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NOT TO BE PUBLISHED OPINION

THIS OPINION IS DESIGNATED "NOT TO BE PUBLISHED." PURSUANT TO THE RULES OF CIVIL PROCEDURE PROMULGATED BY THE SUPREME COURT, CR 76.28(4)(C), THIS OPINION IS NOT TO BE PUBLISHED AND SHALL NOT BE CITED OR USED AS BINDING PRECEDENT IN ANY OTHER CASE IN ANY COURT OF THIS STATE; HOWEVER, UNPUBLISHED KENTUCKY APPELLATE DECISIONS, RENDERED AFTER JANUARY 1, 2003, MAY BE CITED FOR CONSIDERATION BY THE COURT IF THERE IS NO PUBLISHED OPINION THAT WOULD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 OPINIONS CITED FOR CONSIDERATION BY THE COURT SHALL BE SET OUT AS AN UNPUBLISHED DECISION IN THE FILED DOCUMENT AND A COPY OF THE ENTIRE DECISION SHALL BE TENDERED ALONG WITH THE DOCUMENT TO THE COURT AND ALL PARTIES TO THE ACTION.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: NOVEMBER 26, 2008
NOT TO BE PUBLISHED

Supreme Court of Kentucky

2007-SC-000884-WC

FARAHNAZ MIRZAEE — APPELLANT

V.

ON APPEAL FROM COURT OF APPEALS
CASE NO. 2006-CA-002045-WC
WORKERS' COMPENSATION BOARD NO. 03-84215

UNITED PARCEL SERVICE;
HONORABLE HOWARD FRASIER,
ADMINISTRATIVE LAW JUDGE;
AND WORKERS' COMPENSATION BOARD — APPELLEES

MEMORANDUM OPINION OF THE COURT

AFFIRMING

An Administrative Law Judge (ALJ) determined that the claimant sustained a temporary injury to her arm and hands but dismissed her claim for a cervical condition. The Workers ' Compensation Board (Board) and the Court of Appeals affirmed. Appealing, the claimant asserts that the ALJ erred by failing to determine that her cervical condition and expenses for treating an overdose of medication for the condition are work-related. She also asserts that the ALJ erred by refusing to permit her to amend her claim to include a psychiatric condition.

We affirm. The ALJ did not overlook or misunderstand any relevant

evidence or misapply the law. The evidence did not compel a finding that the July 24, 2002, incident caused a work-related neck injury. An argument regarding the motion to amend was not raised before the Board; thus, it is not preserved for judicial review.

The claimant was born in 1973, completed high school as well as some college credits, and came to the United States as a refugee from Iran in 1998. She began working for the defendant-employer in 2001 as a part-time package handler and loader, working five- to six-hour shifts. Her application for benefits alleged that she sustained a work-related injury to her hands and neck on July 24, 2002, while lifting a 60-pound package. She was permitted to amend the claim a month later to include a shoulder injury. When deposed in January 2004 she testified that her employer terminated her on October 17, 2002, and that pain in her hands, shoulder, neck, back, and legs prevented her from performing other work or continuing her college classes. She testified in February 2006 at the hearing that she could not perform even a desk job due to her pain. The parties stipulated that the employer paid temporary total disability benefits voluntarily from September 9, 2002, through May 19, 2003, and paid $28,321.00 in medical expenses.

Records from BaptistWorx indicated that the claimant sought treatment for right hand and forearm pain on several occasions between April 10, 2002, and May 21, 2002. She received medication and physical therapy and was released to return to regular duty on May 21, 2002. She returned on July 24,

2002, "very distressed" and complaining of bilateral wrist and arm pain after lifting a 60-pound package at work. She was diagnosed with a right arm strain and left bicep tendonitis. On August 8, 2002, she indicated that she was ready for regular duty. Although she complained of slight pain on the left side of her neck, she exhibited a full range of motion in her neck and arms. She continued to have some tenderness in the left bicep tendon and in her right forearm, near the wrist. The physician released her for regular duty.

The claimant's primary care physician gave her an injection, prescribed Vicodin and Skelaxin, and took her off work from August 22, 2002, to August 26, 2002. On August 23, 2002, she was taken to BaptistWorx complaining of severe left arm and trapezius pain and of feeling faint. She was advised to take her prescriptions as directed and referred to Dr. Gormley.

On August 29, 2002, Dr. Gormley, a specialist in physical medicine and rehabilitation, noted complaints of left arm and neck pain. The claimant denied significant right arm symptoms. Dr. Gormley examined her and diagnosed "left bicipital tendonitis with referred pain/rule out rotator cuff tear" as well as status right arm strain. He imposed a 10-pound lifting restriction, limited use of the left hand, and prohibited work above shoulder height with the left arm. He also recommended physical therapy. On September 5, 2002, the claimant began to complain of right arm pain, which she attributed to performing one-arm duty. Dr. Gormley referred her to Dr. George, an orthopedic specialist.

The employer instituted temporary total disability (TTD) benefits on September 9, 2002. Surveillance video taken for the employer on September 12 and 13, 2002, indicated that the claimant displayed no limited range of motion or outward signs of pain. Among other things, she loaded groceries from a shopping cart into her automobile, unloaded them, and took them into her home.

On September 16, 2002, the claimant complained to Dr. George of bilateral shoulder pain. She exhibited a significant restriction in motion in the left shoulder only. A left shoulder MRI showed minimal tendonopathy and peritendinitis and no evidence of a rotator cuff tear or other abnormality. Dr. George noted on September 30, 2002, that the findings were consistent with an impingement and thought that the claimant had irritated her rotator cuff. She injected the shoulder and recommended continued physical therapy. Physical therapy records from September 17, 2002, noted the claimant's "self-limiting and unrealistic behaviors and excessive verbal, postural, and pain behaviors." They also noted that she was able to use her left upper extremity to place packages on an overhead belt when she was unaware of being observed. The physical therapy discharge summary, dated October 7, 2002, indicated that the claimant could perform competitive, full-time work and listed no permanent restrictions. The claimant reported to Dr. George on October 18, 2002, that the injection did not relieve her symptoms. She returned on October 21, 2002, complaining of increasing pain in the right elbow. A cervical MRI performed on

October 28, 2002, revealed a moderate left paracentral disc bulge or broad-based herniation at C4-5 that resulted in a moderate degree of neural foraminal compromise on the left.

Dr. Villanueva, a neurosurgeon, saw the claimant on November 26, 2002, regarding the cervical disc herniation. He placed her in physical therapy, but she complained of increased pain and was discharged without meeting any of the treatment goals. He saw her again on December 26, 2002, during her admission to Baptist Hospital East for complaints of intractable neck pain and cervicalgia. He ordered a cervical MRI, which was performed on December 27, 2002. It revealed no change since the previous study and no obvious compression of the spinal cord. Physical examination revealed no motor or sensory radiculopathy and no myelopathy. Dr. Villanueva noted that the claimant did not move her right arm and grimaced in pain when he touched it but that she moved the left arm well. He thought that surgery for the herniated cervical disc was unnecessary due to the lack of radicular symptoms and referred her to Dr. Reasor for pain management.

Dr. Reasor examined the claimant in the hospital on December 27, 2002. He noted marked spasm and tenderness, bilaterally, in the trapezius muscles as well as a marked decrease in the range of motion of the cervical spine. He also noted a history of a herniated cervical disc at C4-5. Dr. Reasor diagnosed severe myositis and spasm of the trapezius muscle as well as acute spasmodic torticollis, which he later defined as a spasm or abnormal tone of the cervical

musculature. On January 20, 2003, he admitted her to the hospital again to treat a severe exacerbation of symptoms that occurred during an attempt to administer trigger point injections into the left trapezius muscle. He ordered another cervical MRI and consultations with Dr. Villanueva as well as with Dr. Bensenhaver, a psychiatrist and Dr. Alt, a neurologist. A cervical MRI performed on January 22, 2003, revealed abnormalities at C4-5 that produced mild canal stenosis and bilateral foramenal stenosis. It also revealed abnormalities at C5-6.

Dr. Alt reported on January 21, 2003, that any attempt to test range of motion caused the claimant to scream violently. He noted, however, that the nursing staff had observed her moving her arms easily, without pain. He found her complaints and behavior to be out of proportion to what would be expected from a simple torticollis and recommended a repeat MRI to rule out an acute spinal cord impingement. He noted neck and arm pain of a non-neurological etiology as of January 22, 2003, and suspected a possible conversion reaction. The claimant was discharged from the hospital on January 26, 2003, with Dr. Reasor recommending that she follow up with himself and Dr. Bensenhaver.

Dr. Bensenhaver reported on January 23, 2003, that the claimant denied any suicidal or homicidal thoughts, psychotic features, or depressive symptoms. Given the unusual pain distribution and some of his neurological findings, he thought that there was likely a conversion component to her pain symptoms but that all other causes should be ruled out before diagnosing a

conversion or factitious disorder. He thought that Dr. Reasor should consider prescribing an anti-depressant, which would positively address some of her pain symptoms.

Dr. Ghazi evaluated the claimant for the employer on February 27, 2003. He diagnosed a resolving musculoskeletal strain with a resolving inflammatory reaction and thought it very likely that the onset of symptoms coincided with the alleged injury. He also thought that her complaints were out of proportion to the medical findings and that she would recover fully and be able to return to work without restrictions.

Dr. Reasor administered Botox injections in March 2003 in an attempt to relieve the muscle spasms, but the claimant failed to respond. A functional capacity test performed on April 1, 2003, revealed multiple inconsistencies but indicated that she should be able to work at a sedentary level. Dr. Reasor testified subsequently that she reached maximum medical improvement on May 19, 2003. He assigned an 8% permanent impairment rating based on the cervical spine and an additional 3% rating for pain, for a combined rating of 11%.

On February 24, 2004, the claimant was hospitalized for a near-fatal overdose of the drugs that Dr. Reasor prescribed for pain. When deposed on March 26, 2004, he testified that she appeared to have taken 35 Percocet and 108 Baclofen tablets and characterized the overdose as being accidental, due to a communication problem. He testified that he did not have medical records

from any of the physicians who had treated her previously but thought that her chronic neck pain probably resulted from her work activities. He supported his diagnosis of spasmodic torticollis with the observed tightness of her neck muscles and the limitations on the range of motion of her neck. Dr. Reasor testified that the diagnostic studies revealed no cervical radiculopathy and that the radiographic findings were not significant. He also testified that he had ordered the psychiatric consult in January 2003 because he thought that the claimant was depressed and that there was a psychogenic component to her pain. He also thought her chronic pain probably caused a situational depression. His diagnosis as of May 3, 2004, was idiopathic cervical dystonia, spasmodic torticollis, and history of accidental OxyContin overdose. He stated in a report prepared on July 27, 2004, that the conditions resulted from the repetitive nature of the claimant's work.

Dr. Wood evaluated the claimant for the employer on April 1, 2004, and again on May 17, 2004. His initial report noted that she exhibited a restricted range of motion in the cervical spine on physical examination but failed to do so during the interview. He also noted that the activities observed in the surveillance video taken on September 12 and 13, 2002, were not consistent with Dr. George's notes from September 16, 2002. Dr. Wood diagnosed neck pain, bilateral shoulder pain, cervical spondylosis without radiculopathy, and supraspinatus tendonitis by MRI diagnosis. His supplemental report indicated that the initial complaints of left shoulder pain probably resulted from the July

24, 2002, incident at work but that the present global complaints resulted from pre-existing cervical spondylosis or some other cause that was unrelated to the incident. In his opinion, the incident caused acute left shoulder tendinitis that had resolved and required no further medical treatment. He found no objective evidence of a permanent harmful change to the claimant's neck or upper extremities that resulted from the incident and recommended a psychiatric evaluation to consider the possibility of a conversion disorder or factitious disorder.

Dr. Ballard performed a pain management evaluation on September 15, 2004, for the employer, noting complaints of pain in the neck, shoulders, arms, hands, and legs as well as weakness in the arms and hands. Dr. Ballard noted that the claimant demonstrated normal motion during their initial conversation but demonstrated only trace movement of her cervical spine and shoulders during formal testing and failed to perform on grip strength testing. Dr. Ballard recommended that she discontinue all medications and return in two weeks. On November 8, 2004, she recommended four weeks of daily work conditioning therapy. The claimant returned on December 13, 2004, complaining that therapy had increased her symptoms. A physical therapy note recorded her complaint that therapy rendered her unable to do housework for three days but indicated that, when questioned about what housework she performed, she stated that she did none. Dr. Ballard noted that she attributed a burn on her right hand to the stove but later stated that she did not cook

because she was unable to do anything. She concluded that the claimant was making no progress, that her symptoms had no objective basis, and that the efficacy of further treatment was questionable.

In a supplemental report, dated March 15, 2005, Dr. Ballard diagnosed neck pain and possible cervical strain as a result of the work-related incident. She stated, however, that no objective medical findings evidenced a harmful change as a result of the incident. In her opinion, the incident produced a 0% permanent impairment rating and warranted no permanent restrictions or future treatment. She stated that the claimant's complaints in September and December 2004, were inconsistent with the behavior recorded on the surveillance video.

Dr. Changaris treated the claimant from July 11, 2005, through October 3, 2005. She reported that her neck pain remained severe, exhibited decreased arm strength, and declined to perform much range of motion. Dr. Changaris diagnosed a herniated disc at C4-5 based on MRI, non-anatomical pain, and decreased strength and range of motion due to reports of pain. He assigned an 8% permanent impairment rating based on the cervical condition. Although he noted earlier in the report that a depression inventory revealed no or minimal depression, he concluded that the claimant probably had a psychiatric impairment and recommended that further medical treatment be suspended pending a psychiatric evaluation.

On November 22, 2005, the claimant requested the ALJ to appoint a

psychiatric evaluator. The ALJ denied the motion, on December 14, 2005, the date of the benefit review conference. The ALJ reasoned that the claimant had denied the existence of depressive symptoms or suicide attempts throughout the litigation. Also, no testing or other medical evidence supported Dr. Changaris's conclusion and he did not recommend treatment. On December 20, 2005, the claimant moved to amend her Form 101 to include a psychiatric claim and again requested the appointment of a university evaluator regarding the condition. The ALJ denied the motion, noting that he had been "extraordinarily tolerant" in granting her previous extensions of proof time and that she failed to explain why she could not have identified the alleged psychiatric condition earlier and had it evaluated at her own expense.[1]

The ALJ found the claimant not to be credible regarding the merits of her claim, noting that her post-injury complaints were inconsistent with the videotape taken three months later and also with her behavior at the benefit review conference and hearing, to which she wore a neck brace. The ALJ noted that most of the medical evidence did not support her extreme pain complaints or indicate that the July 24, 2002, incident caused the herniated disc. Moreover, her inactivity in the more than three years since the incident belied any assertion that her present complaints resulted from an overuse injury. The ALJ acknowledged that Dr. Gormley had thought that cervical

[1] 803 KAR 25:010, § 8(2) requires discovery to be completed within 105 days. 803 KAR 25:010, § 15(4) permits only one extension of 30 days to each side in the absence of compelling circumstances. Discovery in this case spanned more than two years.

radiculopathy might be possible but noted that his suspicion was not borne out by subsequent medical testing. Noting that no objective medical findings close in time to the incident showed any permanent nerve damage, radiculopathy, or other mechanical injury, the ALJ concluded that she suffered no more than a temporary muscle strain to her arms and hands that resolved before she reached MMI. As a consequence, the expense of treating the resulting drug overdose was not compensable.

A worker bears the burden of proof and risk of non-persuasion before the fact-finder with regard to every element of a claim.[2] KRS 342.285 provides that the ALJ's decision is "conclusive and binding as to all questions of fact" and that the Board "shall not substitute its judgment for that of the [ALJ] as to the weight of evidence on questions of fact." KRS 342.290 limits the scope of review by the Court of Appeals to that of the Board and also to errors of law arising before the Board. As a consequence, the ALJ has the sole discretion to determine the quality, character, and substance of evidence.[3] An ALJ may 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.[4] Although a party may note evidence that would have supported a different decision, such evidence is not an adequate basis for

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[2] 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); Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979).

[3] Paramount Foods, Inc. v. Burkhardt, 695 S.W.2d 418 (Ky. 1985).

[4] Caudill v. Maloney's Discount Stores, 560 S.W.2d 15, 16 (Ky. 1977).

reversal on appeal.[5] When the party with the burden of proof fails to convince the ALJ, the party's burden on appeal is to show that overwhelming evidence compelled a favorable finding, i.e., that no reasonable person could fail to be persuaded by the evidence.[6] This is not such a case.

Relying on evidence favorable to her position, the claimant asserts that the July 24, 2002, incident caused a herniated cervical disc that impinged on the spinal cord at C4-5, causing her symptoms. She discounts the surveillance video, arguing that it was taken before her pain increased to the point that she was unable to work. She notes that the MRIs and Dr. Reasor's observations provided objective medical findings of the herniation, the foramenal compromise on the left, and the obvious spasm and tightness of her neck muscles. Finally, she argues that the ALJ erred by rejecting the opinions of Drs. Reasor and Changaris as to causation.

Although the MRIs and Dr. Reasor's examination documented the existence of a herniated disc and muscle spasms several months after the July 24, 2002, incident, they did not compel the ALJ to conclude that the incident caused the harmful changes. The surveillance video was taken after the employer instituted TTD benefits. As the ALJ noted, the claimant evolved from having bilateral wrist and arm pain but no neck complaints immediately after

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[5] McCloud v. Beth-Elkhorn Corp., 514 S.W.2d 46 (Ky. 1974).

[6] Special Fund v. Francis, 708 S.W.2d 641, 643 (Ky. 1986); Paramount Foods, Inc. v. Burkhardt, supra; Mosley v. Ford Motor Co., 968 S.W. 2d 675 (Ky. App. 1998); REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985).

the injury to complaining of severe pain that caused her to use a neck brace at the hearing. Contrary to the claimant's assertions that the ALJ misstated or misunderstood the evidence, even Dr. Reasor testified that the diagnostic studies revealed no cervical radiculopathy. Medical records close in time to the injury as well as the reports from Drs. Wood, Ghazi, and Ballard supported the ALJ's conclusion that the incident caused no more than temporary harm. Questions regarding timely notice of a cervical disc injury and the compensability of medical treatment for an overdose of medication for the condition are moot under the circumstances.

The decision of the Court of Appeals is affirmed.

All sitting. All concur.

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