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Commonwealth of Kentucky

Court of Appeals

NO. 2015-CA-001255-WC

FLAT ROCK FURNITURE — APPELLANT

v. PETITION FOR REVIEW OF A DECISION OF THE WORKERS' COMPENSATION BOARD ACTION NO. WC-11-70462

STEVEN NEELEY;
HONORABLE WILLIAM J. RUDLOFF, ADMINISTRATIVE LAW JUDGE;
AND WORKERS' COMPENSATION BOARD — APPELLEES

OPINION
AFFIRMING

** ** ** ** **

BEFORE: ACREE, J. LAMBERT, AND MAZE, JUDGES.

LAMBERT, J., JUDGE: Flat Rock Furniture has petitioned this Court for review of the opinion of the Workers' Compensation Board (the Board) affirming the Administrative Law Judge's (ALJ) award of permanent total disability (PTD)

benefits to Steven Neeley as a result of a work-related injury to his eye. Finding no error, we affirm.

Neeley is a 52-year-old resident of Jackson County, Kentucky. He worked for Flat Rock as a machine operator from September 2000 until October 10, 2011. On that day, Neeley sustained an injury to his right eye when a piece of wood hit him. He provided verbal notice to his manager, Clarence Ward, and sought treatment from Dr. Sheila Sanders at the University of Kentucky Hospital. Neeley filed a Form 101 Application for Resolution of Injury Claim on February 23, 2013, seeking benefits for his injury. He attached to his Form 101 a faxed copy of a work status form signed by Dr. Sanders and dated November 27, 2012. Dr. Sanders indicated that Neeley would not be able to complete his usual shift and was not able to drive the company vehicle. She indicated that he was "limited by severe light sensitivity." Dr. Sanders included a handwritten note stating:

> Please note:
>
> Mr. Neeley is visually impaired in his right eye and has intractable diplopia with severe light sensitivity. Currently we have exhausted all possibilities of improving his symptoms. I believe it is unlikely that he can return to work ever unless he experiences spontaneous improvement.

Neeley's next office visit was scheduled for six months later. Flat Rock accepted Neeley's claim as compensable, but disputed the amount of compensation that he was owed.

Neeley filed the Form 107 medical report of Dr. Raymond A. Schultz's independent medical evaluation (IME) dated April 26, 2013. Dr. Schultz said Neeley described his complaints as follows: "[H]e could not drive because of his eye injury and he could not tolerate light. Mr. Neeley related that he could not handle bright light and was still having some pain in the eye. The light sensitivity was constant[,] and he has been wearing a patch over the right eye to reduce glare and double vision." Neeley's corrected visual acuity was 20/70 in his right eye and 20/20 in his left, and Dr. Schultz noted that Neeley had undergone surgery in his right eye. He diagnosed a corneal abrasion of the right eye, resolved, with no residual scarring; contusions of the right orbital area and lids, resolved, without any significant scarring; decreased visual acuity in the right eye; secondary cataract of the right eye; traumatic glaucoma of the right eye; light sensitivity and double vision, unresolved; and maculopathy, unresolved. Dr. Schultz attributed his injury to his complaints and related his diagnoses to the work injury. Dr. Schultz explained: "Mr. Neeley was bending a piece of wood when the wood slipped out of the holder and hit him in the right eye causing his injury. The patient was wearing spectacle glasses at the time of the injury and the patient felt that the wood hit him directly in the eye." Dr. Schultz was unable to assign a permanent impairment rating because Neeley had not yet reached maximum medical improvement (MMI) due to his unresolved issues, including his elevated pressures and traumatic glaucoma. Dr. Schultz also noted that Neeley had recently had cataract surgery for his left eye to "decrease the imbalance in the two eyes in the

glass prescription that he had been wearing." At that time, Neeley was unable to return to the work he performed when he was injured, and Dr. Schultz restricted him from driving and working with machinery until some of his problems had been resolved.

Flat Rock filed the medical reports of Dr. Ben Mackey. Dr. Mackey first saw Neeley on February 11, 2013, for a dilated pupil, glaucoma, eye irritation, double vision, and continual light sensitivity. In addition to the October 2011 eye injury, Dr. Mackey noted that Neeley had been diagnosed with glaucoma in November 2011 and with cataracts in December 2011. He further noted that Dr. Sanders had performed surgery on Neeley's right eye on April 23, 2013, as well as shunt revision on July 18, 2012. He was on several medications to treat his condition. Dr. Mackey diagnosed borderline glaucoma with ocular hypertension and obscuring vision after-cataract, both related to the right eye. He began treating Neeley with medication. In a February 20, 2013, letter, Dr. Mackey stated his belief that Neeley could work but that he would "have difficulty with certain duties including, but not limited to, placing or moving around small objects in a small space, reading very fine print and driving at night." The date he would reach MMI was uncertain. Dr. Mackey recommended a capsulotomy in his right eye and possibly cataract surgery on the left eye to address his anisometropia (a huge difference in his glasses prescription between his two eyes), after which he would need a new prescription for his eyeglasses. Dr. Mackey stated that his injury was causally related to the work accident. Dr. Mackey performed a capsulotomy on

March 7, 2013, and an iridotomy on March 20, 2013, both on his right eye. He also performed cataract surgery on his left eye on April 18, 2013. Dr. Mackey saw Neeley in follow up on April 19, 2013, noting "everything looks good." In a work status form dated May 10, 2013, Dr. Mackey indicated that Neeley could return to his usual work based on his vision exam, but could not drive the company vehicle without glasses. He was able to return to full work without restrictions immediately. Dr. Mackey saw Neeley again on June 8, 2013, when he provided a prescription for glasses to help with certain activities.

On June 3, 2013, Neeley moved the ALJ to bifurcate the threshold issues and determine whether he was entitled to temporary total disability (TTD) benefits based on Dr. Schulz's assessment that he had not yet reached MMI. Flat Rock objected to the motion as moot and moved to place the claim in abeyance, noting that it had approved surgical treatment as recommended by Dr. Schultz and Dr. Sanders and would voluntarily pay TTD benefits while Neeley was in treatment and recovering from the procedure. Flat Rock attached a note from Dr. Mackey dated May 28, 2013, indicating that Neeley's intraocular pressure continued to be high in his right eye, which made him concerned that Neeley would continue to lose his vision. He recommended treatment from a glaucoma specialist, such as Dr. Sanders. The ALJ granted the motion to bifurcate on June 13, 2013.

Flat Rock filed a medical record from Dr. Sanders, which was a letter to Dr. James Huffman dated November 27, 2012, detailing Neeley's office visit with her that day. She provided a history that Neeley had undergone tube shunt explant on

his right eye in August and listed his current eye drop regimen, noting that he had not used any of the drops to treat pressure and wore tinted sunglasses over an eye patch on his right eye. Neeley reported to her that he continued "to have severe photophobia in many lighting situations. The light sensitivity brings on severe pain in the right eye, making him unable to function." Following a physical examination, Dr. Sanders concluded as follows:

> I am at a loss to completely explain Mr. Neeley's symptoms and have little to offer him in the way of additional improvement. As we have previously discussed, the severity of his symptoms seems inconsistent with physical findings, and an element of embellishment is suspected.

Flat Rock filed the medical records of Dr. Huffman. Dr. Huffman saw Neeley on January 27, 2012, related to problems with seeing the color yellow. He diagnosed orbital floor fracture, resolved corneal abrasion, and trauma induced glaucoma in the right eye. Dr. Huffman noted that "Dr. Jim" believed that Neeley could return to work at any time using dark glasses to protect his eye. Dr. Huffman saw Neeley again on March 6, 2012, when he complained of blurred vision. He noted that per "Dr. Amy" it would be alright for him to wear an eye patch to work on March 14, 2012. Dr. Huffman's April 9, 2012, report indicated that Neeley was still complaining of blurred vision.

Neeley filed an "off work" statement from Dr. Sanders dated June 20, 2013. The note stated that Neeley had undergone glaucoma surgery that day and asked that he be excused from work for the next six weeks. Flat Rock then moved to

place the claim in abeyance until Neeley had reached MMI. It attached the operative report from Neeley's June 19, 2013, endocyclophotocoagulation (ECP) of the right eye performed by Dr. Sanders.

At the July 13, 2013, benefit review conference (BRC), the ALJ placed the claim in abeyance until Neeley reached MMI. The parties stipulated jurisdiction under the Act, that an employment relationship existed, that Neeley sustained a work-related injury on October 10, 2010, which was also the last day he worked, that his date of birth is October 26, 1963, and that he is a high school graduate. Contested issues remained benefits, medical expenses, and TTD.

Neeley testified by deposition. For his work at Flat Rock, a company that manufactures furniture, Neeley stated that he operated a saw, drove a forklift, and worked in the bending, shipping, and building departments. He described how he received his injury on October 10, 2011: "We were bending hoops for chairs. One of the pieces, we boil several at once, I had taken one out of the tank, put it in the holder, was preparing to lock it down to finish and it slipped from the holder and the end slapped me in the [right] eyeball." He was wearing eyeglasses at the time, which the wood broke, "and then the end of the stick raked across my eye, impacted it." He had been wearing glasses since he was eight or nine years old to correct his nearsightedness and astigmatism. For treatment, a clean cloth was put over his eye and he was taken to Whitehouse Clinic and then to St. Joseph London. Due to the severity, he was eventually sent to the University of Kentucky emergency room. At UK, the medical providers performed an examination, did a

pressure check, stabilized his eye, and applied numbing spray and a patch. He followed up the next day. He also treated with Dr. Huffman in London, Dr. Mackey in Corbin, and Dr. Schultz in Cincinnati. He underwent three surgeries and multiple laser procedures. He was scheduled for another laser procedure on his right eye at UK with Dr. Sanders the day after the deposition. He had cataract surgery on his left eye to take the strain from his right eye, but he still had double vision.

Neeley testified that he was wearing a patch over his right eye and heavy sunglasses during the deposition due to light sensitivity. He said that, "[a]ny bright light, any bright sunlight then causes extreme pain in the eye and causes loss of vision in the left eye." He had been experiencing this since the work injury. For his medication, he was on three drops to treat his condition. From his perspective, he was not able to go back to work due to his loss of vision and light sensitivity. He was not driving, and he did not have any depth perception. He did not report any problems with his left eye since he had the cataract removed, except for light sensitivity.

Neeley filed the medical records from UK HealthCare for statistical and informational purposes. These records included letters from Dr. Sanders to Dr. Huffman detailing her treatment of Neeley and operative reports. In an eye clinic letter to Dr. Huffman dated July 23, 2013, Dr. Sanders summarized Neeley's treatment in her care. This included tube shunt and cataract extractions on the right eye in April 2012, but the tube shunt was explanted in August of that year. Due to

increasing pressure, Dr. Sanders performed an ECP of the right eye on June 19, 2013. She noted that he continued to have intractable diplopia and severe light sensitivity since the procedure. She also noted his concern about being able to function safely at work due to high visual demands and working with heavy machinery. His uncorrected vision in his right eye was 20/100 and 20/20 in his left eye. An earlier letter to Dr. Huffman dated November 27, 2012, is detailed above. The records also included consultation reports from Dr. P. Andrew Pearson from early 2012.

Flat Rock filed the IME report of Dr. Woodford S. Van Meter dated September 19, 2013. He related Neeley's history and performed a physical examination. Neeley's vision in his right eye was 20/100, and Dr. Van Meter stated that "it is unlikely correctible any better than that." The vision in his left eye was 20/20. Dr. Van Meter stated that Neeley's "vision, because of the chronic glaucoma and retinal membrane, is probably stable but definitely capable of getting worse in the future. The operations that Mr. Neeley had to lower his intraocular pressure were appropriate and justifiable based on his history; he may also require additional surgery in the future." Based upon Neeley's best corrected visual acuity as well as his visual field, Dr. Van Meter assessed a 17% whole person impairment rating. Dr. Van Meter was unable to explain all of Neeley's symptoms, noting that he had "a mild nuclear cataract in his left eye, but his acuity is 20/20 and he does not need cataract surgery in his left eye any time soon. His right eye is stable at this time, and will probably not (possibly will) change. He

has no restrictions on his activity." Flat Rock also filed Dr. Van Meter's supplemental IME report dated November 18, 2013, which included Neeley's visual acuity and visual field test results.

Flat Rock filed a supplemental IME report dated December 3, 2013, further explaining his impairment rating. Dr. Van Meter stated that he did not have an explanation for Neeley's photosensitivity and diplopia. He did not find any evidence "of any clinical correlation to explain his subjective symptoms." He stated that Neeley had reached MMI and that he had used the 6th Edition of the AMA *Guides* to reach his determinations. He said there was "little change numerically" between the 6th and 5th editions. Dr. Van Meter also stated that his right eye condition was stable as long as the vision in Neeley's left eye was 20/20. Neeley was able to return to his preinjury work in furniture manufacturing or any other employment. He added that "[w]hile it would not be practical for him to work in any specific job where stereopsis (depth perception) is necessary, i.e., operating heavy machinery or some power tools where he might be at risk of injury because he does not have adequate depth perception." Dr. Van Meter concluded that Neeley did not have any restrictions or exertion due to his eyes.

On December 6, 2013, Flat Rock moved the ALJ to remove the claim from abeyance because Neeley had reached MMI and a permanent impairment rating had been issued. The ALJ granted the motion.

Flat Rock filed a vocational evaluation report by Dr. Ralph Crystal dated March 17, 2014. Subjectively, Neeley reported that he had sympathetic pain and

sensitivity in his left eye for which he needed low light. He could not use both eyes at the same time due to double vision and blurriness. He also lacked distance vision and depth perception. Neeley described the pain in his right eye as moderate and stated that "the pain in his left eye increases with light and motion." He reported that he was not looking for work because he did "not feel capable of returning to his prior or other work because of the light sensitivity in both eyes and the pain he experiences." He would return to work if he did not have light sensitivity and pain. Based upon the medical records, his interview with Neeley, and various vocational tests, Dr. Crystal concluded that Neeley did "not have a complete and permanent inability to perform any type of work because of the injury." He was not disabled from employment, and he was able to perform his prior work in the furniture industry.

Neeley testified in a follow-up deposition on January 17, 2014. He was not employed and was not seeking employment. He was still taking eye drop medications. He had been diagnosed with diabetes one and one-half years previously, and he took medication for that condition as well. He also took medication to control his blood pressure and for arthritis. Neeley did not report any change in his condition since the last deposition and said he was still not able to drive.

After proof closed, a telephonic BRC was scheduled for June 3, 2014. At the BRC, the parties stipulated to jurisdiction under the Act, than an employment relationship existed, that Neeley sustained a work-related injury on October 10,

2011, that Flat Rock received timely notice, that TTD benefits were paid at a rate of $333.40 per week with the time period to be documented, that his average weekly wage was $500.19, that he last worked on October 10, 2011, that his birthday was August 26, 1963, and that he was a high school graduate. Contested issues remained benefits, overpayment of TTD, vocational rehabilitation, medical benefits, and whether he was entitled to permanent total disability benefits.

The ALJ held a final hearing on June 19, 2014. At the hearing, Neeley testified that he had lost the vision in his right eye and had double or triple vision if he tried to look through both eyes. Regarding his left eye, Neeley stated that he began having light issues with it. He would lose vision in his left eye if he stayed in bright light for an extended period of time. He was unable to drive. At the time of the work incident, Neeley had been wearing glasses to correct his nearsightedness that were shatter proof and met the standards for safety glasses. At the hearing, Neeley was wearing a patch over his right eye as well as standard sunglasses. He also stated that he had been working as a preacher earning $100.00 per month. During the course of the hearing, the parties stipulated that Neeley had sustained a 17% whole person permanent impairment due to his work injury. Flat Rock argued that Neeley was entitled to an award of permanent partial disability (PPD) benefits based on the 17% impairment rating without multipliers, while Neeley argued that he was entitled to PTD benefits.

Following the hearing, Flat Rock filed supplemental stipulations to the effect that TTD was paid for 118 weeks at a rate of $330.75 per week from October 11,

2011, through January 15, 2014, for a total of $39,170.67 and that $78,254.39 had been paid in medical expenses. Flat Rock added a supplemental contest issue related to the payment of TTD benefits; there was an overpayment of $5,717.31 and an underpayment of $273.74 for a total overpayment of $5,443.57.

The ALJ rendered an opinion and order on July 14, 2014. After setting forth the applicable factual background, the ALJ first found that Neeley was entitled to TTD benefits from October 11, 2011, through December 3, 2013, at the rate of $333.46 per week. He based the date on which Neeley reached MMI on Dr. Van Meter's report. Turning to disability benefits, after observing Neeley at the hearing and listening to his testimony, the ALJ made "the factual determination that he was a credible and convincing lay witness and his testimony rang true." The ALJ determined that Neeley was permanently and totally disabled based on the following considerations:

- The severity of his right eye injuries on October 11, 2011;
- His "credible and convincing sworn testimony" at the final hearing;
- Medical evidence from Dr. Schultz;
- The parties' stipulation that Neeley had sustained a 17% permanent impairment due to his work injury;
- His age of 50, "meaning that he is an older worker in the highly competitive job market" and that he would have "an extremely difficult time" in finding any employment;

- That he had not worked since the date of the work injury;
- Neeley's testimony that he had lost his vision in his right eye, had double and triple vision, was sensitive to light in his left eye, did not drive, and could not return to any employment; and
- That he had graduated from high school "many years ago" and did not have any specialized or vocational training.

Based on his conclusion that Neeley "cannot find work consistently under regular work circumstances and work dependably[,]" the ALJ found him to be permanently and totally disabled beginning December 4, 2013, based upon Dr. Van Meter's report that he had reached MMI the day before. The ALJ went on to award medical benefits pursuant to Kentucky Revised Statutes (KRS) 342.020 and found that vocational rehabilitation benefits were not appropriate.

Flat Rock filed a petition for reconsideration, disputing the ALJ's finding that Neeley was entitled to PTD benefits based upon Dr. Schultz's report because the physician did not find him to be at MMI or impose any permanent restrictions on the date of his examination as well as upon Neeley's own testimony because the medical evidence contradicted his testimony. Flat Rock also disputed the ALJ's finding that vocational rehabilitation was not appropriate, pointing out factual errors in the Opinion and Order. The ALJ denied the petition, but amended the Opinion and Order to read that his legal conclusions, rather than factual ones, were that Neeley was permanently and totally disabled and that vocational rehabilitation was not appropriate.

Flat Rock appealed the ALJ's decisions to the Board, arguing that there was no substantial evidence to support the ALJ's finding of PTD and that the ALJ did not support this conclusion with factual findings. Neeley argued in response that there was substantial evidence to support the ALJ's decision, citing to the medical evidence of both Dr. Schultz and Dr. Van Meter as well as the parties' stipulation that Neeley had a 17% whole person impairment. He also argued that his own testimony was competent evidence of both his physical condition and his ability to perform activities.

In an opinion and order entered November 14, 2014, the Board vacated the ALJ's opinion in part and remanded with direction that the ALJ specifically provide his factual findings and the evidence necessary to support his conclusion that Neeley was permanently and totally disabled, holding that "the ALJ failed to provide an adequate analysis of how he reached his determination of permanent total disability." The Board further directed the ALJ to address whether Neeley's left eye complaints were related as well as the medical records and findings of Dr. Sanders, Dr. Mackey, and Dr. Huffman.

The ALJ entered an amended Opinion and Order on January 12, 2015. In addressing his permanent impairment, the ALJ again relied upon Neeley's own testimony as well as his medical providers and examiners. The ALJ specifically found that medical evidence from Dr. Schultz and Dr. Sanders was persuasive and compelling, noting that Dr. Sanders was Neeley's treating eye specialist. Based upon his review of the medical records and Neeley's testimony, the ALJ found his

testimony and Dr. Sanders' medical evidence to be "consistent, credible, persuasive and compelling." Taking into consideration all of the factors, the ALJ again concluded that Neeley was permanently and totally disabled. Similarly, the ALJ awarded medical benefits and found that vocational rehabilitation was not appropriate.

Flat Rock filed a petition for reconsideration of the amended Opinion and Order on remand, disputing the ALJ's attribution of statements in Dr. Sanders' November 27, 2012, treatment record and the existence of cited medical records in the record. Flat Rock also pointed out that some of the records the ALJ relied upon were from before Neeley reached MMI. The ALJ denied the petition, and Flat Rock subsequently filed a notice of appeal to the Board. In its brief, Flat Rock contended that the ALJ used evidence that was not in the record to support a finding that Neeley was entitled to PTD benefits, that the ALJ misconstrued the evidence when he attributed statements to the wrong witness, and that the ALJ relied upon medical conclusions made prior to Neeley reaching MMI to support his finding of PTD. In his brief, Neeley again argued that the ALJ's decision was based upon substantial evidence in the record.

The Board entered an opinion affirming on July 24, 2015. This petition for review now follows.

Pursuant to well-established Kentucky law, "[t]he claimant in a workman's compensation case has the burden of proof and the risk of persuading the board in his favor." *Snawder v. Stice*, 576 S.W.2d 276, 279 (Ky. App. 1979)

(citations omitted). "When the decision of the fact-finder favors the person with the burden of proof, his only burden on appeal is to show that there was some evidence of substance to support the finding, meaning evidence which would permit a fact-finder to reasonably find as it did." *Special Fund v. Francis*, 708 S.W.2d 641, 643 (Ky. 1986). However, "[i]f the board finds against a claimant who had the burden of proof and the risk of persuasion, the court upon review is confined to determining whether or not the total evidence was so strong as to compel a finding in claimant's favor." *Snawder*, 576 S.W.2d at 280 (citations omitted). In addition, we recognize that:

> The ALJ, as the finder of fact, and not the reviewing court, has the sole authority to determine the quality, character, and substance of the evidence. *Paramount Foods, Inc. v. Burkhardt*, Ky., 695 S.W.2d 418 (1985). Where, as here, the medical evidence is conflicting, the question of which evidence to believe is the exclusive province of the ALJ. *Pruitt v. Bugg Brothers*, Ky., 547 S.W.2d 123 (1977).

Square D Co. v. Tipton, 862 S.W.2d 308, 309 (Ky. 1993). Because the ALJ's decision favored Neeley, we must determine whether there was some evidence of substance to support the ALJ's findings.

> Although a court cannot substitute its evaluation of the weight and credibility of the evidence for that of the Workmen's Compensation Board, nevertheless, the findings of fact of the board when it decides in favor of the claimant must be supported by substantial evidence. Substantial evidence means evidence of substance and relevant consequence having the fitness to induce conviction in the minds of reasonable men.

Smyzer v. Goodrich Chemical Co., 474 S.W.2d 367, 369 (Ky. 1971).

For its first argument, Flat Rock contends that the ALJ and the Board relied on two medical records that were not in evidence. These records are a November 27, 2012, work status form and a January 20, 2013, work restriction, both from Dr. Sanders.

Regarding the November 27, 2012, form, Flat Rock states that this record was attached to Neeley's Form 101, but it was not filed separately into evidence and did not meet the requirements of 803 Kentucky Administrative Regulations (KAR) 25:010 Section 8(4). That regulation provides:

> (4) All medical reports filed with Forms 101, 102-0D, or 103 shall be admitted into evidence without further order if:
>
> > (a) An objection is not filed prior to or with the filing of the Form 111; and
> >
> > (b) The medical reports comply with Section 10 of this administrative regulation.

While Flat Rock did not object to the report, it contends that the form did not comply with subsection (b), which references 803 KAR 25:010 Section 10. That section provides in relevant part as follows:

> (2) Medical reports shall be submitted on Form 107-I (injury), Form 107-P (psychological), Form 108-OD (occupational disease), Form 108-CWP (coal workers' pneumoconiosis), or Form 108-HL (hearing loss), as appropriate, except that an administrative law judge may permit the introduction of other reports.
>
> (3) Medical reports shall be signed by the physician making the report, or be accompanied by an affidavit from the physician or submitting party or representative verifying the authenticity of the report.

> (4) Medical reports shall include, within the body of the report or as an attachment, a statement of qualifications of the person making the report. If the qualifications of the physician who prepared the written medical report have been filed with the executive director and the physician has been assigned a medical qualifications index number, reference may be made to the physicians index number in lieu of attaching qualifications.
>
> (5) Narratives in medical reports shall be typewritten. Other portions, including spirometric tracings, shall be clearly legible.

The Board rejected Flat Rock's argument on appeal, observing that Dr. Sanders had signed the form (803 KAR 25:010 §10(3)) and that Flat Rock had submitted her physicians index number when it filed another of her medical reports.

Flat Rock contends that the Board erred as a matter of law because the November 27, 2012, note was not submitted on a Form 107-I, did not include a statement of qualifications or an index number, and the narrative portion was not typewritten, meaning that it did not meet the requirements of the regulation to be admitted into evidence. Flat Rock relies on *Puckett v. Neal's Delivery Serv., Inc.*, No. 2009-CA-001550-WC, 2010 WL 1041054, at *5 (Ky. App. Mar. 19, 2010), to argue that this medical record should not have been considered by the ALJ in reaching his decision:

> Furthermore, we also agree with the Board that 803 KAR 25:010 directs that all medical reports filed with Forms 101 shall be admitted into evidence without further order only if: 1) an objection is not filed prior to or with the filing of the Form 111; and 2) the medical report complies with Section 10 of this administrative regulation. As previously pointed out herein, although

> the medical report was signed by Dr. Hodes, the physician making the report, the medical report did not include Dr. Hodes' qualifications or the medical qualifications index number of the physician as required by Section 10(4). Therefore, because the medical report did not comply with the applicable provisions of Section 10 of 803 KAR 25:010, it could not be submitted into evidence without an order as mandated by 803 KAR 25:010 Section 8(4)(b).

We agree with the Board and Neeley that the ALJ properly relied upon this record because it substantially complied with the applicable regulations. While the document did not contain a statement of qualifications or index number for Dr. Sanders, this information was included in a separate filing by Flat Rock. In addition, the handwritten portion of the record was legible. Therefore, we find no error in the ALJ's reliance on this medical record.

Turning to the second record at issue, the Board also rejected Flat Rock's argument regarding a January 20, 2013, "off work statement," noting that the record filed by Neeley was instead dated June 20, 2013. In other words, the ALJ made a clerical error in noting the date of the record. We agree with the Board and Neeley that the ALJ's reference to the January record rather than the June record was a clerical error, and therefore we find no error on this issue.

For its second argument, Flat Rock contends that the ALJ flagrantly misconstrued the evidence when he attributed Neeley's complaints into a physician's conclusions or objective medical findings. The ALJ summarized Dr. Sanders' medical records as follows:

> The medical records of Dr. Sheila Sanders were filed in the record. In her November 27, 2012 record, Dr. Sanders stated that Mr. Neeley has right eye pain and photophobia in his left eye, that his activities are limited due to light sensitivity stemming from his October 10, 2011 work injury, that Mr. Neeley is visually impaired in his right eye and has untreatable diplopia with severe light sensitivity, and that Mr. Neeley is unable to drive a company vehicle. Dr. Sanders further stated that it is unlikely that the plaintiff can ever return to work unless he experiences spontaneous improvement. In the [June] 20, 2013 record, Dr. Sanders stated that Mr. Neeley is unable to work. In the July 23, 2013 record, Dr. Sanders stated that she is concerned about whether Mr. Neeley will ever be able to function safely at work.

Later in the amended opinion and order on remand, the ALJ found:

> Dr. Sanders was Mr. Neeley's treating eye specialist. She stated that he has right eye pain and photophobia in his left eye. She stated that he is unable to drive a company vehicle. She stated that his activities are limited due to light sensitivity stemming from the October 10, 2011 work injury. She stated that Mr. Neeley is visually impaired in his right eye and has untreatable diplopia with severe light sensitivity. She stated that it is unlikely that he can ever return to work unless he experiences spontaneous improvement. She stated that Mr. Neeley is concerned about being able to function safely at work. She stated that Mr. Neeley is unable to work. I make the determination that the medical evidence from Dr. Sanders, the plaintiff's treating eye specialist, is very persuasive and compelling.

The Board affirmed on this issue, noting that while the ALJ's recitation of Dr. Sanders' letter was "arguably misleading," the ALJ later corrected this by acknowledging that Neeley told Dr. Sanders about his concerns regarding his ability to work. The Board also concluded that the ALJ tacitly endorsed Neeley's

concern about his ability to work safely by repeating this in a letter to Dr. Huffman.

This Court is well aware that "[t]he ALJ, as the finder of fact, and not the reviewing court, has the sole authority to determine the quality, character, and substance of the evidence. Where, as here, the medical evidence is conflicting, the question of which evidence to believe is the exclusive province of the ALJ." *Square D Co. v. Tipton*, 862 S.W.2d at 309, citing *Paramount Foods, Inc. v. Burkhardt*, 695 S.W.2d 418 (Ky. 1985), and *Pruitt v. Bugg Brothers*, 547 S.W.2d 123 (1977). Furthermore, neither this Court nor the Board is permitted to reweigh the evidence. *Whitaker v. Rowland*, 998 S.W.2d 479, 481 (Ky. 1999).

Having considered Dr. Sanders' records as well as the other medical evidence of record, we must agree with the Board that the ALJ corrected his misleading statement in the amended opinion and order related to the July 23, 2013, letter to Dr. Huffman to reflect that it was Neeley's belief that he could not function safely at work as opposed to Dr. Sanders' belief. That clarification, in conjunction with the other evidence from physicians such as Dr. Schultz, provide substantial evidence to support the ALJ's finding in this case. We do, however, agree with the Board that the ALJ could have been more thorough and precise in summarizing Dr. Sanders' records. Had Dr. Sanders been the only medical witness upon which the ALJ based his decision, the result could have been different.

In addition, Flat Rock relies upon language in Dr. Sanders' November 27, 2012, letter to Dr. Huffman to the effect that she could not explain his symptoms

and that she suspected embellishment. We note that the ALJ is permitted to "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 Co. v. Fox*, 19 S.W.3d 88, 96 (Ky. 2000), citing *Caudill v. Maloney's Discount Stores*, 560 S.W.2d 15, 16 (Ky. 1977). But again, had there not been other evidence of record supporting the ALJ's ultimate conclusion, the result may have been different.

For its next argument, Flat Rock contends that the medical evidence the ALJ relied upon to support a finding of PTD was dated before Neeley had reached MMI on December 4, 2013, and constituted temporary restrictions. Therefore, it contends that there was no medical evidence to support the ALJ's finding of PTD. The Board rejected this argument, concluding as follows:

> We first note that there is no blanket prohibition against reliance upon a physician's statement made prior to the attainment of maximum medical improvement. The particular statement was made by Dr. Sanders in the November 27, 2012 report. She indicated her concern Neeley would ever be able to return to work "unless he experiences spontaneous improvement." When considered in conjunction with Neeley's ongoing treatment after this statement was made, we believe it is probative of Dr. Sanders' impression of his overall condition. Stated otherwise, Dr. Sanders' subsequent medical records indicate Neeley never did experience "spontaneous improvement". Rather, his condition worsened and required further surgical intervention.

KRS 342.0011(11)(c) defines "Permanent total disability," in relevant part, 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[.]" In *Brooks v. Univ. of Louisville Hosp.*, 33 S.W.3d 526, 530 (Ky. 2000), our Supreme Court explained, "KRS 342.730 provides a remedy for permanent occupational disability due to work-related injury in the form of income benefits. Income benefits are awarded based upon the amount of occupational disability which exists at the time the worker reaches maximum medical improvement following an injury." In addition to its citation to *Brooks*, Flat Rock cites to *Colwell v. Dresser Instrument Div.*, 217 S.W.3d 213, 217 (Ky. 2006), in which the Supreme Court cited to the Fifth Edition of the AMA *Guides* in its general discussion of how medical impairments are evaluated: "Impairment is considered to be permanent when it has reached maximum medical improvement (MMI), meaning it is well stabilized and unlikely to change substantially in the next year with or without medical treatment." (Internal quotations omitted).

In support of his finding of PTD, the ALJ relied upon the Supreme Court of Kentucky's opinion of *Hush v. Abrams*, 584 S.W.2d 48, 50 (Ky. 1979), for its acceptance of lay testimony to support a permanent disability award in a case decided by the old Board:

> If there is any evidence of a substantial probative nature tending to support the Board's conclusions, this court is without authority to substitute its findings of fact for those of the Board. *Three Point Coal Co. v. Moser*, 298 Ky. 868, 184 S.W.2d 242 (1944); *Armco Steel Corporation v. Mullins*, Ky., 501 S.W.2d 261 (1973).
>
> In the instant case, what we have is lay testimony descriptive of and supportive of a permanent disability,

> together with medical testimony that is not in conflict with lay testimony. The Court of Appeals concluded that the Board based its opinion and award on lay evidence as opposed to medical testimony. To this premise the Court of Appeals applied *Walker v. Porter Product Finishers*, Ky., 505 S.W.2d 178 (1974), and concluded that the decision of the Board was not supported by substantial evidence. In *Walker* the Workmen's Compensation Board granted an award for so long as Walker remained disabled (open-end award), not to exceed 425 weeks. On appeal to the Jefferson Circuit Court, the open-end portion of the award was reversed. In doing so, the circuit judge wrote:
>
> > " '* * * that this action be and hereby is remanded to the Board for a determination of plaintiff's disability based upon the medical evidence * * *.' "
>
> This court said:
>
> "The circuit court has misapplied the law; we are unaware of any requirement that the Board need consider only medical evidence in making its determination. As we have stated before:
>
> " '* * * as the basis for an award * * * there must be some evidence showing to what extent the claimant is "disabled." This is not always exclusively a matter of medical testimony * * *. In many cases, particularly those involving internal injuries, medical evidence may be the only competent evidence to prove the actual bodily condition of the employe * * * ; but once the bodily condition has been established, lay testimony may be competent on the question of the extent of the Disability that has resulted from the bodily condition.' "

The *Hush* Court went on to rely upon the holding in a much earlier case to support its holding:

> In *City of Olive Hill v. Parsons*, 306 Ky. 83, 206 S.W.2d 41 (1947), we wrote:

> "Appellant also raises a question concerning the extent and duration of appellee's disability. It suggests that the testimony of the employee without any medical evidence is not sufficient to support a finding of permanent disability. Disability is a question of fact to be determined by the Board, and we know of no rule which requires the employee to produce medical proof. Appellee himself testified at length with respect to his condition and his inability to obtain regular employment. He stated that since March 1943 he had worked about one-fourth of the time, and that was principally light work. There seems to be no question that he is suffering from a recurrence of the hernia, and is to some extent disabled. A review of all the evidence in the case convinces us that it was sufficient as a basis for the Board's finding of seventy-five percent partial permanent disability."

Hush, 584 S.W.2d at 50-51.

More recently, the Supreme Court cited *Hush* for the proposition that "[a]lthough causation and the date of MMI are medical questions, a worker's testimony may provide adequate support for a finding concerning his inability to work at a particular point in time." *Arnold v. Toyota Motor Mfg.*, 375 S.W.3d 56, 61 (Ky. 2012). In *Arnold*, the Supreme Court addressed whether the worker was entitled to temporary total disability benefits.

In the present case, the ALJ found that Neeley's lay testimony and Dr. Sanders' expert medical evidence were "consistent, credible, persuasive and compelling." He relied upon Dr. Van Meter's expert opinion for the date on which Neeley reached MMI and upon Dr. Sanders' testimony for causation. The ALJ

also relied upon Neeley's own testimony to determine that he was permanently and totally disabled. He considered such factors as Neeley's age, the competitive nature of the job market, his lack of specialized or vocational training, Neeley's testimony of the problems he has with his vision in both eyes, and his inability to be able to find regular, gainful employment. We acknowledge that this issue is a close call, as Flat Rock correctly points out that no physician assigned any permanent restrictions after Neeley had reached MMI. However, as the Board held and the case law supports, lay testimony is sufficient in this instance to support the ALJ's finding that Neeley was permanently and totally disabled. Therefore, we affirm the Board's opinion on this issue.

Finally, Flat Rock contends that the ALJ failed on remand to comply with the Board's direction to identify evidence of a work-related injury to Neeley's left eye. Among other directions related to specific findings, the Board directed the ALJ to "address whether the left eye complaints are related, and why." In both the opinion and order on remand and the order on reconsideration, the ALJ mentioned Neeley's left eye complaints and attributed to Dr. Sanders a statement that he had photophobia in his left eye. However, the ALJ did not address whether the left eye complaints were related to his work injury. Rather, the ALJ noted that "Dr. Mackey's medical records reflect that Mr. Neeley suffered from light sensitivity in his left eye after his work injuries and performed surgery on the left eye to improve the plaintiff's condition." However, as Flat Rock points out, Dr. Mackey's records do not reflect that Neeley had light sensitivity in his left eye; his records only

mention light sensitivity in the right eye, which had been injured in the work accident. But because Dr. Sanders mentioned Neeley's complaints of light sensitivity in his left eye in her medical reports, which we have addressed above, we hold that this is sufficient to overcome Flat Rock's argument. As we have stated previously in this opinion, the ALJ is cautioned to carefully summarize the medical records supporting his findings of fact and conclusions of law.

Accordingly, and for the foregoing reasons, we affirm the opinion of the Board affirming the ALJ's opinion and order on remand.

ALL CONCUR.

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