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NOT TO BE PUBLISHED OPINION

THIS OPINION IS DESIGNATED "NOT TO BE PUBLISHED." PURSUANT TO THE RULES OF CIVIL PROCEDURE PROMULGATED BY THE SUPREME COURT, CR 76.28 (4) (c), THIS OPINION IS NOT TO BE PUBLISHED AND SHALL NOT BE CITED OR USED AS AUTHORITY IN ANY OTHER CASE IN ANY COURT OF THIS STATE.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: OCTOBER 19, 2006
CORRECTED: October 24, 2006
NOT TO BE PUBLISHED

Supreme Court of Kentucky

FINAL
DATE 11-9-06 ELAGraumP.C.

2006-SC-0010-WC

KEVIN JAMES STOCTON — APPELLANT

V.

APPEAL FROM COURT OF APPEALS
2004-CA-2637-WC
WORKERS' COMPENSATION NO. 03-96811

J. L. FRENCH; HON. IRENE STEEN,
ADMINISTRATIVE LAW JUDGE; AND
WORKERS' COMPENSATION BOARD — APPELLEES

MEMORANDUM OPINION OF THE COURT

AFFIRMING

The Workers' Compensation Board and the Court of Appeals affirmed an Administrative Law Judge's (ALJ's) decision to dismiss the claimant's application for benefits on the ground that his physical complaints were not work-related and that notice was incomplete. Appealing, he raises two arguments: 1.) that because he submitted uncontroverted medical evidence that proved his work for the defendant-employer to be the cause of his cervical condition, the ALJ erred by failing to rely on it, and 2.) that the ALJ failed to state sufficient reasons for the finding regarding notice. Having concluded that the medical evidence was not so overwhelming as to compel a favorable finding and that the claimant failed to preserve his notice argument by requesting a further explanation, we affirm.

The claimant's application for benefits alleged that on March 1, 2002, he

sustained injuries to his back, neck, abdomen, and right arm due to a fall while loading parts and also to lifting while on the production line. He had an extensive medical history that included references to longstanding alcohol and drug abuse, prior injuries to his head and right shoulder, and a brain tumor for which he refused to have surgery. He acknowledged that he had been convicted of 3rd degree burglary and theft by unlawful taking, convicted three times for alcohol intoxication, three times for DUI, and three times for passing cold checks.

In April, 2000, the claimant was involved in a non-work-related, head-on automobile accident. In the emergency room, he complained of neck and shoulder pain as well as numbness, tingling, and loss of grip strength in the right hand. He was diagnosed with a cervical strain and was given a soft collar and medication. A September 25, 2001, letter from Dr. Brooks (his family physician) noted that extensive x-rays revealed no bony fractures, but emergency room physicians were "impressed with the seriousness of the injury" and prescribed narcotic pain medications. The claimant sustained "very significant soft-tissue type injuries" and was very slow to respond to treatment. Dr. Brooks stated that he was "totally incapacitated for at least a year following this accident" and just now could "consider resuming some semblance of normal activities." He would be limited in lifting or pushing heavy items and in the flexibility of his neck and lower back and also had some residual neurological deficits of his right upper extremity. He would require treatment for significant psychological problems due to the delay in beginning a normal life and having to live with ongoing pain, and he would continue to require extensive long-term medical treatment, including physical therapy and medication. Testifying subsequently about the accident, the claimant stated that his symptoms were attributed to "muscle strain," that they resolved

within two months, and that they required no further medical treatment.

In October, 2001, the claimant began working for the employer's automotive parts manufacturing facility. After operating a "C dial machine" for a while, he moved to the B oil pan line, where he used his left hand to remove the parts and set them down. In January, 2002, he was transferred to the A line, which required him to use his right hand. Shortly thereafter, he began to experience pain down the right side of his neck, shoulder, and arm as well as numbness in his right thumb, index, and middle fingers. He attributed the symptoms to muscle soreness initially, but they persisted. In mid-February, he informed his supervisor and was transferred to the crankshaft area. There, he lifted 28-pound parts from the floor and placed them into a machine at chest level. After a couple of shifts, he developed a crick in the neck, told his supervisor, and was advised to tough it out.

The claimant stated that about three days later he informed Radonna Jewell, who worked in human resources, that he was going to Dr. Brooks. He signed a paper requesting leave, but Ms. Jewell filled it in because he did not understand it. He later testified that he thought he was requesting workers' compensation benefits rather than sick leave. A signed application for accident and sickness benefits indicated that he first noticed symptoms on April 21, 2002; that he first sought treatment on April 23, 2002, from Pamela Bills; that he last worked on April 23, 2002; and that the symptoms were not related to his job. Confronted with the form, the claimant insisted that he did not fill it in but only signed it. He asserted that he told Ms. Jewell that his injury was work-related and tried to ask about workmen's comp or getting his bills paid.

Ms. Jewell testified subsequently that she read each question to the claimant and recorded his responses on the accident and sickness leave application. She stated

that his personnel file contained no accident reports or any mention of a work-related injury. Angie Read, the company nurse, testified subsequently that company policy required her to be notified if a worker indicated that a medical condition was work-related. She knew of nothing that suggested the claimant's neck condition was work-related. The claimant's supervisor testified that at the end of 2001 or early 2002 the claimant told him that he was experiencing shoulder pain. He stated that he asked the claimant if he injured himself at work and was told that an old injury from an auto accident had flared up.

An April 26, 2002, report by Pamela Bills, a nurse practitioner in Dr. Brooks' office, indicated that the claimant had thrown horse shoes on Sunday, taken a nap, and awakened with a spasm in the right neck and shoulder and numbness in his right thumb. He had first been seen at the office on April 23, and diagnosed with a right neck/trapezius muscle strain. His neck was worse, and he was holding it to the right. He was given an excuse for light duty work and prescribed Bextra, Valium, and Lortab. X-rays taken that day revealed mild disc space narrowing at C5-6.

A subsequent MRI revealed a right paramedian disc protrusion at C5-6 and a mild disc displacement or bulge at C6-7. On May 16, 2002, Ms. Bills indicated that the claimant needed to be off work until he was seen by a neurosurgeon. A May 21, 2002, report by Ms. Bills referred to the diagnostic findings and indicated that the condition did not arise from the claimant's employment. After recovering from a cervical diskectomy and fusion, the claimant was released to return to work with a 10-pound lifting restriction. The employer terminated him shortly thereafter.

In a letter dated February 25, 2003, Dr. Brooks stated that the claimant sustained a work-related injury in April, 2002. After MRI, he had undergone a June,

2002, surgery at C5 but retained some residual numbness and difficulty with the radial and median nerve distribution in his right hand. He continued to require aggressive treatment, including epidural injections, and was unable to work. The letter stated that the prior neck injuries from the automobile accident had resolved and that Dr. Brooks did not believe them to be a factor in the need for surgery in 2002. The letter concluded that the claimant had sustained a significant injury to his neck with residual difficulties that could reasonably be expected to affect him for the rest of his life.

Dr. Whobry performed an IME on July 1, 2003. She reviewed some medical records, examined the claimant, and noted that he attributed his symptoms to repetitive activities with his right arm while working on an assembly line in March, 2002. Noting that the C5-6 disc herniation correlated with his symptoms, she determined that the herniation and right arm symptoms were due to his work in the spring of 2002. She assigned a 25% impairment and restricted him from lifting more than 25 pounds. In her opinion, he could not return to his work.

The claimant acknowledged that he received a settlement of $4,000.00 for lost wages due to the automobile accident. He also acknowledged that he injured his neck on April 21, 2002, while playing horseshoes at his home. Finally, he acknowledged that he struck his head and suffered a brief loss of consciousness after falling off a deck at a party on August 17, 2002.

After summarizing the evidence, the ALJ noted that there was ample medical evidence to indicate that the claimant's cervical condition was due to "non-work-related activities and accidents." The ALJ was not convinced that the claimant thought he was signing a form for workers' compensation rather than sickness and accident benefits. Nor was the ALJ convinced by Dr. Brooks' letter of February 25, 2003, particularly in

light of his September 25, 2001, letter. The ALJ also found that notice was "incomplete" and dismissed the claim.

In a petition for reconsideration, the claimant asserted that the ALJ committed patent error by disregarding his uncontradicted medical evidence and finding that he failed to prove causation. The claimant did not request an explanation of the ruling regarding notice. Instead, he asserted that the ALJ committed patent error by relying on his supervisor's testimony that he attributed his symptoms to the automobile accident and concluding that he failed to prove notice. The claimant reasoned that his medical evidence established that the injury was cumulative and that he had no reason to think that he had a work-related gradual injury until Dr. Brooks' letter of February 25, 2003. Therefore, notice was proper because he filed his claim on February 6, 2003.

The claimant had the burden to prove every element of his claim, including the fact that his cervical condition was work-related. Having failed to convince the ALJ, his burden on appeal is to show that the favorable evidence was so overwhelming that the ALJ's conclusion was unreasonable. He relies on Mengel v. Hawaiian-Tropic Northwest and Central Distributors, Inc., 618 S.W.2d 184 (Ky. App. 1981), for the principle that an ALJ may not disregard uncontradicted medical opinions regarding a matter that requires medical expertise. He maintains that because no medical evidence contradicted the opinions of Drs. Brooks and Whobry that his cervical condition was caused by his work, the ALJ had no choice but to rely on them. We disagree.

In Bullock v. Gay, 296 Ky. 489, 177 S.W.2d 883, 885 (1944), the court discussed the effect of uncontradicted testimony, explaining as follows:

> The general rule in respect to the weight to be accorded uncontradicted testimony is: If the witness is disinterested, and in no way discredited by other evidence, and the

> testimony is to a fact not improbable or in conflict with other evidence, and is within his own knowledge, such a fact may be taken as conclusive.

In Osborne v. Pepsi-Cola, 816 S.W.2d 643 (Ky. 1991), the court cited that explanation when rejecting the notion that an ALJ lacks the authority reject an uncontradicted medical opinion that the ALJ finds to be unreliable. Subsequently, in Cepero v. Fabricated Metals Corp., 132 S.W.3d 839 (Ky. 2004), the court explained that a medical opinion based upon a substantially inaccurate or largely incomplete medical history and unsupported by other credible evidence is not substantial evidence.

KRS 342.285 designates the ALJ as the finder of fact in workers' compensation claims. Even in matters requiring medical expertise, it is the ALJ's function to consider all of the evidence, to draw reasonable inferences, and to determine the character, quality, and substance of a physician's testimony. An ALJ may reject even an uncontradicted medical opinion if there is a reasonable basis for doing so. In Mengel, supra, there was no conflict between the medical experts and no other evidence that called the reliability of their opinions into question; therefore, to reject their opinions was unreasonable. The evidence in the present case was considerably different.

The claimant alleged that he sustained injuries to his back, neck, abdomen, and right arm on March 1, 2002, due to a fall while loading parts and to lifting while on the production line. In a letter written less than six months before the alleged injury, Dr. Brooks had stated that a neck injury sustained in a non-work-related automobile accident resulted in neurological deficits, significant limitations, and the need for extensive, long-term medical treatment. No medical evidence refers to a fall at work, and the claimant did not testify to such a fall. He first sought medical treatment at Dr. Brooks' office on April 23 and 26, 2002, and gave Ms. Bills a history of neck and

shoulder pain that began on April 21 after throwing horseshoes. The records from Dr. Brooks' office that were in evidence contained no mention of a work-related injury in the spring of 2002 and nothing to connect the claimant's symptoms to his work. Nonetheless, the February 25, 2003, letter stated that the prior neck injury had resolved before the claimant sustained a significant work-related neck injury in April, 2002; that the work-related injury necessitated the surgery; and that it caused permanent residual deficits. Under the circumstances, the 2001 letter and other evidence of record formed a reasonable basis for the ALJ to the reject the opinions expressed in the 2003 letter.

Dr. Whobry prepared her report in July, 2003, at the request of the claimant's attorney. She diagnosed a work-related repetitive motion injury, but she clearly indicated that she based her opinion of causation on the history related by the claimant and that she assumed his representations to be true and correct. Dr. Whobry's report failed to note that the neck pain treated on April 23 and 26, 2002, began after playing horseshoes. Nor did it indicate that she reviewed the medical records relating to the non-work-related automobile accident; that she saw Dr. Brooks' letter from September, 2001; or that she was aware of the claimant's other previous Injuries. Unlike the situation in Mengel, supra, the record contained an ample basis to question the accuracy and completeness of the history on which Dr. Whobry based her opinions. Under the circumstances, it was reasonable for the ALJ to reject them.

Relying on Big Sandy Community Action Program v. Chaffins, 502 S.W.2d 526 (Ky. 1979), and Shields v. Pittsburgh & Midway Coal Mining Co., 634 S.W.2d 440 (Ky. App. 1982), the claimant asserts that the ALJ failed to provide a sufficient rationale for concluding that notice was incomplete, precluding a meaningful appellate review. In

Eaton Axle Corp. v. Nally, 688 S.W.2d 334 (Ky. 1985), the court explained, however, that a party must request all necessary findings at the administrative level before appealing to a court. Because the claimant failed to bring this alleged deficiency to the ALJ's attention and request an explanation, he failed to preserve an argument that the ALJ erred by failing to provide one.

The decision of the Court of Appeals is affirmed.

All concur.

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ORDER CORRECTING OPINION

On the Court's own motion, page 7 of the above-styled opinion is hereby corrected due to a typographical error. Copies of page 1 and page 7, as corrected, are attached hereto and are substituted for pages 1 and 7 of the opinion rendered on October 19, 2006.

ENTERED: October 24, 2006

Chief Justice

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