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Commonwealth of Kentucky

Court of Appeals

NO. 2007-CA-001155-WC

DANIEL JOHNSON — APPELLANT

v.

PETITION FOR REVIEW OF A DECISION
OF THE WORKERS' COMPENSATION BOARD
ACTION NO. WC-04-84702

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

OPINION
AFFIRMING

** ** ** ** **

BEFORE: DIXON, VANMETER AND WINE, JUDGES.

VANMETER, JUDGE: Daniel Johnson petitions for the review of a Workers' Compensation Board's opinion affirming an Administrative Law Judge's (ALJ's) opinion and order dismissing Johnson's claim for benefits. For the following reasons, we affirm.

On June 12, 2004, while operating a ram car for Diamond May Coal Company, Johnson hit a bump, driving his head and body together. He subsequently felt pain in his neck and lower back. Johnson returned to work the next day, but he filed an Application for Resolution of Injury Claim in April 2006.

During the claim proceedings, evidence was presented that although Johnson had not filed a previous workers' compensation claim, he was paid workers' compensation benefits in 1997 for an injury he sustained to his low back. He received medical treatment from the time of this injury until at least April 30, 2004, which was some six weeks before the June 2004 injury. In addition, medical evidence was presented, which the ALJ summarized in his opinion and order as follows:

> **Dr. Van S. Breeding**. In July 2004, plaintiff reported neck pain sustained during an alleged accident at work. A week later, plaintiff reported back pain radiating into his leg and foot. He had a history of chronic back pain. Dr. Breeding noted an MRI taken in April 2004 that showed L4-5 disc herniation. Plaintiff had had persistent lumbago. Dr. Breeding diagnosed cervical strain and lumbosacral radiculopathy with chronic sciatica. An MRI showed the disc herniation at L4-5 had resolved and plaintiff had a bulging disc at L4-5. Dr. Breeding referred plaintiff to Dr. Gilbert for increased pain. Plaintiff medicated with Ketaprofen, Flexeril, Topamax, Trazadone and Ultracet.
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> **Dr. John Gilbert, neurosurgeon**. In October 2004, plaintiff reported severe pain in the head, right arm, mid back, low back, and right leg of several months' duration. Modifying factors included Lortab, Methadone, Percocet, Lorcet Plus, Xanax, and physical therapy. Dr. Gilbert diagnosed lumbar nerve root injury, thoracic nerve root injury, cervical nerve root injury, cervicalgia, cervical radiculopathy, cervical strain/sprain, thoracic radiculopathy, thoracic pain, thoracic strain/sprain, lumbar lumbago, lumbar

strain/sprain, lumbar sciatica, pain with psychological/ medical factors, muscle spasm, numbness and tingling, anxiety, depression, and insomnia. In May 2005, plaintiff's functional status and activities of daily living were stable on medication. He was treated conservatively. Epidural steroid injections and physical therapy provided no lasting relief.

A 2004 lumbar x-ray revealed degenerative disc disease at L3-4, L4-5, and L5-S1, a mild annular bulge at L4-5, mild facet disease, and neural foramen narrowing on the right at L4-5, secondary to annular disc bulge and facet hypertrophy and arthritis. A February 2006 MRI revealed degenerative disc disease, spondylosis, scoliosis, small calcified protrusions with a mild relative canal encroachment at C5-6 and C6-7. Plaintiff's ability to function and perform his activities of daily living was improving.

Dr. Ira Potter. In May 2006, plaintiff reported multiple positional intolerances and limitations with his ADLS. His medical history was significant for a lower back injury that had occurred on the job in 1996 but had resolved. Currently, plaintiff continued to work with pain and without restrictions. He demonstrated a mildly antalgic gait. Dr. Potter diagnosed C5-6 and C6-7 [degenerative disc disease], spondylosis, small calcified protrusions with canal encroachment; chronic cervical strain/myofascial pain; right cervical radiculitis; L3 through S1 [degenerative disc disease], spondylosis, and facet arthropathy; chronic lumbosacral strain/myofascial pain; and right lumbosacral radiculitis. He attributed causation to the work injury superimposed upon many years of cumulative trauma and repetitive strain at work. He assigned a 14% whole person impairment. Plaintiff asked Dr. Potter not to place any restrictions on him because he had feared he would be terminated from his employment. However, Dr. Potter offered an extensive list of potential restrictions. He said plaintiff could return to work[.]

Dr. Gregory Snider. Dr. Snider indicated that plaintiff was under the care of Dr. Breeding for chronic low back pain at the time of his alleged injury. He was taking Ultracet and had undergone an MRI only a few weeks prior to

the injury. Dr. Snider diagnosed cervical strain and aggravation of chronic low back pain. He placed plaintiff at maximum medical improvement without recommending future medical treatment or further imaging studies unless objective examination findings supported evidence for an anatomic change. He recommended that plaintiff avoid the use of narcotics during working hours. He released him to return to work and assigned a 1% WPI for subjective worsening of a pre existing 5% impairment for low back pain.

Deposition of Dr. Gregory Snider. Dr. Snider did not have any pre-injury records when he evaluated plaintiff. Plaintiff told him that [he] was taking Ultracet and was under the care of Dr. Breeding prior to the injury. Plaintiff told him that he had undergone an MRI a few weeks prior to the alleged injury. Dr. Snider testified that plaintiff was vague about his pre-injury status. Plaintiff said he had had a previous workers' compensation claim for his low back, for which he did not receive any settlement.

Plaintiff reported only neck and low back pain during the evaluation. He did not report arm and leg pain or arm and leg numbness. Dr. Snider did not find anything specific in his examination with regard to neck or back pain. Plaintiff had a good gait, a negative straight leg raise, and good pulses. His reflexes were symmetrically diminished, and he had normal lumbar flexion and range of motion. There was no atrophy in the arms or focal weakness. He had excellent grip strength. There was no pattern of reflex loss. He had good motion in all the joints of his arms. There was a little diminishment in general neck motion but not in a specific plane.

Dr. Snider reviewed pre-injury medical records after the evaluation. Plaintiff's physical findings had remained unchanged, which indicated that there was no gross shift in his condition, at least from the standpoint of physical examination. There was no additional pathology over and above what was present prior to June 2004 on radiographic studies. Plaintiff told Dr. Snider that he had developed a tremor after the alleged injury, but medical records indicated that Dr. Gutti had evaluated and treated him for a tremor as early as 2001. On April 1, 2004, plaintiff reported neck and

low back pain that started in 1997 to Dr. Agtarap. At that time, plaintiff had missed six months of work, and although he returned at light duty, he had never been able to achieve the same level of work intensity as he had before. He was medicating with Ultracet and Lorcet at that time. Dr. Snider said that in 2004, "He gave a history of gradual progression of his neck pain. He said that two years prior to that . . . he had [had] a lifting accident which exacerbated his pain." He had complained of neck pain radiating into both shoulders and back pain that radiated into the right leg and foot. X-rays had showed degenerative changes. Dr. Agtarap had referred plaintiff to Dr. Tibbs on April 30, 2004. Dr. Agtarap had performed bilateral sacroiliac joint injections using CT guidance. Dr. Gutti had performed electromyographic studies and nerve conduction studies in January 2001. She reported abnormal results of "right L5 radiculopathy [and] . . . mild sensory/motor type of neuropathy."

Dr. Snider was skeptical with regard to causation because plaintiff had not disclosed his previous treatment. Dr. Snider did not see any objective medical evidence illustrated anywhere in the totality of the post-injury medical records of an injury that had produced a permanent impairment. Dr. Snider conceded that an increase in pain two days after the alleged accident was consistent with an injury.

Dr. David Jenkinson. In June 2006, plaintiff reported a tremor and other vague neurological symptoms in his arms and legs. Plaintiff denied any previous back injury but said he had previously taken medication for high blood pressure. Dr. Jenkinson said there was no objective evidence on examination to support a diagnosis of neurological abnormality. He said, "In particular, I do not believe he has any significant disc herniation or nerve root irritation that could be attributed to any injury. His MRI scan demonstrated nonspecific degenerative changes consistent with his age." He released plaintiff to return to work without restrictions. He did not assign a permanent impairment.

The ALJ was most persuaded by Dr. Snider's opinions and concluded that Johnson had not sustained an injury pursuant to KRS 342.0011(1), as there had been "no

objective change in pathology from the medical records and diagnostic studies done before June 12, 2004 as compared to those performed afterward." Further, the ALJ opined that Johnson's "current conditions preexisted the alleged injury and were not otherwise caused or increased by the events of June 12, 2004." The Board affirmed, and this petition for review followed.

First, we note that a workers' compensation claimant has the burden of proving every element of his claim. *Jefferson County Pub. Sch./Jefferson County Bd. of Educ. v. Stephens*, 208 S.W.3d 862, 866 (Ky. 2006). Because Johnson failed to meet his burden below, the issue on appeal is "whether the evidence was so overwhelming, upon consideration of the entire record, as to have compelled a finding in his favor."[1] *Wolf Creek Collieries v. Crum*, 673 S.W.2d 735, 736 (Ky.App. 1984). Compelling evidence is that which is so overwhelming, no reasonable person could reach the same conclusion as the ALJ. *Neace v. Adena Processing*, 7 S.W.3d 382, 385 (Ky.App. 1999).

Johnson argues that the Board erred by affirming the ALJ's decision that he did not sustain an "injury" as defined in KRS 342.0011(1). We disagree.

Although the ALJ did not accept it, there was objective medical evidence to support a finding in Johnson's favor. For example, Dr. Potter opined that while Johnson's medical history was significant for a lower back injury in 1996, the injury had resolved. Dr. Potter diagnosed Johnson with a number of conditions, all of which he attributed as

[1] Johnson argues incorrectly that the standard of review applicable here is whether the ALJ's decision was supported by substantial evidence. However, that standard applies when the party with the burden of proof is successful before the ALJ, *Wolf Creek Collieries v. Crum*, 673 S.W.2d 735, 736 (Ky.App. 1984), which did not occur here.

being caused by the incident involving the ram car "superimposed upon many years of cumulative trauma and repetitive strain at work." However, there was also evidence supporting a finding that Johnson did not sustain an "injury" as defined in KRS 342.0011(1). Specifically, Dr. Snider testified in his deposition that there was "no objective measure that indicates there has been any change in [Johnson's] anatomy based on the June 2004 work injury." Further, as set forth above, Dr. Jenkinson "said there was no objective evidence on examination to support a diagnosis of neurological abnormality. He said, 'In particular, I do not believe he has any significant disc herniation or nerve root irritation that could be attributed to any injury. His MRI scan demonstrated nonspecific degenerative changes consistent with his age.'" Accordingly, the evidence did not compel a finding in Johnson's favor, and the Board did not err by affirming the ALJ's decision.

A different result is not compelled by the fact that Dr. Snider testified that he did not review the MRI films taken before and after Johnson's work injury. Kentucky courts have stated on numerous occasions that as the fact-finder in a workers' compensation proceeding, the ALJ has the sole authority to judge the weight, credibility, and inferences to be drawn from the evidence. *E.g.*, *Miller v. East Ky. Beverage/Pepsico, Inc.*, 951 S.W.2d 329, 331 (Ky. 1997). He also has the sole discretion to determine the quality, character, and substance of the evidence. *Square D Co. v. Tipton*, 862 S.W.2d 308, 309 (Ky. 1993). And he is free to reject any testimony, and to believe or disbelieve various parts of the evidence, regardless of whether it comes from the same witness or the

same party's proof. *Magic Coal Co. v. Fox*, 19 S.W.3d 88, 96 (Ky. 2000). Here, Dr. Snider's deposition, which was submitted into evidence, revealed that he did not review the MRI films. Dr. Snider's deposition also revealed the evidence he did consider when rendering his opinions, which he testified were based upon a reasonable medical probability. Ultimately, it was for the ALJ to determine the weight of Dr. Snider's testimony, as well as the weight to be given to the MRIs themselves. A different result is not compelled by the fact that Johnson reported an increase in his pain after the ram car incident, as one's complaints of pain are subjective rather than objective measures.

Next, Johnson argues that the ALJ erred by failing to address the issues Johnson raised regarding Dr. Snider's credibility, i.e., that Dr. Snider primarily testifies for defendant-employers. We disagree.

Pursuant to KRS 342.275(2), the record in a workers' compensation proceeding shall contain an ALJ's "award, order, or decision, together with a statement of the findings of fact, rulings of law, and any other matters pertinent to the question at issue[.]" Here, the ALJ did not commit error by failing to specifically address the fact that Dr. Snider primarily testifies for defendant-employers. Instead, the ALJ's conclusion that he was "ultimately persuaded by the opinions of Dr. Snider" is sufficient to properly apprise the parties as well as the reviewing bodies of the basis for the decision, *Shields v. Pittsburg & Midway Coal Mining Co*., 634 S.W.2d 440, 444 (Ky.App. 1982).

The Board's opinion affirming the ALJ's opinion and order dismissing Johnson's claim for benefits is affirmed.

ALL CONCUR.

BRIEF FOR APPELLANT:

Dustin R. Williams
Pikeville, Kentucky

BRIEF FOR APPELLEE DIAMOND MAY COAL COMPANY:

David H. Neeley
Prestonsburg, Kentucky