parties only upon a determination that there is no just reason for delay. The judgment shall recite such determination and shall recite that the judgment is final. In the absence of such recital, any order or other form of decision, however designated, which adjudicates less than all the claims or the rights and liabilities of less than all the parties shall not terminate the action as to any of the claims or parties, and the order or other form of decision is interlocutory and subject to revision at any time before the entry of judgment adjudicating all the claims and the rights and liabilities of all the parties.

(2) When the remaining claim or claims in a multiple claim action are disposed of by judgment, that judgment shall be deemed to readjudicate finally as of that date and in the same terms all prior interlocutory orders and judgments determining claims which are not specifically disposed of in such final judgment.

Hence, an order of an ALJ is appealable only if: 1) it terminates the action itself; 2) acts to decide all matters litigated by the parties; and, 3) operates to determine all the rights of the parties so as to divest the ALJ of authority. Tube Turns Div. v. Logsdon, 677 S.W.2d 897 (Ky. App. 1984); cf. Searcy v. Three Point Coal Co., 280 Ky. 683, 134 S.W.2d 228 (1939); and Transit Authority of River City vs. Sailing, 774 S.W.2d 468 (Ky. App. 1989); see also Ramada Inn vs. Thomas, 892 S.W.2d 593 (Ky. 1995). The Board found that the January 9, 2017, opinion and the January 27, 2017, order denying the Employer's petition for reconsideration were interlocutory, and not final and appealable since they did not operate to terminate the action or finally decide all outstanding issues. Likewise, they did not operate to determine all the rights of the parties so as to divest the ALJ once and for all of the authority to decide the merits of the claim. Therefore, the Board dismissed the Employer's appeal, and remanded the claim to the ALJ to conduct all proceedings necessary for final adjudication of the claim.
FACTS: The Claimant worked for the Employer from 1976 until May, 2015. At all relevant times, he worked as a maintenance technician. On March 7, 2014, a forklift driven by a co-worker backed over a service cart the Claimant was operating. He gradually developed symptoms in his neck, right shoulder, right wrist, sternum, back and both knees. The Claimant eventually underwent low back surgery in May, 2015. The Claimant acknowledged having prior right hip and right rotator cuff problems, as well as treatment for his right knee in 2012. Claimant's evaluating physician diagnosed a lumbar herniated nucleus pulposus with radiculopathy, cervical pain, and bilateral knee contusions as a result of the work accident. He assessed a 20 percent impairment rating pursuant to the AMA Guides, attributing 13 percent to the lumbar condition, 6 percent to the cervical condition, and 3 percent to the bilateral knee contusions. He opined all of the impairment ratings were caused by the March 7, 2014, work injury. Subsequently, after reviewing a February 12, 2014, treatment record, the evaluating physician determined 6 percent of the impairment could have been pre-existing and active prior to the work accident. He stated the Claimant's low back condition was worsened by the work accident. Another evaluating physician assessed a 10 percent impairment rating for the lumbar condition, but did not address causation.

Claimant's treating physician diagnosed him with a herniated lumbar disc superimposed on a chronic bulging disc, and he recommended an L4-L5 epidural injection. He specifically stated, "My interpretation is that he is [sic] an acute herniated disc at that level. The acute rupture is likely what was precipitated by the accident." He performed lumbar surgery in May, 2015, and additionally treated the cervical condition. Treatment records prior to the work accident were submitted and demonstrated the Claimant was treated for bilateral knee degenerative joint disease and right hip pain from 2011 to 2013. A treatment note of February 12, 2014, reflected the Claimant complained of low back and right hip pain with right leg pain. The treating physician suspected radiculopathy, and prescribed a Medrol Dosepak and Flexeril to be taken as needed. The ALJ found the bilateral knee conditions were work-related, and warranted a 3 percent impairment rating. He dismissed the claim for the cervical condition. He found the lumbar condition was work-related based upon the treating physician's opinion and adopted the 10 percent impairment rating.

ISSUE: Did the ALJ err in failing to find a pre-existing, active lumbar condition?

HOLDING: No. To succeed in establishing a pre-existing active condition, the Employer was required to prove it was both symptomatic and impairment ratable prior to the date of the accident. Finley v. DBM Technologies, 217 S.W.3d 261 (Ky. App. 2007). There was no question the Claimant was previously treated for right shoulder, lumbar, and right knee complaints, and treated less than a month prior to the date of the work accident for low back and right hip pain, which may have indicated
radiculopathy. However, the only information in the record regarding the interim between February and March was a note that the Claimant reported he took a dosepak and the problem resolved. Likewise, the Claimant's treating physician repeatedly stated the condition for which he performed surgery was due to the March 7, 2014, accident. The Board noted the evidence did not establish what information was provided to the treating physician, or all of the elements he relied upon in reaching his determination. He also was not deposed. Likewise, the Board noted the record was completely devoid of any evidence establishing the Claimant's ability to work was in any way restricted or that he was disabled in any manner prior to the date of the injury. Rather, the evidence established the Claimant was able to work on a daily basis performing his usual job until the accident. He continued to work until the surgery performed in May, 2015. Likewise, his treating physician opined, as relied upon by the ALJ, the Claimant sustained a herniated disc at L5-S1 on March 7, 2014, which ultimately required surgery. While the Employer introduced medical evidence regarding a pre-existing impairment, the Board found the evidence did not compel a finding the Claimant had a pre-existing active disability prior to the date of injury due to his lumbar condition.

Q. Christopher Turner v. Cumberland River Coal Company, Claim #: 2015-01853, Rendered: 03/10/2017, Status: Final

FACTS: The Claimant alleged injuries to his neck, low back and upper extremities due to the repetitive nature of his work in underground coal mining. He alleged he was injured on May 5, 2014, in Eolia, Letcher County, Kentucky. The Claimant has lived in Linefork, Kentucky for over fifty years, and worked in the coal mining industry for approximately thirty-three years. The Claimant heard the Employer was hiring in January, 2009, and completed an application at its office in Partridge, Kentucky for a repairman/electrician position. The Employer contacted him to complete an oral test. The Claimant then performed testing on equipment underground in Eolia, Kentucky. He also underwent a pre-employment physical in Harlan, Kentucky. The Claimant interviewed for the job in Eolia, Kentucky. The Claimant was hired by the Employer on February 16, 2009, as a repairman/electrician. At the time, the Employer had mining operations in Partridge, Kentucky and Virginia, which were geographically linked. A belt corridor ran from the Kentucky mine to the Virginia mine to transfer coal mined in Kentucky to a preparation plant in Virginia. The Claimant did not work on the belt corridor. When he first began working, the Claimant reported to the office in Partridge, Kentucky, and worked at the mining operation in Kentucky. It was mandatory to become a member of the local union, and Claimant had authorized his dues to be deducted from his paycheck. The Claimant attended quarterly union meetings in Partridge, Kentucky.

The Claimant worked approximately three months from February 16, 2009, to May 14, 2009, in Kentucky, until he was laid off. The Employer recalled the Claimant ten months later on March 22, 2010, to a repairman/electrician position at the mining operation in Partridge, Kentucky. He successfully bid on a repairman/electrician job on the high
wall miner located in Partridge, Kentucky in July, 2010, and worked there until February 5, 2012. He then successfully bid on a repairman/electrician position in Pine Branch, Virginia. The Claimant indicated the Employer was laying off employees on the high wall miner, and he had no choice but to bid on the Virginia job. The Claimant was required to get a Virginia underground card, complete testing, and get his electrician card. During his employment in Virginia with the Employer, the Claimant paid Kentucky state taxes. The Claimant desired to work in Kentucky. However, the Claimant did not bid on any positions posted in Kentucky during his two year employment in Virginia because he did not qualify for them. The Claimant continued to attend union meetings at a union hall in Partridge, Kentucky, during his Virginia employment. The Claimant agreed all of his work remained in Virginia once he was transferred there. The Claimant stated he returned "several times" to Kentucky to remove parts from a piece of equipment which he took back to the mine in Virginia. However, the Claimant could only specifically recall one such occasion in 2013. His treating physician restricted him from work on May 2, 2014, when he was working at the Virginia mine.

The Claimant acknowledged he sustained an acute injury to his head and mouth in April, 2013, while employed by the Employer in Virginia. He retained an attorney to pursue a claim in Virginia, and settled that claim. The January 28, 2015, order approving the Virginia compromised settlement was introduced. The order listed the Employer with an address in Appalachia, Virginia. Subsequent to his cessation of employment in May, 2014, the Claimant filed coal workers' pneumoconiosis and hearing loss claims in Virginia. The Claimant did not pursue a claim for cumulative trauma injuries in Virginia.

ISSUE: Did the ALJ err in finding Kentucky did not have extraterritorial jurisdiction during the time he worked in Virginia pursuant to KRS 342.670?

HOLDING: No. KRS 342.670(1) states an employee who is injured while working outside the territorial limits of Kentucky is entitled to benefits provided by the Kentucky Workers' Compensation Act, if at the time of injury:

(a) His or her employment is principally localized in this state; or

(b) He or she is working under a contract of hire made in this state in employment not principally located in any state; or

(c) He or she is working under a contract of hire made in this state in employment principally localized in another state whose workers' compensation law is not applicable to his or her employer; or
(d) He or she is working under a contract of hire made in this state for employment outside the United States and Canada.

KRS 342.670(5)(d) defines "principally localized." A person's employment is principally localized in this or another state when:

1. His or her employer has a place of business in this or the other state and he or she regularly works at or from that place of business, or

2. If subparagraph 1 foregoing is not applicable, he or she is domiciled and spends a substantial part of his or her working time in the service of his or her employer in this or the other state.

In this instance, the ALJ found KRS 342.670(1)(c) and (d) did not apply and focused her analysis on subsections (1)(a) and (5)(d)1 to conclude the Claimant's employment was principally located in Virginia. The Kentucky Supreme Court has construed the term "has a place of business" as used in the extraterritorial coverage provision to mean, "the employer must either lease or own a location in the state at which it regularly conducts its business affairs, and the subject employee must regularly work at or from that location." Haney v. Butler, 990 S.W.2d 611, 617 (Ky. 1999). The Court also explained pursuant to KRS 342.670(5)(d)1 and 2, "a particular set of facts must be considered, first, in view of subsection (4)(d)1. Only if that provision does not apply does the analysis proceed to subsection (4)(d)2." Id. at 616. A conclusion that a particular employment is not principally localized in any state can only be made after a determination that both subsections (5)(d)1 and (5)(d)2 do not apply. Id. The Board noted the ALJ first found the Employer maintained a place of business in Virginia at the time of the Claimant's injury since it had an active mining operation there, satisfying the first element of KRS 342.670(5)(d)1. The Claimant testified he worked at the Virginia mine for over two years from February 6, 2012, to May 5, 2014. The ALJ also found the Claimant returned to Kentucky on one occasion for two days in either 2012 or 2013 to retrieve the head from a high miner wall. Therefore, the ALJ concluded the Claimant regularly worked in Cumberland's Virginia mine pursuant to KRS 342.670(5)(d)1 since he worked there exclusively from February 6, 2012, to May 5, 2014, with the exception of one or two days in Kentucky to remove the miner head and take it to Virginia.

The Board rejected the Claimant's argument he did not "regularly" work in either Kentucky or Virginia, because he worked in Kentucky for three years and in Virginia for two years over the course of his career with the Employer, and was eligible to bid on a transfer at any time. "When the plain meaning of the statutory language is clear, we are not at liberty to base our interpretation of the statute on other sources." Revenue Cabinet v. O'Daniel, 153 S.W.3d 815, 819 (Ky. 2005). "We must interpret words with their literal meaning unless to do so would lead to an absurd result."
"Regular" means "normal, typical, usual or ordinary." *Webster's New World College Dictionary* (2010). Aside from the two days at the Kentucky mine to retrieve a miner head to take back to Virginia in 2012 or 2013, the Board noted the Claimant worked exclusively at the Virginia mine for over two years from February, 2012, to May, 2014. As of May 5, 2014, his last date of exposure, the Claimant was working daily in Virginia. The Board found no logical basis to conclude the Claimant did not "regularly" work in Virginia. The Board affirmed the ALJ since substantial evidence supported her determination the Claimant's employment was principally located in Virginia since the Employer had a place of business there from which the Claimant regularly worked, and no contrary result was compelled. The Board noted KRS 342.670(5)(d)2 is only available if the requirements of KRS 342.670(5)(d)1 are not satisfied. In this instance, KRS 342.670(5)(d)1 applied and instructed the Claimant's employment was principally located in Virginia.

**R. Billy Joe Gibson v. Columbus Hoggs Agent, Claim #: 2015-02010, Rendered: 03/24/2017, Status: Appealed to Court of Appeals**

**FACTS:** The Claimant resides in Pikeville, Kentucky, and has worked for the Employer since 1994 as a well tender. He is responsible for thirty-five to forty wells. The Claimant sets his own schedule, but is on call twenty-four hours a day. The Claimant has a helper who assisted him with job tasks which required two people. The Employer furnished the Claimant a truck, which he kept in his possession at all times and drove every day. The Claimant was not required to turn in the truck to his Employer and was not provided restrictions on its use. The Employer paid for the automobile insurance and fuel, and provided the Claimant with the tools necessary to perform his job. The Claimant took the company truck home every night. No representative from his Employer told the Claimant he could not use the company truck for personal use. The Claimant stated it was normal for him to travel directly from his home to the wells, and he did not have to first report to an office. On the morning of December 16, 2013, the Claimant left his home driving the company truck. He was going to work on a gas well at Island Creek that morning, but first dropped off his stepdaughter at Pike Central High School. The Claimant was stopped at a stop sign in the school parking lot while waiting to exit the Pike Central High School premises in order to pull onto US 119 when he was rear-ended by a driver of another vehicle. The Claimant confirmed he was still in the school parking lot at the time of the MVA. The Claimant stated he was never told he could not do this. The school and the Island Creek well were in the same direction. The Claimant sustained injuries as a result of the MVA.

**ISSUE:** Did the ALJ err in determining the Claimant's injury occurred while he was engaged in a substantial deviation from the course and scope of his employment to perform an entirely personal errand?

**HOLDING:** No. The "going and coming" rule sets forth "that injuries sustained by workers when they are going to or returning from the place
where they regularly perform the duties connected with their employment are not deemed to arise out of and in the course of the employment as the hazards ordinarily encountered in such journeys are not incident to the employer's business." Receveur Const. Co./Realm, Inc. v. Rogers, 958 S.W.2d 18, 20 (Ky. 1997). The "going and coming" rule generally applies to travel to and from a fixed-situs or regular place of work where an employee's substantial employment duties begin and end. 82 Am.Jur.2d Workers' Compensation §270 (2003); Larson's Workmen's Compensation §13.01[1]. There are several exceptions to the "going and coming" rule, including the traveling employee doctrine and the service to the employer exception. The traveling employee doctrine provides:

When travel is a requirement of employment and is implicit in the understanding between the employee and the employer at the time the employment contract was entered into, then injuries which occur going to or coming from a work place will generally be held to be work-related and compensable, except when a distinct departure or deviation on a personal errand is shown. (Emphasis added) William S. Haynes, Kentucky Jurisprudence, Workers' Compensation, §10-3 (revised 1990).

Professor Larson elaborates, "[e]mployees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown." Larson's Workmen's Compensation, §25.01. In Black v. Tichenor, 396 S.W.2d 794, 796-97 (Ky. 1965), the Supreme Court held as follows:

It is quite a different thing to go to and from a work site away from the regular place of employment, than it is to go to and from one's home to one's usual place of employment; it is the latter which generally comes within the so-called 'going and coming rule' absolving employers from Workmen's Compensation liability. The former comes within the principle stated in Larson, Workmen's Compensation Law, Vol. 1, Sec. 25.00: 'Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually held compensable.' Turner Day & Woolworth Handle Co. v. Pennington, 250 Ky. 433, 63 S.W.2d 490 [(1933)]; Standard Oil Company (Ky.) v. Witt, 283 Ky. 327, 141 S.W.2d 271 [(1940)].

Although traffic perils are ones to which all travelers are exposed, the particular exposure of Tichenor in the case at
bar was caused by the requirements of his employment and was implicit in the understanding his employer had with him at the time he was hired. Palmer v. Main, 209 Ky. 226, 272 S.W. 736 [(1925)]; Hinkle v. Allen-Codell Co., 298 Ky. 102, 182 S.W.2d 20 [(1944)]. In the recent case of Corken v. Corken Steel Products, Inc. [(1964)], Ky., 385 S.W.2d 949, where a traveling salesman was killed on a public street by a demented stranger, we approved an award of compensation, and said:

We accept the view that causal connection is sufficient if the exposure results from the employment. Corken's employment was the reason for his presence at what turned out to be a place of danger, and except for his presence there he would not have been killed.

In Gaines Gentry Thoroughbreds/Fayette Farms v. Mandujano, 366 S.W.3d 456, 463-464 (Ky. 2012), the Kentucky Supreme Court held as follows:

Kentucky applies the traveling employee doctrine in instances where a worker's employment requires travel. Grounded in the position risk doctrine, the traveling employee doctrine considers an injury that occurs while employee is in travel status to be work-related unless the worker was engaged in a significant departure from the purpose of the trip. The ALJ did not err by concluding that the traveling employee and position risk doctrines permitted compensation in this case.

The claimant's accident did not occur while he was working for Eaton or Paramount but while he was traveling from Saratoga back to Lexington. As found by the ALJ, the parties contemplated that he would work at the sales and return to his duties at the farm when the sales ended. The accident in which he was injured occurred during the "necessary and inevitable" act of completing the journey he undertook for Gaines Gentry. In other words, travel necessitated by the claimant's employer placed him in what turned out to be a place of danger and he was injured as a consequence.

The Kentucky Supreme Court also recognized the "service to the employer" exception to the "going and coming" rule in Receveur Construction, Co. v. Rogers, supra. The Kentucky Supreme Court acknowledged that generally injuries incurred while traveling to and from work are not deemed to arise out of and in the course of the employment. However, the Court held the accident to be compensable under the "service to the employer" exception. Id. at 20. The Court in its reasoning
did not focus on the particular trip during which the accident occurred, but rather the benefit the employer received generally from Rogers' use of the company vehicle. The Court applied "some benefit" test to the particular facts and in finding work-relatedness stated:

Therefore, based on our interpretation of the applicable case law as summarized above, as well as the facts presented in the case at bar, it appears that there was substantial evidence to support a conclusion that Rogers' use of the company truck was of benefit to the company. The employer's purpose in providing such a vehicle to Rogers was to allow him to better perform the requirements and completion of his duties. Included within such objective was the premise that use of the company truck as transportation between Rogers' home and the job site would allow Rogers to begin his actual duties earlier, and to remain productive longer, by avoiding a stop at the company's business office in Louisville.

Thus, although the use of such a conveyance was a convenience for Rogers, it was primarily of benefit to the employer. Hence, as it can be concluded that Rogers was performing a service to the employer at the time of his death, it can be determined that his death was work-related under the service to the employer exception to the going and coming rule.

Id. at 21.

The Court further noted the claim contained no specific allegation of substantial deviation from the course and scope of employment.

In view of the foregoing, we need not . . . reach the question of whether we adopt the theories that an employer's deliberate and substantial payment for the expense of travel, the employer's issuance of a company vehicle, or the employer's furnishing of transportation in a conveyance, makes the journey held to be in the course of employment. [citation omitted]. Nor do we find that the evidence compelled the conclusion that there was a substantial deviation from the course and scope of the employment, and there is no such specific allegation herein. Id. See also Port v. Kern, 187 S.W.3d 329 (Ky. App. 2006);

In Fortney v. Airtran Airways, Inc., 319 S.W.3d 325, 329 (Ky. 2010), the Kentucky Supreme Court held the rule excluding injuries occurring off of the employer's premises, during travel between work and home, does not apply if the travel is part of the service for which the worker is employed, or otherwise benefits the employer. Fortney, a pilot for the employer, resided in Lexington, Kentucky, while his work was based in Atlanta,
Georgia. He flew between Lexington and Atlanta, and was not reimbursed for his commuting-related expenses. However, the employer provided free or reduced fare travel to its employees and their families. Fortney was killed when the plane in which he was a passenger crashed on takeoff in Lexington in route to Atlanta. Ultimately, the Court remanded the claim to the ALJ since he failed to consider whether the free or reduced fare arrangement induced the claimant to accept or continue employment with Airtran. Id. at 330. There was no allegation of substantial deviation on Fortney's part.

After reviewing the above case law, the Board found the ALJ engaged in a proper analysis in determining the Claimant substantially deviated from the course and scope of his employment at the time of the MVA, and no contrary result was compelled. It was undisputed the Claimant was provided a company vehicle which he used for the Employer's benefit, as well as for personal use and errands. The Claimant used the vehicle to travel to numerous gas wells located within his territory. He was provided tools which he stored in the vehicle. Although he set his own schedule, the Claimant stated he was on call twenty-four hours a day. The Employer acknowledged the Claimant's travel to the gas wells was a necessary part of his service. It also acknowledged injuries occurring while traveling from the Claimant's home to the wells and from the wells to home would be considered in the course and scope of his employment, and compensable.

However, the traveling employee doctrine and the service to the employer exception do not apply when there is a significant departure or deviation from the course and scope of the employment. The ALJ found that at the time of the MVA, the Claimant was engaged in the personal errand of dropping off his stepdaughter to school with no business purpose being served, and this constituted a substantial deviation from his regular work activity of taking a normal travel route to a work site. The Board stated the exceptions do not apply under these circumstances since the Claimant was not merely traveling between home and work sites at the time of his injury. Although he was attempting to resume his travel to service a well, he had not yet done so, and at the time of the accident he was still engaged in a personal errand. His deviation was not part of the service for which he was employed and did not benefit the Employer. See Abbott Laboratories v. Smith, 205 S.W.3d 249 (Ky. App. 2006).

The Board stated Receveur, supra; Kern, supra; and Fortney, supra, were factually distinguishable since, in all of those situations, the claimants were injured while traveling between work and home in company-provided vehicles or at company expense, and not during a portion of a journey to complete a purely personal errand outside of the normal route home. Likewise, none of these cases involved an allegation of a substantial deviation from the course and scope of the employment as in the case sub judice. Additionally, the Board noted there was no evidence the personal errand was "still part of the integral and necessary travel for the business." See Abbott Laboratories v. Smith, supra. Based upon the
foregoing, the Board found the ALJ's dismissal supported by substantial evidence and a contrary result was not compelled.


FACTS: The Claimant worked as a manager for the Employer. On November 20, 2014, the Claimant injured her right shoulder while unloading a truck. The Claimant's treating physician performed surgery on January 27, 2015. Subsequently, the treating physician restricted the Claimant from work for approximately six weeks, prescribed pain medication, and placed her right upper extremity in an immobilizer. The Claimant testified the treating physician advised her to sleep in an upright position to avoid inadvertently laying on her right shoulder. Approximately one week following her surgery on February 5, 2015, the Claimant stated she was sleeping in a recliner to keep her right shoulder immobile. The Claimant stood and pushed her blankets off to go to the restroom. The Claimant got her feet tangled in the blankets, causing her to trip and fall, reinjuring her right shoulder. A subsequent MRI revealed a new tear. The treating physician repaired the tear in a second procedure on August 5, 2015. The Claimant emphasized she was sleeping in the recliner to keep her right shoulder immobile and to prevent herself from laying on it in bed, and was still taking hydrocodone for pain. Prior to the November work injury, the Claimant did not normally sleep in the recliner. The Claimant testified the only reason she was sleeping in the recliner was due to her shoulder injury and resulting surgery.

ISSUE: Did the ALJ err in finding the February 5, 2015, fall at home traceable to the original work injury, thereby finding the resulting surgery and impairment work-related?

HOLDING: No. KRS 342.0011(1) defines injury as, "any work-related traumatic event or series of traumatic events, including cumulative trauma, arising out of and in the course of employment which is the proximate cause producing a harmful change in the human organism evidenced by objective medical findings." "[T]he language 'in the course of... employment' refers to the time, place, and circumstances of the accident, and the words 'arising out of... employment' relate to the cause or source of the accident." Masonic Widows and Orphans Home v. Lewis, 330 S.W.2d 103, 104 (Ky. 1959). There the Court explained, "The cause must have had its origin in a risk connected with the employment and the injury have flowed from that source as a rational consequence." Id. at 104. Black's Law Dictionary, 10th Edition, defines proximate cause as, "a cause that directly produces an event and without which the event would not have occurred." Consistent with the doctrine of proximate cause, our courts have long recognized the general rule that workers' compensation benefits must be allowed for all the injurious consequences flowing from a work-related injury. Beech Creek Coal Co. v. Cox, 314 Ky. 743, 744, 237 S.W.2d 56 (Ky. 1951). For purposes of the Act, "injury" has been held to include all direct and natural consequences of the original injury that are not attributable to an independent, intervening
cause. In Addington Resources, Inc. v. Perkins, 947 S.W.2d 421, 423 (Ky. App. 1997), the Court explained the "direct and natural consequence rule" as follows:

The applicable rule has been referred to as the direct and natural consequence rule and is explained in Larson, Workmen's Compensation Law, §13.11 (1996), as follows:

The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury is compensable if it is the direct and natural result of a compensable primary injury. See also Dutton v. Industrial Com’n of Arizona, 140 Ariz. 448, 682 P.2d 453 (Ct. App. 1984); and Beech Creek Coal Co. v. Cox, 314 Ky. 743, 237 S.W.2d 56 (1951).

In this instance, the Board found substantial evidence supported the ALJ's determination the subsequent fall at home was work-related. In an October 22, 2015, letter, the Claimant's treating physician opined, "the reinjury was clearly related to the 2014 work injury as it would not have been necessary for her to sleep in a recliner had she not had the work injury resulting in subsequent weakness and susceptibility to injury." In an August 18, 2016, letter, the treating physician again opined, "the February, 2015, re-injury is related to the 2014 work-related accident. If [the Claimant] had not had the 2014 injury and surgery, she would not have needed to be in a recliner. I absolutely associate this injury in 2015 with her prior injury and surgery[sic] 2014." In addition, an evaluating physician noted the fall at home, "was a result of a combination of several factors, but most notably being forced to sleep in a chair with her arm (appropriately) immobilized while also on pain medication which obviously would affect coordination and balance." He reiterated the fall at home and subsequent surgery happened because the Claimant was appropriately in a position for post-operative recovery, which allowed her to fall as she got out of the chair. The evaluating physician noted if it had not been for her recovery from the first surgery, "the subsequent fall and need for the second surgery would have never happened." Therefore, the Board found the opinions of the treating physician and the evaluating physician, as well as the Claimant's testimony, constituted substantial evidence supporting the ALJ's determination the subsequent fall and resulting surgery were work-related.


FACTS: It was undisputed the Claimant injured her left foot at work on November 25, 2012. The Claimant also alleged she developed complex regional pain syndrome ("CRPS") or reflex sympathetic dystrophy ("RSD") as a result of the November 25, 2012, work injury. The parties settled the claim regarding her left ankle injury only. The settlement agreement,
approved on November 17, 2016, reflected the parties agreed to submit to the ALJ the determination of whether Claimant suffered from CRPS/RSD, and whether any treatment for CRPS/RSD is reasonable, necessary and related to the original work injury. The Claimant testified she injured her left ankle at work on November 25, 2012, and was sent to the emergency room where she was provided an air cast, crutches and medication. The Claimant missed a few days of work, and then returned with restrictions until she was terminated in January, 2013. After the Claimant returned to work, the left ankle swelling worsened. She sought treatment and was ultimately referred to a pain management physician, who diagnosed her with RSD. The pain management physician performed one of a series of three injections, which provided no relief, and referred her to a psychiatrist. Voluminous medical records were filed by the parties. The Employer also took the deposition of a private investigator, through which photographs, a surveillance report and videos of the Claimant's activities on July 28, 2014, September 24, 2014, and February 6, 2015, were introduced. The Employer submitted additional video footage on July 17, 2015, of the Claimant's activities on June 27, 2015. An interlocutory opinion was rendered on July 9, 2015. The ALJ found the Claimant had developed CRPS. He also determined she was entitled to the spinal cord stimulator trial, which was never attempted due to the Claimant's pregnancy. Although the ALJ referenced the surveillance videos, he apparently did not have the opportunity to review the video taken on June 27, 2015, a mere twelve days prior to the entry of his decision. That video footage was not submitted by the Employer until July 17, 2015.

During the pendency of the litigation, the claim was assigned to another ALJ who rendered an opinion on January 3, 2017. He relied upon the reports of an evaluating physician. In his initial report dated September 24, 2014, the physician diagnosed the Claimant with CRPS, agreed with the need for a trial of a spinal column stimulator, and recommended a brain MRI. On August 26, 2015, after reviewing a video of the Claimant's activities, the evaluating physician noted she did not appear to be in pain, nor did she favor one leg over the other. At that time, he stated a spinal cord stimulator was not recommended because she appeared to be pregnant. Based upon the video, he opined the Claimant reached MMI on May 1, 2015. In his report dated February 8, 2016, the evaluating physician stated the Claimant had no definite findings of CRPS. He assessed a 5 percent impairment rating pursuant to the AMA Guides. He assigned restrictions but found the Claimant could return to her former job. He stated the Claimant had some subjective symptom magnification, and does not meet the criteria for a diagnosis of CRPS. In a supplemental report dated March 23, 2016, he stated the Claimant could return to the workplace, she could walk and bear weight on the left foot, and is not permanently totally disabled. On April 28, 2016, the evaluating physician again noted the Claimant had no physical findings consistent with CRPS.

In the January 3, 2017, opinion, in reliance upon the evaluating physician's conclusions, the ALJ found the Claimant does not have CRPS/RSD and, as such, the Employer is not responsible for any medical
expenses associated with treatment of such alleged conditions. In an order on petition for reconsideration, the ALJ noted the evaluating physician did not have the opportunity to view and comment upon the surveillance video at the time the prior ALJ rendered his interlocutory decision. Therefore, his opinions constitute new and substantial evidence since the interlocutory decision, which supports this ALJ's conclusions. The ALJ reiterated his reliance upon the evaluating physician's most recent conclusions.

ISSUE: Did the holding in Bowerman v. Black Equipment Co., 297 S.W.3d 858 (Ky. App. 2009) preclude the ALJ from reversing the previous dispositive finding made by the prior ALJ in the interlocutory decision?

HOLDING: No. In Bowerman v. Black Equipment Co., 297 S.W.3d 858, 867 (Ky. App. 2009), the Court determined an ALJ as fact-finder may not reverse a dispositive interlocutory factual finding on the merits in a subsequent final opinion, absent a showing of new evidence, fraud or mistake. The ALJ had rendered a November, 2005, interlocutory opinion finding Bowerman had not reached MMI from an October, 2004, work injury, but had improved enough to return to some sort of work. The ALJ awarded medical benefits and placed the claim in abeyance pending MMI. The claim was subsequently removed from abeyance and no new evidence was introduced. In the final August 20, 2007, opinion, the ALJ abandoned her factual finding regarding MMI reached in the interlocutory opinion, and found MMI was reached on September 6, 2005, based upon a different physician's opinion. Id. at 861-865. The Court of Appeals concluded the ALJ's reversal of her prior dispositive factual finding in an interlocutory opinion, absent new evidence, fraud, or mistake is arbitrary, unreasonable, unfair and unsupported by sound legal principles. Id. at 867-868.

Here, the Board held Bowerman v. Black Equipment Co., supra, was not dispositive. First, there was no evidence the former ALJ reviewed the June 27, 2015, video. The record reflected this video was not submitted until July 17, 2015, eight days after the former ALJ entered the interlocutory decision. The only surveillance video in the record was for the dates of July 28, 2014, September 24, 2014, and February 6, 2015. This notwithstanding, the Board found the ALJ clearly provided his reasoning and basis for reliance upon the evaluating physician's opinion which changed after he had the opportunity to review the video. Unlike the situation in Bowerman v. Black Equipment Co., supra, subsequent evidence was introduced after the interlocutory decision.


FACTS: The Claimant sustained a work-related low back injury on June 14, 1998. An ALJ determined the work-related back injury warranted a 5 percent impairment rating pursuant to the AMA Guides. The Employer filed a Motion to Reopen on September 19, 2016, challenging the Claimant's treatment with her treating physician inclusive of ongoing office
visits, and prescriptions for Celebrex, Tizanidine, Norco and Lidoderm patches. The Employer challenged whether the contested treatment is for the work-related injury, and whether it is reasonable. In support of the Motion to Reopen, the Employer filed a report of a physician who evaluated the Claimant at its request. The evaluating physician noted the Claimant complained of low back pain radiating to the right along with left lower extremity pain. The evaluating physician opined the treating physician's treatment IS reasonable and productive. (Emphasis added). He specifically stated, "Yes; she appears to be receiving a modest amount of narcotic pain medication combined with anti-inflammatory and an as-needed muscle relaxer that have kept her productive through the years." With regard to the relationship of the Claimant's treatment to her 1998 work injury, the evaluating physician noted a possible second injury in 2007. He stated, "It appears that the 1998 work injury was a sprain or strain, as X-rays revealed severe scoliosis, but the MRI was unremarkable; thus, although [the Claimant] may require ongoing treatment, I cannot say within a reasonable degree of medical certainty that the visits are related to the 1998 incident." Likewise, he could not state within a reasonable degree of medical probability that office visits every two months are required for treatment of the 1998 work injury. He stated treatment with Norco and Celebrex is reasonable and necessary. He recommended reducing the prescription level for Zanaflex. He also opined the use of Lidoderm patches is unnecessary, although at the low doses taken, there is only minimal risk. He additionally recommended office visits with the treatment physician every six months rather than every two months. One month after the motion to reopen was filed, the Employer submitted a form checked and signed by the treating physician, who checked a block on a form indicating it is impossible to state the Claimant's conditions are due to the June 14, 1998, work injury or to a June 17, 2006, MVA or a December 8, 2007, slip and fall accident. The Chief Administrative Law Judge ("CALJ") overruled the motion to reopen.

ISSUE: Did the CALJ err in overruling the motion to reopen?

HOLDING: No. The procedure for reopening a workers' compensation claim pursuant to KRS 342.125 is a two-step process. Colwell v. Dresser Instrument Div., 217 S.W.3d 213, 216 (Ky. 2006). The first step is the prima facie motion, which requires the moving party to provide sufficient information to demonstrate a substantial possibility of success in the event evidence is permitted to be taken. Stambaugh v. Cedar Creek Mining Co., 488 S.W.2d 681 (Ky. 1972). "Prima facie evidence" is evidence which "if unrebutted or unexplained is sufficient to maintain the proposition, and warrant the conclusion [in] support [of] which it has been introduced ... but it does not shift the general burden ...." Prudential Ins. Co. of America v. Tuggle's Adm'r., 254 Ky. 814, 72 S.W.2d 440, 443 (1934). The burden during the initial step is on the moving party and requires establishment of grounds for which the reopening is sought. Jude v. Cubbage, 251 S.W.2d 584 (Ky. 1952); W.E. Caldwell Co. v. Borders, 301 Ky. 843, 193 S.W.2d 453 (Ky. 1946). It is only after the moving party prevails in making a prima facie showing as to all essential elements of the grounds alleged for reopening that the adverse party is
put to the expense of further litigation. Big Elk Creek Coal Co. v. Miller, 47 S.W.3d 330 (Ky. 2001). When an ALJ determines the movant failed to present a *prima facie* case for reopening, the decision is reviewed for an abuse of discretion. Turner v. Bluegrass Tire Co., Inc., 331 S.W.3d 605, 610 (Ky. 2010). An abuse of discretion occurs when the decision was arbitrary, unreasonable, unfair, or unsupported by sound legal principles. *Id.*

After reviewing the Employer's motion to reopen and its supporting documents, the Board found the CALJ did not abuse his discretion in finding it failed to present *prima facie* evidence supporting its motion. The ALJ clearly articulated his reasoning for finding the evaluating physician's opinion did not constitute *prima facie* evidence supporting the medical dispute challenging the treatment provided by the treating physician. In his opinion, with regard to the issue of work-relatedness/causation, the CALJ found the evaluating physician did not say the visits are not related to the 1998 incident. Rather, the evaluating physician said that he could not express an opinion with regard to the issue of causation and work-relatedness. Likewise, the CALJ provided additional findings of fact in an order denying the Employer's petition for reconsideration. The sole authority to determine issues of fact lies with an ALJ, and unless the evidence compels the opposite result, the ALJ's factual determination may not be disturbed on appeal. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986). With respect to the issue of reasonableness and necessity, the CALJ found the Employer had failed to follow the utilization review procedures set forth in 803 KAR 25:096 and :190, and therefore, pursuant to 803 KAR 25:012, cannot contest medical expenses on the basis of reasonableness and necessity in the absence of appropriate utilization review. The Board rejected the Employer's argument it was not required to have a utilization review since the dispute was based upon work-relatedness, and the medical treatment was challenged in "good faith." Courts of this Commonwealth have used the term "good faith" in literally hundreds of cases without defining it. What constitutes "good faith" is a subjective determination. Star Bank, Kenton County, Inc. v. Parnell, 992 S.W.2d 189 (Ky. 1998). In that case, the court stated the determination of good faith is subjective, and is generally one for the jury, or the CALJ in this case. The court used the definition of "good faith" set forth in *KRS 355.1-201(19).* That statute defines "good faith" as "honesty in fact in the conduct of the transaction concerned." In any event, whether "good faith" exists is a determination, which must be made by the trier of fact, which in this case is the CALJ. In this instance, the CALJ determined a utilization review was required. While work-relatedness was set forth as a basis for the motion to reopen, the Employer also challenged the reasonableness of the challenged treatment. The Board stated this required a utilization review, which was not done. The Board found the CALJ provided an adequate analysis regarding why utilization review was necessary, and found no error in his determination.
FACTS: The Claimant sustained a compensable work-related L3 compression fracture on March 7, 2014. He went to the emergency room where a surgeon performed kyphoplasty surgery to repair the compression fracture. In his March 8, 2014, record, the surgeon noted the Claimant had underwent reduction and internal fixation by kyphoplasty, and the fracture was reduced almost 90 percent. Prior to the surgery, the Claimant had experienced approximately 50 percent loss of the vertebral height of the L3. On September 18, 2014, the surgeon noted the Claimant demonstrated full mobility of the lumbar and thoracic spines. The surgeon specifically noted x-rays revealed, "kyphoplasty at the level of L3, no acute compression is noted. Normal disc height is seen." On October 2, 2016, the surgeon noted the Claimant had reached MMI, and his only restrictions were to use a back brace while working.

Three impairment ratings were assessed by evaluating physicians for the L3 compression fracture. Dr. Hughes evaluated the Claimant on December 15, 2015, and diagnosed status post kyphoplasty for the L3 compression fracture, along with persistent low back pain and left lower radicular pain, all due to the work injury. He assessed a 13 percent impairment rating pursuant to the *AMA Guides* for the compression fracture, although this was based upon an x-ray taken prior to the kyphoplasty. Dr. Hughes stated the Claimant was not at MMI, but could be considered as such if he had no additional treatment. Dr. Hughes also testified by deposition. He admitted an individual has to be at MMI in order to assess an impairment rating pursuant to the *AMA Guides*. Dr. Hughes stated the 13 percent impairment rating he assessed was based upon a 50 percent compression reflected in x-rays taken prior to the kyphoplasty. He also stated it takes approximately six weeks for a compression fracture to heal, and in order to determine what remains of the condition it would be necessary to wait that length of time. He did not order any x-rays, nor did he review any subsequent films after the kyphoplasty was performed. Dr. Autry evaluated the Claimant on November 9, 2016. Dr. Autry noted the work-related L3 compression fracture, and that the Claimant reinjured his back in July, 2014, while driving a bobcat. Dr. Autry diagnosed the Claimant with the compression fracture at L3 with kyphoplasty, as well as a compression fracture at L4 and rotator cuff tendinitis impingement. He assessed a 13 percent impairment rating pursuant to the *AMA Guides* for the compression fractures at L3 and L4, but did not specify the percentage attributable to each. He found the Claimant had reached MMI, and does not retain the capacity to return to the type of work performed on the date of the injury. Dr. Kriss evaluated the Claimant on December 23, 2015, and found him to be status post percutaneous kyphoplasty, reduction and internal fixation treatment for a 20 percent L3 vertebral body anterior wedge compression fracture. He stated the kyphoplasty surgery was successful in restoring the vertebral height. He reviewed the October 23, 2015, MRI which he stated demonstrated a 10 percent or less anterior wedge compression. Based upon the fact the kyphoplasty successfully restored
vertebral height, and the reduction is less than 25 percent, Dr. Kriss assessed only a 5 percent impairment rating. He stated the Claimant had reached MMI by October 2, 2014. The ALJ determined the Claimant sustained an L3 compression fracture in the course and scope of his employment. He additionally found the Claimant is not totally disabled due to this injury. The ALJ adopted the 13 percent impairment rating assessed by Drs. Hughes and Autry. The ALJ awarded PPD benefits enhanced by the three multiplier.

ISSUE: Did the ALJ err in adopting an impairment rating based upon the degree of compression fracture found on the date of injury rather than when the Claimant attained MMI?

HOLDING: Yes. KRS 342.0011(35) defines permanent impairment rating as the percentage of whole body impairment caused by the injury as determined by the AMA Guides. KRS 342.0011(36) defines permanent disability rating as the permanent impairment rating selected by an ALJ times the factor set forth in the table that appears at KRS 342.730(1)(b). KRS 342.0011(37) requires the 5th Edition of the AMA Guides be utilized in assessing impairment ratings. MMI and the proper method of assessment of impairment is set forth in the AMA Guides. Chapter 1, Philosophy, Purpose and Appropriate Use of the Guides, 1.2(a), p. 2, states, "An impairment is considered permanent when it has reached maximal medical improvement (MMI), meaning it is well stabilized and unlikely to change substantially in the next year with or without residual treatment." The AMA Guides in Chapter 15, which deals with spinal impairment, Introduction, P. 374, states as follows:

As stated in this edition, an individual with a spinal condition is rated only when the condition is stabilized (unlikely to change within the next year regardless of treatment), i.e., when MMI has been reached (Chapter 1 and Glossary). The individual is evaluated based on medical findings that are present when MMI has been reached. (Emphasis added).

In the Glossary of the AMA Guides, P. 601, MMI is defined as "[a] condition or state that is well stabilized and unlikely to change substantially in the next year, with or without medical treatment. Over time, there may be some change; however, further recovery or deterioration is not anticipated."

In this case, the Board noted the impairment rating assessed by Dr. Hughes was based upon an x-ray report of the Claimant's condition prior to undergoing corrective surgery on March 8, 2014, one day after his injury. Dr. Hughes admitted he did not review any post-surgical radiographic studies. He admitted it would take approximately six weeks for a compression fracture to heal, and this would include post kyphoplasty surgery. The Board also noted the ALJ made no specific finding as to when the Claimant reached MMI. However, TTD benefits were awarded through June 24, 2014, when the surgeon released him to
return to work without restrictions other than wearing a back brace. Because Dr. Hughes' assessment of impairment is based upon a review of a report of an x-ray prior to the Claimant's surgery, and prior to his reaching MMI, or being allowed to return to work in June, 2014, the Board found it cannot constitute substantial evidence supporting the ALJ's decision. Likewise, the Board determined the impairment rating assessed by Dr. Autry cannot constitute substantial evidence supporting the ALJ's determination. Dr. Autry evaluated the Claimant subsequent to a later fracture at L4, which was determined to not be work-related. This subsequent injury occurred long after the Claimant had returned to work, and after he had been released from his surgeon's care. Likewise, this was long after Dr. Kriss determined he had reached MMI for the L3 injury. The Board stated the impairment rating assessed by Dr. Autry is inclusive of a rating for both the L3 and the non-compensable L4 injury. Dr. Autry did not apportion the impairment rating between the two conditions. Because this rating is inclusive of an unrelated condition, the Board found it does not constitute substantial evidence supporting the ALJ's determination. Therefore, the Board vacated the ALJ's award of PPD benefits. The Board remanded the claim to the ALJ with directions to determine when the Claimant reached MMI, and what award of PPD benefits to which he is entitled based upon his condition at that time, exclusive of any rating for his subsequent injury.


FACTS: On January 21, 2015, the Claimant sustained a laceration to his right middle and index fingers while working in the slaughtering department for the Employer and ultimately had surgery. The Claimant missed no work, and was initially released to one-handed duty. He was later released to light duty work. The Claimant performed various jobs while on light duty including cleaning the floor, running the hogs from the barn to chutes, and hanging hogs for processing. He also operated a bone-cutting machine for a few days, which he complained was beyond his restrictions. The last job he performed for his Employer consisted of separating boxes for sausage patties. Additional surgery was recommended, but the Claimant declined to undergo the procedure. The Claimant last worked for the Employer in April, 2015. He testified he quit working for the Employer because he felt he was mistreated, and his restrictions were not honored. He also admitted he was in jail from April 15, 2015, through August 15, 2015. The Claimant stated the Employer was not cooperative in working with him to obtain a work release so he could continue his employment while incarcerated. The Claimant does not believe he can perform any of his past work due to the limitations with his right hand.

The safety director for the Employer testified the Claimant continued to work with light duty restrictions after the January 21, 2015, injury. The Claimant was initially placed in the pens guiding hogs to chutes, which did not require the use of his right hand. When he was released to light duty his job included hanging carcasses, which he complained was too
difficult. He was next placed in a job where he washed carcasses. He only performed that job for approximately an hour and a half and complained it jarred his right hand too much. He was then placed in a job in the patty room, which the safety director stated required only one-handed activity. On April 2, 2015, the Claimant left work early for a court appearance, and never returned to work. On April 7, 2015, the safety director called to check on him after he had not returned to work, and had not communicated with the Employer in anyway. The Claimant advised he would not return to work because he had to go to jail for four months to serve a sentence. Although he was not going to begin serving the sentence until later in the month, he advised he would not return because he had to resolve certain matters. The Claimant never presented paperwork for a work release, nor did he inquire or request any assistance with this process.

The ALJ awarded PPD benefits, and declined to award the three multiplier pursuant to KRS 342.730(1)(c)1. She also declined to award the two multiplier pursuant to Livingood v. Transfreight, LLC, 467 S.W.3d 249 (Ky. 2015). The ALJ noted although the Claimant continued to work after the injury, he was no longer doing so due to his own misconduct. The ALJ also determined the Claimant was not entitled to TTD benefits because he returned to work the day after the surgery, and was able to continue to work until he walked away from his employment. She noted the Claimant quit working, and then served his jail sentence. In the order on petition for reconsideration, the ALJ reviewed Livingood v. Transfreight, LLC, supra, and concluded the Claimant acted in a completely irresponsible manner when he quit work without communicating with his Employer. Therefore, he was not entitled to the two multiplier. The ALJ also found the Claimant is able to return to the same job he was performing at the time of his injury. The ALJ did not make further findings of fact on the issue of TTD benefits, despite the Claimant's request in his petition for reconsideration.

ISSUES: 1) Did the ALJ err in declining to enhance the Claimant's PPD benefits by the two multiplier contained in KRS 342.730(1)(c)2? 2) Did the ALJ perform an appropriate TTD analysis?

HOLDING: No to both. KRS 342.730(1)(c)2 states specifically as follows:

If an employee returns to work at a weekly wage equal to or greater than the average weekly wage at the time of injury, the weekly benefit for permanent partial disability shall be determined under paragraph (b) of this subsection for each week during which that employment is sustained. During any period of cessation of that employment, temporary or permanent, for any reason, with or without cause, payment of weekly benefits for permanent partial disability during the period of cessation shall be two (2) times the amount otherwise payable under paragraph (b) of this subsection. (emphasis added).
In Chrysalis House, Inc. v. Tackett, 283 S.W.3d 671, 674 (Ky. 2009), the Court held the section permits double benefit during a period of cessation of employment at the same or greater wage "for any reason, with or without cause,' provided that the reason relates to the disabling injury." Subsequently, the Kentucky Supreme Court overruled Chrysalis House, Inc. v. Tackett, supra, through its holding in Livingood v. Transfreight, LLC, supra. There, the Court held section c(2) "permits a double income benefit during any period that employment at the same or a greater wage ceases 'for any reason, with or without cause,' except where the reason is the employee's conduct shown to have been an intentional, deliberate action with a reckless disregard of the consequences either to himself or to another." Id. at 259. In Fuertes v. Ford Motor Co., 481 S.W.3d 808, 810 (Ky. 2016), the Court reiterated its holding in Livingood v. Transfreight, LLC, supra, and stated the burden of proof rests with the employer to show the cessation was due to misconduct. The Court additionally stated, "This is a high standard and basic bad behavior will not bar application of the two multiplier. If Fuertes did not engage in such conduct, the two multiplier may be applied to his award." Id.

In this case, the Board noted the Claimant continued to work after the date of the injury. He subsequently abandoned his employment. Additionally, he was incarcerated for four months for an offense unrelated to his employment. Although the testimony regarding his leaving employment with the Employer was disputed, the ALJ determined he is no longer employed there due to his own "irresponsible" behavior. The Board stated it was clearly within her discretion to make this factual determination. The Board stated the ALJ's decision regarding why the Claimant is no longer employed by the Employer, and is not entitled to the application of the two-multiplier, is supported by the evidence, and will not be disturbed. The Board remanded the claim for additional findings regarding TTD benefits. Although the ALJ addressed the request for TTD benefits in the Opinion, the Claimant asked for additional findings regarding this issue in his petition for reconsideration. Upon review of the ALJ's decision, the Board found her analysis regarding TTD benefits deficient in light of Livingood v. Transfreight, LLC, supra, and Trane Commercial Systems v. Tipton, 481 S.W.3d 800 (Ky. 2016).

TTD is statutorily defined in KRS 342.0011(11)(a) as "the condition of an employee who has not reached maximum medical improvement from an injury and has not reached a level of improvement that would permit a return to employment[.]" In Magellan Behavioral Health v. Helms, 140 S.W.3d 579 (Ky. App. 2004), the Court of Appeals instructed that until MMI is achieved, an employee is entitled to TTD benefits so long as he remains disabled from his customary work or the work he was performing at the time of the injury. In Central Kentucky Steel v. Wise, 19 S.W.3d 657, 659 (Ky. 2000), the Kentucky Supreme Court explained, "It would not be reasonable to terminate the benefits of an employee when he is released to perform minimal work but not the type that is customary or that he was performing at the time of his injury." Thus, a release "to perform minimal work" does not constitute a "return to work" for purposes
of KRS 342.0011(11)(a). In Livingood v. Transfreight, LLC, supra, the Supreme Court declined to hold a claimant is entitled to TTD benefits so long as he or she is unable to perform the work performed at the time of the injury. The Court stated, ". . . we reiterate today, Wise does not 'stand for the principle that workers who are unable to perform their customary work after an injury are always entitled to TTD.'" Id. at 254. Most recently in Trane Commercial Systems v. Tipton, supra, the Supreme Court clarified when TTD benefits are appropriate in cases where the employee returns to modified duty. The Court stated:

As we have previously held, "[i]t would not be reasonable to terminate the benefits of an employee when he is released to perform minimal work but not the type [of work] that is customary or that he was performing at the time of his injury." Central Kentucky Steel v. Wise, 19 S.W.3d at 659. However, it is also not reasonable, and it does not further the purpose for paying income benefits, to pay TTD benefits to an injured employee who has returned to employment simply because the work differs from what she performed at the time of injury. Therefore, absent extraordinary circumstances, an award of TTD benefits is inappropriate if an injured employee has been released to return to customary employment, i.e. work within her physical restrictions and for which she has the experience, training, and education; and the employee has actually returned to employment. We do not attempt to foresee what extraordinary circumstances might justify an award of TTD benefits to an employee who has returned to employment under those circumstances; however, in making any such award, an ALJ must take into consideration the purpose for paying income benefits and set forth specific evidence-based reasons why an award of TTD benefits in addition to the employee's wages would forward that purpose.

The Board noted the analysis is not simply whether the Claimant had been released to light duty work while not having reached MMI. The ALJ is required to determine if the Claimant had been released to return to customary employment, i.e. work within his physical restrictions and for which he has the experience, training, and education; and whether he had actually returned to employment. Trane Commercial Systems v. Tipton, 481 S.W.3d at 807. On remand, the Board directed the ALJ to determine, based upon the evidence, if the Claimant is entitled to TTD benefits during any period prior to his reaching MMI, pursuant to Livingood v. Transfreight, LLC, supra, and Trane Commercial Systems v. Tipton, supra.

FACTS: The Claimant sustained multiple injuries on December 2, 2015, when he fell approximately forty feet from a bridge while working as a general laborer for the Employer. The Employer asserted a safety violation by the Claimant pursuant to KRS 342.165. The Employer filed a Form SVE, and identified the following safety rule/regulation the Claimant allegedly failed to follow: "Section 1926.760(a) requires that an employee 'tie off' when working on a surface more than 15 [sic] above level. Plaintiff was not wearing a safety harness at the time of the fall, and same were made available to employees." The Employer did not attach or subsequently file any supporting documentation or additional evidence outside of the Claimant's testimony. The Claimant testified that his Employer provided a safety harness, which he wore daily. He typically wore a full body harness, which had to be removed when he used the restroom. The Claimant also testified safety procedures were reviewed before every shift. The Claimant agreed the Employer had a policy requiring all employees to wear a harness. The Claimant testified that on December 2, 2015, he had been working on a bridge. He wore his safety harness and hard hat the entire day. At approximately 3:00 p.m., near the end of his shift, the Claimant had to use the restroom. Before entering the restroom, the Claimant removed his safety harness. At that time, his supervisor told him and the crew to take down the last form before going home. The Claimant testified he jumped back across the bridge without his harness to help with this task, and was knocked off the bridge in the process. The Claimant did have on a hard hat. The Claimant testified he "wasn't thinking" and was "in a hurry" when asked why he did not have on his harness at the time of the fall. Prior to the fall, the Claimant had never been reprimanded or written up by his Employer for failure to wear safety gear. The ALJ then determined the 15 percent safety violation was not applicable since there was no evidence the Claimant consciously disregarded or willfully ignored using his safety harness. The ALJ found the Claimant's accident occurred not as result of any willful misconduct by him, but due to a simple act of negligence.

ISSUE: Did the ALJ err in finding the 15 percent safety violation not applicable?

HOLDING: No. The purpose of KRS 342.165 is to reduce the frequency of industrial accidents by penalizing those who intentionally fail to comply with known safety regulations. See Apex Min. v. Blankenship, 918 S.W.2d 225 (Ky. 1996). The burden is on the claimant to demonstrate an employer's intentional violation of a safety statute or regulations, and conversely, the burden is upon the employer to establish an employee's intentional violation. See Cabinet for Workforce Development v. Cummins, 950 S.W.2d 834 (Ky. 1997). KRS 342.165(1) provides:

. . . . If an accident is caused in any degree by the intentional failure of the employee to use any safety appliance furnished by the employer or to obey any lawful
and reasonable order or administrative regulation of the commissioner or the employer for the safety of employees or the public, the compensation for which the employer would otherwise have been liable under this chapter shall be decreased fifteen percent (15%) in the amount of each payment.

The application of the safety penalty requires proof of a violation of a specific safety provision, whether state or federal. Second, evidence of "intent" to violate a specific safety provision must also be present. Finally, the violation must be a cause of the accident. Application of KRS 342.165 does not automatically flow from a showing of a violation of a specific safety regulation followed by a compensable injury. Burton v. Foster Wheeler Corp., 72 S.W.3d 925 (Ky. 2002).

The Board found the ALJ sufficiently outlined her reason for determining the Claimant did not intentionally violate a safety rule. The ALJ found persuasive the Claimant's testimony he had worn his safety harness and hard hat for the entire day prior to the accident. He removed his harness near the end of his workday in order to use the restroom. At that time, his supervisor told the crew to take down the last form and then they could go home. The Claimant testified that he "wasn't thinking" and was "in a hurry" when he jumped back across the bridge without his safety harness on. The ALJ concluded, "In that moment while trying to hurry to go home, Plaintiff inadvertently forgot to put back on his harness. The accident occurred not as result of any willful misconduct of the Plaintiff but due to a simple act of negligence." The Board found the ALJ acted within her authority in drawing this conclusion from the Claimant's testimony. As fact-finder, the ALJ has the sole authority to determine the weight, credibility and substance of the evidence, and reasonable inferences to be drawn. Square D Co. v. Tipton, supra; Miller v. East Kentucky Beverage/Pepsico, Inc., 951 S.W.2d 329 (Ky. 1997). Also, the ALJ provided additional findings in the order on petition for reconsideration and cited to two Board opinions, Terry v. AFG Industries, WCB Opinion No. 2000-94292 (January 2, 2003), and Swift Transport v. Pryor, WCB Opinion No. 2013-80504 (January 30, 2015), in support of her opinion. The Board found the ALJ correctly concluded the Employer failed to prove anything other than negligence, which is insufficient to warrant application of KRS 342.165(1). Finally, the Board found Hornback v. Hardin Memorial Hosp., 411 S.W.3d 220 (Ky. 2013) distinguishable on two grounds, thus providing limited value. First, it involved the allegation of an employer violation rather than an employee violation. More importantly, the Claimant in Hornback alleged the employer violated the general duties provision contained in KRS 338.031, rather than a specific safety statute or regulation. Only the alleged violation of the general duties provision triggers the four-factor test set forth in Lexington--Fayette Urban County Government v. Offutt, 11 S.W.3d 598 (Ky. App. 2000). In this instance, the Employer alleged the Claimant violated a specific safety statute/regulation. Therefore, the general duty clause contained in KRS 338.031 and the Offutt test are not implicated.
FACTS: The Claimant sustained multiple injuries in a MVA on March 26, 1997. A Form 110 settlement agreement was approved July 13, 1999. The Form 110 reflects the parties settled the Claimant's claims for income benefits but future medical benefits remained open. The Form 110 settlement agreement specifically noted the Claimant injured her neck, low back, left shoulder and left knee. The evidence reflected the Claimant continued to treat for her work injuries since the date of the accident, specifically for her low back and left knee. The Claimant filed a motion to reopen and a Form 112 medical dispute alleging the Employer's insurer refused to pay for treatment for her right knee, despite her consistent complaints and treatment for that condition since the date of the MVA. The Employer argued the right knee condition is not compensable because it was not listed as an injured body part in the settlement agreement. The Claimant testified she had consistent problems with her right knee since the MVA, noting she struck both knees on the steering column. However, those complaints were subordinate to the symptoms for her low back, neck, left shoulder and left knee. Her primary focus was her left knee, and subsequently underwent five surgeries for the condition. Her right knee had always been problematic since the MVA and progressively worsened, especially in the last ten years. She first treated for the right knee condition in 2015 when she had injections. The Claimant noted Dr. Jerrel Friesen observed in his note of October 8, 2007, that she provided a history of the MVA where she injured both knees. The Claimant was unaware the right knee was not covered until she received a denial for the surgery recommended by her treating physician. An adjuster testified the Claimant continuously treated for the injuries she sustained in the 1997 MVA. She stated the settlement agreement reflects the Claimant injured her neck, back, left shoulder and left knee, and she did not believe the right knee was part of the claim. She stated the first notice she received of the right knee involvement was the request for surgery by the treating physician, which she denied. The adjuster did not issue a written denial, nor was a medical dispute filed. The Adjuster never advised the Claimant that treatment for the right knee, including injections, would be approved. The treating physician saw the Claimant on April 21, 2016, for pain in both knees. He noted the Claimant had post-traumatic chondromalacia and degenerative changes in the right knee caused by the work injury. He believed the Claimant's right and left knee conditions are due to the work-related MVA. The CALJ found the right knee condition directly and causally related to the underlying work-related MVA and resolved the medical dispute in the Claimant's favor.

ISSUE: Did the CALJ err in finding the right knee condition causally related to the MVA in light of the language contained in the settlement agreement?

HOLDING: No. The central issue on appeal is whether the CALJ erred in finding the treatment to the right knee compensable, in spite of the language contained in the settlement agreement, which only noted the
injuries to the neck, back, left shoulder and left knee.  

Where an agreement has become an award by approval of
the administrative law judge, and a reopening and review
of that award is initiated, no statement contained in the
agreement, whether as to jurisdiction, liability of the
employer, nature and extent of disability, or as to any
other matter, shall be considered by the administrative
law judge as an admission against the interests of any
party. The parties may raise any issue upon reopening
and review of this type of award which could have been
considered upon an original application for benefits.
(Emphasis added).

The Board did not disagree with the CALJ's determination. The Claimant
sustained multiple injuries due to the MVA in March, 1997. The Board
stated the Claimant's testimony, along with the medical records,
supported the CALJ determination, noting he had the discretion to make
independent findings and determine the nature of the injury at the time of
the settlement agreement.  Beale v. Faultless Hardware, 837 S.W.2d 893
(Ky. 1992). The Board noted the Claimant did not litigate her initial claim
to completion and the arbitrator who approved the settlement agreement
made no judicial determination on any issue. As such, the settlement
agreement did not bind the parties regarding whether the Claimant
sustained a right knee injury in addition to the other conditions outlined in
the settlement agreement in the MVA. A settlement is the product of a
compromise. Therefore, the terms contained in the agreement may or
may not be totally accurate. Whittaker v. Rowland, 998 S.W.2d 479 (Ky.
1999), Beale v. Faultless Hardware, supra, and Newberg v. Davis, 841
S.W.2d 164 (Ky. 1992), explain that the parties to a settlement are
entitled to the benefit of their bargain, and KRS 342.125(7) prohibits any
statement contained in a settlement agreement from being considered as
an admission against interest if the claim is reopened. That said, the
Board determined the CALJ was not precluded from determining
treatment for the right knee is compensable and causally related to the
March 26, 1997, work injury. The Board further concluded the CALJ's
determination is in accordance with the law and is supported by
substantial evidence.

Z. Sherry Langer v. Holiday Inn Express, Claim #: 2008-85862, Rendered:
09/08/2017, Status: Appealed to Court of Appeals

FACTS: The Claimant injured her right shoulder, right elbow, right arm,
neck and back on May 25, 2008, while working as a housekeeper for her
Employer. The Claimant was awarded income and medical benefits due
to her work-related injuries in a decision issued by the ALJ on March 25,
2013. In the order on petition for reconsideration issued May 29, 2013,
the ALJ found the Employer responsible for reasonably related medical
expenses which the ALJ believed includes the treatment for opioid abuse
with her treating physician. Neither the ALJ's decision nor order on
reconsideration were appealed. The Claimant submitted a Form 114 request for reimbursement, which the Employer's workers' compensation insurer received on July 17, 2013. This request included reimbursement for many office visits beginning in 2012. On July 14, 2014, the Claimant filed a motion to reopen the claim. The Claimant requested an order directing payment for treatment with her treating physician. She also argued her Employer/Insurer had thirty days to file a motion to reopen to challenge expenses tendered to them, and failed to do so. The Claimant requested not only the tendered expenses be paid, but additionally the ALJ should award costs and attorney fees resulting from this proceeding. The Claimant noted she had requested reimbursement for mileage, prescriptions and medical treatment which were not timely challenged by either her Employer or the workers’ compensation insurer. A claims examiner with the insurer stated that due to confusion, the Claimant was informed treatment with her treating physician was not authorized. The examiner stated the Claimant was paid for out-of-pocket prescription expenses on August 7, 2013, and for reimbursement for mileage requests on November 25, 2013. The Claimant advised the examiner she continued to treat with her treating physician for opioid dependency, but he refused to bill the insurer directly. The Claimant paid the treating physician and had asked for reimbursement.

The examiner testified that immediately after she received the initial decision from the ALJ in 2013 she had a discussion with the Claimant regarding treatment. She admitted she received a Form 114 request for reimbursement from the Claimant on July 17, 2013. This request was rejected due to confusion about the award by the ALJ. The examiner stated none of the amounts requested in the July, 2013, Form 114 were paid until November 25, 2013. She stated a letter was sent to the Claimant denying the reimbursement on August 7, 2013; however, neither a motion to reopen nor a Form 112 was filed. Likewise, utilization review was not performed. The examiner also admitted she had a Form 106 medical authorization. The examiner acknowledged she received a letter from the Claimant's counsel regarding reimbursements on February 6, 2014. The examiner did not respond to the letter, and again no medical dispute was filed. The ALJ ordered that within sixty days of her order, the insurer shall reimburse the Claimant or the treating physician for expenses related to the work injury. The ALJ ordered that within thirty days of the date of the order, the Claimant or the treating physician shall provide all paperwork required by the regulations to support any request for payment or reimbursement of expenses. The ALJ stated should the Claimant or treating physician fail to provide appropriate paperwork within thirty days, the charge will not be the liability of the Employer/Insurer.

ISSUE: Did the Employer/Insurer properly dispute the Claimant's post-injury request for reimbursement of expenses related to her work-injury?

HOLDING: No. **KRS 342.020(1)** entitles an injured worker to reasonable and necessary medical treatment for a work-related injury. **KRS 342.020(1)** and **803 KAR 25:096 §8(1)** require an employer to either tender payment or initiate a medical fee dispute within thirty days.
following receipt of a completed statement for services. Here, the mileage reimbursements, prescription reimbursements, and payments to the treating physician were for treatment clearly authorized in the 2013 order on reconsideration issued by the ALJ. The Board noted it is undisputed that neither the Employer nor the insurer initiated a medical dispute within thirty days after receiving the July, 2013, request from the Claimant, or the February, 2014, request from her attorney. Regarding challenges to statements for services following the resolution of a claim, 803 KAR 25:096 §8(2)(d) specifically states, "the thirty day period for filing a medical fee dispute shall commence on the date of rendition of the final decision from the utilization review." Here, utilization review was not initiated, so the thirty day time period to challenge or file a medical dispute was not delayed or expanded. At no time did the Employer or the insurer avail themselves of the dispute/review procedure set forth in the statute or applicable regulations. If the tendered request is submitted to utilization review, the thirty days does not begin to run until that process is exhausted. The burden to formally challenge any disputed payment rests with the obligor, in this case the Employer or the insurer.

In Westvaco Corp. v. Fondaw, 698 S.W.2d 837 (Ky. 1985), the Court stated KRS 342.125 provides the mechanism to reopen a claim for a decision by an ALJ on any medical expenses submitted which are contested. In Phillip Morris, Inc. v. Poynter, 786 S.W.3d 124 (Ky. App. 1990), the Kentucky Court of Appeals held failure of the employer to challenge bills submitted by the employee, post-award, constituted a waiver of its right to challenge them. This holding was echoed by the Kentucky Court of Appeals in National Pizza Company v. Curry, 802 S.W.2d 949 (Ky. App. 1991), which stated, "Clearly the employer must raise the issue of compensability of medical treatment with the board or the right to object is waived." This holding was reiterated by the Kentucky Supreme Court in R.J. Corman R.R. Const. v. Haddix, 864 S.W.2d 915 (Ky. 1993). Later in Kentucky Associated General Contractors Self-Insurance Fund v. Lowther, 330 S.W.3d 456 (Ky. 2010), the Kentucky Supreme Court determined, "the employer has the burden to initiate a formal medical dispute following a final utilization decision denying pre-authorization." Later, in Richey v. Perry Arnold, Inc., 391 S.W.3d 705, 712 (Ky. 2012), the Court further analyzed the Lowther decision:

The [Lowther] court acknowledged that neither KRS 342.020 nor the applicable regulations states explicitly that a decision to deny pre-authorization constitutes a statement for services," which 803 KAR 25:096 Section 8(1) requires the employer to pay or contest within 30 days. We noted with approval, however that the Board had interpreted the regulations since 2001 as equating a final utilization review decision to deny pre-authorization with a "statement for services." The same rule clearly applies when an employer refuses to pre-authorize a medical procedure without submitting it to utilization review because the effect of the utilization review process under
In this instance, the Board noted the Claimant submitted a request for reimbursement for expenses she had paid with the proper form authorized by the Kentucky Department of Workers' Claims, which was admittedly received by the insurer on July 17, 2013. The Claimant received the denial of this request on August 7, 2013. However, the insurer neither filed a motion to reopen, nor instituted a formal medical dispute. The same is true for subsequent requests made by counsel for the Claimant. While the insurer may well have had reasons for refusal to pay, merely not paying or not responding are not available options. If legitimate objections to the request existed, the Board stated it was incumbent upon the insurer to formally assert the objections. The Board found it clear the Claimant, post-award, attempted to obtain reimbursement for expenses she had paid including travel, prescriptions, and office visits with her treating physician. It was equally clear the insurer did nothing to bring this before the ALJ for a determination. The first determination which must be made is whether the Employer/Insurer timely contested the request for reimbursement. Only after the Employer/Insurer cleared that hurdle were other defenses available. Therefore, the Board vacated the ALJ's decision, and remanded for a determination of whether the Employer/Insurer appropriately disputed the Claimant's request. The Board also directed the ALJ to consider whether sanctions should be assessed pursuant to KRS 342.310, and whether referral of this claim to the Commissioner for the assessment of penalties pursuant to KRS 342.267 is appropriate.
I.  **KRS 342.730** – FACTORS

   3.  1996.
   5.  2018?

II.  **KRS 342.125** – REOPENING

   3.  1996.
   5.  2018?

III.  **KRS 342.730(4)** – AGE BENEFITS; **PARKER v. WEBSTER COUNTY COAL CO.**; ¹ **KRS 342.730(7)** – OFFSET FOR WAGES

   3.  1996.
   5.  2018?

   Livingood v. Transfreight, LLC, 467 S.W.3d 249 (Ky. 2015).

IV.  **KRS 342.020** – MEDICAL BENEFITS


¹ Parker v. Webster County Coal Co., LLC (Dotiki Mine), 529 S.W.3d 759 (Ky. 2017).
V. **KRS 342.035 – TREATMENT GUIDELINES, DRUG FORMULARITIES, UR**
   3. 1996.
   5. 2018?

VI. **KRS 342.040 – INTEREST**
   3. 1996.
   5. 2018?

VII. **KRS 342.185 – CUMULATIVE TRAUMA**
   3. 1996.
   5. 2018?


*Hale v. CDR Operations, Inc.*, 474 S.W.3d 129 (Ky. 2015).
VIII. **KRS 342.320** – ATTORNEYS FEES

3. 1996.
5. 2018?

IX. **KRS 342.730** – STATE AVERAGE WEEKLY WAGE

3. 1996.
5. 2018?

X. **KRS 342.700** – SUBROGATION

3. 1996.
5. 2018?

XI. **KRS 342.0011(1)** – MENTAL-MENTAL DISORDERS

3. 1996.
5. 2018?

XII. **KRS 342.316(4)(C)** – FIREFIGHTER RELATED CANCERS

3. 1996.
5. 2018?

XIII. **KRS 342.265** – LUMP SUM SETTLEMENTS – DISCOUNT RATE

3. 1996.
5. 2018?

XIV. **OTHER PROPOSALS UNDER DISCUSSION**
MARSHALL PARKER

v.

WEBSTER COUNTY COAL, LLC (DOTIKI MINE); HON. STEVEN G. BOLTON, ADMINISTRATIVE LAW JUDGE; AND WORKERS’ COMPENSATION BOARD

APPELLANT

APPELLEES

AND

WEBSTER COUNTY COAL, LLC (DOTIKI MINE)

APPELLANT

v.

MARSHALL PARKER; MULTICARE MADISONVILLE; DR. RICHARD HOLZKNECHT; COOP HEALTH SERVICES; DEACONESS HOSPITAL; DAVID D. EGGERS, M.D.; NEUROSURGICAL CONSULTANTS; JAMES M. DONLEY, M.D.; CENTER FOR ORTHOPEDICS; WAYNE C. COLE, D.O.; KELLY L. COLE, D.O.; HON. STEVEN G. BOLTON, ADMINISTRATIVE LAW JUDGE; AND WORKERS’ COMPENSATION BOARD

APPELLEES


Supreme Court of Kentucky

April 27, 2017

ON APPEAL FROM COURT OF APPEALS CASE NOS. 2013-CA-001978-WC, 2013-CA-001968-WC WORKERS’ COMPENSATION BOARD NO. 09-WC-99663

COUNSEL FOR APPELLANT/APPELLEE MARSHALL PARKER: Thomas Lawrence Hicks, Cetrulo, Mowery & Hicks, PSC

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OPINION

KELLER, JUSTICE

In separate appeals, Marshall Parker challenges the constitutionality of Kentucky Revised Statute (KRS) 342.730(4) and Webster County Coal (Webster County) challenges the Administrative Law Judge's (ALJ) award of benefits to Parker for a back injury. The Board affirmed the ALJ's award of benefits but, because it lacks the jurisdiction to do so, the Board did not address Parker's constitutional claim. [1] The Court of Appeals affirmed the Board and found that KRS 342.730(4) is constitutional. For the following reasons, we affirm the Court of Appeals regarding Parker's entitlement to benefits. However, we reverse that Court's holding that KRS 342.730(4) is constitutional and remand this matter to the ALJ for an award consistent with this opinion.

I. BACKGROUND.

Parker was born on October 5, 1939, and he began working as an underground coal miner for Webster County in 1974. On September 8, 2008, Parker slipped while trying to climb over a conveyor belt. He testified that he felt pain in his right knee, right hip, and low back after this incident. Despite his injuries, Parker continued to work for approximately three months. Parker eventually underwent right knee surgery in December, 2008, and lumbar spine surgery in June, 2011. Following treatment, Parker has continued to have back pain, and he has difficulty walking and climbing stairs. He has not returned to any type of work.

Webster County accepted liability for Parker's right knee injury and has paid all medical benefits associated with that injury. Because Webster County is not contesting Parker's knee injury claim, we do not set forth the medical evidence regarding that claim. However, Webster County did contest Parker's back injury claim based on medical records containing pre-injury complaints of low back pain and diagnostic testing that showed significant degenerative changes. Therefore, we summarize the medical evidence related to that claim below.

In support of his back injury claim, Parker filed medical records and a report from his spine surgeon, Dr. David Eggers. In his May 20, 2009, office note, Dr. Eggers stated that Parker had suffered from "intractable low back and right radicular leg pain" since an injury in September 2008. In his Form 107 Medical Report - Injury/Hearing Loss/Psychological Condition, Dr. Eggers stated that Parker suffered from displacement of a lumbar disc, spinal stenosis, and acquired spondylolisthesis. Dr. Eggers related these conditions to Parker's injury; however, he did not specify the date of the injury. Furthermore, although he had been asked to do so, Dr. Eggers would not give an opinion regarding what permanent impairment or restrictions Parker has.

Webster County filed records from Tri-State Orthopedic Surgeons and Dr. James Donley. The Tri-State records showed, in pertinent part, that Parker complained of and sought treatment for low back and leg pain in September 2003, March 2005, and May 2006. It appears from the records that Parker received at least one epidural steroid injection in late 2005 and one epidural steroid injection in May 2006. Furthermore, Parker's 2003 lumbar MRI revealed multi-level degenerative changes with mild to moderate stenosis. Dr. Donley's records reveal, in pertinent part, that Parker complained
of aches and pains/strains but had not received any treatment for back pain in the two years before the work injury.

Webster County also filed reports from Dr. Russell Travis, Dr. Bart Goldman, and Dr. William Gavigan. Dr. Travis, in his October 9, 2009, report, stated that Parker suffered from right L4 radiculopathy secondary to degenerative spondylolisthesis with a bulging disc at L4-5 and significant degenerative changes throughout the lumbar spine. Dr. Travis concluded that, despite Parker's significant pre-existing lumbar degenerative changes, the surgery then being recommended by Dr. Eggers was work-related. In reaching that conclusion, Dr. Travis stated that he had seen "no records that indicate Mr. Parker had significant low back pain and no right lower extremity pain prior to this." In a November 20, 2009, addendum to his October report, Dr. Travis stated that, upon review of an office note from one of Parker's physicians dated September 28, 2009, Parker's "current problem is not related directly to the injury of 9/28/2008, but is clearly a question of pre-existing severe degenerative changes with neural impingement and previous symptomatic problems with his low back." We note that Dr. Travis had reviewed and summarized the September 28, 2008, office note in his October 2009 report.

Dr. Goldman stated that Parker suffered from degenerative retrolisthesis at L3-4 which pre-existed the September 8, 2008, work-injury. According to Dr. Goldman, the surgery performed by Dr. Eggers was to alleviate an active preexisting condition, not because of Parker's work injury.

Dr. Gavigan made diagnoses of severe degenerative disc disease that actively pre-existed the work injury. He opined that all of Parker's back treatment was related to that pre-existing active condition and not to the work injury. Finally, Dr. Gavigan, who imposed no restrictions, assigned Parker a 22 percent impairment rating, all of which he attributed to the pre-existing active condition.

Based on the preceding evidence, the ALJ found that Parker suffered a lower back injury on September 8, 2008, and that none of Parker's back-related impairment was the result of a pre-existing active "disability/impairment of the back under the holding in Finley (supra)."[2] The ALJ also determined that Parker is not totally disabled and awarded income benefits based on Parker's 4 percent knee impairment and his 22 percent lumbar spine impairment for a combined permanent impairment rating of 26 percent. However, because Parker had already received two years of temporary total disability income benefits, the ALJ found that Webster County did not have liability for payment of any additional income benefits pursuant to KRS 342.730(4). The Board and the Court of Appeals affirmed.

As noted above, both Webster County and Parker have appealed from the Court of Appeals's opinion. Webster County argues that the evidence did not support the ALJ's award of benefits related to Parker's low back condition. Parker appeals the ALJ's termination of income benefits pursuant to KRS 342.730(4). We set forth additional necessary background information below.

II. STANDARD OF REVIEW.

The ALJ has the sole discretion to determine the quality, character, and substance of the evidence and 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 party's total
proof. Paramount Foods, Inc. v. Burkhardt, 695 S.W.2d 418, 419 (Ky. 1985). Parker had the burden of proving that his back condition is related to the work injury. Gibbs v. Premier Scale Company/Indiana Scale Co., 50 S.W.3d 754, 763 (Ky. 2001), as modified on denial of reh’g (Aug. 23, 2001). Because he was successful before the ALJ, the question for us on appeal is whether the ALJ's finding of work relatedness is supported by substantial evidence. Whittaker v. Rowland, 998 S.W.2d 479, 481 (Ky. 1999). "Substantial evidence has been defined as some evidence of substance and relevant consequence, having the fitness to induce conviction in the minds of reasonable men." Id. at 481-82. Thus, the determinative question to be answered on review is whether the ALJ's finding that Parker's back condition is related to the work injury "is so unreasonable under the evidence that it must be viewed as erroneous as a matter of law." KRS 342.285; Ira A. Watson Dept. Store v. Hamilton, 34 S.W.3d 48, 52 (Ky. 2000).

While we give great deference to the ALJ's factual findings, questions of law, i.e., whether KRS 342.370(4) is constitutional, we review de novo. See U.S. Bank Home Mortgage v. Schrecker, 455 S.W.3d 382, 384 (Ky. 2014). With the preceding standards in mind, we first address Webster County's argument that the ALJ's finding that Parker suffered a work-related back injury is not supported by the evidence. We then address Parker's argument that KRS 342.730(4) is unconstitutional.

III. ANALYSIS.

A. Whether Parker suffered a work-related back injury.

Webster County argues that there was not sufficient evidence to support a finding that Parker suffered a work-related back injury. It notes that Drs. Gavigan, Travis, and Goldman all opined that Parker's back condition actively pre­existed his September, 2008, injury. It also notes that, although Dr. Eggers referred to an injury as being the cause of Parker's back condition in his Form 107, he did not specify which injury. Finally, Webster County notes that Parker's medical records and his testimony indicate that he had complaints of low back pain for several years preceding the September 2008 injury.

While Dr. Eggers's Form 107 may have been deficient regarding causation, he related Parker's back condition to the work injury in his initial office note. Furthermore, Dr. Travis's two reports are arguably inconsistent. Initially, Dr. Travis, who listed and summarized the medical records he reviewed, opined that Parker's back condition was related to the work injury. In his second report, Dr. Travis listed and summarized those same medical records as supporting his opinion that Parker's back condition actively pre-existed the work injury. The ALJ was free to consider all of Dr. Eggers's records and to believe Dr. Travis's initial report and to disbelieve his second report. That evidence was substantive and sufficient to support the ALJ's finding of work-relatedness.

Furthermore, although Parker did complain of and receive treatment for low back pain prior to the work injury, he made no such complaints nor received any such treatment in the two years preceding the September 2008 work injury. In fact, Parker worked an average of seventy hours per week in that two-year period, and Webster County produced no evidence that any physician had assigned Parker an impairment rating or imposed permanent restrictions on Parker's work activities as a result of his pre-injury complaints of back pain. As stated in Finley v. DBM Technologies., 217 S.W.3d 261, 265 (Ky. App. 2007):
a pre-existing condition that is both asymptomatic and produces no impairment prior to the work-related injury constitutes a preexisting dormant condition. When a pre-existing dormant condition is aroused into disabling reality by a work-related injury, any impairment or medical expense related solely to the pre-existing condition is compensable. A pre-existing condition may be either temporarily or permanently aroused. If the pre-existing condition completely reverts to its pre-injury dormant state, the arousal is considered temporary. If the pre-existing condition does not completely revert to its pre-injury dormant state, the arousal is considered permanent, rather than temporary.

The ALJ's finding that Parker's back condition did not actively pre-exist the work injury but is related to that injury is supported by both the evidence and the law. We cannot say the ALJ's finding was erroneous as a matter of law, and we therefore affirm it. See Ira A. Watson Dept. Store, 34 S.W.3d at 48.

B. Whether KRS 342.730(4) is constitutional.

KRS 342.730(4) states in pertinent part that:

All income benefits payable pursuant to this chapter shall terminate as of the date upon which the employee qualifies for normal old-age Social Security retirement benefits under the United States Social Security Act, 42 U.S.C. secs. 301 to 1397f, or two (2) years after the employee's injury or last exposure, whichever last occurs.

At the time of his injury, Parker was sixty-eight years of age and qualified for "normal old-age Social Security retirement benefits." Under KRS 342.730(4), the ALJ found that Parker, who had received two years of temporary total disability benefits, was not entitled to any additional income benefits related to his permanent disability. Parker argues that KRS 342.730(4) unconstitutionally infringes on his right to due process, abrogates his jural rights, and violates the Equal Protection Clauses of the United States and Kentucky Constitutions. Webster County argues that, based on this Court's precedent, Parker's argument is without merit.

At the outset, we note that this Court previously determined that KRS 342.730(4) as it presently exists is constitutional.[3] See McDowell v. Jackson Energy RECC, 84 S.W.3d 71 (Ky. 2002); and Keith v. Hopple Plastics, 178 S.W.3d 463 (Ky. 2005), as corrected (Dec. 13, 2005). We also are cognizant of the strong presumption of constitutionality afforded to legislative acts. Id. at 468. However, having reviewed our prior opinions, we now determine that they were incorrectly decided regarding the issue of equal protection. In doing so, we are:

as always, mindful of the value of precedent and the doctrine of stare decisis. The doctrine of stare decisis "is the means by which we ensure that the law will not merely change erratically, but will develop in a principled and intelligible fashion." Changing the "ebb and flow of settled law" is not something we take lightly, and we do so only after careful consideration. While stare decisis "permits society to presume that bedrock principles are founded in the law rather than in the proclivities of individuals," it does not necessitate that this Court "unquestioningly follow
prior decisions” when we are otherwise compelled. This Court is not assigned the duty of maintaining the watch as the law ossifies.

Osborne v. Keeney, 399 S.W.3d 1, 16-17 (Ky. 2012) (footnotes omitted).

The dissent questions our decision to re-visit McDowell, stating that the only change that has occurred since that opinion is to the composition of this Court. We do not disagree that the composition of the Court has changed; however, we note that the Court was closely divided on this issue in McDowell. Furthermore, this Court determined in 2011 that there was no rational basis for applying a different evidentiary standard to employees who contracted coal workers' pneumoconiosis than that applied to workers who contracted non-coal workers' pneumoconiosis. See Vision Mining, Inc. v. Gardner, 364 S.W.3d 455 (Ky. 2011). This Court did so despite previously holding that a rational basis existed for treating those two groups differently. See Kentucky Harlan Coal Co. v. Holmes, 872 S.W.2d 446 (Ky. 1994).[4]

It is undisputed that, because of KRS 342.730(4), injured older workers are treated differently from their younger counterparts. When a statutory provision results in disparate treatment, we look to the 14th Amendment of the United States Constitution and to Sections 1, 2, and 3 of the Kentucky Constitution. The goal of those constitutional provisions "is to 'keep[] governmental decision makers from treating differently persons who are in all relevant respects alike'" while recognizing that "nearly all legislation differentiates in some manner between different classes of persons." Vision Mining, 364 S.W.3d at 465 (citation and footnote omitted). In order to maintain the necessary balance between the goals of the constitutional provisions and legislative reality, the Courts apply different levels of scrutiny depending "on the classification made in the statute and the interest affected by it." ld.

Currently, there are three levels of review applicable to an equal protection challenge. Strict or intermediate scrutiny applies whenever a statute makes a classification on the basis of a "suspect" or "quasi-suspect" class, respectively. Conversely, "if the statute merely affects social or economic policy, it is subject" to a less searching form of judicial scrutiny, i.e. the "rational basis" test.

Vision Mining, Inc. v. Gardner, 364 S.W.3d 455, 465-66 (Ky. 2011) (citations and footnotes omitted). "Workers' compensation statutes concern matters of social and economic policy. As a result, such a statute is not subject to strict or [intermediate] scrutiny and therefore must be upheld if a 'rational basis' or 'substantial and justifiable reason' supports the classifications that it creates." ld. at 466 (citation omitted).[5] Proving the absence of a rational basis or of a substantial and justifiable reason for a statutory provision is a steep burden; however, it is not an insurmountable one. ld. at 468-69.

The focus of the parties (and of the majorities in our prior decisions) is on the perceived discrimination between injured older workers and injured younger workers. This focus is understandable because, under the statute, a worker who is injured more than 425 weeks (or 520 weeks under certain circumstances) before he or she reaches normal Social Security retirement age will receive all of the permanent partial disability income benefits to which he or she is entitled.[6] A worker who is injured less than 425 weeks before he or she reaches normal Social Security retirement age will not receive all of the
permanent partial disability income benefits to which he or she is entitled. The rational bases for treating younger and older workers differently is: (1) it prevents duplication of benefits; and (2) it results in savings for the workers' compensation system. Undoubtedly, both of these are rational bases for treating those who, based on their age, have qualified for normal Social Security retirement benefits differently from those who, based on their age, have yet to do so.

However, the equal protection problem with KRS 342.730(4) is that it treats injured older workers who qualify for normal old-age Social Security retirement benefits differently than it treats injured older workers who do not qualify. As Justice Graves noted in his dissent in McDowell, "Kentucky teachers . . . have a retirement program and do not participate in social security." 84 S.W.3d at 79. Thus, a teacher who has not had any outside employment and who suffers a work-related injury will not be subject to the limitation in KRS 342.730(4) because that teacher will never qualify for Social Security retirement benefits. There is no rational basis for treating all other workers in the Commonwealth differently than teachers. Both sets of workers will qualify for retirement benefits and both have contributed, in part, to their "retirement plans." However, while teachers will receive all of the workers' compensation income benefits to which they are entitled, nearly every other worker in the Commonwealth will not. This disparate treatment does not accomplish the goals posited as the rational bases for KRS 342.730(4). The statute does prevent duplication of benefits, but only for non-teachers because, while nearly every other worker is foreclosed from receiving "duplicate benefits," teachers are not.

The dissent indicates that our analysis should be limited to determining if the "overall statutory scheme unlawfully discriminates on the basis of age." According to the dissent, we have wrongly viewed this matter through the "lens" of teacher retirement and have concluded that "there is no rational basis for treating teachers differently from all other workers in the Commonwealth." To the contrary, what we have concluded is that there is no rational basis for treating all other workers in the Commonwealth differently from teachers.

The dissent also states that we have undertaken to reverse the Court of Appeals based on a reason not presented on appeal. However, we note that Parker has challenged the constitutionality of KRS 342.730(4) on equal protection grounds at every level. While he has not specifically mentioned the disparate treatment between teachers and all other employees in the Commonwealth, he has challenged the disparate treatment between those who qualify for normal old age social security retirement and those who do not. Thus, we believe that is sufficient to preserve the issue for our review.

As to the alleged savings to the workers' compensation program, we discern no rational basis for this disparate treatment. In Vision Mining, we addressed the evidentiary standard and claims' processing procedures that were being applied in coal workers' pneumoconiosis claims. We concluded that there was no rational basis for treating coal workers suffering from pneumoconiosis differently from other workers suffering from pneumoconiosis. 364 S.W.3d at 473. In doing so, we rejected the employer's argument that the disparate treatment was justified because it resulted in monetary savings to the workers' compensation system. Id. at 472. ("The state would save more money by subjecting all occupational pneumoconiosis claimants to the more exacting procedure and higher rebuttable standard.") (emphasis in original). Furthermore, we noted that "[i]n considering an equal protection challenge, a court does not engage in accounting of
debits and credits; rather the court must examine whether similarly situated individuals have been treated differently . . . and, if so, whether or not such treatment is rationally related to a legitimate state interest." Id. at 474. Here, injured older workers who qualify for normal old-age Social Security retirement benefits are treated differently than injured older workers who do not. There is no rational basis for treating these two groups of injured older workers differently.

The dissent states that KRS 342.730(4) is constitutional, despite its disparate treatment of older workers, because the exclusion of teachers from its benefit limitation is an example of acceptable "underinclusiveness." We agree with the dissent that a statutory scheme need not attack "every aspect of a problem" in order to pass constitutional muster; however such a statute must be "free from invidious discrimination." Dandridge v. Williams, 397 U.S. 471 (1970).[7] The problem with KRS 342.730(4) is not that it fails to attack every aspect of the "problem" of injured workers collecting workers' compensation benefits and retirement benefits. The problem with KRS 342.730(4) is that it invidiously discriminates against those who qualify for one type of retirement benefit (social security) from those who do not qualify for that type of retirement benefit but do qualify for another type of retirement benefit (teacher retirement).[8] Based on the dissent's interpretation of underinclusiveness, this Court erred when it determined that it is unconstitutional to treat those who suffer from coal workers' pneumoconiosis differently from those who suffer from non-coal workers' pneumoconiosis. We discern no reason to reconsider the wisdom of that decision.

Finally, although Parker did not argue it, KRS 342.730(4) violates the prohibition against special legislation found in Section 59 of the Kentucky Constitution. "A special law is legislation which arbitrarily or beyond reasonable justification discriminates against some persons or objects and favors others." Board of Ed. of Jefferson County v. Board of Ed. of Louisville, 472 S.W.2d 496, 498 (Ky. 1971). As set forth above, KRS 342.730(4) favors those who will not qualify for normal old-age Social Security retirement while discriminating against those who do qualify. Because we have found KRS 342.730(4) to be constitutionally infirm on equal protection grounds, we need not address the other arguments raised by Parker.

IV. CONCLUSION.

Having reviewed the record and the arguments of the parties, we discern no rational basis or substantial and justifiable reason for the disparate treatment of two groups of injured older workers. Thus, KRS 342.730(4) violates the right to equal protection and is constitutionally infirm. Our opinions to the contrary are hereby overruled, and this matter is remanded to the ALJ for entry of an opinion and award consistent with this opinion.

All sitting.

Cunningham, Keller, Venters and Wright, JJ, concur Minton, CJ, concurs in part and dissents in part by separate opinion, in which Hughes and VanMeter, JJ., join.

MINTON, C.J., CONCURRING IN PART AND DISSenting IN PART:

I fully concur with the majority's holding that there was sufficient evidence to support the ALJ's finding that Parker suffered a work-related injury. But I must respectfully dissent
with regard to the majority's holding that KRS 342.730(4) violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution as an unlawful discrimination on the basis of age. I see no reason justifying our departure from well-established precedent on this exact same issue.

In conducting this constitutional analysis, I wholeheartedly follow the majority's general approach. The United States Supreme Court has consistently held that "age is not a suspect classification" for purposes of the Fourteenth Amendment. See Kimel v. Florida Bd. of Regents, 528 U.S. 62 (2000). "Age classifications, unlike governmental conduct based on race or gender, cannot be characterized as 'so seldom relevant to the achievement of any legitimate state interest that laws grounded in such considerations are deemed to reflect prejudice and antipathy.'" Id. at 83. This standard echoes the one in place for equal-protection claims premised on social or economic-class discrimination. In such instances, no suspect class exists, and "a statute will comply with the Fourteenth Amendment's right to equal protection if it furthers a legitimate state interest and there is any conceivable rational basis for the classes it creates." Keith v. Hopple Plastics, 178 S.W.3d 463, 466 (Ky. 2005).

So there is no disagreement that the proper standard of review for equal-protection claims based on age or socioeconomic status is rational-basis review – the weakest tier of constitutional scrutiny on appeal. That is, so long as a statute is rationally related to a legitimate government interest, an examining court will not hold the act unconstitutional. See Heller v. Doe, 509 U.S. 312 (1993); Keith, 178 S.W.3d at 463. Legislative acts are as such presumed valid and the burden rests with the challenger to prove no rational basis exists for this classification. See Lehnhausen v. Lake Shore Auto Parts Co., 410 U.S. 356, 364 (1973) (emphasis added).

The rational-basis test imposes an admittedly enormously high bar for challengers seeking to invalidate perceived unconstitutional statutes. The United States Supreme Court has declared the rational-basis test is the proper measure for distinctions of this type for purposes of the Fourteenth Amendment, and, absent a finding that our own constitution offers heightened equal-protection rights, we are powerless to change that standard today. So in both the majority decision and in my interpretation, KRS 342.730(4) remains constitutionally valid so long as its goals are rationally related to a legitimate state interest. I unfortunately disagree with the majority's conclusion that the General Assembly has no rational basis in classifying the workforce in this manner.

We dealt with this precise issue just over a decade ago in McDowell v. Jackson Energy RECC, 84 S.W.3d 71 (Ky. 2002) and Keith. And in the time that has elapsed since, I see no changes or developments in the law other than the composition of this Court. There has been no adjustment in either Kentucky or federal law predating reconsideration of the wisdom of these relatively recent rulings. As such, I vote to affirm this deeply rooted precedent.

In McDowell, we determined that KRS 342.730(4) exists to avoid duplication of income-replacement benefits. This structure reduces the overall cost of workers' compensation and improves the economic stability within state government. This reflects a similar policy goal from the pre-1996 tier-down structure that had previously been upheld by this Court. See Wynn v. Ibold, Inc., 969 S.W.2d 695 (Ky. 1998). And this view of the benefit structure as "wage-loss" protection by placing a ceiling on combined benefits "was viewed widely as being sound public policy." Keith, 178 S.W.3d at 467 (referring to
Arthur Larson and Lex K. Larson, 9 Larson's Workers' Compensation Law §97.35(a) and (b) (Matthew Bender 1997)). The McDowell Court also relied on the United States Supreme Court decision in Richardson v. Belcher, 404 U.S. 78 (1971), in support of its holding. In Belcher, the Court rejected an equal-protection challenge to a portion of the Social Security Act that allowed social security disability benefits to be reduced through overlapping state workers' compensation benefits. Belcher, 404 U.S. at 92. The McDowell Court found no difference under the rational-basis standard between the federal offset provision and that found in KRS 342.730. And I agree.

The Commonwealth's goal of financial stability to ensure the overall viability of the state worker's compensation structure is not one I consider irrational. And it does so by first recognizing that workers' compensation exists to offset wage-loss resulting from workplace injury and then coordinating the receipt of benefits to avoid duplicate recovery. Essentially, the statute exists to prevent workers eligible for old-age social security benefits from "receiving greater workers' compensation benefits than similarly situated workers who are totally disabled." Keith, 178 S.W.3d at 468. Though the statute admittedly and obviously discriminates against older workers, it advances a legitimate state goal of ensuring the overall viability and stability of the workers' compensation structure as a whole. While this may appear unfair and exploitative of some of the Commonwealth's oldest and most vulnerable workers, I am not prepared to say it is unconstitutional to do so.

The majority opinion in fact agrees that the prevention of duplicate benefits and the continued solvency of the workers' compensation system are indeed rational bases for treating those who have qualified for normal social security retirement benefits differently from those who have yet to do so. And though it does not expressly say so, I imagine the majority would also find these state interests legitimate. So according to our highly deferential standard of review, the analysis should end there.

But the majority continues by contrasting the general workers' compensation structure with the teacher retirement system, a point not raised or argued to us or in the proceedings below. As the majority reminds us, teachers have their own retirement and do not participate in social security. So accordingly, an older teacher who suffers a workplace injury will never be subject to the limitation in KRS 342.730(4) because the teacher will never qualify for social security. This leads to the majority's ultimate conclusion that there is no rational basis for treating teachers differently from all other workers in the Commonwealth. But that is not the question before this Court in the case before us today.

In addressing this observation, the analysis is no longer a dispute over whether our overall statutory scheme unlawfully discriminates on the basis of age. Instead, the majority takes its eyes off the issue before us and refocuses attention on whether state government unconstitutionally distinguishes benefit availability across different professions. And the majority is justified in recognizing this distinction. Perhaps there is indeed a novel question whether there is a rational basis (or whatever standard is invoked for distinctions of this type – if it even exists) to treat teachers differently from any other worker in the Commonwealth. Maybe the real question at the heart of that issue requires a close examination of the teacher retirement system to see whether there is a good reason to continue to exempt this profession from KRS 342.730(4), or whether this is simply a loophole in the system.
Those disparities considered, that statute simply is not before the court for our review. It has no doubt appeared in cases of this kind, to be sure, and it formed the central basis in Justice Graves's dissent in McDowell. The majority reprises Justice Graves's argument, though this time crafted as a majority opinion of this Court. But make no mistake, we have not been tasked with reviewing the exception retired teachers enjoy under the current parameters of the workers' compensation system. Even entertaining this argument, for the moment, leaves me equally unpersuaded. To me, viewing teacher retirement through the lens of this current matter, I am highly skeptical of its usefulness in conclusively determining that this statute – KRS 242.730(4) – violates the Fourth Amendment's guarantees of equal protection under the law. And the highly deferential rational-basis standard of review clinches the issue for me. For KRS 342.730(4) to remain constitutional, we need only consider any reasonably conceivable state of facts that could offer a rational basis for the classifications made by the General Assembly in drafting the statute. See Commonwealth Natural Resources and Environmental Protection Cabinet v. Kenetec Coal Co., Inc., 177 S.W.3d 718, 738 (Ky. 2005) (Cooper, J., concurring in part and dissenting in part). Though certainly some in the majority may conclude there is no conceivable basis of rationality in the statute's distinction altogether, comparison to the teacher retirement system offers us little to no guidance in reaching a determination either way. Under rational-basis review, "the possibility that a classification might result in some practical inequity does not cause it [the statute] to fail." Id. As the Supreme Court held in Heller v. Doe, 509 U.S. 312 (1993), a statutory classification can fail only if it is completely irrelevant to the achievement of what the majority admits are legitimate state interests. Id. at 324 (emphasis added).

Additionally, a statute's underinclusiveness in achieving its stated purpose is insufficient grounds to hold it unconstitutional under the rational-basis test. See Kenetec Coal, 177 S.W.3d at 740. In exercise of its constitutional powers, a legislature is "free to choose to remedy only part of a problem. It may select one phase of a field and apply a remedy there, neglecting the others." Id. (internal citations omitted). In Dandridge v. Williams, 397 U.S. 471 (1970), the Supreme Court held that the "Equal Protection Clause does not require that a State must choose between attacking every aspect of a problem or not attacking the problem at all. It is enough that the State's action be rationally based and free from invidious discrimination." Id. at 486-87. See also Minnesota v. Clover Leaf Creamery Co., 449 U.S. 456, 466 (1981) ("[A] legislature need not strike at all evils at the same time or in the same way."). I believe the General Assembly's failure to include all retired workers in its comprehensive workers' compensation scheme is this underinclusiveness doctrine at work. This incomplete application does not undermine the legislature's goals or undercut the rationality of its distinction; it only highlights its failure to perfectly tailor its interest across the board. But ultimately, the fact that the line may have been drawn differently at one point is a question more appropriately committed for legislative, rather than judicial, consideration. See United States R.R. Ret. Bd. v. Fritz, 449 U.S. 166, 179) (1980).

To me, this distinction actually mitigates accusations of ageism; the statutory distinction is more about benefit eligibility and less about age discrimination. A distinction between teachers and general workers undoubtedly exists, but I cannot say it is an age-based classification. I am unprepared and unwilling to evaluate these other equal-protection concerns today. I do recognize the majority's concerns, but I am uncomfortable departing from Court precedent at this juncture.
I must also further take issue that the majority opinion classifies KRS 342.730(4) as unconstitutional special legislation prohibited under Section 59 of the Kentucky Constitution. Unfortunately, like the teacher-retirement exception, no party raised this issue at any point in the proceedings below nor offered any arguments in their brief to us suggesting that this statute is special legislation. Although we may affirm a lower-court ruling for any reason appearing in the record, case law and our own judicial prudence dictate that we should be reluctant to reverse a judgment for reasons not presented on appeal or argued below. And with respect to workers' compensation, KRS 342.285 further guides us; if the issue is not raised before an Administrative Law Judge, it may not be raised later on appeal. Because this issue appears for the first time in the majority opinion, we should refrain from addressing it without at least inviting the parties to brief this new constitutional argument.

I respectfully dissent as to these portions of the majority opinion. Hughes and VanMeter, JJ., join.

Notes:

[1] The Board noted in its opinion that Webster County filed a number of medical fee disputes while the appeal was pending and that the ALJ had issued an order joining additional parties after the notice of appeal had been filed. Because the ALJ lost jurisdiction once the notice of appeal was filed, the Board vacated his order. Furthermore, the Board remanded the medical fee disputes for a determination on the merits and on the necessity of joining additional parties. Neither party has contested this portion of the Board's opinion; therefore, we do not address it.


[3] In 1994, the legislature added paragraph (4) to KRS 342.730, which provided that workers' compensation income benefits would be reduced by 10 percent when an employee reached age sixty-five and by 10 percent every year thereafter until the employee reached age seventy. In Wynn v. Ibold, Inc., 969 S.W.2d 695 (Ky. 1998), we held that version of KRS 342.730(4) was constitutional. The legislature adopted the current version of KRS 342.730(4) in 1996.

[4] We recognize that the Court in Holmes specifically addressed the different basis for awarding benefits to employees who have contracted coal workers' vs. non-coal workers' pneumoconiosis, while the Court in Vision Mining was addressing the standard of proof and the consensus process. However, the dissent in Vision would have relied on Holmes to support affirming the disparate evidentiary standards and the consensus process. Regardless, the fact remains that this Court has revisited its decisions regarding the constitutionality of portions of KRS 342 when appropriate to do so.

[5] We note that, while federal case law may be instructive regarding issues of equal protection, we are not bound to follow federal equal protection analysis. As we noted in Elk Horn Coal Corp. v. Cheyenne Resources, Inc., 163 S.W.3d 408, 418 (Ky. 2005), "the Kentucky Constitution's equal protection provisions . . . are much more detailed and specific than the Equal Protection Clause of the United States Constitution." The analysis employed by our federal counter-parts acts as a floor, below which we may not fall, not as a ceiling, above which we may not rise. Id. In fact, "we have construed our Constitution as requiring a 'reasonable basis' or a 'substantial and justifiable reason' for
discriminatory legislation in areas of social and economic policy.” *Id.* at 418-19. In this case however, the preceding distinction, while important, is one without a difference because [KRS 342.730(4)](https://www.law.ky.gov/Acts/Acts20112012/2012Act001/2012Act001.pdf) does not pass the less stringent rational basis test.

[6] This does not take into account any payment of temporary total disability income benefits, which could, as it did here, alter the number of weeks of entitlement to permanent disability benefits.

[7] In *Dandridge*, the plaintiffs, who had large families, challenged the Maryland Department of Public Welfare maximum cap on AFDC benefits. 397 U.S. at 474-75. The Court determined that the cap did not violate equal protection. *Id.* at 487. *Dandridge* differs from the case herein because the Maryland statute treated all AFDC recipients the same because all were subject to the cap. Here, [KRS 342.730(4)](https://www.law.ky.gov/Acts/Acts20112012/2012Act001/2012Act001.pdf) treats two different groups of elderly workers differently.

[8] The dissent also cites to *Minnesota v. Clover Leaf Creamery Co.*, 449 U.S. 456 (1981) to support its underinclusiveness argument. However, as with *Dandridge*, *Clover Leaf Creamery* is distinguishable. In *Clover Leaf Creamery*, the state of Minnesota passed legislation regulating the sale of milk in plastic containers but permitting the sale of milk in cardboard containers. 449 U.S. at 456. The Court held that the statute bore a rational relationship to that state's goals of reducing landfill and reducing energy consumption. *Id.* at 458. The Minnesota statute treated different containers differently, but it treated all plastic containers, or containers of the same "class," the same. Here, *KRS 342.730(4)* treats younger and elderly workers differently, which is acceptable. However, it does not treat workers of the same "class," elderly workers, equally.
ALTON LIVINGOOD,  

v.  

TRANSFREIGHT, LLC, ET. AL.,  

2014-SC-000100-WC  

Supreme Court of Kentucky  
August 20, 2015  
Released for Publication September 10, 2015.  

ON APPEAL FROM COURT OF APPEALS. CASE NO. 2013-CA-000349-WC. WORKERS' COMPENSATION BOARD NO. 09-WC-73444.  

COUNSEL FOR APPELLANT: Larry Duane Ashlock, Esq., Morgan & Morgan.  

COUNSEL FOR APPELLEE: Walter A. Ward, Donnie James Niehaus, Ward, Hocker, Thornton, PLLC.  

All sitting. All concur.  

OPINION  

BARBER, JUSTICE.  

This workers' compensation appeal involves entitlement to temporary total disability ("TTD") benefits during a period of light-duty work and application of the two multiplier, KRS 342.730(1)(c)2. The ALJ denied both. The Workers' Compensation Board ("Board") and the Court of Appeals affirmed. We affirm the denial of TTD benefits and reverse and remand with respect to the two multiplier, because our analysis here today convinces us to reconsider the holding in Chrysalis House, Inc. v. Tackett, 283 S.W.3d 671 (Ky. 2009).  

I. BACKGROUND  

Appellant, Alton Livingood ("Livingood"), injured his left shoulder on September 16, 2009, while working as a certified forklift operator for Appellee, Transfreight, LLC ("Transfreight"). He underwent two shoulder surgeries and was off work from November 11, 2009, through March 2, 2010. He returned to light duty from March 3, 2010, through October 5, 2010. Livingood subsequently underwent a third shoulder surgery and was off work again from October 6, 2010, through December 12, 2010. TTD benefits were paid for the periods he was off work.  

On December 13, 2010, Livingood returned to work without restrictions. Four hours into his shift, Livingood accidentally bumped into a pole while operating the forklift in an
unfamiliar area. There was no damage. At the time of the incident, Livingood was still under a physician's care and taking prescribed Lortab. On December 23, 2010, Transfreight terminated his employment.

Livingood testified that "[t]hey said I should have been paying more attention to what I was doing, and they fired me." Stephanie Baldwin, Transfreight's human resources business partner, testified that Transfreight has a progressive discipline policy "that from infraction to infraction, we either go directly to the next step or depending upon the matter, we can skip steps." Ms. Baldwin thought that the forklift incident was the third incident. It was a "preventable accident, ... deemed to be relative." But, in Livingood's case, he was already on "full and final warning" status with the next step being termination when the forklift incident occurred. Otherwise, his employment would have continued.

On December 18, 2011, Livingood started working for Vogt Management packing post-it notes at $8.50 an hour. Livingood testified that he would have had to work two weeks at Vogt to get close to what he had earned in one week at Transfreight.

On August 15, 2012, the ALJ rendered an Opinion, Award & Order. It reflects a stipulated average weekly wage ("AWW") of $550.43. The ALJ noted that Livingood's hourly rate remained $13.25 from the time of the injury until his termination. While on light duty, Livingood "was on the payroll at his regular rate of pay." His light-duty activities included:

- changing batteries in forklifts and monitoring restrooms to see who was writing on walls. In addition, he was given an assignment to find freight that was in the wrong place, write it down and have the forklift operators move it. He estimated that he spent 50 percent of his time changing batteries, 25 percent of his time monitoring bathrooms and 25 percent going around and making sure everything was in the right place. Even before his injury, he performed the "misplaced freight" duties on a daily basis. Prior to the injury [Livingood] also had the job of changing batteries for about a five month period. . . . Immediately before his injury, however, he operated a forklift 100 percent of the time....

The ALJ denied Livingood's request for TTD benefits while he was on light duty. Except for bathroom monitoring, Livingood had performed the other activities before the injury; further, they were not a make-work project. The ALJ was not persuaded that Livingood was terminated due to his disabling shoulder injury and declined to award the two multiplier under KRS 342.730(1)(c)2 and Chrysalis House v. Tackett, 283 S.W.3d 671 (Ky. 2009). The ALJ awarded permanent partial disability ["PPD"] benefits in the amount of $11.93 per week, based upon a straight 5 percent impairment rating. Livingood filed a petition for reconsideration contending, inter alia, that the ALJ erred in not awarding the two multiplier. By Order of September 18, 2012, the ALJ denied the petition for reconsideration.

Livingood appealed to the Board, which affirmed by Opinion rendered January 25, 2013. The Board disagreed with Livingood's argument that he was entitled to additional TTD benefits while he was on light duty:
Pursuant to KRS 342.0011(11)(a), in order for a claimant to be entitled to TTD benefits, he must satisfy a two-prong test: (1) he must not have reached maximum medical improvement ("MMI"); and (2) he must not have reached a level of improvement that would permit his return to employment. Double L Constr., Inc. v. Mitchell, 182 S.W.3d 509, 513 (Ky. 2005). A release to perform minimal work rather than the type that is customary or that the employee was performing at the time of the injury does not constitute "a level of improvement that would permit a return to employment" under KRS 342.0011(11)(a). Id. at 514 (citing Central Kentucky Steel v. Wise, 19 S.W.3d 657, 659 (Ky. 2000)). However, during his return to work, Livingood was paid the same wage he was paid prior to his injury. The ALJ found that a majority of Livingood's work during this time was work he had been trained to do, and ... had previously performed for the employer.... In total, 75 percent of Livingood's post-injury work was work he customarily and regularly performed for his employer pre-injury. The ALJ found that Livingood had therefore not satisfied the second prong of the KRS 342.0011(11)(a) test for TTD benefits. We are not persuaded that the evidence in the record renders the ALJ's finding unreasonable or compels a different outcome.

The Board found no error in the ALJ's decision not to award the two multiplier under KRS 342.730(1)(c)(2).

[T]he Kentucky Supreme Court has held that KRS 342.730(1)(c)(2) only permits a double income benefit when employment ceases for a reason relating to the disabbling injury. Chrysalis House, Inc. v. Tackett, 283 S.W.3d 671, 674 (Ky. 2009). Livingood was ultimately let go due to the December 13, 2010 forklift incident. He claims this incident actually was a result of his injury.... Transfreight's human resources representative testified that but for multiple prior infractions, the forklift incident would not have resulted in Livingood's termination. The ALJ ultimately decided that the termination was unrelated to Livingood's injury. This decision was within the ALJ's discretion and was not unreasonable in light of the evidence presented.

By Opinion rendered January 31, 2014, the Court of Appeals affirmed. The Court of Appeals was not convinced that the ALJ had misapplied the law or misinterpreted the evidence.

II. ANALYSIS

Livingood contends that he was entitled to additional TTD from March 3, 2010, until October 5, 2010, while on light duty, because he did not perform his customary work as a forklift operator. KRS 342.0011(11)(a) defines TTD as "the condition of an employee who has not reached maximum medical improvement from an injury and has not reached a level of improvement that would permit a return to employment." Livingood relies upon Central Kentucky Steel v. Wise, 19 S.W.3d 657 (Ky. 2000) and Double L Const., Inc., v. Mitchell, 182 S.W.3d 509 (Ky. 2005). Both are distinguishable on their facts. Double L Construction involved concurrent employment which is not at issue here.[1]
In *Wise*, the employee was not working during the period TTD was in issue. Wise, an ironworker, fractured his arm on April 28, 1997. The employer voluntarily paid TTD through August 1, 1997. At the end of September 1997, Wise moved to Florida and started working for a different employer. His treating physician did not assign MMI until October 28, 1997. The ALJ awarded TTD benefits through September 30, 1997. The employer argued that under KRS 342.0011(11)(a), TTD should have been terminated in July 1997, when the treating physician would have allowed Wise to return to work with a five-pound lifting restriction. The Court disagreed, because "[i]t would not be reasonable to terminate the benefits of an employee when he is released to perform minimal work but not the type that is customary or that he was performing at the time of his injury." *Id.* at 659.

As the Court explained in *Advance Auto Parts v. Mathis*, No. 2004-SC-0146-WC, 2005 WL 119750, at *3 (Ky. Jan. 20, 2005), and we reiterate today, *Wise* does not "stand for the principle that workers who are unable to perform their customary work after an injury are always entitled to TTD." Livingood had the burden of proof on the issue. Where the ALJ finds against the party with the burden of proof, the standard of review on appeal is whether the evidence compelled a contrary finding. *FEI Installation, Inc. v. Williams*, 214 S.W.3d 313 (Ky. 2007). The Board and the Court of Appeals were not convinced that it did. Nor are we. "The function of further review in our Court is to address new or novel questions of statutory construction, or to reconsider precedent when such appears necessary, or to review a question of constitutional magnitude." *Western Baptist Hosp. v. Kelly*, 827 S.W.2d 685, 688,394 Ky. L. Summary 54 (Ky. 1992).

Livingood also contends that he should have been awarded the two multiplier pursuant to KRS 342.730(1)(c)2 which provides:

If an employee returns to work at a weekly wage equal to or greater than the average weekly wage at the time of injury, the weekly benefit for permanent partial disability shall be determined under paragraph (b) of this subsection for each week during which that employment is sustained. During any period of cessation of that employment, temporary or permanent, for any reason, with or without cause, payment of weekly benefits for permanent partial disability during the period of cessation shall be two (2) times the amount otherwise payable under paragraph (b) of this subsection. This provision shall not be construed so as to extend the duration of payments.

The Board observed that it would appear "this statute provides for a doubled benefit anytime a cessation of employment at the same or greater wage occurs," but that as construed in *Chrysalis House*, KRS 342.730(1)(c)2 only permits a double income benefit when the reason relates to the disabling injury.

In *Chrysalis House*, the claimant worked at a residential substance abuse treatment center. He was discharged for stealing a money order belonging to one of the residents. The ALJ determined that the claimant stole the money order, endorsed and cashed it, but that it was irrelevant for purposes of KRS 342.730(1)(c)2. On appeal, the employer argued that the legislature did not intend for the words "with or without cause" to supersede Kentucky's longstanding policy preventing individuals from profiting from their illegal acts; further, that to construe the statute in a way that encourages illegal conduct would be contrary to public policy. The Board and the Court of Appeals affirmed the
ALJ's decision based on the unambiguous language of KRS 342.730(1)(c)2. This Court reversed:

We presume when interpreting a statute that the legislature intended for it to mean exactly what it says. Although ambiguous language must be interpreted based on legislative purpose and intent, unambiguous language requires no interpretation. Yet, nothing requires a statute's subsection to be read in a vacuum rather than in the context of the entire statute.

KRS 342.730(1)(c)2 appears at first blush to provide clearly and unambiguously for a double benefit during a period of cessation of employment at the same or a greater wage "for any reason, with or without cause." It is, however, a subsection of KRS 342.730(1), which authorizes income benefits to be awarded for "disability" that results from a work-related injury. We conclude for that reason that, when read in context, KRS 342.730(1)(c)2 permits a double income benefit during any period that employment at the same or a greater wage ceases "for any reason, with or without cause," provided that the reason relates to the disabling injury.

Id. at 674 (footnotes omitted).

Here, the ALJ was not persuaded that the reason for Livingood's termination related to his disabling injury. We cannot say that the evidence compels a contrary finding in that regard. Nevertheless, the circumstances in the present case are very different from those in Chrysalis House and lead us to reconsider our construction of KRS 342.730(1)(c)2.

KRS 446.080(1) mandates that "[a]ll statutes of this state shall be liberally construed with a view to promote their objects and carry out the intent of the legislature...." "The mandate of KRS 446.080 is particularly applicable to the Workers' Compensation Act which is often cited as an act to be liberally construed to effect its remedial purpose. All presumptions will be indulged in favor of those for whose protection the enactment was made." Firestone Textile Co. Div., Firestone Tire and Rubber Co. v. Meadows, 666 S.W.2d 730, 732 (Ky. 1983).

In construing statutes, our goal, of course, is to give effect to the intent of the General Assembly. We derive that intent, if at all possible, from the language the General Assembly chose, either as defined by the General Assembly or as generally understood in the context of the matter under consideration. We presume that the General Assembly intended for the statute to be construed as a whole, for all of its parts to have meaning, and for it to harmonize with related statutes. Shawnee Telecom Resources, Inc. v. Brown, 354 S.W.3d 542, 551 (Ky. 2011) (citation omitted).

"It has long been established that the purpose of awarding income benefits to injured workers is to provide an ongoing stream of income to enable them to meet their essential needs and those of their dependents." Ball v. Big Elk Creek Coal Co., Inc., 25 S.W.3d 115, 117 (Ky. 2000).
KRS 342.730(1) provides income benefits to replace some of the wages that workers lose due to the occupational effects of work-related injuries.

Consistent with the purpose of the benefit and with KRS 342.710(1)'s goal of encouraging a return to work, KRS 342.730(1)(c)2 focuses on post-injury wages...

The purpose of KRS 342.730(1)(c)2 is to keep partially disabled workers in the habit of working and earning as much as they are able. It creates an incentive for them to return to work at which they will earn the same or a greater average weekly wage by permitting them to receive a basic benefit in addition to their wage but assuring them of a double benefit if the attempt proves to be unsuccessful.

Toy v. Coca Cola Enterprises, 274 S.W.3d 433, 434-35 (Ky. 2008). The statute also "discourages an employer from continuing to employ an injured worker at the same or a greater wage for the sole purpose of securing a finding of partial rather than total disability or a finding under KRS 342.730(1)(c)2 rather than [a triple benefit under] KRS 342.730(1)(c)1." Chrysalis House at 675.

In Kentucky Mountain Coal Co. v. Witt, 358 S.W.2d 517 (Ky. 1962), the Court construed the former KRS 342.120(5)[2], which provided for awards to be paid from the Subsequent Claim Fund ("SCF") where a claimant was employed by the same employer after an injury at the same or greater wage. At issue was whether the SCF remained liable for payment of the award after the claimant's employment was terminated. There, the award commenced on September 12, 1960. The claimant was reemployed at wages equal to or exceeding his former wages. The SCF proceeded to pay the award until June 1961, when it discovered that the reemployment had ended on March 2, 1961. The then Board relieved the SCF from payment and imposed liability upon the employer for future payments during such time as the claimant was not employed at the same or greater wage. The employer appealed. The Court affirmed.

The obvious purpose of the statute is to encourage reemployment of injured workmen at adequate wages by relieving the employer of the requirement of paying disability compensation in addition to full wages...

But the inducement or encouragement the legislature has extended is clearly for continued reemployment. It is not conceivable that the legislature intended to relieve an employer completely of liability for compensation payments if he should reemploy the workman for only one day.

In construing a statute the courts will consider the purpose which the statute is intended to accomplish.

Id. at 518.

We conclude that the construction of KRS 342.730(1)(c)2 in Chrysalis House does not effectuate the legislative intent. Requiring that the cessation of employment at the same or greater wage must relate to the disabling injury does not promote the statute's obvious purpose of encouraging continued employment. Instead, it limits the statute's
application. Moreover, such a construction does little to discourage employers from taking workers back after an injury just long enough to avoid liability for a greater award.

Re-examining the statute in context reinforces our conclusion. The preceding subsection, KRS 342.730(1)(c)1 governs application of the three multiplier and provides: "If, due to an injury, an employee does not retain the physical capacity to return to the type of work that the employee performed at the time of injury, the benefit for permanent partial disability shall be multiplied by three...." By contrast, KRS 342.730(1)(c)2, governing application of the two multiplier, does not include the language, "if due to an injury." "[W]here the legislation includes particular language in one section of a statute, but omits it in another section of the same Act, it is generally presumed that the legislature acted intentionally and purposefully in the disparate inclusion or exclusion." Turner v. Nelson, 342 S.W.3d 866, 873 (Ky. 2011) (citing Palmer v. Commonwealth, 3 S.W.3d 763, 46, 14 Ky. L. Summary 3 (Ky. App.1999)).

Given our analysis, we conclude that Chrysalis House was incorrect in holding that the reason for cessation of work at the same or greater wage under KRS 342.730(1)(c)2 must relate to the disabling injury. To that extent, Chrysalis House is overruled. Nevertheless, a literal construction of KRS 342.730(1)(c)2 would lead to an unreasonable result if an employee like the one in Chrysalis House is allowed to benefit from his own wrongdoing.

"General principles of statutory construction hold that a court must not be guided by a single sentence of a statute but must look to the provisions of the whole statute and its object and policy." County of Harlan v. Appalachian Reg' Healthcare, Inc., Ky., 85 S.W.3d 607, 611 (2002)... In addition, "[w]e have a duty to accord to words of a statute their literal meaning unless to do so would lead to an absurd or wholly unreasonable conclusion." Bailey v. Reeves, Ky., 662 S.W.2d 832, 834 (1984)... The legislature's intention" shall be effectuated, even at the expense of the letter of the law." Commonwealth v. Rosenfield Bros. & Co., 118 Ky. 374, 80 S.W. 1178, 1180, 25 Ky. L. Rptr. 2229 (1904).

We must further acknowledge that the General Assembly "intends an Act to be effective as an entirety. No rule of statutory construction has been more definitely stated or more often repeated than the cardinal rule that significance and effect shall, if possible, be accorded to every part of the Act." George v. Scent, Ky., 346 S.W.2d 784, 789 (1961).

Cosby v. Com., 147 S.W.3d 56, 58-59 (Ky. 2004).

KRS Chapter 342 evinces a legislative intent that an employee should not benefit from his own wrongdoing. KRS 342.165(2)[3] bars compensation where an employee knowingly and willfully makes a false representation regarding his or her physical condition or medical history in writing at the time of entering employment. KRS 342.610(3) provides that "[i]liability for compensation shall not apply where injury, occupational disease, or death to the employee was proximately caused primarily by voluntary intoxication as defined in KRS 501.010, or by his or her willful intention to injure or kill himself, herself, or another." In Advance Aluminum Co. v. Leslie, 869 S.W.2d 39, 40 (Ky. 1994), the Court explained that "KRS 342.610(3) encompasses situations including horseplay, intoxication, or other employee conduct shown to have
been an intentional, deliberate action with a reckless disregard of the consequences either to himself or to another."[4]

An employee's conduct after an injury may also result in the termination or reduction of income benefits. KRS 342.035(3) provides that "[n]o compensation shall be payable for the ... disability of an employee ... if and insofar as his disability is aggravated, caused, or continued, by an unreasonable failure to submit to or follow any competent surgical treatment or medical aid or advice." Where an employee refuses to submit to or obstructs an independent medical exam, KRS 342.205(3) provides that "his or her right to take or prosecute any proceedings under this chapter shall be suspended until the refusal or obstruction ceases. No compensation shall be payable for the period during which the refusal or obstruction continues." KRS 342.710(5) provides that "[r]efusal to accept [vocational] rehabilitation pursuant to an order of an administrative law judge shall result in a fifty percent (50%) loss of compensation for each week of the period of refusal."

Consistent with the foregoing, we conclude that the legislature did not intend to reward an employee's wrongdoing with a double benefit. We hold that KRS 342.730(1)(c)2 permits a double income benefit during any period that employment at the same or a greater wage ceases "for any reason, with or without cause," except where the reason is the employee's conduct shown to have been an intentional, deliberate action with a reckless disregard of the consequences either to himself or to another. In the instant case, the substantial evidence of record does not establish that Livingood's conduct was of that nature. Rather, the ALJ concluded that "but for the prior transgressions the pole bumping incident would not have resulted in [Livingood's] termination."

As noted by the Board, the ALJ and the parties appeared to assume that Livingood had returned to work at the same or greater wage; however, the ALJ did not determine Livingood's post-injury AWW. KRS 342.730(1)(c)2 requires a comparison of the pre-injury and post-injury AWW calculated in accordance with KRS 342.140. Ball v. Big Elk Creek Coal, at 118. The Opinion of the Court of Appeals is hereby affirmed in part and reversed in part and this claim is remanded for a determination of Livingood's post-injury AWW; if it is the "same or greater," the ALJ is instructed to apply the two multiplier pursuant to KRS 342.730(1)(c)2.

All sitting. All concur.

Notes:

[1] There, the claimant was injured in his full-time job as a carpenter. He had a second job as a janitor fifteen hours a week. The employer argued that the claimant was not entitled to TTD because he had worked continuously as a janitor after the injury, although he could not perform his carpentry job. The Court disagreed:

[A] worker is entitled to TTD benefits if a work-related injury results in a temporary inability to perform the job in which it occurred. If the injury also causes an inability to perform a concurrent job of which the employer has knowledge, income benefits are based on the wages from both.... by operation of KRS 342.140(5). If the injury does not cause an inability to perform a concurrent job, ... income benefits are based solely on the wages from the job in which the injury occurred. In contrast, if a work-
related injury does not prevent the worker from performing the job in which it occurred, the worker is not entitled to TTD despite an inability to perform a concurrent job.

_id. at 514-15 (footnote omitted).

[2] The statute provided:

[A] claimant who has been awarded compensation under ... this chapter [who] becomes re-employed by the employer against whom the award was made, or continues in his employment in which he was injured, any part of the award not paid at the time the claimant becomes re-employed shall be paid out of the Subsequent Claim Fund; or, if the claimant has continued in his employment then the whole award shall be paid from the Subsequent Claim Fund.... The employment or re-employment contemplated herein shall be at wages equal to or greater than the employee was receiving before the traumatic injury by accident.

[3] The statute provides:

No compensation shall be payable for work-related injuries if the employee at the time of entering the employment of the employer by whom compensation would otherwise be payable falsely represents, in writing, his or her physical condition or medical history, if all of the following factors are present:

(a) The employee has knowingly and willfully made a false representation as to his or her physical condition or medical history;

(b) The employer has relied upon the false representation, and this reliance was a substantial factor in the hiring; and

(c) There is a causal connection between the false representation and the injury for which compensation has been claimed.

[4] The version of [KRS 342.610(3)] in effect at that time provided that "liability for compensation shall not apply where the injury, occupational disease, or death to the employee was proximately caused primarily by his intoxication or by his willful intention to injure or kill himself or another."
Supreme Court of Kentucky
2014-SC-000062-WC

Ronnie Hale

Appellant

On appeal from Court of Appeals
v.
2013-CA-001030-MR and 2013-CA-001072-MR
Workers' Compensation No. 12-WC-00467

CDR Operations, Inc., et al.

Appellees

2014-SC-000066-WC

CDR Operations, Inc., et al.

Cross Appellants

ON APPEAL FROM COURT OF APPEALS
v.
2013-CA-001030-MR and 2013-CA-001072-MR
Workers' Compensation No. 12-WC-00467

Ronnie Hale, et al.

Cross Appellees

Opinion of the Court by Justice Barber

Affirming in part, Reversing in part, and Reinstating

Appellant/Cross-Appellee, Ronnie Hale was employed by Appellee/Cross-Appellant, CDR Operations, Inc., for approximately three months as a bulldozer operator. Before that, Hale had worked as a bulldozer operator for various other employers for approximately thirty years. Hale filed a workers' compensation claim against CDR alleging cumulative trauma and an injury date of February 7, 2012. The parties subsequently stipulated that date at the Benefit Review Conference ("BRC"). Relying on Dr. Madden, the administrative law judge ("ALJ") concluded that Hale sustained cumulative trauma injuries which became manifest on February 7, 2012, while he was employed at CDR, and that he was permanently and totally disabled. Although the Workers' Compensation Board ("Board") noted that the ALJ's determination was consistent with Dr. Madden's opinion, it vacated and remanded, concluding that February 7, 2012, could not be the date of manifestation and that Southern Kentucky Concrete Contractors, Inc. v. Horace W. Campbell, 662 S.W.2d 221 (Ky. App. 1983),
required apportionment of liability based upon the percentage of Hale's impairment attributable to the three months he worked at CDR. The Court of Appeals affirmed. Hale appealed and contends that Southern Kentucky Concrete is inapplicable. CDR cross-appeals and contends that the evidence failed to establish that Hale sustained a cumulative trauma injury during his three-month employment there.

For the reasons set forth below, we affirm to the extent that Dr. Madden's opinion provides a sufficient evidentiary foundation to support the ALJ's award. We reverse with respect to the issues of the manifestation date and apportionment of liability and reinstate the AW's decision.

I. BACKGROUND

On April 16, 2012, Hale filed an Application for Resolution of Injury Claim (Form 101), alleging cumulative trauma to his neck and back and an injury date of February 7, 2012.¹ Hale had worked as a dozer operator for various employers over approximately thirty years, most recently for CDR from November, 2011, through February 7, 2012. Before that, he worked for Ikerd Bandy from 2001 until November, 2011.

In his June 20, 2012, deposition, Hale explained that he stopped working for Ikerd because CDR bought it out, then CDR ceased operation. Hale testified that he worked for CDR at Redbird Mine in Clay County. He operated a dozer removing spoil off the top of the coal. The dozer had an air seat which, according to Hale, "was broke." On February 7, 2012, the job at Redbird ended and Hale was laid off.

At the September 6, 2012, BRC, the parties stipulated that "[Hale] sustained work-related injury(ies) on 2-7-12 (alleged)." The BRC Memorandum and Order lists the contested issues as: "Extent/duration; Notice & occurrence/causation; exclusion of any active or non-work related conditions; credit for any unemployment benefits[;] whether plaintiff sustained an injury, TTD & meds, multipliers[.]" The date of manifestation was not listed as a contested issue.

At the December 12, 2012, hearing, Hale testified that, over the past thirty years, his jobs included running a dozer, an excavator and a loader. He stated the dozer was the most physically demanding. At CDR, Hale worked on rough terrain with a lot of jarring and bouncing. He "mostly broke down the shot after the-the dynamite was put off .... Most of the time it leaves pretty big boulders...." Hale had to "push them out of the way ... so the smaller material, the loader can get to...." Hale worked every day that he was employed by CDR until the job ended. He testified that Dr. Madden was the first person who told him that he had a work-related problem caused by years of operating heavy equipment.

On December 17, 2012, the ALJ rendered an Opinion and Order which recites that the parties had stipulated an ("alleged") injury date of February 7, 2012.² The ALJ found

¹ Hale subsequently amended his cumulative trauma claim to include injuries to his knees, right foot and white-knuckle syndrome/chronic vibration injury.

² The ALJ's Opinion also lists the contested issues which are the same as contained in the BRC Memorandum and Order. The date of manifestation was not a contested issue.
Hale credible and convincing, determined that notice was timely under KRS 342.185, and concluded that Hale was permanently and totally disabled:

Based upon the totality of the evidence, including the plaintiff's sworn testimony and the medical reports and deposition of Dr. Madden, which I found to be very persuasive, I make the factual determination that Mr. Hale sustained cumulative trauma to his neck and back and also to both upper extremities and his left lower extremity and his right lower extremity as a result of working for a long period of time in the operation of heavy machinery and in the mines. I make the factual determination that there is sufficient reliable probative evidence in the record to support the finding that Mr. Hale's permanent impairment and occupational disability occurred during his lifetime of employment in the operation of heavy equipment and in the coal mines, and that his painful conditions manifested themselves on or about February 7, 2012, when he was employed by CDR Operations, Inc.

This case is like unto [sic] Southern Kentucky Concrete Contractors, Inc. v. Campbell, 662 S.W.2d 221 (Ky. App. 1983). Mr. Campbell was employed by Southern Kentucky at the time his back pain manifested itself. Mr. Campbell had worked for many years, doing heavy labor, primarily as a concrete worker for a number of companies. The [old] Workers' Compensation Board found that there was sufficient reliable probative evidence in the record to show that Mr. Campbell suffered a permanent total occupational disability that occurred over his lifetime of employment as a manual laborer and that this condition manifested itself while he was employed by Southern Kentucky Concrete.

The ALJ was not persuaded that Hale had any prior active disability, citing Roberts Brothers Coal Company v. Robinson, 113 S.W.3d 181 (Ky. 2001). The ALJ explained that although Hale "had previous injuries and painful spinal symptoms," he was working without any restrictions while he was employed by CDR.

Roberts Bros. explains that when enacting the 1996 amendments, the legislature used different standards for awarding benefits for permanent total disability ("PTD") under KRS 342.730(1)(a) and for permanent partial disability ("PPD") under KRS 342.730(1)(b). PTD awards are based upon a finding of disability, and some of the Osborne v. Johnson, 432 S.W.2d 800 (Ky. 1968), factors are still relevant to that determination. By contrast, PPD awards are based upon a finding that the injury resulted in an impairment rating under the AMA Guides, and the PPD benefit amount is determined by statute.

Impairment and disability are not synonymous. We conclude, therefore, that an exclusion from a [PTD] award must be based upon pre-existing [occupational] disability, while an exclusion from a [PPD] award must be based upon pre-existing impairment [under the AMA Guides]. For that reason, if an individual is working without restrictions at the time a work-related injury is sustained, a finding of pre-existing [AMA] impairment does not compel a finding of pre-existing disability with regard to an award that is made that is made under KRS 342.730(1)(a) [for PTD].

Id. at 183.
The ALJ awarded PTD benefits against CDR and/or its workers' compensation insurer beginning on February 7, 2012, continuing for the duration of Hale's disability pursuant to KRS 342.730(4).4

Both parties sought reconsideration. Hale raised an error in the amount of the weekly benefit rate. CDR contended that the "overwhelming medical testimony would indicate no objective harmful change in the human organism as a consequence of [Hale's] brief three-month employment by CDR." By Opinion and Order on Reconsideration rendered January 14, 2013, the ALJ granted Hale's petition and denied CDR's.

On January 31, 2013, CDR filed Notice of Appeal to the Board. The sole issue CDR raised on appeal was that the evidence failed to support a cumulative trauma injury during Hale's employment at CDR. By Opinion rendered May 17, 2013, the Board noted that the ALJ's determination was "certainly consistent" with Dr. Madden's opinion, but vacated and remanded on other grounds:

The record reveals February 7, 2012, is the date Hale was laid off from work for reasons unrelated to his alleged injury. This does not comprise a date of manifestation. Therefore, the ALJ's determination Hale sustained a cumulative trauma injury which manifested on February 7, 2012, and the award of PTD benefits must be vacated. On remand, the ALJ must determine the date of manifestation of Hale's alleged cumulative trauma injury....

The ALJ also erred in another critical respect. While in claims for hearing loss, KRS 342.7305 causes liability to fall on the last employer, this is not the case with non-hearing loss cumulative trauma claims.

In Southern Kentucky Concrete Contractors, Inc. v. Horace W. Campbell, 662 S.W.2d 221, 222 (Ky. App. 1983), a case misinterpreted by the ALJ, . . . the claimant's preexisting condition was found to be attributable to "his hard manual labor" with multiple employers over the years of his work life....

In Southern Kentucky Concrete, supra, the fact-finder determined "Campbell suffered a permanent, total, occupational disability that occurred during his lifetime of employment as a manual laborer." Similarly, in the case sub judice, the ALJ determined "Mr. Hale's permanent impairment and occupational disability occurred during his lifetime of employment in the operation of heavy equipment and in the coal mines." (emphasis added). This is certainly consistent with the medical opinions of Dr. Madden upon which the ALJ relied....

We acknowledge the ALJ determined Hale "did not have any prior active disability due to other accidents, injuries or conditions." However, this

4 KRS 342.730(4) provides in relevant part: "All income benefits payable pursuant to this chapter shall terminate as of the date upon which the employee qualifies for normal old-age Social Security retirement benefits ... or two (2) years after the employee's injury or last exposure, whichever last occurs." Hale was sixty-three years old at the time of the alleged injury.
finding clearly does not establish a dormant condition was aroused into disabling reality during Hale's brief employment at CDR. In fact, by finding Hale sustained cumulative trauma over his thirty year history of operating heavy machinery in the mines, the ALJ, by implication specifically rejected the premise Hale's work at CDR resulted in an arousal of a previously dormant non-disabling condition into disability reality. The ALJ is left, then, with analyzing this as a cumulative trauma claim with multiple employers, and Southern Kentucky Concrete, supra, is determinative. As required by Southern Kentucky Concrete, supra, the ALJ must determine what percentage of Hale's impairment, if any, is directly attributable to Hale's three months at CDR. . . . Simply because Hale was last employed by CDR does not place the entirety of the liability for Hale's alleged permanent and total occupational disability on CDR. There must be evidence of record establishing that Hale's work activities performed during his three months employment with CDR contributed to his overall permanent condition, producing some degree of harmful change to the human organism.

The language in Southern Kentucky Concrete, supra, regarding responsibility of the Special Fund is obviously no longer relevant.

Both parties appealed to the Court of Appeals. CDR argued that the ALJ and the Board erred in failing to dismiss Hale's claim, because the medical evidence failed to establish that Hale had sustained a cumulative trauma injury. Specifically, CDR maintained that Dr. Madden could not point to any objective medical findings attributable to the three-month period Hale worked at CDR. Hale argued that the Board substituted its judgment for that of the ALJ and erred in vacating and remanding the ALJ's decision, because the ALJ correctly applied the law to the evidence he found more credible.

By Opinion rendered January 31, 2014, the Court of Appeals affirmed:

[T]he Board reversed entirely appropriately on the grounds that the ALJ had applied the wrong legal standard to the facts: firstly, by choosing as the date of manifestation the day that Hale was laid off, . . . and secondly, by assessing all liability. . . to CDR, rather than apportioning what percentage of [Hale's] injury, if any, was attributable to his three months of employment there. The Board's reasoning was correct as a matter of law under Southern Kentucky Concrete Contractor's Inc. v. Campbell, 622 S.W.2d 221, 222-23 (Ky. App. 1983), which stands for the proposition that liability should be apportioned to the employer based upon the percentage of disability attributable to the work performed by the employee while in the employ of that company.

The Court of Appeals concluded that Dr. Madden's opinion was sufficient "to support the ALJ's finding that Hale had sustained a cumulative work injury. As to determining the portion that can be attributed to his employment with CDR, the Board left open the

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5 Hale subsequently filed a Motion to Consolidate. By Order of August 8, 2013, the motion was granted to the extent that the appeals were assigned to the same panel for consideration on the merits.
possibility that none of Hale's impairment is directly attributable to his employment at CDR."

Hale appeals and contends that Southern Kentucky Concrete is inapplicable. CDR cross-appeals and contends that the evidence failed to establish that Hale sustained a cumulative trauma injury during his three-month employment there.

II. ANALYSIS

A. Apportionment

In Southern Kentucky Concrete, the claimant, a concrete worker, worked for Southern from July, 1978, through November 17, 1979. Before that, he had worked approximately twenty-four years primarily as a concrete worker for other employers. The old Board found that Campbell suffered a permanent, total, occupational disability which occurred during his lifetime of employment as a manual laborer, and that this condition manifested itself in April of 1979. On appeal, the Court held that apportionment of liability was governed by Haycraft v. Corhart Refractories Co., 544 S.W.2d 222 (Ky. 1976) and that "Southern shall be liable for that percentage of [the claimant's] disability which is equal to the percentage of [his] worklife spent with Southern. The remainder of his disability is the responsibility of the Special Fund." Southern Kentucky Concrete at 222-23.

In Haycraft, the Court had to determine "what was meant by the 1972 legislative definition of the word, 'injury,' [in] KRS 342.620(1)." Id. at 223. The statute provided that "'[i]njury' means any work related harmful change in the human organism . . . but does not include any communicable disease unless the risk of contracting such disease is increased by the nature of the employment. 'Injury' when used generally . . . shall include an occupational disease." Id. at 224. Previously, "compensation coverage [had been limited] to disabilities 'resulting from traumatic personal injury sustained . . . by accident' or from occupational diseases." Id. Haycraft explained that when the Legislature enacted KRS 342.620(1)," it also amended the apportionment statute, KRS 342.120.

Before the 1972 amendment, KRS 342.120(1)(b) provided that liability would be apportioned between the employer and the Special Fund, if a dormant, nondisabling "disease condition" was aggravated or aroused by a work-related injury. Id. If the pre-existing condition was not a "disease," the Special Fund was not liable.

For example, in Young v. City Bus Co., 450 S.W.2d 510 (Ky. 1969), a nondisabling, pre-existing degenerative disc in itself was not considered to be a "disease condition" for which the Special Fund was liable under the pre-1972 version of KRS 342.120(1)(b). The Court concluded that "the employer should bear the risk in such situations. . . . [T]he statutory intent is clear that the employer may pass off part of the risk to the Special Fund only. . . where the nondisabling, dormant, pre-existing condition is caused by disease." Id. at 515.

In Central Uniform Rentals v. Richburg, 468 S.W.2d 268, 272 (Ky. 1971), the Court explained that:

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1 Editor's note: KRS 342.620(1) was renumbered KRS 342.0011, effective 1987.
It was stated in City Bus [sic] that a dormant, non-disabling, preexisting degenerative disc in itself is not a disease for which the Special Fund is liable under KRS 342.120. The effect of that conclusion was not that the employee shall go uncompensated with respect to the disability caused by arousal of such a condition. Rather, it was noted that the employer shall be liable under the theory that industry takes the worker as it finds him.

In 1972, the Legislature amended the language in KRS 342.120(1)(b) from "disease condition," to "disease or condition," thus shifting liability to the Special Fund for the portion of disability attributable to a pre-existing, nondisabling condition. Haycraft, at 224-25.

[But] unless the disability was precipitated or 'aroused' by some identifiable or noticeable incident that occurred on the job, . . . it simply was not compensable, because it was held to have resulted from a normal degenerative process rather than the work. We think now, however, especially in view of the 1972 legislation . . . [t]hat this view is unrealistic and unnecessarily restrictive.

[Just as constant exposure to the dust and dampness of underground coal mining is certain to increase the risk of emphysema and chronic bronchitis, so are the rigors of strenuous manual labor bound to hasten toward its breaking point the debilitating process of a degenerative spinal disc. We are therefore [sic] of the opinion that if it be found, or should be found, that the nature and duration of the work probably aggravated a degenerative disc condition to the degree that it culminated in an active physical impairment sooner than would have been the case had the work been less strenuous, to that extent the pre-existing condition is itself an injury as now defined in KRS 342.620(1) . . .]

To the extent that the claimant was actively disabled prior to [the date of injury], under KRS 342.120 he cannot be compensated. For the remainder of his disability attributable to the present condition of his back he is entitled to compensation to be divided between the employer and the Special Fund, the employer's portion to be assigned not on the basis of how much of it would have occurred in the absence of the degenerative disc condition, but on the basis of how much the work has contributed to it.

Id. at 225, 228 (footnote omitted) (emphasis added).

The Legislature has amended KRS Chapter 342 many times since Haycraft and Southern Kentucky Concrete were decided. Effective October 26, 1987, KRS 342.1202 was enacted, mandating 50-50 apportionment of liability between the employer and the Special Fund in back and heart claims.6 Com., Cent. State Hosp. v. Gray, 880 S.W.2d 557, 558-59 (Ky. 1994) explained that:

An award for income benefits for total or partial disability under this chapter

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6 As enacted in 1987, KRS 342.1202 provided:
The 1987 Special Session was, in part, an attempt to deal with the escalating and unfunded liability of the Special Fund. At that time KRS 342.1202 was enacted in an apparent response to judicial decisions which had shifted liability from the employer to the Special Fund, particularly in cumulative trauma and gradual injury cases as well as in heart attack cases. Haycraft v. Corhart Refractories, Ky., 544 S.W.2d 222 (1976); Wells v. Boyd, Ky. App., 715 S.W.2d 906 (1986); Southern Kentucky Concrete Contractors, Inc. v. Campbell, Ky. App., 662 S.W.2d 221 (1983); O.K. Precision Tool & Die Co. v. Wells, Ky., 678 S.W.2d 397 (1984); Wells v. Bailey, Ky. App., 698 S.W.2d 841 (1985); Stovall v. Dal-Camp, Inc., Ky. App., 669 S.W.2d 531 (1984).

Effective April 4, 1994, KRS 342.1202(2) was enacted, limiting the Special Fund's liability in all other injury claims. The statute provided that:

The special fund's liability for income benefits for all other injury claims shall not exceed fifty percent (50%) of the income benefits awarded for permanent disability. In those injury claims where the administrative law judge determines that the apportionment to the special fund under KRS 342.120 exceeds fifty percent (50%) of the award of permanent disability, that portion of the award exceeding fifty percent (50%) shall be paid by the employer.

Effective December 12, 1996, KRS 342.1202 was repealed and the Special Fund's liability was abolished. KRS 342.120(2) provides that "[t]he special fund shall have no liability upon any claim in which the injury occurred, or for cumulative trauma, the disability became manifest, or, for occupational disease, if the date of injury or last exposure occurred, after December 12, 1996." At the same time, the Legislature amended KRS 342.0011(1) to specifically include the words, "cumulative trauma," in the definition of a compensable injury.

"Injury" means any work-related traumatic event or series of traumatic events, including cumulative trauma, arising out of and in the course of employment which is the proximate cause producing a harmful change in the human organism evidenced by objective medical findings. "Injury"

In 1990, the statute was amended and the word "permanent" was inserted before the words "total or partial disability." Com., Cent. State Hosp. v. Gray, 880 S.W.2d 557, 558 (Ky. 1994).

7 In Shoney's of London/Corbin v. Swafford, 96-CA-2925 WC (Ky. App. Aug. 8, 1997), the claimant alleged carpal tunnel syndrome due to cumulative trauma, caused at least in part by her work at Shoney's. The ALJ found the claimant to be totally occupationally disabled and apportioned liability 60 percent to the Special Fund and 40 percent to the employer under Southern Kentucky Concrete. On appeal, the Court held that KRS 342.1202(2) controlled and mandated 50-50 apportionment, because the date of manifestation occurred after the statute's effective date.
does not include the effects of the natural aging process, and does not include any communicable disease unless the risk of contracting the disease is increased by the nature of the employment. "Injury" when used generally, unless the context indicates otherwise, shall include an occupational disease and damage to a prosthetic appliance, but shall not include a psychological, psychiatric; or stress-related change in the human organism, unless it is a direct result of a physical injury.

However, KRS 342.610(1) was not amended. It provides that "[e]very employer subject to this chapter shall be liable for compensation for injury . . . ."

"[T]he law in effect on the date of injury or last injurious exposure is deemed to control. . . . an employer's obligations with regard to any claim arising out of and in the course of the employment." Magic Coal Co. v. Fox, 19 S.W.3d 88, 93 (Ky. 2000). Here, the Board held that "the ALJ is left, then, with analyzing this as a cumulative trauma claim with multiple employers, and Southern Kentucky Concrete . . . is determinative." The Court of Appeals explained that Southern Kentucky Concrete stands "for the proposition that liability should be apportioned to the employer based upon the percentage of disability attributable to the work performed by the employee while in the employ of that company." But, a different version of KRS Chapter 342 was in effect when Southern Kentucky Concrete was decided. To hold that Southern Kentucky Concrete governs apportionment under the current statutory scheme is like applying the proverbial apples to oranges, and confuses liability with compensability.

Land v. Burden, 626 S.W.2d 221, 222 (Ky. App. 1981) is illustrative. There, the old Board found the claimant to be permanently and totally disabled. Ten percent of his disability was pre-existing active and non-compensable. The remaining 90 percent compensable disability was found to have resulted entirely from the arousal of a preexisting dormant condition and liability was assessed against the Special Fund.

The Special Fund then contends that since the injury resulted in no liability for payment of compensation by [the] employer, it was therefore not a "subsequent compensable injury" within the meaning of the [then KRS 342.120], and, as a consequence, the Fund can have no liability for compensation. This contention confuses the statutory concept of "compensable injury" with the statutory provisions for who is liable to pay compensation. KRS 342.620(1) defines "injury" to be "any work related harmful change in the human organism." KRS 342.610(1) provides that every employer subject to the Workers' Compensation Act "shall be liable for compensation for injury." These statutes plainly make a work-related harmful change in the human organism a compensable injury with the employer liable for payment of any compensation due. KRS 342.120, on the other hand, shifts the liability for payment of the compensation. It does not render an otherwise compensable injury noncompensable.

Id. at 222 (citation omitted).

Since the 1996 amendments, what was once the Special Fund's liability has shifted back to the employer. "[T]he legislature's decision to abolish Special Fund apportionment with regard to traumatic injury claims had no effect on the longstanding principle that a harmful change to a worker's body that is caused by work is an "injury" for the purposes

Resurrecting the apportionment scheme of Southern Kentucky Concrete would in essence create a "lesser" class of claimants. In hearing loss and occupational disease claims – which are quite similar in nature to cumulative trauma because they occur gradually over time – the employer at the time of the last injurious or hazardous exposure is liable.9 The employee is entitled to the same amount of compensation whether he worked for one employer or many. An employee who sustains a harmful change in his human organism due to cumulative trauma over many years working for the same employer is entitled to compensation to the full extent of his resultant disability. But, someone like Hale would not be fully compensated, simply because he worked for multiple employers. We can discern no basis for such a distinction.

"Although both the employee and the employer have rights under the [Workers' Compensation] Act, the primary purpose of the law is to aid injured. . . workers." Zurich American Ins. Co. v. Brierly, 936 S.W.2d 561, 563 (Ky. 1996). Nothing in KRS Chapter 342 limits the liability of the employer, in whose employ the date of manifestation occurred, to the percentage of the claimant's work-life spent there. Kentucky Southern Concrete has no application under the current statutory scheme.

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8 We also note the Board's Opinion in Danny Coleman v. Teco, Claim No. 05- 01356, rendered August 11, 2006, where it reversed the ALJ's apportionment of liability in a cumulative trauma case. There, the claimant had worked in the mines for thirty-six years, but only one and one-half years for Teco. Dr. Templin and Dr. Potter both attributed the cumulative trauma they diagnosed to the claimant's overall work history. On reconsideration, the ALJ determined that Teco was only liable for four percent of the compensation awarded, based upon the length of time the claimant had worked there. The Board reversed and explained that Teco was responsible for the entire award. Although the Special Fund previously shared liability with the last employer where the apportionment provisions of KRS 342.120 were properly implicated, "[s]ince the 1996 amendments to the Act, in cases involving cumulative trauma, what was once the liability of the Special Fund now falls to the employer...."

9 KRS 342.7305(4) provides that "the employer with whom the employee was last injuriously exposed to hazardous noise shall be exclusively liable for benefits."

KRS 342.316(1)(a) provides that "[t]he employer liable for compensation for occupational disease shall be the employer in whose employment the employee was last exposed to the hazard of the occupational disease."
B. Date of Manifestation

In cumulative trauma cases, a rule of discovery applies for establishing the date of injury.

In Alcan Foil Products v. Huff, [2 S.W.3d 96 (Ky. 1999)] . . . [w]e determined that the obligation to give notice and the period of limitations for a gradual injury are triggered by a worker's knowledge of the harmful change and its cause rather than by the specific incidents of trauma that caused it. . . .

The principles that Alcan addressed were refined in a number of subsequent cases, including Hill v. Sextet Mining Corp., [65 S.W.3d 503 (Ky. 2001)], in which we determined that a worker is not required to self-diagnose the cause of a harmful change as being a work-related gradual injury for the purpose of giving notice.

[N]othing prohibits a worker who thinks she has sustained a work-related gradual injury from reporting it to her employer before the law requires her to do so, and nothing prevents her from reporting an injury that she thinks is work-related before a physician confirms her suspicion.


The date of manifestation was not raised as an issue on appeal to the Board. Nevertheless, the Board determined that February 7, 2012, "does not comprise a date of manifestation. Therefore, the ALJ's determination Hale sustained a cumulative trauma injury which manifested on February 7, 2012, and the award of PTD benefits must be vacated." The Board instructed the ALJ to determine the date of manifestation on remand. The Court of Appeals affirmed.

The date of manifestation was never at issue before the ALJ. It was stipulated. The signed BRC Memorandum and Order reflects that the parties stipulated that "[Hale] sustained work-related injury(ies) on 2-7-12 (alleged)." Neither party sought relief from the stipulation. 10 Although "causation" was listed as a contested issue, the parties did not include the date of manifestation among the contested issues in the signed BRC Memorandum and Order. 11

10 803 KAR 25:010 Section 16(2) provides: "Upon cause shown, a party may be relieved of a stipulation if the motion for relief is filed at least ten (10) days prior to the date of the hearing, or as soon as practicable after discovery that the stipulation was erroneous."

11 803 KAR 25:010 Section 13 provides in relevant part:

(13) If at the conclusion of the [BRC] the parties have not reached agreement on all the issues, the [AW] shall:

(a) Prepare a summary stipulation of all contested and uncontested issues which shall be signed by representatives of the parties and by the [ALJ]; . . .

(14) Only contested issues shall be the subject of further proceedings.
In *Stewart v. Unifirst Corp.*, No. 2006-SC-0396-WC, 2007 WL 542143, at *5 (Ky. Feb. 22, 2007), the parties had stipulated that the "plaintiff alleges a work related injury on January 10, 2002." But, payroll records showed that the plaintiff's last day of work was January 8, 2002. This Court explained that:

Under the regulations, agreements contained in a signed BRC memorandum are the equivalent of a contract from which a party may not be released without a showing of cause.

The parties stipulated that, "The plaintiff allegedly suffered a work related injury on January 10, 2002." . . . [Work-relatedness was] contested, but [the parties] did not include the alleged date of injury among the contested issues. Therefore, the legal effect of the stipulation was to establish the date of the alleged work-related injury. Because neither party moved to be released from the stipulation, they were bound by it. It relieved the claimant of the burden to prove the actual date of her injury and enabled the employer to base its defense on the agreed-upon date. Although the ALJ was free to judge the credibility of witnesses and to weigh conflicting evidence, the ALJ was not free to disregard the date to which they agreed.

Here, the ALJ properly found that the date of manifestation was February 7, 2012, because he was bound by the parties' stipulation. *Lappinen v. Union Ore Co.*, 29 N.W.2d 8, 17 (Minn. 1947) ("As long as a stipulation remains in effect it is binding not only on the parties, but on both the trial and appellate court."); *Federal Deposit Ins. Corp. v. St. Paul Fire & Marine Ins. Co.*, 942 F.2d 1032, 1038 (6th Cir. 1991) ("Stipulations voluntarily entered by the parties are binding, both on the district court and on us."); *Double M Const., Inc. v. State Corp. Com'n*, 202 P.3d 7, 10 (Kan. 2009) ("Parties are bound to their stipulations, however, and a trial court or appellate court must render judgment based on those stipulated facts."); *Bruggner v. Shaffer*, 210 N.E.2d 439, 441 (Ind. App. 1965) ("[F]acts which are stipulated . . . not having been set aside or withdrawn are conclusive upon the parties and the tribunal. . . . While the specific question of the stipulated facts was not raised in appellant's briefs, this court . . . is not so restricted that it must close its eyes to what is clearly before it.").

On appeal to the Court of Appeals, Hale argued that the Board impermissibly substituted its judgment for the ALJ's, but neither Hale, nor CDR, specifically raised the issue of the stipulation or the fact that the date of manifestation was not a contested issue before the ALJ. In the case at bar, Hale only broaches the issue in his combined Reply Brief and Response.

Ordinarily, this Court confines itself rather closely to deciding only those issues which the parties present. We take the view that counsel and the courts below have sufficiently identified the issues; that we need not redefine the question in the last stage of the litigation. However, we are constrained by no rule of court or constitutional provision to observe this procedure, and on rare occasions, the facts mandate a departure from the normal practice. When the facts reveal a fundamental basis for decision not presented by the parties, it is our duty to address the issue to avoid a misleading application of the law.

Although the Board held that the ALJ's determination as to the date of manifestation must be vacated, the Board has no authority to set aside a valid stipulation of fact, *sua sponte.* Even if the ALJ's decision were vacated, the stipulation contained in the September 6, 2012, BRC Memorandum and Order remains in effect and is binding. The date of manifestation is February 7, 2012, as stipulated.

C. Sufficiency of the Evidence to Establish a Cumulative Trauma Injury

CDR cross-appeals and contends that the evidence failed to establish that Hale sustained a cumulative trauma injury during his three-month employment there. The standard of review on appeal is whether the ALJ's decision is supported by substantial evidence. *Wolf Creek Collieres v. Crum,* 673 S.W.2d 735, 736 (Ky. App. 1984). The Board stated that the ALJ's determination was "certainly consistent" with Dr. Madden's opinion. The Court of Appeals concluded that there was sufficient evidence in the form of Dr. Madden's evidence to support the ALJ's finding that Hale had sustained a cumulative work injury. We agree.

Dr. Madden evaluated Hale on May 17, 2012. His Form 107 report reflects that Hale had worked for more than thirty years operating heavy machinery. Chief complaints included low back pain and neck/upper back pain, both with bilateral radiculopathy. Dr. Madden noted that Hale’s past medical history was significant for two injuries due to MVAs – a lumbar compression fracture in 2008 with subsequent kyphoplasty and a cervical fracture in the late 1980s. Dr. Madden reviewed medical records from Hale’s primary care provider from 2004-2010 which suggest "a gradual progression of increasing neck and back problems due to chronic degenerative changes...." He also reviewed the report of a 2008 lumbar MRI which revealed lumbar degenerative disc disease, post traumatic changes with kyphoplasty due to L1 compression fracture, and the report of a 2010 CT scan of the head which was negative.

Dr. Madden's report details the findings of his physical exam. He opined that within

\[12 \text{KRS 342.285 provides in relevant part:} \]

(2) The board shall not substitute its judgment for that of the administrative law judge as to the weight of evidence on questions of fact, its review being limited to determining whether or not:

(a) The administrative law judge acted without or in excess of his powers;

(b) The order, decision, or award was procured by fraud;

(c) The order, decision, or award is not in conformity to the provisions of this chapter;

(d) The order, decision, or award is clearly erroneous on the basis of the reliable, probative, and material evidence contained in the whole record; or

(e) The order, decision, or award is arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

\[13 \text{Dr. Madden's findings included positive straight leg raising bilaterally at twenty-five degrees} \]
reasonable medical probability the plaintiff's injury was the cause of his complaints, and stated that the "patient is suffering from cumulative workplace trauma[.]" Dr. Madden explained that Hale "suffered cumulative workplace trauma over the course of many years, resulting in a cervical and lumbar disc disorder with radiculopathy that is consistent with the abnormal findings on exam." Dr. Madden noted that Hale has problems with activities of daily living due to his knee pain and restricted range of motion, and that his chronic osteoarthritic degenerative changes were certainly exacerbated by the cumulative, repetitive pedal motion driving a bulldozer. In his Form 107 report, Dr. Madden opined that Hale did not have any prior active impairment. He did not believe that Hale could return to heavy machine operation/bulldozing as a means of regular employment and felt that Hale would require permanent light-duty restrictions. \(^{14}\)

In his deposition, Dr. Madden was asked if he could determine, within reasonable medical probability, whether the three-month period Hale operated a bulldozer at CDR would have contributed to his condition. Dr. Madden explained that he considered operating a bulldozer to be fairly significant trauma, noting that his father-in-law worked excavators and bulldozers. Dr. Madden testified that even three months, "[e]ven a short period of time -- again, that straw that broke the camel's back scenario . . . . So yes, that could have occurred during that three month period."

CDR discusses Dr. Madden's deposition testimony regarding Hale's prior injuries and treatment; however, CDR did not appeal the ALJ's determination that Hale had no prior active disability. \(^{15}\) CDR emphasizes that Dr. Madden did not review any diagnostic studies performed after Hale started working there. Neither did Dr. Primm, to whom CDR sent Hale for an IME, or Dr. Snider, who performed a records review for CDR. It is not apparent of record that any diagnostic studies were performed after Hale started working at CDR. It matters not.

KRS 342.0011(1), defining injury, requires "a harmful change in the human organism [to be] evidenced by objective medical findings." KRS 342.0011(33) defines objective medical findings as "information gained through direct observation and testing of the patient applying objective or standardized methods[.]

confirmed in the seated position, tenderness to palpation of the spinal musculature, chronic tissue texture changes, muscle guarding in the thoracolumbar junction and upper thoracics, consistent with reported trauma. There was asymmetrical and/or decreased range of motion in the lumbar and cervical spine, positive Spurling's test bilaterally, right worse than left, and left knee medial joint pain to palpation with crepitus noted, decreased passive flexion and tibial external rotation left.

\(^{14}\) In his amended Form 107 report, Dr. Madden assigned a whole person combined impairment rating of 30 percent 5th Ed. AMA Guides, comprised of DRE Lumbar category III – 11 percent, DRE Cervical Category III – 15 percent and knee impairment – 8 percent.

\(^{15}\) Parker Transfer v. Riley, No. 2004-SC-0822-WC, 2005 WL 2045490, at *2 (Ky. Aug. 25, 2005), explains, in its discussion of Robert Bros., that a "properly-supported finding that no active disability existed at the time of the injury would preclude a finding that pre-existing impairment accounted for a pre-existing disability and would imply a finding that work-related impairment, by itself, was totally disabling." Here, the ALJ found that there was no active disability, because Hale was working without restrictions, despite his previous injuries and painful spinal symptoms, during the time he was employed by CDR.
In Gibbs v. Premier Scale Co./Indiana Scale Co., 50 S.W.3d 754, 762 (Ky. 2001), this Court explained:

[We are not persuaded that] a harmful change must be, or is capable of being, documented by means of sophisticated diagnostic tools such as the x-ray, CAT scan, EEG, or MRI in order to be compensable. . . . Likewise, we are not persuaded that a harmful change must be both directly observed and apparent on testing in order to be compensable as an injury.

We know of no reason why the existence of a harmful change could not be established, indirectly, through information gained by direct observation and/or testing applying objective or standardized methods that demonstrated the existence of symptoms of such a change. Furthermore, we know of no reason why a diagnosis which was derived from symptoms that were confirmed by direct objective and/or testing applying objective standardized methods would not comply with the requirements of KRS 342.0011(1).

The requirement of "objective medical findings" only applies to the harmful change, not to causation. "Although KRS 342.0011(1) clearly requires that there be objective medical findings of a harmful change in the human organism in order for that change to be compensable, we are not persuaded that KRS 342.0011(1) requires causation to be proved by objective medical findings." Staples, Inc. v. Konvelski, 56 S.W.3d 412, 415-16 (Ky. 2001).

The ALJ 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 Disc. Stores, 560 S.W.2d 15, 16 (Ky. 1977). We agree with the Court of Appeals that Dr. Madden's opinion provides a sufficient evidentiary foundation to support the ALJ's decision.

III. CONCLUSION

Accordingly, the decision of the Court of Appeals is affirmed in part and reversed in part, and the decision of the ALJ is reinstated.

All sitting. Cunningham, Keller, Noble, and Venters, JJ., concur.

Minton, C.J., concurs in result only by separate opinion in which Abramson, J., joins.

MINTON, C.J., CONCURRING IN RESULT ONLY: I concur in today's result; but I believe the majority opinion mischaracterizes February 7, 2012, as the "stipulated date" that Hale's injury manifested. A close look at the record renders this assertion ambiguous at best, and that – coupled with the fact that this rather significant finding has eluded the keen eye of administrative and judicial reviewers at every level – causes me to reject the majority's finding on that point. But because I am not persuaded that using Hale's lay-off date as the date of manifestation (and, thus, the date of discovery) would change the outcome of this case, this is a harmless mistake.
Ultimately, I think there is enough in the ALJ's opinion to qualify for deference under the substantial-evidence standard of review. Dr. Madden testified that three decades of jolting labor as a bulldozer operator gave rise to the cumulative trauma that resulted in Hale’s disability. CDR employed Hale to continue his job as a bulldozer operator – the same work activity that Dr. Madden felt caused Hale’s cumulative-trauma injury. Although evidence in this record establishing proximate causation certainly is not extensive, there is just enough to find that the ALJ's conclusion linking CDR to Hale's claim was supported by substantial evidence.

As for the issue of apportioning CDR's liability for Hale's injury, I am troubled with the result. But the majority appropriately framed the current state of our law. In light of the dissolution of the Special Fund, we can no longer give effect to Southern Kentucky Concrete and its rule of apportionment. And although I am concerned that an employer of three months may foot the bill for thirty years of gradual trauma, this Court is left with no choice under the current workers' compensation law. I am also doubtful that this is the result that the General Assembly intended with the workers' compensation statutory scheme; but until the text is modified, I have no alternative other than to concur in today's result.

Abramson, J., joins.

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Toyota Motor Manufacturing, Kentucky, Inc., appeals from an opinion of the Court of Appeals which affirmed the decisions of the Workers’ Compensation Board (Board) and the Administrative Law Judge (ALJ) holding that the claimant, Kathy Prichard, was entitled to reopen her workplace injury claim almost seven years after her initial award of workers’ compensation benefits, but within four years of a subsequent order granting her additional disability benefits. As grounds for relief Toyota contends that (1) Prichard’s motion to reopen was barred by the four-year limitation period contained in KRS 342.125(3); and (2) Prichard failed to demonstrate through objective medical evidence a change in her disability indicating a worsening of her impairment as required for reopening a claim under KRS 342.125(1)(d).

For the reasons stated below we affirm the opinion of the Court of Appeals.

I. FACTUAL AND PROCEDURAL BACKGROUND

On March 14, 2007, Prichard filed a claim with the Department of Workers’ Claims contending that, on March 16, 2005, she had sustained an injury to her neck while working as an assembly line employee at Toyota’s Georgetown factory. As a result of her injury, Prichard was diagnosed with a cervical strain and degenerative disc disease in her neck area. On November 13, 2007, the ALJ approved an award of permanent
partial disability benefits based upon a permanent impairment rating of eight percent. Prichard returned to work but left after a few months due to continuing pain resulting from the original injury. In an effort to alleviate Prichard's problem, in August, 2008, Dr. James Bean performed surgery to fuse four of Prichard's cervical vertebrae.

In April, 2009, well within the four-year limitation period, Prichard filed a motion to reopen her 2007 award on the basis that her injury and the resulting impairment had worsened. In September, 2011, the ALJ determined that Prichard was not totally disabled, but that her permanent partial disability rating had increased from eight percent to twenty-eight percent, based upon testimony indicating that Prichard could still perform sedentary work and that she suffered from non-work-related conditions.

Prichard continued to suffer pain, headaches, and impairment attributed to her initial work-place injury. After further evaluation, Dr. Bean concluded in April 2014 that Prichard's condition had further deteriorated in that she had "an essentially immobile neck that would be unable to sustain routine neck movements in an employed position for a full day's work." Dr. Bean concluded that Prichard was unable to return to even sedentary work. Dr. Bean imposed additional restrictions on Prichard's physical movements as a result of his revised medical conclusions.

On August 12, 2014, based upon Dr. Bean's latest evaluation, Prichard moved to reopen the 2011 award. At the hearing, Prichard testified that the pain in her neck had increased and her cervical range of motion had decreased since her first award. She stated that she had last worked in 2008.

In addition to Prichard's testimony and the record of her extensive medical history, the ALJ considered evidence from Dr. Bean, from Prichard's primary care physician since 1999, Dr. William Childers, and from Toyota's expert medical witness, Dr. Timir Banerjee. Dr. Childers largely concurred with Dr. Bean's determination that Prichard was unable to perform even sedentary work because of her chronic pain and her need for strong pain-relieving medications. In opposition to Prichard's motion, Dr. Banerjee concluded that Prichard's condition had remained unchanged with an impairment rating of eight percent since he first examined her in 2009.

On May 20, 2015, the ALJ entered an opinion and award, concluding that as a result of the further deterioration of Prichard's work-related cervical condition, she was totally disabled. The ALJ based his decision, in part, upon what he described as the "persuasive, compelling and reliable" medical evidence. The Board and the Court of Appeals subsequently affirmed the ALJ's decision. This appeal followed.

II. STANDARD OF REVIEW

"An award or order of the administrative law judge . . . shall be conclusive and binding as to all questions of fact . . .:"

KRS 342.285(1). Accordingly, as the statutorily assigned fact-finder in this proceeding, the ALJ has the sole authority to determine the quality, character, and substance of the evidence. Square D Co. v. Tipton, 862 S.W.2d 308, 309 (Ky. 1993) (citation omitted). Similarly, the ALJ has the sole authority to judge the weight and inferences to be drawn from the evidence. Miller v. East Kentucky Beverage/PepsiCo, Inc., 951 S.W.2d 329, 331 (Ky. 1997) (citation omitted). As the fact finder, 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." Magic Coal v. Fox, 19 S.W.3d 88, 96 (Ky. 2000) (citation omitted).

When reviewing a decision of the Board, we will affirm, absent a finding that the Board has misconstrued or overlooked controlling law or has so flagrantly erred in evaluating the evidence that a gross injustice has occurred. Western Baptist Hosp. v. Kelly, 827 S.W.2d 685, 687-688 (Ky. 1992).

III. THE OPENING WAS AUTHORIZED UNDER KRS 342.125(3)

Except in circumstances not applicable in this case, KRS 342.125(3) provides that "no claim shall be reopened more than four (4) years following the date of the original award or order granting or denying benefits." Toyota contends that because Prichard's original workers' compensation award occurred in 2007, her 2014 motion to reopen was time-barred by the four-year limitation period stated in KRS 342.125(3). Toyota's interpretation of the statutory language depends upon the assumption that the adjective "original" pertains to the entire phrase, "award or order granting or denying benefits." (Emphasis added.) This Court manifestly rejected that interpretation in Hall v. Hospitality Resources, Inc., 276 S.W.3d 775 (Ky. 2008).

In Hall, we explained that, based upon the use of the language in other provisions of KRS 342.125, the legislature recognized an "original award" as something separate and distinct from a subsequent "order granting or denying benefits" and intended to allow a four-year period for the reopening of an order granting or denying benefits. 276 S.W.3d at 784-785. We need not repeat the analysis here. It suffices to say, that we are not persuaded that our decision in Hall misinterpreted or misstated the legislative intent of KRS 342.125(3).

Moreover, we cannot fail to observe that several legislative sessions have come and gone in the nine years since Hall was rendered, and the legislature has not acted to amend the statute. "[T]he failure of the legislature to change a known judicial interpretation of a statute [is] extremely persuasive evidence of the true legislative intent. There is a strong implication that the legislature agrees with a prior court interpretation of its statute when it does not amend the statute interpreted." Rye v. Weasel, 934 S.W.2d. 257, 262 (Ky. 1996) (citation omitted). Accordingly, we reiterate that when an order granting or denying workers' compensation benefits has been entered subsequent to the date of the original award, the four-year limitation period prescribed by KRS 342.125(3) for reopening the claim is calculated from the later date, rather than from the original award.

Toyota argues that even if Hall was correctly decided, factual differences distinguish this case from Hall and therefore, compel a different result in the application of KRS 342.125(3). We acknowledge those factual differences. They pertain to the nature of the injury for which the original award in each case was made. The claimant in Hall was awarded temporary total disability benefits. "[G]iven the fact that Hall was still receiving [temporary total disability] benefits and had not reached [maximum medical improvement] by the time the four-year limitation allegedly ran, she could not have made the prima facie showing as is required upon the filing of a motion to reopen prior to its alleged expiration date." 276 S.W.3d at 781. Here, Prichard was not hampered by that circumstance. But the obstacles Hall faced in altering her disability benefits played no role in our interpretation of the statute in Hall. The obstacles merely illustrated an
injustice arising from the alternative interpretation of KRS 342.125(3) – the interpretation now favored by Toyota. Indeed, KRS 342.125(3) has no language that would authorize us to adopt one interpretation of the statute for claimants in Prichard's situation and another interpretation for claimants situated as in Hall. Toyota's analysis of KRS 342.125(3) does not offer arguments beyond those we considered and rejected in Hall.

In summary, we conclude that Prichard's 2014 motion to reopen the 2011 order granting benefits was timely filed within the four-year period provided by KRS 342.125(3).

**IV. THE REOPENING WAS AUTHORIZED UNDER KRS 342.125(1)(d)**

Toyota also claims that Prichard failed to meet the burden imposed by KRS 342.125(1)(d) for reopening her claim by demonstrating a "[c]hange of disability as shown by objective medical evidence of worsening or improvement of impairment due to a condition caused by the injury since the date of the award or order."¹ The company also argues that the ALJ decided the question based upon medical evidence which predated the 2011 opinion and award.

We are unpersuaded by Toyota's arguments because recent "objective medical evidence" was, in fact, presented to support the ALJ's finding of a worsened impairment of a condition caused by her work-related injury. The updated medical conclusions of Dr. Bean and Dr. Childers supported the conclusion that Prichard's condition had worsened from partial disability to total disability between the dates of the original award and the first reopening, and from then until the filing of the second reopening. The ALJ expressly referenced the determinations of Dr. Bean and Dr. Childers, describing it as "the persuasive, compelling and reliable medical evidence." Crucially, both doctors clearly stated that the onset of Prichard's inability to perform even sedentary work occurred after the 2011 order. These updated expert professional determinations by Dr. Bean² and Dr. Childers manifestly qualify as "objective medical evidence of [the] worsening" of "a condition caused by the injury since the date of the award or order."

To be sure, Dr. Bean did indeed reference, and therefore, we may presume his conclusions were influenced by, a functional capacity evaluation which predated the 2011 ALJ opinion and award. Toyota criticizes the use of this information as constituting medical evidence of a change in Prichard's condition. However, this was just one aspect of Dr. Bean's overall evaluation of Prichard's changing physical impairment, and it is not unusual for a thorough physician to make use of prior medical evaluations in a later evaluation setting. The bottom line, however, is that the previous proceeding established a twenty-eight percent impairment rating under which Prichard could continue to work in a sedentary work environment, whereas later medical evidence supported the ALJ's finding of a subsequent onset of total disability, characterized by Prichard's inability to

¹ KRS 342.125(1) provides four grounds for reopening a claim but only subsection (d) is applicable here. The other grounds for reopening, (a) fraud, (b) newly-discovered evidence which could not have been discovered with the exercise of due diligence, and (c) mistake, have not been invoked here.

² The 2011 order concluded Prichard's partial disability had increased but rejected her claim that she had, by then, become totally disabled.
perform even sedentary work. Substantial evidence supports the ALJ's determination that objective medical evidence was present to support the reopening.

We are mindful that Dr. Banerjee expressed the opinion that no objective change in Prichard's impairment occurred. Given the sufficiency of the evidence presented by Drs. Bean and Childers, Dr. Banerjee's opposing view constitutes merely a battle of the experts, the resolution of which is properly left to the ALJ as the individual privileged to view first-hand the totality of the evidence and the credibility of witnesses. Square D. Co., 862 S.W.2d at 309 ("Where, as here, the medical evidence is conflicting, the question of which evidence to believe is the exclusive province of the ALJ."). The existence of conflicting medical evidence in the record, by itself, does not render the ALJ's decision erroneous.

V. CONCLUSION

For the foregoing reasons the decision of the Court of Appeals is affirmed.

All sitting. Minton, C.J.; Cunningham, Hughes, Keller, and Wright, JJ., sitting. All.concur. VanMeter, J., not sitting.

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In July of 2006, Hon. William P. Emrick, Executive Director of the Kentucky Office of Workers Claims (OWC), commissioned a study of the utilization review process currently employed by the OWC: the 2006 Utilization Review Study (URS). The study was conducted by Ms. Sue Barber, Director, Division of Ombudsmen and Specialist Service of the OWC. Ms. Barber formed several committees and staffed the committees with individuals who have both an expertise in the delivery and/or management of medical services in the workers compensation arena as well as a vested interest in the Kentucky workers compensation system. One of those committees formed was the Treatment Guidelines (TG) committee.

The TG committee was staffed by six medical doctors ("physicians"), two doctors of chiropractic ("chiropractors"), two representatives of the insurance community, two attorneys specializing in workers compensation practice and one OWC administrative law judge (ALJ). The doctors are James Bean, M.D., an actively practicing neurosurgeon; Steven Glassman, M.D., an actively practicing orthopedic and spine surgeon; Gregory Gleis, M.D., an orthopedic surgeon and medical evaluator; Timothy R. Kriss, M.D., a neurosurgeon and medical evaluator; Russell Travis, M.D., a neurosurgeon and medical evaluator; and Daniel Wolens, M.D., an occupational and environmental medicine specialist and medical evaluator. The chiropractors are Michael Hillyer, D.C., and Andrew Slavik, D.C. Representing the insurance sector is Ms. Rosemary Sterling, with GAB Robbins, and Ms. Mary Camey, with Cannon Cochran Management Services, Inc. The lawyers are Hon. Bonnie Hoskins, who practices exclusively for the defense in workers compensation and Hon. John E. Anderson, who practices exclusively for plaintiffs in workers compensation. The ALJ and committee chair is J. Landon Overfield.

As the process began, the TG committee was charged by the Executive Director with the responsibility of gathering and studying information relating to and making recommendations concerning 1) the 1996 "Clinical Practice Parameters on Acute Low Back Problems in Adults" adopted by the (then) Department of Workers Claims, 2) existing evidence based studies of treatment of industrial injuries and occupational diseases, 3) weight to be given treatment guidelines if such were adopted by the Kentucky OWC, 4) the experience of other states in the implementation and application of treatment guidelines in workers compensation, and 5) what is best for Kentucky workers compensation.

The full TG committee met on July 24, 2006 and August 21, 2006 in Lexington, Kentucky and on September 19, 2006 in Frankfort, Kentucky. In addition, the members of the committee have corresponded on a frequent and consistent basis via the Internet and the telephone. The physicians have met together and the chiropractors have met together on multiple occasions. The "legal section" of the committee (the insurance
representatives, lawyers and judge) corresponded via the Internet and telephone on a frequent and consistent basis. The intent of this document is to report the consideration given by the committee and its individual members to the issues to be addressed and to deliver the recommendations of the committee to the Executive Director.

The TG committee decided, early on, that the 1996 acute low back treatment parameters have not been effective. The opinion was that this ineffectiveness is due, in large part, to the fact that the parameters addressed an extremely abbreviated time period relative to a workers compensation claim. By the time a claim was ripe for filing, the acute phase of the injury has[sic] passed. The TG committee recommends that the 1996 parameters be abandoned. The TG committee also decided that issues relating to pain management should be left to the Pain Management committee of the URS. The committee also concluded that any recommendation for treatment guidelines, at this point in time, should be limited to treatment of low back conditions. That decision, the committee believed, was necessitated by the brief time span of the URS.

The TG committee, guided by its doctors and chiropractors, investigated many of the existing "evidence based studies." The studies reviewed included the Official Disability Guidelines (ODG) as well as the guidelines of the American College of Occupational and Environmental Medicine (ACOEM), the American Association of Orthopedic Surgeons (AAOS), Intercorp and the McKesson Group. Various interests are undoubtedly to be found in all studies/guidelines and while none of the studies/guidelines appear to be without flaw or criticism, it seemed to most of the TG committee members that the ODG were the most up-to-date treatment guidelines and, in the states adopting treatment guidelines, the most often adopted.

The TG committee members were unanimous concerning what weight should be given treatment guidelines by the OWC. The unanimous opinion by the TG committee members is that the Kentucky workers compensation system NEEDS treatment guidelines. These opinions were expressed not just on a personal basis but after each member had[sic] conference with his or her colleagues in their respective fields of expertise. The only expression of any concern was that some members of the plaintiffs[sic] bar feared that the adoption of any type of treatment guidelines would result in their clients experiencing more difficulty in obtaining needed medical treatment.

The consensus of the TG committee is that, if treatment guidelines are adopted by the OWC, there should be regulatory or statutory provisions which would make the guidelines effective. The lawyers and insurance representatives on the TG committee have a[sic] recommended that, if treatment guidelines are adopted, 803 KAR 25:012 should be amended. The amendment could provide that no medical fee dispute would be required for medical treatment not approved by the guidelines. Conversely, if medical treatment approved by the guidelines were contested, sanctions could be issued if the contesting party did not prevail in the medical fee dispute. Non-recommended medical procedures could still be approved if the requesting party presented evidence which convinced an ALJ that the treatment was reasonably necessary and compensable. A proposed amendment is attached to this document as "Addendum 1."

The TG committee reviewed the current procedure in several other states. Many of our sister states have adopted treatment guidelines and the most adopted guidelines are from the ODG. The states adopting treatment guidelines have reported mixed results. Many claim to have experienced a reduction in medical costs. Some, however, also
report confusion and difficulty in effectively applying the adopted guidelines. Studies performed by the International Association of Industrial Accident Boards and Commissions (IAIABC) of states that have adopted treatment guidelines report that the most successful use of treatment guidelines have been found to be in states which have full-time medical directors in their workers compensation system.

The advisability of the Kentucky OWC having a medical director has been discussed in the TG committee and has met with favor. The general consensus of the TG committee is that the Kentucky OWC would be well served by adding a medical director to its staff. One chiropractor on the TG committee is of the opinion that the Kentucky OWC should also add a chiropractic director to its staff. The other chiropractor believes there could be an assistant medical director who is a chiropractor. It does not appear that these opinions are shared by the remainder of the TG committee members. The consensus of the TG committee is that one medical director will be able to ensure proper application of any adopted guidelines to all providers of health care.

The most important issue to be addressed by the TG committee is: **What is best for Kentucky workers compensation.** Unfortunately the TG committee does not have a unanimous recommendation. Dr. Wolens has prepared a written proposal (which is attached to this document as "Addendum 2") which, in essence, recommends adoption of the ODG as the Kentucky OWC's treatment guidelines for the treatment of low back injuries and diseases. Dr. Wolens' proposal is that there be no exceptions or additions to the ODG as this would allow "provider/discipline specific" guidelines. All but two members of the TG committee have expressed the opinion that the recommendation to the Executive Director should be that, if low back treatment guidelines are adopted by the OWC, the ODG should be adopted in the manner proposed by Dr. Wolens.

Dr. Hillyer and Dr. Slavik voiced significant opposition to adoption of the ODG. These committee members, both chiropractors, believe that the ODG is unduly restrictive relating to many treatment modalities employed by chiropractors. Drs. Hillyer and Slavik have prepared written proposals (which are attached to this document as "addenda 3A and 3B," both containing the same recommendations and one being an abbreviated version of the original version). These proposals, in essence, recommend adoption of a "chiropractic low back guideline" based on the workers compensation guidelines adopted by the workers compensation systems in the states of Minnesota and Wisconsin. Drs. Hillyer and Slavik are not opposed to the ODG parameters as they relate to treatment modalities administered by doctors in non-chiropractic disciplines. However, they are opposed to the application of the ODG to chiropractic treatment.

Many of the physicians on the TG committee have objected to the chiropractic community having specific guidelines. They note that for treatment modalities that are in common to both the practice of medicine and the practice of chiropractic, what ODG denies of physicians, the chiropractic guidelines allow for chiropractors. It is the position [sic] the physicians that the ODG addresses treatment modalities without regard to the medical discipline using those modalities.

In deference to the committee as a whole, both proposals will be presented to the Executive Director. The question of which proposal was favored by the individual members of the committee was subjected to what, for lack of a better term, can be referred to as an "Internet vote." The "majority" recommendation is that the ODG be adopted as Kentucky's low back treatment guidelines without exceptions or "add-ons."
The chiropractor recommendation is that, if the ODG is adopted by the OWC, it should not be applied to chiropractic treatment and a specific "chiropractic low back guideline" should also be adopted. The only votes for that position were from the two TG committee members who are chiropractors. Of the six physicians, five were in favor of the majority recommendation and one did not cast a vote. Both members of the insurance community, both lawyers and the ALJ voted for the majority position.

The full text of the ODG low back treatment guidelines (well in excess of 100 pages) will not be included in this document. The ODG treatment guidelines can be accessed via the Internet. The annual subscription fee [sic] quite inexpensive and is well within the budget of any health care provider, insurance carrier, [sic] workers compensation practitioner who routinely practices workers compensation law and the OWC. The ODG treatment guidelines are periodically updated and the TG committee recommends periodic review and amendment by the OWC of any guidelines it adopts.

RECOMMENDATIONS TO THE EXECUTIVE DIRECTOR

The Treatment Guidelines Committee makes the following recommendations:

1. Abandonment of the 1996 "Clinical Practice Parameters on Acute Low Back Problems in Adults."

2. Amendment of 803 KAR 25:012 in order to ensure effectiveness of any adopted low back treatment guidelines.

3. Addition to the staff of the OWC, a full-time medical director.

The majority of the treatment guidelines committee makes the following recommendation:

Adoption [sic] the low back treatment guidelines of the ODG as the low back treatment guidelines of the Kentucky OWC has proposed in Addendum 2.

The minority of the treatment guidelines committee makes the following recommendation:

Adoption of the treatment guidelines as adopted by the workers compensation systems of the sites out of Minnesota and Wisconsin with specific chiropractic low back treatment guidelines proposed in Addenda 3A and 3B.
Love them or hate them, we all handle Medical Fee Disputes, and field questions about them on a regular basis. From the defense perspective, when one comes across your desk, it is nearly always in the context of taking immediate action to get it filed in a timely fashion. They don't tend to be the most exciting or glamorous types of litigation, and their importance is easily overlooked. However, from the defense perspective, the outcome of a dispute can have a significant impact on the expenses associated with a particular claim (such as paying for surgery).

For Plaintiff's counsel, the Medical Fee Dispute is generally something to be taken on rather begrudgingly because in most cases, they are effectively cases of pro bono representation for former clients. Nonetheless, the outcome is likely to be critical for your client, particularly in a situation where there is no other insurance coverage to step in and cover medical expenses that are not paid under workers' comp.

Before everyone starts to roll their eyes, how long has it been since you reviewed all the statutes and regulations pertaining to Medical Fee Disputes? A thorough understanding is key to achieving the best possible outcome for your client.

I. MEDICAL EXPENSES

The obligation to pay or challenge medical expenses is set forth in KRS 342.020(1), which states that:

…the employer shall pay for the cure and relief from the effects of an injury or occupational disease the medical, surgical, and hospital treatment, including nursing, medical, and surgical supplies and appliances, as may reasonably be required at the time of the injury and thereafter during disability, or as may be required for the cure and treatment of an occupational disease.

The employer's obligation to pay the benefits specified in this section shall continue for so long as the employee is disabled regardless of the duration of the employee's income benefits.

The employer, insurer, or payment obligor acting on behalf of the employer, shall make all payments for services rendered to an employee directly to the provider of the services within thirty (30) days of receipt of a statement for services.

A. Carrier's Responsibilities before the Claim is Filed

1. Tender a Form 113 Physician Designation form to the injured employee within ten (10) days following notice of a work injury. Failure to do so will waive all objections to medical treatment by other physicians prior to receipt of the form. (803 KAR 25:096, Section 3).
2. If a pre-claim medical expense is being denied, the denial must be issued in writing within thirty days of receiving the bill or pre-authorization request. (803 KAR 25:096, Section 7). The denial shall include a statement of the basis for the denial, and a brief synopsis of available UR or medical bill audit procedures with relevant contact information, and must be denied only for a good faith reason.

B. Employee's Responsibilities before the Claim is Filed

1. Complete a Form 113 designating a "gatekeeper" physician with authority to supervise treatment and make referrals. (KRS 342.020(5); 803 KAR 25:096, Section 3). If there is an unreasonable failure to complete and return the Form 113, the carrier may suspend benefits until the form is received.

2. The employee may change designated physicians one time without approval of the employer or ALJ. Thereafter, approval is required. (803 KAR 25:096, Section 4).

3. The employee must submit all out of pocket expenses (including requests for mileage reimbursement) within sixty days of the time they are incurred. Failure to timely submit expenses without a reasonable basis may result in a finding that the expenses are not compensable. (803 KAR 25:096, Section 11). As the adjuster, it is not a bad practice to supply the employee with several Form 114s at the outset. That way, you eliminate the question later of whether or not the employee was made aware of their right to reimbursement, etc.

4. The employee should submit receipts, travel distances and other supporting documentation with the request for reimbursement. It is not the carrier's job to look up and crosscheck every submission with mileage and dates of service. If the employee does not provide this information, the adjuster may (and should) request it.

C. Threshold Issues for Medical Expenses

1. The employee/medical provider must submit a completed Statement for Services. This includes a UB-04 for a hospital, or a HCFA 1500 for other types of treatment. The bill must be accompanied by legible treatment notes, a hospital admission and discharge summary, or other supporting documentation for the treatment/procedure. The legible part is critical. If the documentation leaves you with no idea what service was performed, or why, you have the right to request additional information or clarification.

2. In the case of pharmaceutical bills, the submission must include the medication prescribed, quantity prescribed, date of prescription and name of prescriber. While an employee may
request that a brand name drug be used, this is not required unless the provider indicates that a generic drug may not be substituted. Otherwise, the employee bears the difference in cost between generic and brand name.

II. CHALLENGING MEDICAL BILLS OR PRE-AUTHORIZATION REQUESTS

A. The Issues in a Medical Fee Dispute Fall into One of Two Categories:

1. Reasonableness/necessity of medical treatment; and
2. Relationship of the treatment to the work-related injury.

If a medical bill or pre-authorization request is submitted that is clearly unrelated to the work injury, it may be denied outright without the need for Utilization Review or a Medical Fee Dispute. (803 KAR 25:096, Section 8(3)). Note that this is not simply a case of the adjuster not believing the treatment is related or warranted. This would be the type of treatment that would immediately strike a reasonable person as unrelated to the claimed work injury, and in most cases, would involve treatment for a different area of the body or a different condition.

B. There are Three Distinct Time Frames Applicable to Medical Fee Disputes

1. Before a claim is filed;
2. During the pendency of the litigation; and
3. After an award is made or a final settlement is approved.

C. Medical Fee Disputes before a Claim is Filed

1. If Utilization Review is required by 803 KAR 25:190, UR must be completed before a dispute is filed. (803 KAR 25:012, Section 1(8)). Sanctions may be imposed under KRS 342.310 for filing a dispute before exhaustion of the required UR. (803 KAR 25:012 (2)). NOTE: UR is required in cases when reasonableness and necessity are in dispute, but not when challenging work-relatedness/causation.

2. A Form 112 must be filed through LMS, and served on all parties (Plaintiff, Plaintiff's counsel, all medical providers whose treatment is being challenged). The Form 112 must be accompanied by the following:

   a. Copies of all disputed bills;

   b. Supporting affidavits setting forth entitlement to the relief sought;
c. Any necessary supporting expert testimony; and

d. Final UR or medical bill audit opinion.

3. A single Form 112 may encompass both past and future treatment. It is not necessary to continue filing Form 112s if the original Form 112 specifically states that it covers similar treatment that may be rendered in the future for the same condition. (803 KAR 25:012 Section 1(3)(b)). However, if there is a different type of treatment disputed or another issue to be raised, either a new Form 112 will need to be filed or the original 112 will need to be amended.

4. The Dispute is filed with the Frankfort Motion Docket, and may be decided summarily on the pleadings or assigned to an ALJ for further adjudication.

5. Appeals are permitted from the ALJ's Motion Docket to the Workers' Compensation Board, Court of Appeals or Supreme Court.

6. Once a ruling denying future medical treatment becomes final, the provider shall not tender future statements for services covered by that order.

D. Medical Fee Disputes during the Pendency of a Claim

1. The parties have responsibility for placing all matters in dispute before the ALJ, including contested expenses, procedures and courses of treatment, and are obligated to present these during the adjudication of the claim. If a claim is denied, or there is treatment being rendered that is contrary to a party's medical proof, this should be fully presented to the ALJ;

2. If the claim is pending before an ALJ, it is not required that a Form 112 be filed for any and all procedures, provided that they are addressed by the medical evidence being presented as part of the claim. In other words, if there is an IME doctor or provider that a party is relying upon, each proposed treatment that differs from that opinion is not required to be submitted as part of a Medical Fee Dispute. The matter is before the ALJ as part of the adjudication of the entirety of the case; and

3. A Form 112 may always be filed for treatment in dispute in a litigated claim, but it is most helpful to do so if there is something in particular to be highlighted (such as excessive treatment with a particular provider, or treatment that is ongoing as part of a prior or subsequent injury). Using this judiciously gives greater weight to the matters that are presented through a Form 112. In other words, if either party files numerous disputes when the initial claim
is pending before the ALJ, it is likely that no one disputed treatment will have any real impact.

E. Post-Award or Settlement Disputes

1. Once a claim is resolved, a timely Motion to Reopen must be filed with a Medical Fee Dispute and a Motion to Join the providers whose treatment is being challenged. (803 KAR 25:012, Section 1(6); Westvaco Corp. v. Fondaw, 698 S.W.2d 837 (Ky. 1985));

2. A Motion to Reopen must comply with 803 KAR 25:010 Section 4(6), and must include the following:
   a. An Affidavit setting forth the basis for the reopening;
   b. A current medical report, if necessary (UR and/or IME/records review, depending on the circumstances) supporting the basis for the reopening; and
   c. A copy of the Opinion, settlement agreement or other decision showing final resolution of the claim.

3. A Motion to Reopen must set forth a *prima facie* case for reopening (Stambaugh v. Cedar Creek Mining Co., 488 S.W.2d 681 (Ky. 1972)). In most cases, medical evidence will be necessary to present a *prima facie* case that contested treatment is not reasonable and necessary;

4. A Motion to Reopen should be accompanied by an appropriately prepared Form 112 Medical Fee Dispute, as well as a Motion to Join the provider or providers whose treatment is contested. The Motion to Reopen, Form 112 and Motion to Join must be filed within thirty days of receipt of the bill or thirty days from the final UR decision, whichever is later, unless the time period is tolled as set forth below;

5. If UR is required, UR must be completed, and a copy of the final UR decision must be attached to the Form 112 (803 KAR 25:190). If UR is not required (such as when only the work-relatedness of the treatment is in dispute), the Form 112 should be accompanied by a supporting medical report; and

6. Once the claim is final, the burden of proving a lack of reasonableness/necessity is on the employer/carrier. (National Pizza Co. v. Curry, 802 S.W.2d 949 (Ky. App. 1991); Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993)).
F. Tolling the Time Period for Payment or Challenge

There are several things that toll the required time period for paying or challenging a medical expense, and all are related to the good faith investigation of the claim submitted:

1. The medical provider submits an incomplete statement for services. The carrier should immediately notify the medical provider of the deficiency, and shall request specific documentation. The thirty day time period for the carrier's obligation to pay or challenge the expense or pre-authorization request begins once the required documentation is submitted;

2. If a medical provider fails to respond to a reasonable request for information from the employer or carrier pursuant to KRS 342.020(4), the time does not begin to run until such time as the information is submitted. Be sure that your efforts to obtain the documentation are well documented. If the request is telephonic, make sure you have detailed notes to document the substance of the communication;

3. The medical provider fails to provide a treatment plan, if the same is required by the regulation;

4. The Utilization Review required by 803 KAR 25:190 is pending. The thirty day period for filing a Medical Fee Dispute shall commence on the date of rendition of the final decision from Utilization Review. A Medical Fee Dispute filed thereafter shall include a copy of the Final Utilization Review decision and the supporting medical opinions.

G. Treatment Plans

Requesting a treatment plan is a helpful (and often underutilized) tool in management of the claim. A treatment plan is required pursuant to 803 KAR 25:096 Section 5(1) if:

1. Long term medical care is required as a result of a work-related injury or occupational disease;

2. The employee has received treatment with passive modalities, including electronic stimulation, head and cold packs, massage, ultrasound, diathermy, whirlpool, or similar procedures for a period exceeding sixty (60) days. The treatment plan shall detail the need for the passive treatment, the risks attendant to termination of the treatment, and the projected period of future treatment; or

3. An elective surgical procedure or placement into a residential work hardening, pain management or medical rehabilitation program is recommended. The treatment plan shall set forth specific and
measurable goals for the employee through the surgery, work hardening, or medical rehabilitation program.

803 KAR 25:096 Section 5(2) further provides that the designated physician shall provide a copy of the treatment plan to the medical payment obligor seven (7) days in advance of an elective surgical procedure or placement into a residential work hardening, pain management, or medical rehabilitation program. In all other instances when a treatment plan is required, a copy of the treatment plan shall be provided within fifteen (15) days following a request by the medical payment obligor. An amendment, supplement, or change to a treatment plan shall be furnished within fifteen (15) days following a request. Section (3) further notes that preparation of a treatment plan shall be a necessary part of the care to be rendered and shall be an integral part of the fee authorized in the medical fee schedule for the underlying services. An additional fee shall not be charged for the preparation of a treatment plan or progress report, except for the reasonable cost of photocopying and mailing the records.

It is a good idea to have a copy of 803 KAR 25:096 Section 5 handy so that you can send it out to the carrier or provider whenever any of these circumstances are met. The regulation appears to require the medical provider to provide a treatment plan in the listed circumstances without a formal request. However, any time the opportunity presents itself (as with a pre-authorization request), you should go ahead and formally request the treatment plan so there is no question.

H. Expedited Medical Fee Disputes

1. This applies to cases in which delay of recommended medical treatment beyond forty-five (45) days could lead to "serious physical or mental disability or death." (803 KAR 25:012, Section 3). This will be initiated by the Plaintiff/Employee, and filed on a Form 120 EX – the requirements for affidavits are set forth in the regulation;

2. A Response must be filed within ten (10) days, with the ALJ's expedited decision to be rendered within seven (7) days after expiration of the response time.

***If you represent employers/carriers/TPAs, your clients need to understand that if one of these is received, they need to contact counsel immediately.

I. Utilization Review under 803 KAR 25:190

1. Each carrier must have an approved UR/medical bill audit plan in place with qualified reviewers or a contract with an approved vendor that provides these services;
2. If the claim is denied in good faith as non-compensable, no UR is required. (803 KAR 25:190 Section 5(1)). If work-relatedness/causation is in issue, UR is not necessary, because UR does not address causation.

3. Claim selection criteria for Utilization Review:
   a. A provider requests pre-authorization of a particular treatment or procedure;
   b. Notification/pre-authorization request for a proposed surgery or residential treatment placement is received;
   c. Total medical costs for the claim exceed $3,000.00;
   d. Total lost work/days exceed thirty days; or
   e. ALJ orders Utilization Review.

4. Prospective UR Request for Pre-authorization.
   a. The initial UR decision is to be made and communicated within two (2) working days of the request, unless additional information is required. A request by the carrier for additional information shall be made in a single request within two (2) working days. Requested information must be supplied by the medical provider within ten (10) working days. The carrier then has an additional two (2) days for its initial UR decision.
   b. Payment cannot be denied on the basis of lack of information unless it is documented that a good faith effort was made to secure the information (803 KAR 25:190, Section 7).

5. Retrospective Utilization Review.
   The initial UR decision should be communicated to the medical provider and employee within ten (10) days after initiation of the UR process. A request by the carrier for additional information must be made in a single request within two (2) working days. The carrier has two (2) additional working days for its initial UR decision.

6. If a requested procedure or expense is denied, the denial must be in the form of a document entitled "Utilization Review-Notice of Denial" which contains:
   a. A statement of the basis for the denial;
b. The name, state of licensure and medical license number of the reviewer; and

c. An explanation of reconsideration rights under UR.

7. Reconsideration after an initial UR Decision.

a. The reconsideration must be requested within fourteen (14) days of the notice of denial;

b. The reconsideration must be conducted by a different reviewer with at least the same qualifications as the initial reviewer;

c. A decision must be rendered within ten (10) days of the request for reconsideration, and shall be titled "Utilization Review - Reconsideration Decision;"

d. If denial of a procedure is upheld on reconsideration, an aggrieved party may request review by a medical specialist or chiropractor. A written decision must be rendered within ten (10) days, and shall be titled "Final Utilization Review Decision."
The going and coming rule states that travel to and from a fixed location or regular place of work where the employee's employment duties begin and end is not a covered work-related injury. The exceptions to this rule are many and must be proved based upon the complete set of facts "rather than the existence or non-existence of any particular factor." Jackson v. Cowden Mfg. Co., 578 S.W. 2d 259, 262 (Ky. 1978).

I. EXCEPTIONS

A. Traveling Employee

B. Benefit to Employer/Service to Employer

C. When Will such Service or Benefit to the Employer be Overcome to Show an Injury is not Work-related?

D. Comfort and Convenience Doctrine

E. Operating Premises

II. TRAVELING EMPLOYEE

The traveling employee doctrine governs employees who are working away from the employer's premises as opposed to traveling to and from a fixed work place. Typically, that travel for the employee will be held as within their course of employment, except when there has been a distinct departure for a personal errand. Black v. Tichenor, 396 S.W.2d 794 (Ky. 1965) stated:

Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of employment continuously during the trip, except where a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels, or eating in restaurants while away from the employer's premises on the business trip are usually held compensable.

Id. at 797.

In Caring People Services, LLC v. Gray, 2016-CA-001032-WC, 2016 WL 7324248 (Ky. App. Dec. 16, 2016), the employee was awarded benefits by the Administrative Law Judge and the Board affirmed it on appeal. The employer appealed to the Court of Appeals arguing she did not have a work-related injury because the injury occurred while she was in her personal vehicle during her commute from home to her regular work site. The Court of Appeals found that her work duties for "Caring People" were primarily providing non-medical personal care services to clients at various locations, including their homes.
While traveling to a client’s home, she was involved in a car accident and sustained substantial injuries.

The Court stated the appropriate scope of review is to consider the entire nature of Gray’s employment and the services she was performing in determining whether the traveling employee exception is applicable. The employer’s business was to provide off-site care for clients, and Ms. Gray was required to be able to transport herself to the client. Such travel was an essential element of her job duties and therefore, for the benefit of Caring People. The Court found that her travel to a client is what caused the injuries in question, and those services were necessary for the business of Caring People. The Court of Appeals stated that the ALJ correctly determined that her injuries were compensable. A copy of the Opinion is attached.

Corken v. Corken Steel Products, Inc., 385 S.W.2d 949 (Ky.1964) discussed the "positional risk" doctrine, which provides that when an employee, in the course of his job duties, finds himself in a position of danger, then injury or death resulting from that would be compensable. In Corken, the employee was traveling making calls on customers. He stopped for a lunch break. While on the break, he was killed by a stranger acting without provocation. That was held to be a compensable claim since the employee’s presence at that location resulted from him performing work duties. The same idea attaches to the traveling employee and compensation for injuries suffered during the course of that travel, even though traffic perils apply to all travelers.

III. BENEFIT TO EMPLOYER/SERVICE TO EMPLOYER

These exceptions often arise when traveling is involved. The fact situations often involve employees using company vehicles or working at remote job sites. Bailey Port v. Kern, 187 S.W.3d 329 (Ky. App. 2006), involved a car wreck suffered by Kern while driving home from work in a company owned vehicle. The issue on appeal was whether or not this injury was work-related. Mr. Kern was provided a company vehicle as part of his job. Mr. Kern worked on call at all times and was sometimes called back to work before reaching home. The company vehicle was where his tools were kept. The Court said that the evidence showed Bailey Port derived a benefit from Kern’s use of the vehicle from the time saved and having it available at all times, particularly if he was called to go to another site other than the port itself.

The Administrative Law Judge said that these circumstances gave rise to use of the "service to the employer" exception to the going and coming rule. The employer appealed, arguing the case law cited by the ALJ did not apply because in that case the worker was traveling home in a company vehicle from a remote work site and in this case, the worker was not. Receveur Const. Company/Realm, Inc. v. Rogers, 958 S.W.2d 18 (Ky. 1997). On the employer’s appeal, the Board disagreed, and the employer then sought review from the Court of Appeals. The Court said that the reasoning in Receveur did not rest on the remoteness of the job site, but on the reason that Rogers was driving a company vehicle.
The Court noted that use of the company vehicle enabled Rogers to avoid a stop at the company office before proceeding to a job site. This saved time and allowed him to begin working earlier in the day. The use of the company vehicle by Rogers was a convenience to him, but the vehicle was primarily provided for the benefit of the employer. In Kern’s situation, the use of the vehicle was provided for the company’s benefit. He stored his tools in the vehicle, and it allowed him to travel directly to a job site instead of him stopping at the port to get his tools.

The Court noted that the testimony showed that when Kern was called to a job site, it was important for him to get there as quickly as possible, especially if a report was needed outside of normal work hours. Therefore, the Court agreed with the ALJ and the Board that Receveur was squarely on point. A copy of the Opinion is attached.

IV. WHEN WILL SUCH SERVICE OR BENEFIT TO THE EMPLOYER BE OVERCOME TO SHOW AN INJURY IS NOT WORK-RELATED?

U.S. Bank Home Mortgage v. Schrecker, 455 S.W.3d 382 (Ky. 2014), illustrates this. Schrecker was working in an office in Owensboro, KY, that was on a busy four lane road. She was entitled to a one-hour unpaid lunch break, along with two paid breaks a day. The bank did not have an onsite cafeteria, but had a lunch room and vending machines available for the employees. The employees were permitted to leave the premises for lunch and would often go to the fast food restaurants across the street from the bank.

Schrecker signed out for her paid afternoon break and was crossing the street to a Taco Bell where there was no cross walk. She was struck and injured. The Court noted their review of the Administrative Law Judge’s application of the law is de novo. The bank argued that the injury was not in the course and scope of her employment because:

1. She was not on the premises when injured.
2. She had "temporarily abandoned her job."
3. The personal comfort doctrine applied because she took an unreasonable route to get to Taco Bell from the bank.

The Court stated that there was no case law directly on point in Kentucky and turned to other sources for guidance. Larson's was quoted concerning liability for off premises accidents during paid breaks as:

If the employer, in all the circumstances, including duration, shortness of the off premises distance, and limitations on the off premises activity during the interval can be deemed to have retained authority over the employee, an off premises injury may be found to be within the course of employment.1

The Court also noted that Larson indicates the hazard encountered by the employee off premises must be considered. If those hazards do not flow from employment conditions or are not encountered as part of normal going to and coming from the premises activity, the employer should have no liability. Those observations by Larson were cited by the Court as persuasive.

The Court cited that Schrecker’s break was relatively short in duration, paid and sanctioned, if not encouraged. Those factors weighed in favor of Schrecker, according to the Court. The Court said the same factors weighed in favor of the bank, as they were indicia of the bank’s lack of authority over Schrecker. Weighing those factors would likely result in deference to the Administrative Law Judge.

However, the Court said one factor outweighed the other, and that was the hazard Schrecker encountered. By crossing the street between intersections and not in a cross walk, and walking in front of a moving vehicle, the Court said, "Schrecker voluntarily exposed herself to a hazard so completely outside those normally encountered in going to or coming from work as to negate any authority U.S. Bank may have had over her." Id. at 386.

The Court said it was not injecting negligence into a workers’ compensation claim by this Opinion. It did not hold Schrecker’s claim was not compensable because she was at fault for her injury. They said her claim was not compensable because she deviated from normal coming and going activities and that deviation mandated denial of her claim. A copy of the Opinion is attached.

V. COMFORT AND CONVENIENCE DOCTRINE

This doctrine states that where an injury was caused by a danger inherent in the workplace or resulted from the risk peculiar to or increased by the employment, the fact the injury occurred because the worker was ministering to his own comfort and convenience while at work should not render the resulting disability non-compensable. Where nexus is proven to exist between some danger or risk associated with the employment and the injury which caused the work injury benefits have been allowed. This issue was addressed in Meredith v. Jefferson County Property Valuation Administrator, 19 S.W.3d 106 (Ky. 2000). The employee was a field representative for the Kentucky Revenue Cabinet, though employed by the Jefferson County Property Evaluation Administrator. His job duties were mainly to travel to local banks for work. He would come to his office at the beginning of the day, obtain a list of appointments, and then travel to various banks.

Meredith said he was free to take breaks between appointments. On this occasion, after leaving his office for the first appointment, he arrived at a bank sometime between 8:30-9:00 a.m., but the bank did not open until 9:00. He was unable to get the attention of anyone in the bank to let him in, so he traveled to a fast food restaurant about five to ten minutes away to get coffee. As he was carrying his order from the counter to a table, he slipped and fell, sustaining a serious back injury which required surgery. The ALJ considered whether the injury arose out of natural consequence of performing a duty for his employer, as
well as whether the time, place and circumstances of the accident indicated his employment was the cause.

The ALJ found the injury was outside the course of his employment. He identified the travel to the restaurant five to ten minutes away, rather than waiting for the bank to open. This was a personal errand. The Workers' Compensation Board affirmed the Administrative Law Judge, as did the Court of Appeals, both decisions drawing dissents. The Supreme Court identified the facts as presenting both aspects of a personal comfort doctrine and business trip.

They noted that Larson's identifies deviation from a business trip for a personal reason as being outside the course of employment, unless the deviation is so small that it may be disregarded as insubstantial. The Court also identified circumstances in which an injury resulting from acts at work which minister to the employee’s personal comfort while at work may be considered as work related, according to the doctrine of comfort and convenience.

Where an injury results from an activity performed during an enforced hiatus from work this involves a connection to work. The attached Opinion of the Court lists several different situations where the comfort and convenience doctrine has resulted in allowable benefits.

Disregarding the Opinions of the Administrative Law Judge, Board and Court of Appeals, the Court said that circumstances constituted a period of enforced hiatus and the type of activity was not so unreasonable that it must be viewed as a departure from the employee’s duties. For that reason, the injury was found to be compensable. A copy of the Opinion is attached.

VI. OPERATING PREMISES

Whether an injury occurs on a job site or not often involves the operating premises question. There have been numerous cases that involve injuries close to the premises or use of property owned by the employer but not the actual work location. K-mart Discount Stores v. Schroeder, 623 S.W.2d 900 (Ky. 1981), confirmed the operating premises doctrine can only be applied on a case by case basis. An example of this is Administrative Office of the Courts v. Kathy Blevins which resulted in a Court of Appeals decision with a dissenting decision and an evenly split Supreme Court on February 16, 2017, in Action No. 2016-SC-00233-WC.

The Order of the Court directed the Court of Appeals' decision not to be published and said since the six members of the Court were equally divided, the Court of Appeals decision stood affirmed. Attached is a copy of the Court of Appeals decision in that case. Ms. Blevins was employed as a deputy clerk at the Knox County courthouse. There were various parking areas located around the courthouse where she worked. Ms. Blevins suffered the injury when she parked her car in one of the spaces near the courthouse after an ice storm earlier that morning.

She needed to walk about 150 feet, a few steps across the lot where she parked, and then along a portion of a sidewalk along the perimeter of Court Square, crossing Court Square and entering a security door behind the courthouse. During the walk, she slipped and fell on a patch of ice and filed a workers' compensation claim. The ALJ awarded her benefits, and the Workers' Compensation Board affirmed. The employer appealed to the Court of Appeals.

The decision noted that an exception to the going and coming rule is when the employee is injured while on the employer's "operating premises," and not substantially deviating from the normal activities of coming and going. Ratliff v. Epling, 401 S.W.2d 43 (Ky. 1966). The AOC appeal challenged the finding the injuries were work-related, arguing the going and coming rule barred the claim and that the "operating premises exception" also did not apply under the circumstances. The Court identified the issue on appeal as "whether the place where Blevins was injured (the sidewalk in front of the Sheriff's office) should be deemed as part of AOC's 'operating premises.'" Id. at *1.

The Court said that would be determined by the facts and circumstances of each particular case. The Court noted several different "operating premises" cases including where an employee had parked. The attached Opinion reviews those and the different types of circumstances. K-Mart Discount Stores v. Schroeder, 623 S.W.2d 900 (Ky. 1981), was identified as showing two factors that must be present to fix liability on the employer. The first is control of the area by the employer, and the second is that a work-related injury must have been sustained on that area. Jackson Purchase Medical Associates v. Crossett, 412 S.W.3d 170 (Ky. 2013), was cited for the proposition that the "operating premises" includes an employee injured "while walking a reasonable path from a parking area designated for employee to the place of employment." Id. at *3.

In Blevin's case, the Court noted she did not park in a lot owned, leased, maintained or controlled by AOC; it was a public lot next to a public building. Her injury did not happen on a sidewalk owned, maintained or controlled by AOC; it was a public sidewalk. Finally, she did not park in a place where her employer required her to park. The Court stated the Administrative Law Judge found this a work injury because the AOC told her where to not park. The AOC had directed that she and other employees not park in the lot assigned for AOC employees or on the street, leaving her with being able to park in the next closest space, which is where she parked. That space is owned and maintained by the city of Barbourville and Knox County. The Administrative Law Judge noted that the injury occurred when she stepped from that space onto the sidewalk. The Court of Appeals agreed that the important distinction was that the AOC told Ms. Blevins where she could not park but she had to go to her "operating premises" from some location. Therefore, it was found to be compensable.
OPINION

KELLER, JUSTICE.

The Administrative Law Judge (the ALJ) found that Andrea Schrecker's (Schrecker) injury is work-related and compensable. The Workers' Compensation Board (the Board) and the Court of Appeals affirmed. Having reviewed the record and the arguments of the parties, we reverse.

I. FACTS.

Schrecker worked in the payment processing department at US Bank Home Mortgage (US Bank). The US Bank facility is located on Frederica Street in Owensboro, Kentucky. Frederica Street is a busy four-lane road with a traffic island dividing the northbound and southbound lanes. As a full-time US Bank employee, Schrecker was entitled to a one hour unpaid lunch-break and two fifteen-minute paid breaks per day. US Bank did not have an onsite cafeteria, but it did have a lunchroom and vending machine that were available for employees' use. During their breaks, employees were permitted to leave the premises, and they often did, going to fast food restaurants that are across Frederica Street from US Bank.

On December 31, 2007, one of Schrecker's co-employees was absent; therefore, Schrecker decided to work through her lunch-break. At approximately 1:30 p.m., Schrecker signed out for her paid afternoon break, with the intention of getting something to eat from the Taco Bell across Frederica Street from US Bank and returning to work. Based on Schrecker's testimony and the police report that was entered into evidence, Schrecker was crossing Frederica Street at a point between two intersections where there was no cross-walk. The driver in the inside northbound lane stopped and waved for Schrecker to cross. The driver in the inside northbound lane did not see Schrecker and, when she crossed into that lane, struck her.
Schrecker was treated for her injuries at the scene and returned to work. She continued to work at US Bank until June 2008, when she was terminated.[1]

The dissent emphasizes several times that Schrecker was under "employer-generated time pressure" because she had skipped her lunch break and had "to quickly grab food from a fast food restaurant across the street." While it is true that Schrecker did not take her lunch break when she usually did, there is nothing in the record indicating that she could not have taken her lunch break at 1:30 p.m. In fact, the evidence established that employees had no set lunch time and that a supervisor, Jennifer Roberts, had previously advised Schrecker that she was always entitled to a lunch break. Furthermore, Schrecker testified that three to five days a week she took the three minute trip across the street to get something to eat during her afternoon break. Therefore, the dissent's emphasis on an "employer-generated time pressure" is not supported by the record.

Following the injury, Schrecker complained of pain in her mid and low back, chest, right shoulder, left knee, and left calf. She also complained of headaches, depression, memory loss, difficulty concentrating, and sleep disturbance related to a traumatic brain injury suffered when her head struck the car's windshield. As a result of that injury, Schrecker has had difficulty working and functioning as she did in the past. The parties filed a significant amount of evidence regarding Schrecker's mental and physical conditions. We do not summarize that evidence because our holding only involves whether Schrecker's injury occurred in the course and scope of her employment.

Based on the evidence and our Opinion in Meredith v. Jefferson County Property Valuation Administrator, 19 S.W.3d 106 (Ky. 2000), the ALJ concluded that Schrecker's injury occurred while she was within the course and scope of her employment. He then awarded Schrecker medical expense benefits and income benefits based on a fifteen percent impairment rating. US Bank filed a petition for reconsideration, which the ALJ summarily denied.

US Bank then appealed to the Board. The Board noted that the only issue before it was whether Schrecker's injury occurred within the course and scope of her employment. It then reviewed passages from Larson's Workers' Compensation Law (2011), 9A Couch on Insurance 3d (2011), and 82 Am.Jur.2d Workers' Compensation regarding the "personal comfort doctrine." Based on its review, the Board concluded that the ALJ did not err in finding that Schrecker's injury occurred in the course and scope of her employment.

US Bank appealed to the Court of Appeals, which affirmed the Board. The Court of Appeals, also citing to Larson's and Couch, affirmed the Board, noting that Schrecker was injured while on a paid break seeking refreshment and that US Bank condoned employees crossing the street during such breaks. US Bank appealed from that opinion, again arguing that Schrecker's injury occurred outside the course and scope of her employment.

II. STANDARD OF REVIEW.

When reviewing an ALJ's decision, this Court will reverse only if the ALJ overlooked or misconstrued controlling law or so flagrantly erred in evaluating the evidence that it has caused gross injustice. Western Baptist Hosp. v. Kelly, 827 S.W.2d 685, 687-88 (Ky. 1992). On appellate review, the ALJ's
findings of fact are entitled to considerable deference and will not be set aside unless the evidence compels a contrary finding. Bullock v. Peabody Coal Co., 882 S.W.2d 676 (Ky. 1994). However, we review the ALJ’s application of the law de novo. See Finley v. DBM Technologies, 217 S.W.3d 261, 264 (Ky. App. 2007).

III. ANALYSIS.

As previously indicated, the issue herein is whether Schrecker was in the course and scope of her employment when injured. US Bank argues that Schrecker was not because: (1) she was not on US Bank's operating premises when the injury occurred; (2) she had temporarily abandoned her job; and (3) she lost any protection she may have had by virtue of the personal comfort doctrine when she took an unreasonable route to get from US Bank to Taco Bell. Schrecker argues that she was within the course and scope of her employment because: (1) she was on a paid break; (2) US Bank benefitted generally from the increased employee morale the breaks provided and specifically benefitted from Schrecker working through her lunch break that day; (3) US Bank permitted employees to leave the premises and to cross Frederica Street to seek refreshments on their breaks; (4) employees regularly crossed the street seeking refreshments during their breaks; and (5) there is no evidence that Schrecker had any motive other than personal comfort for crossing the street.

In support of its argument, US Bank cites to Baskin v. Community Towel Service, 466 S.W.2d 456 (Ky. 1971). In Baskin, Mr. Baskin and a co-employee were injured while returning to work after taking an unpaid lunch break. We held that their claims were not compensable because, as employees with a fixed time and place of work, they were outside the course of employment while off the Community Towel Service’s premises during lunch. Baskin is distinguishable because Schrecker was on a paid, not an unpaid break. Furthermore, in Meredith v. Jefferson County Property Valuation Administrator, 19 S.W.3d 106 (Ky. 2000) we recognized that "the doctrine of comfort and convenience" could extend beyond the boundaries of an employer’s premises. Id. at 108.

In Meredith, Mr. Meredith worked as a field representative for the Kentucky Revenue Cabinet. His job required him to travel to local banks to inventory the contents of safety deposit boxes for estate tax purposes. On the date of his injury, Mr. Meredith went to his office, picked up his appointment schedule, and drove to his first appointment. He arrived early and, because he could not get into the bank, he went to a nearby McDonald's. While walking with his tray from the counter to a table, Mr. Meredith fell and suffered a serious back injury. We note that there is nothing in either our opinion or the Court of Appeals's opinion in Meredith which indicates why Mr. Meredith fell or if Mr. Meredith encountered any abnormally hazardous conditions at McDonald's.

In finding Mr. Meredith's claim compensable, we noted that injuries "sustained during a personal mission . . . [generally occur] outside the course of employment; however, under certain circumstances, an injury resulting from acts by a worker which minister to his personal comfort while at work may be considered related to work pursuant to the doctrine of comfort and convenience." Id. at 108. We noted that a number of factors must be considered in applying that doctrine, including: whether an employee's
abandonment of his job was intended to be only temporary; whether an employee's departure from his job was "so unreasonable that it cannot be considered an incident of the employment;" whether the nature of the job includes periods of "enforced hiatus" such as waiting for appointments; and whether the employer prohibits the employee from taking a coffee break during those periods. Taking those factors into consideration, we held that Mr. Meredith was within the course and scope of his employment when he was injured. *Id.* at 108-10. While instructive, *Meredith* is not dispositive because Mr. Meredith, unlike Schrecker, did not have a fixed place of employment.

As the Board stated, there is no case law directly on point in Kentucky. Therefore, like the Board and the Court of Appeals, we turn to other sources for guidance. With regard to employees with fixed places of employment, Professor Larson states as follows:

> Now that the coffee break or rest break has become a fixture of many kinds of employment, close questions continue to arise on the compensability of injuries occurring off the premises during rest periods or coffee breaks of various durations and subject to various conditions. It is clear that one cannot announce an all-purpose "coffee break rule," since there are too many variables that could affect the result. The duration might be five minutes, seven minutes, 10 minutes, or even 20 minutes by which time it is not far from that of a half-hour lunch period. Other variables may involve the question whether the interval is a right fixed by the employment contract, whether it is a paid interval, whether there are restrictions on where the employee can go during the break, and whether the employee's activity during this period constituted a substantial personal deviation.

> The operative principle which should be used to draw the line [regarding liability for off premises accidents during paid breaks] is this: If the employer, in all the circumstances, including duration, shortness of the off-premises distance, and limitations on off-premises activity during the interval can be deemed to have retained authority over the employee, the off-premises injury may be found to be within the course of employment.

Arthur Larson, *Larson's Workers' Compensation Law*, §13.05(4) (2011). Additionally, Professor Larson indicates that the hazards encountered by the employee while off premises must also be considered. If those hazards do not flow from employment conditions or are not encountered as part of normal going to and coming from the premises activities, the employer should not have liability. *Id.*

We find the preceding to be persuasive and note that Professor Larson's factors are similar to those we set forth in *Meredith* to determine when liability attaches to an off-premises injury occurring during a break for an employee with no fixed place of employment. Applying Professor Larson's factors, we must conclude that the ALJ erred when he found that Schrecker was within the course and scope of her employment when injured.

Schrecker's break was: relatively short in duration; paid; and sanctioned, if not encouraged, by US Bank. These factors weigh in favor of Schrecker as they are indicia of US Bank's exercise of authority over Schrecker. Schrecker
was free to go wherever she pleased and to do whatever she wanted to do on her break. These factors weigh in favor of US Bank as they are indicia of U.S. Bank's lack of authority over Schrecker. If this were all of the evidence, we would likely defer to the ALJ. However, one factor – the hazard Schrecker encountered – outweighs the others. By crossing the street between intersections and walking in front of a moving vehicle, Schrecker voluntarily exposed herself to a hazard so completely outside those normally encountered in going to or coming from work as to negate any authority US Bank may have had over her.

We deem this element, varying from the normal going and coming process, to be conclusive based, in large part, on our holding in Ratliff v. Epling, 401 S.W.2d 43 (Ky. 1966). In Ratliff a coal miner (Ratliff) made arrangements to ride home with a co-worker. After leaving the mine at the end of their shift, the two walked to the parking lot and discovered that the coworker's car would not start. While the co-worker went to get help with starting his car, Ratliff began gathering loose pieces of coal for his personal use. Approximately one-half hour later, a "high wall" that Ratliff was standing near collapsed, killing him. Id. at 44.

The Court held that Ratliff's injury was not work-related. In doing so, the Court first determined that Ratliff was within the employer's operating premises. The Court then held that, when Ratliff left the car and began gathering coal, he deviated from the normal coming and going activity of leaving the work station, proceeding to the parking lot, and leaving the employer's property. Because of that deviation, Ratliff's claim was properly denied. Id. at 45-46.

Schrecker, like Ratliff, deviated from normal going and coming activity by crossing the street between intersections. Furthermore, Schrecker, unlike Ratliff, was injured while off her employer's premises. Because Ratliff's deviation from normal going and coming activities barred his on-premises injury claim, Schrecker's deviation must also bar her off-premises injury claim.

The dissent states that we inject negligence into workers' compensation claims by this opinion. However, that is not the case. We have not, and do not, hold that Schrecker's claim is not compensable because she was at fault for her injury. What we do hold is that her claim is not compensable because, like the claimant in Ratliff, she deviated from normal coming and going activities and that deviation mandates denial of her claim.

As Prof. Larson notes, in even "borderline situations such as personal comfort" courts should not delve into negligence, which turns on the "at best rubbery yardstick" of reasonableness, but should apply "the concept of implied prohibition . . . ." LARSON'S WORKERS' COMPENSATION LAW, §21.08(4)(d).

[T]he implied prohibition test . . . permits us to draw a consistent pattern of principle uniting the rules of unreasonableness and prohibited method. We first divide all activities into operating acts and incidental acts. As to operating acts, that is, acts in direct performance of the precise tasks assigned to the claimant, we find that method – whether unreasonable, impliedly prohibited, or even expressly prohibited – is immaterial. As to incidental acts and situations, including . . . personal comfort, . . . we find that a single
test will also suffice: they are outside the course of employment if they are expressly or impliedly forbidden.

Id.

Applying the implied prohibition test herein, we note that KRS 189.570(6)(a) states that: "Every pedestrian crossing a roadway at a point other than within a marked crosswalk or within an unmarked crosswalk at an intersection, shall yield the right-of-way to all vehicles upon the roadway." Schrecker's action, failing to yield to a vehicle on the roadway, was expressly forbidden by the Commonwealth, and impliedly forbidden by US Bank. Therefore, we reverse the Court of Appeals and remand this matter to the ALJ for entry of an opinion and order dismissing Schrecker's claim.

IV. CONCLUSION.

Although encouraged to do so by US Bank, we do not adopt a blanket operating premises rule with regard to employee injuries that occur during personal comfort breaks. Rather, we hold that cases involving such injuries must be evaluated on a case-by-case basis. In doing so, the ALJ must determine the extent to which the employer exercised authority over the employee during his/her break. The factors to consider include, but are not limited to: whether the employee is paid during the break; the length of the break; the extent to which the employer limits the employee's activities during the break; how far from the employer's premises the employee was when injured; whether the employee's activity during the break amounted to a substantial deviation from seeking personal comfort; whether the hazard encountered by the employee flowed from employment or was part of normal going and coming activities; and whether the employee's activity was expressly or impliedly prohibited by the employer. Because Schrecker undertook a route to seek personal comfort that exposed her to a hazard completely removed from normal going and coming activity, and which was expressly prohibited by the Commonwealth and impliedly prohibited by US Bank, we reverse the Court of Appeals and remand to the ALJ for entry of an order dismissing Schrecker's claim.

All sitting. Minton, C.J., Abramson, Noble and Venters, JJ., concur. Scott, J., dissent by separate opinion in which Cunningham, J., joins.

DISSENT

SCOTT, J., DISSENTING:

I begin my dissent with a brief recounting of some of the facts overlooked in this case. On December 31, 2007, Andrea Schrecker began her workday at 7:00 a.m. She did not take her lunch break that day because a co-worker was absent and her employer needed her to complete work to meet end-of-the-year deadlines. After working until 1:30 p.m. without a lunch break, a period of six-and-a-half hours, she took one twenty-minute paid break to try to quickly grab food from a fast food restaurant across the street. Under pressure to return to work within twenty minutes, Schrecker tried to cross the road at the closest place without using a crosswalk. Regrettably, she was struck by a vehicle and suffered injuries that continue to impair her ability to work and function today as she did prior to the accident; so much for a good deed!
The majority, however, chooses to follow precedents that have nothing to do with the work and time pressures Andrea experienced. In fact, the majority now cites to normal work patterns on normal work days as evidence of her fault on this abnormal work day. Ignoring the accumulated workplace and time pressures Schrecker faced and handled that hectic day (solely for the benefit of her employer), today's opinion places the blame for her injuries squarely on her shoulders. This is a betrayal of our precedents establishing that the Workers' Compensation Act is to be construed liberally, and it contradicts the Act's no-fault standard. For these reasons, I cannot join the majority in their opinion, but would affirm the Court of Appeals, which (similarly to the ALJ and the Workers' Compensation Board) held that Schrecker was entitled to recover for her work-related injuries. Three out of four is not bad.

I do so because our decisions have recognized that, "[a]lthough the employee and the employer have rights under the [Workers' Compensation] Act, the primary purpose of the law is to aid injured or deceased workers." Zurich American Ins. Co. v. Brierly, 936 S.W.2d 561, 563 (Ky. 1996); see also, e.g., Apex Min. v. Blankenship, 918 S.W.2d 225, 229 (Ky. 1996) ("[T]he Workers' Compensation Act is social legislation . . . ." ); Grimes v. Goodlett and Adams, 345 S.W.2d 47, 51 (Ky. 1961) (explaining that the " fundamental object" of workers' compensation law is to secure employees against physical disabilities resulting from employment). To that end, we have held that the Act is to be "construed liberally and in a manner consistent with accomplishing the legislative purpose." Blankenship, 918 S.W.2d at 229. In so doing, we have promoted the no-fault standard underlying the Act.[2] As applied here, our policy of liberal construction of the Act should ensure that an employee injured during a brief pause from her labor for the purpose of ministering to her personal comfort should be compensated without regard to fault. See Meredith v. Jefferson County Property Valuation Administrator, 19 S.W.3d 106, 108 (Ky. 2000). Yet, the majority reaches a contrary result. Because the Court today fails to protect injured Kentucky workers' statutory rights to recover for work-related injuries, I respectfully dissent.

The majority explains that it reached its result after considering several variables identified by Professor Larson in his treatise on workers' compensation law. Larson's variables are meant to help determine whether an employee was within the scope of her employment when she was injured during an off-premises break. 1 Arthur Larson, Larson's Workers' Compensation Law §13.05[4] (2011). As the majority notes, Larson's considerations include: the duration of the break, whether it was paid, whether there were restrictions on where the employee could go during the break, and whether the employee's activity during this period constituted a substantial personal deviation from her employment. Furthermore, the majority agrees with Larson that the operative principle to be determined by the consideration of these variables is whether the employer can be deemed to have retained authority over the employee during the break. I, however, would add to Larson's list consideration of employer time pressures that factor into employee decisions.

Continuing with the majority's analysis, it found that several factors mitigated in favor of Schrecker, including that Schrecker's break was short in duration, paid, and sanctioned by US Bank. However, the majority also found that the employer's lack of restrictions over Schrecker's movement during her break indicated a lack of control. I disagree because employer-generated time pressure is a control factor.

Most importantly, the opinion notes that, "[i]f this were all the evidence, we would likely defer to the ALJ." Only after this admission does the opinion find that Schrecker committed a substantial personal deviation from her employment by stepping into the street. In effect, the majority holds that Schrecker's negligence superseded the other variables, and removed her from US Bank's authority.
I simply disagree. First, because I believe that the employer exerted control over Schrecker through accumulated workplace and time pressures and that the majority's analysis of the employer's authority is at odds with our policy of liberally construing workers' compensation law. And second, because of the manner in which today's opinion injects a fault analysis into workers' compensation law.

Beginning with the issue of US Bank's control over Schrecker, I would note that although US Bank did not limit where Schrecker could go on her break, it did require her to clock "out and in," which is an indication of control in these short time spans. Thus, US Bank exerted control over Schrecker through work-related pressure for her to quickly return to work. In this sense, the employer's continuing control came from the special circumstances and urgency surrounding the meal connected with the increased employer deadline needs because of the absent employee. Professor Larson's treatise recognizes that the employer exerts control over the employee when it encourages a quick meal for the employer's benefit. Id. §13.05[2] & [4], We have simply ignored this here.

Thus, it is entirely reasonable to me to assume that Schrecker did not work six-and-a-half hours without a meal and then rush out to get a quick bite to eat because she wanted to. Her actions were the result of influence asserted by US Bank, and she hurried across the street for her employer's benefit and to save the employer's time. I find nothing unusual or startling about an employee making an absent-minded mistake after a day filled with workplace deadline pressure. The hasty method with which she crossed the street is just as attributable to accumulated workplace and time pressure as it is to her negligence (what the majority calls a substantial personal deviation), thus I would find that her injuries were work-related. Therefore, adhering to our policy of liberally construing workers' compensation, I would have found that US Bank retained sufficient authority over Schrecker to allow her to recover for her work-related injuries.

My viewpoint on this issue is neither novel nor controversial. In fact, several other jurisdictions have decided cases on similar grounds. In King Waterproofing Co. v. Slovsky, the claimant planned to use his twenty-minute paid break to go to a nearby restaurant. 71 Md.App. 247, 524 A.2d 1245, 1246 (Md. Ct. Spec. App. 1987). He was struck by a vehicle while attempting to cross the street. Id. at 1248. The court held that his injury was compensable because he had not deviated from his pursuit of personal comfort. Id. at 1249. Similarly, in Rankin v. Workmens' Comp. Appeals Bd., the claimant had taken off six hours for personal reasons and agreed to make it up by working lunch hours. 17 Cal.App.3d 857, 95 Cal.Rptr. 275 (Ca. App. 1971). During a working lunch hour, she left the premises to get a sandwich and was assaulted while returning. Id. The court held that the claimant was on an errand that was for her personal comfort which was to the advantage of her employer, thus, her injuries were compensable. Id. As another example, in State Dept. of Labor v. Yates, the decedent worked through his lunch hour due to the heavy demands made upon him at work. 131 Ga.App. 71, 205 S.E.2d 36, 37 (Ga. Ct. App. 1974). Late that afternoon, he left for a nearby store to purchase some cookies. Id. As he was returning he fell and suffered a fatal head injury. Id. The board found, and the court affirmed, that he was within the scope of his employment. Id. I believe that the approach taken by the above-cited jurisdictions more accurately embodies the inclusive spirit of our Workers' Compensation Act than the ruling issued by this Court today. The Act meant to remove the tort law concept of fault from workers' compensation cases. Regrettably, the view taken by the majority today reinserts this concept. In the majority's hands, an Act meant to be liberally construed to protect Kentucky's workers without regard to fault threatens to become nearly the opposite—a mechanism by which employers can insulate themselves from liability by asserting
contributory negligence. The Court thus undermines the no-fault premise of the Worker's Compensation Act no less than it does our precedent liberally construing the Act. Thus, I must respectfully dissent.

Cunningham, J., joins.

Notes:

[1] We note that the parties dispute why Schrecker was terminated. She claims it was because she could no longer adequately perform her job duties following her injury. However, US Bank employees testified that she was terminated because she abandoned her job by taking an unapproved vacation. Regardless, it is undisputed that Schrecker had already started another job when her employment at US Bank ended.

[2] The fundamental premise of the Worker's Compensation Act is that injured employees should recover without regard to fault. See KRS 342.610. Stated differently, a worker's negligence is not a factor in determining whether an injury is work-related. Warrior Coal Co., LLC v. Stroud, 151 S.W.3d 29, 31 (Ky. 2004).