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NOT TO BE PUBLISHED OPINION

THIS OPINION IS DESIGNATED "NOT TO BE PUBLISHED." PURSUANT TO THE RULES OF CIVIL PROCEDURE PROMULGATED BY THE SUPREME COURT, CR 76.28(4)(C), THIS OPINION IS NOT TO BE PUBLISHED AND SHALL NOT BE CITED OR USED AS BINDING PRECEDENT IN ANY OTHER CASE IN ANY COURT OF THIS STATE; HOWEVER, UNPUBLISHED KENTUCKY APPELLATE DECISIONS, RENDERED AFTER JANUARY 1, 2003, MAY BE CITED FOR CONSIDERATION BY THE COURT IF THERE IS NO PUBLISHED OPINION THAT WOULD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 OPINIONS CITED FOR CONSIDERATION BY THE COURT SHALL BE SET OUT AS AN UNPUBLISHED DECISION IN THE FILED DOCUMENT AND A COPY OF THE ENTIRE DECISION SHALL BE TENDERED ALONG WITH THE DOCUMENT TO THE COURT AND ALL PARTIES TO THE ACTION.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: SEPTEMBER 18, 2008
NOT TO BE PUBLISHED

Supreme Court of Kentucky

2007-SC-000954-WC

DANIEL JOHNSON — APPELLANT

V.

ON APPEAL FROM COURT OF APPEALS
2007-CA-001155-WC
WORKERS' COMPENSATION BOARD NO. 04-84702

DIAMOND MAY COAL COMPANY;
HONORABLE GRANT S. ROARK,
ADMINISTRATIVE LAW JUDGE; AND
WORKERS' COMPENSATION BOARD — APPELLEES

MEMORANDUM OPINION OF THE COURT

AFFIRMING

An Administrative Law Judge (ALJ) found that the claimant did not sustain a permanent work-related injury and dismissed his application for permanent income and future medical benefits. The Workers' Compensation Board and the Court of Appeals affirmed. Appealing, the claimant maintains that overwhelming objective medical evidence compelled a finding that he sustained a work-related injury and that the ALJ erred by failing to address the bias of a physician who testifies primarily for defendants. We find no error and affirm.

The claimant was born in 1949, completed the eleventh grade, and worked as a coal miner. He alleged that he injured his spine on June 12, 2004, when the ram car that he was operating hit a bump and caused his head and body to be "smashed

together" against the canopy. He notified his employer and sought treatment with his family physician, Dr. Breeding, who referred him to Dr. Gilbert.

The claimant continued to work until August 2006, which was shortly before the hearing. His employer paid more than $16,800.00 in medical expenses voluntarily. It resisted the claim for additional benefits based on medical evidence that the claimant had been treated for neck and back complaints since 1997.

Medical records indicated that the claimant sustained an injury to his spine in 1997 and that Dr. Agtarap treated him for neck and low back pain from 1997 until shortly before the alleged injury. His complaints on April 1, 2004, included chronic moderate to severe pain, lumbar radiculopathy, degenerative disc disease, sciatica, sacroiliac pain, pain that radiated from the neck into the arms, and anxiety. MRI performed at that time revealed an L4-5 disc herniation, associated neural foramina encroachment, and advanced, multi-level degenerative changes. On April 30, 2004, Dr. Agtarap referred the claimant to Dr. Tibbs. Medical records indicated that the claimant also saw Dr. Gutti, a neurologist, in 2002 for complaints of back pain and a hand tremor.

When deposed, the claimant denied initially that he had injured his back before June 12, 2004. Later, he admitted that he sustained an injury in 1997 but stated that he did not file a claim.[1] He also denied initially that he received more than a month of medical treatment after the 1997 injury. When confronted with medical records to the contrary, he admitted that he continued to be treated for neck and back pain in April 2004 and that he had been taking Lorcet Plus and Ultracet for several years.

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1 Some evidence indicates that the previous injury occurred in 1996.

Dr. Breeding saw the claimant on June 15, 2004, and received a history of the June 12, 2004, injury. He noted that that the neck showed a full range of motion and that neurological function was "completely normal" but that there was some tenderness to palpation. He diagnosed an acute neck strain and attributed it to the injury. On June 24, 2004, the claimant complained of back pain that radiated into the leg and foot and that was worse since the last visit. Dr. Breeding noted the claimant's history of chronic back pain and the herniated disc found in April 2004. Later, he diagnosed a cervical strain with lumbosacral radiculopathy from chronic sciatica and ordered another MRI, which showed only a bulging disc at L4-5. He referred the claimant to Dr. Gilbert, a neurosurgeon.

Medical records from Dr. Gilbert indicated that in October 2004 the claimant reported severe head, right arm, mid back, low back, and right leg pain that had existed for several months. Dr. Gilbert diagnosed cervical, thoracic, and lumbar nerve root injuries; cervical, thoracic, and lumbar sprain/strain; cervicalgia; cervical and thoracic radiculopathy; thoracic pain; lumbar sciatica; pain with psychological/medical factors; muscle spasm; numbness and tingling; and depression, anxiety, and insomnia. He prescribed steroid injections and physical therapy, which provided no lasting relief.

Dr. Potter examined the claimant in May 2006 at his attorney's request and reviewed medical records, including Dr. Breeding's and Dr. Agtarap's. He received a history of the June 2004 injury and of a previous low back injury that had resolved. The claimant walked with a mildly antalgic gait but continued to work with pain but without restrictions. Dr. Potter diagnosed degenerative disc disease and spondylosis at C5-6, C6-7, and L3 through S1; chronic cervical strain/myofascial pain; right cervical

radiculitis; chronic lumbosacral strain/myofascial pain; and right lumbosacral radiculitis. He attributed the claimant's complaints to the 2004 injury, which was superimposed on years of cumulative trauma and repetitive strain in his work. Dr. Potter assigned a 14% permanent impairment rating based on the cervical and lumbar conditions, stating that no impairment was active before the 2004 injury. Although he restricted lifting and repetitive motion, he thought that the claimant retained the physical capacity to return to the type of work that he performed at the time of the injury.

Dr. Snider examined the claimant for the employer in June 2006 and received a history of a previous back injury from which the claimant recovered rapidly. He assigned a 6% permanent impairment rating, allocating a 5% rating to the pre-existing condition and a 1% rating to the injury. Dr. Snider was deposed after receiving and reviewing the claimant's pre-injury medical records. He conceded that an increase in pain two days after an alleged injury was consistent with an injury but was skeptical about the cause of the claimant's present condition. He explained that although the claimant admitted that he sustained a previous low back injury, he failed to reveal that he missed six months of work, returned to light duty, and was never able to work at the same level of intensity as before. Although he admitted that he underwent an MRI a few weeks before the 2004 injury, he failed to reveal that Dr. Agtarap had treated him for back pain continuously from 1997 through April 30, 2004, and then referred him to Dr. Tibbs. Although the claimant reported that he developed a tremor after the 2004 injury, he failed to report that Dr. Gutti had treated him for such a tremor as early as 2001. Dr. Gutti also noted in January 2001 that nerve conduction studies revealed right L5 radiculopathy and mild neuropathy. Dr. Snider testified that the medical records

revealed no change in the physical findings or radiographic studies after June 12, 2004. In his opinion, no objective measure showed any change in the claimant's anatomy due to the injury.

Dr. Snider testified that he is also board-certified in family practice and also completed a four-week mini-residency in occupational medicine. Most of his practice involves seeing workers with acute injuries and performing pre-employment physical examinations, drug screens, and government-required physical examinations for employers. A smaller part, performed for businesses and other organizations, involves medical issues related to travel. The smallest part is performing independent medical evaluations, reviewing medical records, and peer review, mostly for defendants. He acknowledged that he rarely performs medical evaluations for injured workers.

Dr. Jenkinson, an orthopedic surgeon, evaluated the claimant in June 2006 for the employer. He received a history of the 2004 injury, but the claimant denied any previous back injury. After performing a physical examination and reviewing a February 2006 lumbar MRI, Dr. Jenkinson noted that the scan revealed non-specific degenerative changes that were consistent with the claimant's age. He found no objective evidence of a neurological abnormality and did not think that the June 2004 injury produced a significant disc herniation or nerve root irritation. He described the injury as being "minor," without any residual abnormality or permanent impairment.

The claimant missed no work after the June 2004 incident and continued to work through August 7, 2006. Asked at the hearing if his history was significant for a previous lower back injury, he stated, "I don't know." He stated that he had difficulty remembering his pre-injury treatment and whether he told physicians who saw him after

June 12, 2004, about the treatment. He explained that he had a poor memory and limited education and noted that he returned to work without restrictions after the previous injury. He testified that his present neck and low back pain was constant and worse than the pain before June 12, 2004.

The ALJ found Dr. Snider's deposition testimony to be most persuasive, explaining that he examined the claimant and later performed a complete review of his pre- and post-June 12, 2004, medical records. The ALJ noted that Dr. Snider saw no objective change in pathology from the medical records or diagnostic studies. That testimony and observations at the hearing convinced the ALJ that the claimant did not sustain a permanent injury on June 12, 2004. Having concluded that his present conditions existed before the alleged injury and were neither caused nor increased by the incident, the ALJ dismissed the claim. The claimant appealed after the ALJ denied his petition for reconsideration.

The claimant asserts that the Board and the Court of Appeals erred by affirming because overwhelming objective medical evidence compelled a decision that he sustained a permanent injury, particularly the pre- and post-injury MRI films. He argues that Dr. Snider did not review the films and, in any event, was not qualified to interpret them. Yet, the ALJ relied on his opinion and failed to consider that the radiologists' reports revealed changes after the June 12, 2004, accident. He acknowledges that he suffered from chronic pain before the accident but emphasizes that he complained to Dr. Breeding of significantly greater pain after the accident. He acknowledges that he received some temporary total disability benefits after the previous injury but emphasizes that he returned to work and did not consider the injury to be significant

enough to file a claim. Finally, he complains that the ALJ failed to address his argument regarding bias on Dr. Snider's part under Primm v. Isaac, 127 S.W.3d 630 (Ky. 2004).

An injured worker has the burden to prove every element of a claim. KRS 342.285 designates the ALJ as the finder of fact, which gives the ALJ the sole authority to determine the credibility of witnesses, draw reasonable inferences, and weigh conflicting evidence.[2] Thus, it prohibits a reweighing of the evidence on appeal. Special Fund v. Francis, 708 S.W.2d 641, 643 (Ky. 1986), explains that when the party with the burden of proof fails to convince the fact-finder, the issue on appeal is whether the favorable evidence was so overwhelming that no reasonable person could have failed to be persuaded.[3] If a decision is reasonable, it is immaterial that the record contains evidence that would have permitted a different decision.[4] An appellant must show that the ALJ relied on evidence so lacking in probative value that the decision must be reversed as a matter of law.[5]

The claimant had the burden to prove that the traumatic event of June 12, 2004, caused a harmful change in the human organism that was evidenced by objective medical findings and warranted permanent income benefits and future medical benefits. Although evidence from the claimant's experts would have permitted a favorable

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2 Magic Coal Company v. Fox, 19 S.W.3d 88, 96 (Ky. 2000); Miller v. East Kentucky Beverage/Pepsi Co., Inc., 951 S.W.2d 329, 331 (Ky. 1997); Paramount Foods, Inc. v. Burkhardt, 695 S.W.2d 418 (Ky. 1985); Pruitt v. Bugg Brothers, 547 S.W.2d 123 (Ky. 1977); Caudill v. Maloney's Discount Stores, 560 S.W.2d 15 (Ky. 1977).

3 REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985); Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984).

4 Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999); McCloud v. Beth-Elkhorn Corp., 514 S.W.2d 46 (Ky. 1974).

5 Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000).

decision, the ALJ found testimony by Drs. Snider and Jenkinson to be more persuasive and to support dismissing the claim. Medical records revealed the claimant's extensive history of treatment at a pain clinic for spine complaints since 1997. They also revealed evidence of a hand tremor and lumbar radiculopathy early in 2001. Although he complained that his pain increased after June 12, 2004, complaints of symptoms are not objective medical findings.[6] Although Dr. Snider did not review the actual MRI films, he did review the radiologists' reports, and he was the only physician to review the entire pre- and post-June 12, 2004, medical record and to compare the symptoms, physical findings, and diagnostic studies. He concluded that the incident caused no permanent impairment. Dr. Jenkinson also concluded that that injury caused no permanent harm.

Primm v. Isaac, supra, explains that evidence that tends to expose a witness's bias is relevant to the witness's credibility. The ALJ addressed and rejected the claimant's assertion of bias implicitly. When reciting the evidence, the ALJ noted that Dr. Snider conducted a complete review of the pre- and post-June 12, 2004, medical records. The ALJ stated subsequently that Dr. Snider's opinions were most persuasive, explaining that he reviewed all of the medical records. Although evidence concerning the nature of his practice tended to show a positional bias, it was not so overwhelming as to deprive his testimony of any probative value. His opinions and Dr. Jenkinson's provided an adequate basis to support the decision to dismiss the claim.

The decision of the Court of Appeals is affirmed.

All sitting. All concur.

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6 Gibbs v. Premier Scale Company/Indiana Scale Company, 50 S.W.3d 754, 761-62 (Ky. 2001).

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