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NOT TO BE PUBLISHED OPINION

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RENDERED: SEPTEMBER 22, 2011
NOT TO BE PUBLISHED

Supreme Court of Kentucky

2011-SC-000131-WC

ELMER BLANKENSHIP — APPELLANT

V.

ON APPEAL FROM COURT OF APPEALS
CASE NO. 2010-CA-001097-WC
WORKERS' COMPENSATION NO. 08-01020

WAL-MART STORES, INC.;
HONORABLE EDWARD D. HAYS,
ADMINISTRATIVE LAW JUDGE; AND
WORKERS' COMPENSATION BOARD — APPELLEES

MEMORANDUM OPINION OF THE COURT

AFFIRMING

An Administrative Law Judge (ALJ) dismissed the claimant's application for benefits on the grounds that he failed to prove causation and work-relatedness. The ALJ found that the claimant's lack of credibility concerning his prior medical history rendered the medical opinions attributing his present symptoms to the alleged work-related injury unreliable. Although the Workers' Compensation Board determined that the evidence compelled a decision in the claimant's favor based on the arousal of a pre-existing dormant condition, the Court of Appeals reversed the Board and reinstated the ALJ's decision.

We affirm. The ALJ found the claimant not to be credible, which rendered unreliable the complaints that he voiced to physicians on and after June 20, 2008 as well as the history that he reported concerning his symptoms and the injury on that date. Thus, the ALJ did not err by rejecting medical opinions that were based on the reported history or by concluding that the claimant failed to meet his burden of proving causation.

The claimant was born in 1963 and had a tenth-grade education. His work history consisted of 17 years of self-employment as a landscaper, followed by one- to three-year stints with various employers as a cook, laborer, and stock person. He began to work for the defendant-employer as a maintenance person in November 2007.

The claimant alleged that he injured his neck and left shoulder on June 20, 2008 when attempting to re-start a pressure washer that was not running properly. He testified that he was using his hands to pull on the starter cord when it recoiled, pulling his left arm toward the machine. He experienced pain from the back of his neck, over the top of his left shoulder, and down into his arm, which he rated at ten on a ten-point scale. After he reported the incident to an assistant manager and "filled out a bunch of paperwork" at the office, his supervisor took him for medical treatment. Records from the Kings Daughters Medical Center note complaints of neck and left shoulder pain, which he attributed to the incident.

Shoulder and cervical spine x-rays revealed osteopenia and various degenerative changes but no acute fracture. Dr. Young diagnosed neck pain,

left shoulder pain, and muscle strain. She placed the claimant on modified duty; prescribed Zanaflex; and advised him to return in one week. Subsequent physical therapy and medications failed to relieve the claimant's complaints. He filed an application for benefits on August 13, 2008.

Electrodiagnostics performed on August 19, 2008 revealed an acute lower cervical radiculopathy that was "difficult to localize further" and left ulnar neuropathy at the elbow. When the claimant reported no improvement on August 22, 2008, Dr. Young ordered a left shoulder and cervical spine MRI and took him off work. The shoulder MRI revealed mild supraspinatus and infraspinatus tendinitis or tendinopathy; minimal impingement of the supraspinatus tendon related to osteophytes; but no acute fracture or tear in the rotator cuff or labrum. The cervical MRI revealed a large left-sided herniated nucleus pulposis at C7-T1 with severe left-sided neural foraminal encroachment and nerve root impingement related to a disc fragment. It also revealed advanced disc space narrowing, osteophyte formation, and neural foramenal encroachment at C3-4, C4-5, C5-6, and C6-7; severe encroachment at C3-4 and C5-6; and minimal anterior subluxation of C3 on C4. An appointment with Dr. Powell, a neurosurgeon, was scheduled for November 2008.

Dr. Potter evaluated the claimant at his attorney's request in October 2008. The claimant described the June 2008 incident and reported a history of no previous left upper extremity or neck pain except for an incident of left

shoulder pain that occurred in April 2007. Dr. Potter noted that physicians at Cabell Huntington Hospital diagnosed a rotator cuff strain at that time. He reviewed various diagnostic tests, which included cervical spine x-rays and a CT scan of the head taken in March 2008 as well as the post-injury tests. He attributed the present complaints to the June 2008 incident and assigned an 18% permanent impairment rating, stating that the claimant did not have a pre-existing active impairment. An amended report stated that the impairment rating might be amended when the claimant reached maximum medical improvement (MMI), which would not occur until he received all reasonable therapeutic interventions.

Dr. Jenkinson, an orthopedic surgeon, evaluated the claimant for the employer in November 2008. The claimant reported that he thought his condition was worsening and denied any similar symptoms in the past. He complained of continued left shoulder and arm pain; numbness in the entire left arm; pain that radiated from his lower neck between his shoulder blades; and pain in the right shoulder, which developed in the past two to three weeks. Dr. Jenkinson reviewed the cervical spine MRI, stating that it revealed multilevel degenerative changes and a "good sized disk/osteophyte complex" on the left but that he did not see any evidence of significant spinal cord compression. He also reviewed the Cabell Huntington Hospital records from April 2007 and the electrodiagnostics performed in August 2008.

Dr. Jenkinson reported that the claimant exhibited multiple signs of symptom exaggeration on physical examination. He opined that the claimant

may have sustained a shoulder sprain on June 20, 2008 but, if so, he recovered with no significant residual abnormality. Dr. Jenkinson could not attribute any of the claimant's present symptoms to such an injury. He also found no relationship between the C7-T1 abnormality and any of the claimant's symptoms, which he characterized as being widespread and non-anatomic. Moreover, he stated that the history of injury was not consistent with the creation of the abnormality. Noting the evidence of pre-existing degenerative disease, he opined that the abnormality probably existed before the "relatively minor sprain or strain" and could not reliably be attributed to the injury.

When deposed and asked to opine whether the claimant's symptoms resulted from the work-related injury Dr. Jenkinson testified. "[I]t comes down to whether you believe him or not." Pointing to the "numerous inconsistencies" in the evaluation, he noted that the claimant denied previous arm or shoulder pain despite the Cabell Huntington Hospital records from April 2007. He acknowledged on cross-examination, however, that those records referred to a shoulder problem but showed the claimant's neck to be within normal limits. He also acknowledged that he did not see the results of a post-injury CT myelogram performed in May 2009.

Dr. Powell first saw the claimant shortly after the evaluation by Dr. Jenkinson and continued to treat him when deposed in June 2009. He testified that the claimant's condition had worsened, noting pressure on the spinal cord and decreased function in both upper extremities as well as

sensory loss and motor deficits from C7 downward. He stated that the purpose of the proposed surgery was to decompress the spinal cord at C6-7 and C7-T1.

Dr Powell questioned Dr. Jenkinson's expertise concerning the cervical spine, noting that he was "a shoulder expert" yet failed to mention the evidence of left shoulder tendonitis. He acknowledged that degenerative changes of the cervical spine pre-existed the claimant's injury but stated that the June 2008 incident aroused them and caused them to deteriorate to the point that they required surgery. Without the surgery the claimant's neurological deficits would continue to progress and become severe. Dr. Powell testified elsewhere in the deposition that the claimant probably would not have needed surgery had he not been injured in June 2008. He could not state with certainty whether the accident caused the disc to rupture or simply aggravated it, but he noted that the claimant did not become symptomatic until after it occurred. He thought that both the shoulder tendonitis and the cervical condition contributed to the shoulder pain.

Dr. Powell did not view the Cabell Huntington Hospital records from April 2007 as indicating that the claimant's neck was symptomatic before June 2008 because they described pain in the upper humeral region,[1] which could be considered the shoulder. He did not think that the pain originated in the cervical area because the records did not describe any radicular findings or a pinched nerve. He concluded that the claimant had a dormant non-disabling

[1] The humerus is the bone in upper arm, above the elbow.

degenerative cervical spine condition before June 2008; that the June 2008 incident aroused the condition into disability as evidenced by the objective medical findings; and that the harmful changes necessitated the proposed surgery.

Dr. Wolens performed a utilization review with respect to the proposed surgery. He noted in August 2009 that he did not consider the Cabell Huntington Hospital records from April 2007 to be particularly significant because they were a one-time record; involved only the left shoulder; and did not involve cervical radiculopathy. Having reviewed Dr. Jenkinson's report and Dr. Powell's recommendation, he requested the CT myelogram and a repeat electrodiagnostic study, noting that surgery would be indicated if the study validated the abnormalities.

Dr. Wolens reported in September 2009 that he reviewed the requested test results but that there remained "significant diagnostic confusion," which could not be resolved by a medical records review. He recommended a re-evaluation by Dr. Jenkinson to determine whether the claimant now had a focal radiculopathy and whether the CT myelography correlated with the electrodiagnostics. He recommended that C6-7 and C7-T1 surgery be approved if the claimant was not re-evaluated.

Dr. Jenkinson did not re-examine the claimant. He reviewed Dr. Wolens' report and interpreted it as finding there to be no clear correlation between the C7-T1 abnormality and the reported clinical signs and symptoms. He stated that the finding was consistent with his own November 2008 evaluation. He

remained convinced that the claimant would not be a good surgical candidate, noting that individuals who exaggerate symptoms and demonstrate non-physiological signs do not respond well to surgery.

Dr. Powell reported subsequently that, having failed to re-examine the claimant, Dr. Jenkinson failed to address his well-documented progressive myelopathy and atrophy. He noted also that the absence of electrodiagnostic findings on atrophied muscle did not indicate that the muscle was not atrophied. He opined that the C8 involvement resulted from the severe foraminal stenosis at C7-T1 as noted by Dr. Wolens. Noting the "clear progression of symptoms," he urged that the surgery be authorized before further irreversible neurological damage occurred.

The parties waived a hearing and the claim was bifurcated to determine the compensability of the cervical fusion surgery, including whether the underlying condition was work-related. The claimant asserted that his current symptoms resulted directly from the injury and that he would not reach MMI until he recovered from the surgery. He maintained that he never had problems with his neck before June 2008; that all medical treatment for his neck related directly to the injury; and that even Dr. Jenkinson acknowledged that the Cabell Huntington Hospital records did not pertain to the neck.

The employer argued that the surgery was neither work-related nor reasonable. Relying on the Cabell Huntington Hospital records, the employer asserted that the claimant had "exactly the same symptomatology" six months before their employment relationship although he denied it when deposed.

Relying on Dr. Jenkinson's testimony, the employer argued that the claimant magnified his symptoms; that his symptoms did not correlate with the objective evidence; and that the proposed surgery "would not correct [his] diffuse symptomatology."

The ALJ dismissed the claim on the grounds that the claimant failed to prove causation and work-relatedness. The ALJ acknowledged that a pre-existing degenerative condition is compensable if a work-related injury causes it to become symptomatic[2] but found the "critical issue [to be] whether or not any work related incident ever actually occurred." Convinced that the claimant "deliberately and repeatedly falsified the origin of his subject complaints," the ALJ noted specifically that he denied any previous problem with his neck, left shoulder, or left arm before June 20, 2008. Moreover, even when confronted with records from the Cabell Huntington Hospital, he denied any recollection that he sought treatment for a back/neck injury in February 2000 or for left arm and shoulder pain in April 2007. Yet, he acknowledged that the social security number and the signature they contained were his. Noting that a physician's opinion of what caused an injury is not probative if based on a false history, the ALJ viewed the opinions of physicians who testified on the claimant's behalf as being unreliable with respect to causation.

The claimant appealed following the denial of his petition for reconsideration. He maintained that the ALJ erred because he had a dormant,

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[2] *McNutt Construction/First General Services v. Scott*, 40 S.W.3d 854 (Ky. 2001).

non-disabling degenerative condition that was aroused by the injury and no medical evidence supported the existence of previous neck pain or a prior active neck condition.

The Board reversed for two reasons. First, it concluded that the ALJ erred by considering the claimant's deposition, which was not made part of the record. Second, it concluded that *Finley v. DBM Technologies*[3] compelled a decision in the claimant's favor in any event because no evidence showed his neck condition to be symptomatic and impairment ratable immediately before the work-related accident occurred.

The Court of Appeals granted a motion by the employer to correct and supplement the record to include both the claimant's deposition and an order in which the ALJ corrected the record to include the deposition.[4] That portion of the decision is not at issue presently. The court determined ultimately that the dispute over whether the injury caused a dormant pre-existing condition to become disabling was inapplicable because the ALJ found the critical issue to be whether a work-related injury actually occurred. Noting that the ALJ found the claimant to be untruthful, the court found no error in the decision to reject his evidence of causation because the physicians testifying on his behalf based their opinions on a false history.

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[3] 217 S.W.3d 261 (Ky. App. 2007).

[4] The order noted that both parties referred to the testimony repeatedly in their briefs and that the ALJ received a copy of the transcript before rendering the decision. The ALJ determined that KRS 342.285(2) did not apply to the present circumstances and that CR 75.08 permitted the record to be corrected to "conform to the truth."

The claimant argues that the Court of Appeals erred in its scope of review. He maintains that "the reliable, material, probative, and substantial evidence" given by Dr. Powell and the principles set forth in *Finley* and *McNutt* supported the Board's conclusion. We disagree.

Finley and *McNutt* were inapplicable because the ALJ found the claimant not to be credible and, as a consequence, rejected medical opinions based on a history that the ALJ concluded was false. Among them was Dr. Powell's opinion that a June 20, 2008 injury aroused the claimant's previously dormant degenerative condition, causing the present symptoms and need for surgery.

KRS 342.285 designates the ALJ as the finder of fact, which means that the ALJ, rather than the Board or a reviewing court, has the sole discretion to determine the quality, character, and substance of evidence. When the evidence is conflicting, the ALJ may choose whom and what to believe.[5] 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 party's total proof.[6] Moreover, an ALJ may reject even uncontradicted medical evidence provided a reasonable explanation is given.[7]

A finding that is supported by substantial evidence is reasonable.[8] Substantial evidence has been defined as evidence sufficient to convince

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[5] *Pruitt v. Bugg Brothers*, 547 S.W.2d 123 (Ky. 1977).

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

[7] *Commonwealth v. Workers' Compensation Board of Kentucky*, 697 S.W.2d 540 (Ky. App. 1985).

[8] *Special Fund v. Francis*, 708 S.W.2d 641, 643 (Ky. 1986).

reasonable people.[9] Where such evidence supports a decision, the mere existence of evidence that would have supported a different decision is an inadequate basis to reverse it on appeal.[10]

The Court of Appeals did not err by reinstating the ALJ's decision to dismiss the claim. The claimant's adamant denial of any previous back/neck injury and previous left arm and shoulder complaints even when confronted with hospital records to the contrary provided a reasonable basis for the ALJ to find him not to be credible. His lack of credibility rendered unreliable the complaints that he voiced to physicians on and after June 20, 2008 as well as the history that he reported concerning his symptoms, the alleged injury on that date, and the relationship between them. Having found the claimant not to be credible, the ALJ could properly reject medical opinions that were based on the history he reported and conclude that he failed to meet his burden of proving causation.[11]

The decision of the Court of Appeals is affirmed.

All sitting. All concur.

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[9] *Smyzer v. B. F. Goodrich Chemical Co.*, 474 S.W.2d 367 (Ky. 1971).

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

[11] *See Cepero v. Fabricated Metals Corporation,* 132 S.W.3d 839 (Ky. 2004) (a medical opinion based on a substantially inaccurate medical history and unsupported by other credible evidence cannot constitute substantial evidence); *Osborne v. Pepsi-Cola,* 816 S.W.2d 643, 647 (Ky. 1991) ("If the history is sufficiently impeached, the trier of fact may disregard the opinions based on it. After all, the opinion does not rest on the doctor's own knowledge . . . .")

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