IMPORTANT NOTICE

NOT TO BE PUBLISHED OPINION

THIS OPINION IS DESIGNATED "NOT TO BE PUBLISHED." PURSUANT TO THE RULES OF CIVIL PROCEDURE PROMULGATED BY THE SUPREME COURT, CR 76.28 (4) (c), THIS OPINION IS NOT TO BE PUBLISHED AND SHALL NOT BE CITED OR USED AS AUTHORITY IN ANY OTHER CASE IN ANY COURT OF THIS STATE.

RENDERED: JANUARY 23, 2003
NOT TO BE PUBLISHED

Supreme Court of Kentucky

FINAL
DATE 2-13-03 Elna Grayson, D.C.

2002-SC-0124-WC

DAVID BOWEN — APPELLANT

V.

APPEAL FROM COURT OF APPEALS
2001-CA-0975-WC
WORKERS' COMPENSATION BOARD NO. 00-0276

PONTIKI COAL CORPORATION, ET AL. — APPELLEE

MEMORANDUM OPINION OF THE COURT

AFFIRMING

In two-to-one decisions, the Court of Appeals and the Workers' Compensation Board (Board) have affirmed a decision that the claimant failed to prove either a physical or mental occupational disability due to his work-related injury. Appealing, he maintains that his evidence of a permanent functional impairment compelled a finding of permanent, partial disability under the 1996 Act. We affirm.

Sometime in 1996, the claimant injured his back, but he did not pursue a workers' compensation claim. On March 10, 1998, he injured his lower back and twisted his right knee when he stepped in a hole while working as a stationary equipment operator. His duties involved operating different types of equipment, running a dozer and a dryer, helping the mechanic, filling in for others who were off work, and doing whatever else was needed. He testified that although he did not miss any work after the incident, he was given light duty thereafter. Although he testified that light duty

work consisted of sitting around the office, he also testified to performing a number of his regular duties while on light duty, including operating a dozer.

Although the claimant maintained that he was unable to work after September 2, 1998, due to the effects of his injury, he went to the mine on September 3, 1998, at which time he was laid off because the operation shut down. He testified that although he had received several job offers since being laid off, he had declined them because he remained unable to work. In addition to his physical problems, he alleged that the injury caused problems with his nerves for which he underwent counseling and took Prozac. When asked why, if he was unable to work, he did not seek counsel about filing a claim until February, 2000, he testified that he had spoken with his employer about receiving benefits and was waiting to see if the company would pay.

The claimant's testimony concerning his medical treatment was confusing and sometimes contradictory. Dr. Chaffin was his treating physician and eventually referred him to Drs. Jenkinson and Lowe. Although he continued to see Dr. Chaffin each month for prescriptions for Tylenol 3 and muscle relaxants, Dr. Chaffin's treatment records were not introduced into evidence. As a result, it was impossible to be certain whether he first saw Dr. Chaffin the day after the injury or six months later, on September 2, 1998. He testified that his medical expenses were paid through his health insurance while he was working and that he paid them, himself, after his insurance expired.

The employer introduced an affidavit from Carolyn VanHoose, its disability administrator. She averred that the claimant gave notice of his accident on March 10, 1998, that he did not miss work as a result of the accident, that he continued to work as a stationary equipment operator from March 10, 1998, through September 3, 1998, and that he never presented any bills for medical treatment to the employer.

Dr. Rapier evaluated the claimant on January 3, 2000. His report notes a history of the 1996 injury but, for some reason, indicates that the current injury occurred in April, 1999. Although he attributed the claimant's knee and back conditions to the work-related accident, he did not state which accident. He indicated that the claimant quit working "mostly because of his lower back pain" and made no reference to the lay-off. Dr. Rapier found evidence of muscle spasm and decreased range of motion in the back, and he concluded that the knee pain was more likely related to the back pain than a separate injury. He noted that September 14, 1998, x-rays were negative, aside from showing mild degenerative changes, and that a November 2, 1998, MRI was negative, aside from a decreased signal in the last two lumbar disc spaces. He diagnosed a possible right knee strain and a lumbar strain that aggravated pre-existing, dormant, degenerative disc disease with some right sided radiculopathy. Dr. Rapier assigned a 10% impairment, imposed various work restrictions, and indicated that the claimant did not retain the physical capacity to return to his previous work.

Dr. Johnson, a psychologist, performed various tests, including a test of memory which indicated that the claimant might well be malingering. Furthermore, his low IQ score of 55 did not appear to be consistent with his 21-year history of working in the mines. Dr. Johnson diagnosed single episode major depression, mild, but wanted to rule out social phobia and malingering. Although receiving a history of prior depression and an April, 1999, work injury, Dr. Johnson attributed the present depression to the work injury. He noted that other records indicated that the correct injury date was April, 1998, and that the claimant had quit working on September 2, 1998, due to pain. Dr. Johnson indicated that the claimant had not yet reached maximum medical improvement (MMI), that he had a current impairment rating of 45%, and that a more

permanent rating would likely be 25%, assuming that he was not malingering and that the Prozac was helping. Dr. Johnson recommended a re-evaluation in about one year.

Dr. Granacher, a psychiatrist, also evaluated the claimant at his attorney's request on June 22, 2000. Memory testing yielded a higher score than Dr. Johnson had obtained. Nonetheless, the MMPI-2 validity scores indicated that the resulting profile was invalid. Based upon his entire evaluation, Dr. Granacher diagnosed major depression due to the painful injury of March 10, 1998, functional illiteracy, mild mental retardation, and minor disc degeneration from L4 through S1 with no signs of nerve root compression. He assigned a 10% psychiatric impairment due to depression. Furthermore, he explained psychological testing is not accurate in individuals with an IQ below 65 or 70 and that the claimant's IQ had measured 63. He indicated that mentally retarded individuals are more likely than those of normal intelligence to become depressed in the face of difficult life circumstances. In reviewing the report, the Administrative Law Judge (ALJ) noted that although Dr. Granacher usually does so, he did not indicate whether the claimant could return to work from a psychiatric standpoint, alone.

The employer offered a report from Dr. Jenkinson, who saw the claimant on December 3, 1998, on referral from Dr. Chaffin. At the time, the claimant complained of low back pain that radiated into the right leg. An MRI revealed very minor disc degeneration from L4 to S1, without evidence of herniation or nerve compression, findings that were considered to be normal for a man of his age. In view of the fact that bilateral straight leg raising was normal, and there were no neurological deficits, Dr. Jenkinson was unable to explain the reason for continued back pain. He suggested a physical therapy and exercise regime, but the claimant declined.

Dr. Lowe, saw the claimant on February 5, 1999, also on referral from Dr. Chaffin. His report was introduced by the employer. It indicated that, except for a slightly decreased range of motion, the physical examination was normal. Furthermore, Dr. Lowe found the MRI films to be normal, although there was some dessication in the two lower disc spaces but no evidence of herniation or stenosis. He advised the claimant to stay active. Although he thought that there were insufficient findings to make a specific diagnosis, he noted a lumbosacral strain.

Dr. Goldman evaluated the claimant on May 9, 2000, on behalf of the employer. He reviewed the records of Drs. Rapier and Johnson, noting that the claimant was a poor historian. The claimant advised Dr. Goldman that he saw Dr. Chaffin on the day after the injury and had been treating with him weekly during the 6-month period between the injury and September 2, 1998, at which point he quit working due to increased low back and right leg pain. He rated his pain as 10 out of 10 for the past 30 days, and his range of motion was severely limited due to pain. He informed Dr. Goldman that Dr. Jenkinson had advised surgery. After performing an extensive physical examination and a functional capacity evaluation, during which it was noted that the claimant provided submaximal effort and engaged in symptom magnification, Dr. Goldman reported some evidence of bilateral L5 radiculopathy that did not rise to the level of being diagnostically significant. He assessed an impairment rating of 5% due to muscle spasm but noted that it was difficult to be certain whether the claimant had reached MMI because he had undergone no physical rehabilitation. Dr. Goldman thought that physical therapy would be beneficial and would enable the claimant to return to his work.

Dr. Shraberg performed a psychiatric evaluation on behalf of the employer on May 23, 2000. He was informed of the 1996 and 1998 injuries and that the claimant quit working on September 10, 1998, due to back pain, but he was not informed of the lay-off. His notes also refer to the claimant's statements that Dr. Lowe had informed him he would be in pain the rest of his life, statements that the ALJ noted were contrary to Dr. Lowe's report. Dr. Shraberg noted that the claimant was uncooperative and made a very poor effort that was consistent with overwhelming symptom magnification and bordering on possible malingering. Furthermore, the MMPI-2 resulted in an invalid profile. In Dr. Shraberg's opinion, the injury appeared to be mild and associated with a mild degree of degenerative disc disease, and the claimant's degree of pain appeared to be vastly disproportionate. Thus, he agreed with Dr. Johnson's report of possible malingering. He concluded that there was no psychiatric impairment that would prevent the claimant from returning to his work and no evidence of mental retardation or impairment.

After reviewing the evidence, the ALJ determined that the claimant had failed to prove that he was disabled by the March 10, 1998, incident, noting that he had been "less than forthright" by failing to inform the various physicians that he was laid off on the day after he allegedly decided that he was no longer able to work. Furthermore, the December, 1998, MRI revealed a normally aging spine, with no evidence of disc herniation or nerve entrapment. Likewise, the ALJ was not persuaded that the claimant had sustained a work-related psychiatric disability, concluding that he had engaged in symptom magnification. In reaching this conclusion, the ALJ specifically noted that Dr. Johnson, the claimant's own witness, had indicated that an IQ of 55 was inconsistent with his work history. The ALJ also noted that the claimant was able to

respond coherently to all questions that were presented to him at the hearing. In further support of the conclusion that the claimant appeared to have "settled into a disability role" and did not appear to be interested in returning to work, the ALJ noted the failure to introduce Dr. Chaffin's records into evidence and the "extremely vague histories of what treatment, if any, he actually received subsequent to the injury and prior to the lay off herein." Noting that the claimant had refused earlier physical therapy and reconditioning, the ALJ indicated that, should he change his mind, the employer would be responsible for payment. Otherwise, the injury appeared to have caused no pathology for which medical treatment was necessary.

Petitioning for reconsideration, the claimant pointed to the evidence from Drs. Rapier and Goldman that he had sustained a functional impairment from the injury. He asserted that there was no substantial evidence that he did not have a functional impairment and asserted, therefore, that a partial disability award was compelled as a matter of law. He also pointed out that, unlike Dr. Johnson, Dr. Granacher had indicated that the IQ score he obtained was valid. For that reason, he asserted that the question of psychiatric impairment should be reconsidered in light of Dr. Granacher's findings. Nonetheless, the petition was denied.

Appealing decisions that affirmed, the claimant focuses on the fact that the 1996 version of KRS 342.730(1)(b) relies upon impairment ratings when determining the extent of permanent, partial disability rather than upon the Osborne v. Johnson, Ky., 432 S.W.2d 800 (1968), factors. See Adkins v. R & S Body Co., Ky., 58 S.W.3d 428, 431 (2001). He maintains that under the 1996 statute, the ALJ lacks discretion to make a finding concerning disability unless it is based upon a functional impairment that is of record. Neither Dr. Lowe nor Dr. Jenkinson testified that the back injury did not cause a

functional impairment; whereas, Drs. Rapier and Goldman testified that it did. Thus, the claimant concludes that findings of impairment and disability due to the back injury were compelled as a matter of law. He makes no argument with regard to the alleged psychological injury

The burden was on the claimant to prove every element of his claim. After reviewing the evidence, the ALJ determined that the claimant had failed to meet his burden of proving that he was disabled by his injury. The rationale for doing so was based solely on the medical evidence and the claimant's credibility. There was no mention, whatsoever, of the Osborne v. Johnson, supra, factors. For that reason, there is no indication that the ALJ might have failed to apply the proper law to the facts or that the claim should be remanded for further findings of fact as the dissents at the Board and the Court of Appeals proposed.

Drs. Lowe and Jenkinson saw the claimant for the purposes of treatment, on referral from Dr. Chaffin who was not asked to testify. It is apparent from their testimonies that neither physician thought the injury caused a harmful change that was permanent. Thus, it was not unreasonable for the ALJ to infer that they thought the injury caused no permanent impairment. We are persuaded, therefore, that their testimonies were sufficient to overcome those of Drs. Rapier and Goldman. In any event, there is no merit in the claimant's argument that there must be substantial evidence to support a finding that the party with the burden of proof failed to meet that burden. Butcher v. Island Creek Coal Co., Ky., 465 S.W.2d 49, 51 (1971).

The decision of the Court of Appeals is affirmed.

All concur.

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