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NOT TO BE PUBLISHED OPINION

THIS OPINION IS DESIGNATED "NOT TO BE PUBLISHED." PURSUANT TO THE RULES OF CIVIL PROCEDURE PROMULGATED BY THE SUPREME COURT, CR 76.28(4)(C), THIS OPINION IS NOT TO BE PUBLISHED AND SHALL NOT BE CITED OR USED AS BINDING PRECEDENT IN ANY OTHER CASE IN ANY COURT OF THIS STATE; HOWEVER, UNPUBLISHED KENTUCKY APPELLATE DECISIONS, RENDERED AFTER JANUARY 1, 2003, MAY BE CITED FOR CONSIDERATION BY THE COURT IF THERE IS NO PUBLISHED OPINION THAT WOULD ADEQUATELY ADDRESS THE ISSUE BEFORE THE COURT. OPINIONS CITED FOR CONSIDERATION BY THE COURT SHALL BE SET OUT AS AN UNPUBLISHED DECISION IN THE FILED DOCUMENT AND A COPY OF THE ENTIRE DECISION SHALL BE TENDERED ALONG WITH THE DOCUMENT TO THE COURT AND ALL PARTIES TO THE ACTION.

RENDERED: AUGUST 21, 2008
NOT TO BE PUBLISHED

Supreme Court of Kentucky

FINAL
DATE 9-11-08 ELA

2007-SC-000545-WC

BARRY LONG — APPELLANT

V.

ON APPEAL FROM COURT OF APPEALS
2006-CA-002555-WC
WORKERS' COMPENSATION BOARD NO. 03-01735

AHLSTROM USA;
HON. IRENE STEEN,
ADMINISTRATIVE LAW JUDGE AND
WORKERS' COMPENSATION BOARD — APPELLEES

MEMORANDUM OPINION OF THE COURT

AFFIRMING

An Administrative Law Judge (ALJ) determined that the claimant failed to show that his chronic pain and psychiatric condition resulted from a work-related back injury and, thus, dismissed his application for benefits. The Workers' Compensation Board affirmed and the Court of Appeals affirmed the Board. We affirm because the evidence did not compel a decision in the claimant's favor.

The claimant testified that he experienced severe pain in his low back and legs on January 7, 2003, when pulling a four-foot length of pipe out of a drum of chemicals. He reported the incident to his supervisor, sought medical treatment, and returned to work the next day on restricted duty. MRI performed on January 24, 2003, revealed the presence of bulging discs at T12-L1, L1-L2, and L5-S1.

After physical therapy failed to relieve the claimant's symptoms, he saw Dr. McComis, an orthopedic surgeon. Dr. McComis interpreted the previous MRI as revealing degenerative disc disease at T11-T12, T12-L1, L1-L2, and L5-S1. He also noted disc space narrowing as well as a possible annular tear at L5-S1 and recommended a discogram to confirm the diagnosis and help determine the need for fusion surgery. The employer refused to approve the discogram, which resulted in a medical fee dispute. Drs. Best, Wolens, and Travis evaluated the claimant for the employer concerning the discogram.

Dr. Best examined the claimant and reviewed his medical records in July 2003. He noted a normal physical examination, inconsistent effort on functional capacity testing, no evidence of radiculopathy, and significant evidence of symptom magnification. He diagnosed a musculoligamentous strain, assigned a 0% permanent impairment rating, felt that there was no annular tear or other condition that warranted a lumbar fusion, and stated that a discogram was neither reasonable nor necessary.

Dr. Wolens reported in August 2003 that the MRI revealed no evidence of disc pathology. He did not recommend a discogram because the test was "poorly predictive for the identification of disc mediated pain" and because MRI revealed no disc pathology. He also stated that fusion surgery was unwarranted in the absence of frank instability in the spine.

Dr. Travis reported in August 2003 that the MRI revealed no evidence of a disc abnormality and that discography was an unreliable diagnostic tool. His subsequent report stated that the MRI revealed no pathology but did reveal annular bulging at L4-5 and L5-S1, which was normal for a man of the claimant's age. He thought that

rehabilitation would be more beneficial than fusion surgery and that no evidence supported performing a discogram.

In July 2003 the claimant quit working due to his symptoms. He filed an application for benefits in November 2003 and later amended it to include a psychiatric claim. He testified subsequently that he suffered from constant and severe low back pain that radiated into his right buttock and leg as well as from depression.

Dr. Gaines took the claimant off work in July 2003 due to complaints of chronic back pain. His records indicated that the complaints began with the January 2003 incident at work and continued thereafter. In October 2004, he noted that MRI had revealed a probable lesion, which could be corrected with surgery, and stated that a myelogram would help confirm the presence of the lesion.

Dr. Dennis examined the claimant in November 2003 and found evidence of muscle weakness or atrophy in the right leg as well as decreased reflexes and muscle spasm. He diagnosed severe lumbosacral strain with disc pathology, annular tear, and radiculopathy. He did not complete the portion of the report addressing causation but did assign a 33% permanent impairment rating.

Dr. Donley evaluated the claimant in June 2004 at his attorney's request. He noted a decreased range of motion, normal reflexes and sensation, and diagnosed degenerative disc disease and lumbar strain. Dr. Donley ordered nerve conduction studies due to complaints of low back pain that radiated into the legs, but they revealed no evidence of neuropathy or radiculopathy.

Dr. Gleis evaluated the claimant for the employer in April 2004 and noted decreased range of motion and straight leg raising, normal reflexes, normal motor

strength, no atrophy, normal sensation, complaints of increased low back pain with femoral nerve stretch, and a slow gait. Finding no significant changes on MRI except those associated with the normal aging process, he diagnosed a lumbosacral strain with no evidence of radiculopathy. Noting that Dr. Best had observed no muscle spasm in July 2003, he stated that either the claimant's condition had worsened significantly in the past nine months or that he had acquired "learned pain behaviors" such as a decreased range of motion and muscle guarding. He thought that the claimant qualified for no more than a 5% permanent impairment rating, noting that the rating would be based on questionable objective findings. He stated that a discogram was unwarranted and that the claimant should be able to perform light-duty work.

The claimant submitted a report from Dr. Bays, who had evaluated his psychiatric condition for the Social Security Administration. Dr. Bays diagnosed an adjustment disorder with depressed mood, which was associated by history with the January 2003 back injury. The claimant complained that his mental condition was the primary reason for his inability to work. Dr. Bays noted that he was very irritable and somewhat confrontational.

Dr. Shraberg, a psychiatrist, evaluated the claimant for the employer in April 2004. The claimant complained of irritability, decreased memory and concentration, and a sense of having been betrayed and rejected by his employer and its workers' compensation carrier. Psychological testing revealed evidence of depression, hostility, symptom magnification, somatization disorder, and paranoid personality disorder. Dr. Shraberg diagnosed histrionic personality and related symptom magnification with marked dependent features. He found no evidence that the January 2003 injury

caused a permanent impairment.

Dr. Spence, a psychologist, evaluated the claimant and began treating him in June 2004. She continued to do so when the claim was heard. Dr. Spence noted that the claimant presented with "an underlying degree of frustration and anger." After testing, she diagnosed extreme major depression and adjustment disorder. She assigned a GAF of 30 to 35 and an 80% permanent impairment rating.

A subsequent report by Dr. Shraberg noted that an individual with a GAF of 30 to 35 would "not be able to give a history much less live alone without home health care." He also noted that Dr. Spence based her report on the claimant's subjective complaints rather than objective findings. Thus, he questioned her conclusions.

Dr. Gleis reviewed Dr. Shraberg's report and prepared a supplemental report. It explained that muscle guarding is not an objective medical finding unless it is accompanied by muscle spasm. Absent muscle spasm, it is evidence of a learned pain behavior. Noting that Dr. Shraberg's findings had confirmed his own initial impression that the muscle guarding was a learned pain behavior, Dr. Gleis concluded that the correct permanent impairment rating for the back condition was 0%.

The parties stipulated that the employer received timely notice and paid a period of temporary total disability benefits as well as more than $14,000.00 in medical expenses voluntarily. Whether the claimant sustained an injury as defined by KRS 342.0011(1), work-relatedness, and the extent and duration of disability were among the contested issues.

After conducting a 24-page summary of the evidence, the ALJ noted that at least three physicians had interpreted the January 2003 MRI. All had reported degenerative

changes at various levels, primarily on the left side, and had concluded that the scan revealed only age-related changes because the claimant's complaints involved pain on the right side and into the right buttock. Convinced that a discogram was not a reliable diagnostic test, the ALJ ordered the employer to pay for either a myelogram or another MRI to determine the source of the ongoing complaints and gave the parties additional proof time to address the results. The ALJ found Dr. Shraberg to be most persuasive regarding the psychiatric claim because neither Dr. Bays nor Dr. Spence performed the in-depth study and analysis that he did.

MRI performed In January 2006 revealed small disc protrusions at T12-L1 on the right and L1-2 on the left as well as a small disc herniation at L5-S1 on the left. Neither Dr. Kline nor Dr. Gleis found any change since 2003. Dr. Gaines noted that the MRI confirmed the presence of degenerative lumbar disc disease.

The ALJ concluded that the claimant suffered only from normal, age-related changes that warranted no permanent impairment rating based on the MRI results, Dr. Gleis's supplemental report, and Dr. Shraberg's testimony of severe symptom magnification. As a consequence, the ALJ dismissed the entire claim. The claimant appealed.

As explained in Roark v. Alva Coal Corporation, 371 S.W.2d 856 (Ky. 1963); Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App.1984); and Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979), the burden is on an injured worker to prove every element of a claim, including work-related causation and the extent of disability. KRS 342.285 designates the ALJ as the finder of fact and, thus, the ALJ has the sole discretion to determine the quality, character, and substance of the evidence. McCloud

v. Beth-Elkhorn Corp., Ky., 514 S.W.2d 46 (1974), notes that evidence sufficient to have supported a favorable conclusion is not an adequate basis for reversal on appeal. Special Fund v. Francis, 708 S.W.2d 641, 643 (Ky. 1986), explains that a party with the burden of proof who loses before the fact-finder must show on appeal that the decision was unreasonable because overwhelming favorable evidence compelled a favorable decision. In other words, the party must show that no reasonable person would have failed to be convinced by their evidence.

The claimant argues that the evidence compelled a finding of total disability due to the January 2003 incident at work. KRS 342.0011(1) defines a work-related injury as being a traumatic event that is the proximate cause producing a harmful change in the human organism as evidenced by objective medical findings. It requires a psychiatric injury to directly result from a physical injury. The existence, extent, and cause of a harmful change in the human organism are medical questions, the answer to which must be shown with competent medical evidence unless it is obvious. Grider Hill Dock v. Sloan, 448 S.W.2d 373 (Ky. 1969), and Bullock v. Gay, 177 S.W.2d 883 (Ky. 1944), explain that the testimony of an interested witness is not binding even if it is uncontradicted. Thus, although a worker's testimony is evidence of his history, symptoms, and ability to perform certain activities, it is entitled to no particular weight.

The parties presented conflicting medical evidence regarding the cause of the claimant's symptoms. The claimant related their onset to the incident at work, and three long-time co-workers testified to his positive attitude and work ethic. Although Drs. McComis and Gaines indicated that the incident caused the disabling symptoms of which the claimant complained, testing performed by Dr. Donley failed to support a

diagnosis of neuropathy or radicular pain. Dr. Dennis did not comment on causation. Drs. Best, Wolens, Travis, and Gleis found evidence of normal, age-related changes but no work-related physical injury. Drs. Best and Shraberg found evidence of significant symptom magnification, and Drs. Best, Gleis, Travis, and Shraberg, found no evidence of a work-related permanent impairment rating. The ALJ relied on the employer's experts and determined that the claimant suffered only from normal, age-related changes in his spine, which were not compensable. The finding was reasonable under the evidence and may not be disturbed on appeal. Absent compelling evidence that required the ALJ to determine that the claimant sustained a work-related back injury, questions concerning the permanent impairment rating to the spine, his entitlement to the discogram, and the extent of his combined physical and mental disabilities are moot.

The decision of the Court of Appeals is affirmed.

Minton, C.J., and Abramson, Cunningham, Noble, Schroder, and Scott, JJ., concur. Venters, J., not sitting.

COUNSEL FOR APPELLANT,
BARRY LONG:

THOMAS ELMUS SPRINGER III
ADAMS LAW FIRM
18 COURT STREET
MADISONVILLE, KY 42431

COUNSEL FOR APPELLEE,
AHLSTROM USA:

JOEL WALTER AUBREY
POHL, KISER & AUBREY, P.S.C.
303 NORTH HURSTBOURNE PARKWAY
SUITE 110
LOUISVILLE, KY 40222-5143