

Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: May 13, 2016

CLAIM NO. 201457034

DIAN SLONE

PETITIONER

VS.

APPEAL FROM HON. STEVEN G. BOLTON,
ADMINISTRATIVE LAW JUDGE

SPRINGLEAF FINANCIAL SERVICES and
HON. STEVEN G. BOLTON,
ADMINISTRATIVE LAW JUDGE

RESPONDENTS

OPINION
AFFIRMING

* * * * *

BEFORE: ALVEY, Chairman, STIVERS and RECHTER, Members.

ALVEY, Chairman. Dian Slone ("Slone") appeals from the Opinion and Order rendered January 15, 2016 by Hon. Steven G. Bolton, Administrative Law Judge ("ALJ"), dismissing her claim after determining her bilateral carpal tunnel syndrome ("CTS") was not casually related to her work activities with Springleaf Financial Services

("Springleaf"). Slone also seeks review of the February 24, 2016 order denying her petition for reconsideration.

On appeal, Slone argues the objective medical evidence compels a finding she developed CTS due to her work at Springleaf. Slone also argues the ALJ erroneously required her to prove she actively treated for her condition before it had been formally diagnosed by Dr. James Hammock, who conducted the EMG/NCS study on November 13, 2014. Because substantial evidence supports the ALJ's determination and no contrary result is compelled, we affirm.

Slone filed a Form 101 alleging she developed bilateral CTS due to wear and tear, and the repetitive nature of her work with Springleaf. Slone identified the date of injury as December 16, 2013. The Form 104 indicates Slone worked for Springleaf from November 17, 1980 through December 16, 2013.

Slone testified by deposition on August 25, 2015, and at the hearing held November 16, 2015. Slone was fifty-five years old at the time of the hearing. She worked at Springleaf for over thirty-three years, beginning in November 1980. She stopped working on December 16, 2013, and subsequently received short-term, then long-term disability benefits due to an unrelated left eye condition.

Springleaf is a loan and retail business, "which means that we made loans to people, we did financing of the companies, a lot of paperwork, a lot of typing." Slone began working for Springleaf as a customer service representative, and eventually progressed to a customer account administrator position. Slone indicated although her job title changed over the years, her actual job duties were dictated by what needed to be done.

Prior to the 1990s, Slone processed the company's accounts by using a typewriter. This required the use of cards to post payments. Slone also prepared handwritten applications for customers, opened envelopes, filed, lifted heavy boxes and client files, counted money, and used the telephone and the calculator. In the 1990s, Springleaf went card-less. All the account information had to be entered into a computer system. This technological change required her to use applications and maintain accounts via a keyboard. During this time, she processed more loans. If she worked in the front as a cashier, she collected and counted money, took phone calls, and waited on customers. Slone's job title changed to customer account administrator in 2000, and she continued in this position until she stopped working in December 2013.

Slone testified her job required physical, repetitive activity with her hands. "Throughout the years," Slone noticed tingling and numbness in her thumb, pointer, and middle fingers, with her right hand worse than her left hand. She estimated she began experiencing these symptoms in the mid-1990's or 2000. Initially, Slone shook her hands to obtain relief from her symptoms; however, her condition gradually worsened. Certain work activities, such as typing and writing, aggravated her symptoms and she began to experience a loss in grip strength. She also experienced sharp shooting pain in her elbow and arm into her fingers.

Slone testified she first told her primary care physician, Dr. Darian Ratliff, of numbness in her hands in January 2011, but he did not order tests or recommend treatment at that time. In August 2014, Slone again sought treatment with Dr. Ratliff after experiencing severe hand pain the night before. Dr. Ratliff recommended EMG/NCS testing and wrist splints. Slone also saw Dr. Devesh Sharma, and subsequently sought a second opinion with Dr. Steven Carawan.

Slone had treated with Dr. Ratliff since 2009 for several conditions unrelated to her hands and wrists. Prior to and after December 2013, Slone saw Dr. Ratliff

every three months to manage her cholesterol, blood pressure, thyroid and diabetes with medication. At the time she stopped working, Slone had not been formally diagnosed with CTS. Slone testified she had surgery for a detached retina in December 2013. She underwent a second surgery after her retina detached again. Slone continued to have complications, and ultimately lost vision in her left eye.

As noted above, Slone last worked on December 16, 2013 due to her eye condition. Slone did not seek treatment for her hands following her last day of work until August 2014 because her eye condition was her primary concern. She experienced severe pain in August 2014, and decided to seek treatment with Dr. Ratliff. At the hearing, Slone indicated since she has stopped working, the tingling sensation has improved but her pain has worsened.

Currently, Slone has muscular atrophy in her hands, and her right hand does not open as much as her left one. Slone continues to experience pain, numbness, tingling, weakness, and loss of grip strength. Slone attributes her condition to her many years of repetitive work activities with Springleaf. Slone does not believe she is capable of returning to Springleaf due to her inability to type or hold files.

Both parties filed treatment records from Dr. Ratliff from March 2009 through May 19, 2015. From March 11, 2009 through May 6, 2010, Slone treated with Dr. Ratliff on approximately eight occasions primarily for hypertension, hyperlipidemia, hypothyroidism, B12 deficiency, and allergic rhinitis. On January 13, 2011, Dr. Ratliff prescribed medication for the above conditions, but also noted, "She has occasional numbness in her hands. This has been a little better recently." Dr. Ratliff did not order any tests or recommend treatment for her hand complaints at this time.

Thereafter, the record reflects Slone had approximately eighteen office visits with Dr. Ratliff from February 2011 through May 19, 2014, which reflect no treatment for hand complaints or symptoms. Dr. Ratliff continues to treat Slone for hypertension, hyperlipidemia, hypothyroidism, B12 deficiency, and allergic rhinitis. Dr. Ratliff also diagnosed obesity, retinal detachment, and anxiety. Dr. Ratliff diagnosed diabetes mellitus, type II, in August 2013, and he has continued to prescribe medication regularly for that condition.

On August 15, 2014, Dr. Ratliff noted Slone reported bilateral hand pain the previous evening. He noted Slone "has been canning a lot," and the pain is worse

on the right and at night. Dr. Ratliff diagnosed bilateral CTS and ordered a EMG/NCV study. On November 14, 2014, Dr. Ratliff noted the November 13, 2014 EMG/NCS study revealed CTS and ulnar neuropathy. He then referred her to a hand surgeon.

Slone filed the November 13, 2014 EMG/NCV Study conducted by Dr. Hammock and the December 15, 2014 treatment note of Dr. Sharma. Dr. Hammock noted there was electrodiagnostic evidence of chronic severe right median neuropathy at the wrist; moderate left median neuropathy at wrist; moderate right ulnar neuropathy at the wrist; and mild left ulnar neuropathy at the wrist. On December 15, 2014, Dr. Sharma noted Slone complained of a gradual onset of bilateral hand pain, as well as numbness and tingling, over a period of twenty years. Dr. Sharma noted Slone previously worked for Springleaf, which required a lot of typing. After reviewing the November 2014 studies, Dr. Sharma diagnosed CTS and problems with the ulnar nerve. He recommended carpal tunnel and Guyon's canal releases.

In an undated letter, Dr. Ratliff requested Dr. Sharma's opinion regarding the cause of Slone's CTS. Dr. Sharma provided a handwritten response on the same letter, which stated:

I examined Ms. Slone on 12/15/14 for the bilateral hand pain, associated with numbness & tingling for the past 20 years. PMH is also significant for DM. Carpal tunnel syndrome is a common compression neuropathy especially in diabetics. With the history provided by Ms. Slone, I cannot support or refute her claim that her carpal tunnel syndrome is related to the work. It can only be supported by a physician who has examined her over the last 20 years & who can support with examination findings that symptoms became worse during her working years & improved after stopping the work.

In another undated letter, Dr. Ratliff noted he has treated Slone since March 2009 and, "In my opinion, her Carpal Tunnel Syndrome is related to her long work history."

Slone filed the March 25, 2015 medical record of Dr. Carawan, who noted she has bilateral chronic aching and numbness, with weakness of grip strength. Dr. Carawan noted Slone performed clerical work for over thirty years, and he believed constant keyboarding/typing contributed to her symptoms over the years, "and after her description of her job I agree." Dr. Carawan performed an examination and diagnosed CTS. He again opined her CTS is "due to years of keyboarding/typing/clerical duties and is work related." Dr. Carawan also recommended surgery.

Slone filed the medical report of Dr. Thomas Smith, who examined her at her attorney's request on August 25, 2015. He noted her thirty year work history with Springleaf, in which she extensively typed on a typewriter for ten years, and then used a keyboard. Dr. Smith noted Slone reported a gradual onset of tingling in her hands which she believed was due to constant keyboarding and typing. Dr. Smith noted Dr. Ratliff's opinion on causation. Dr. Smith diagnosed CTS, bilateral chronic wrist pain, hypertension, Diabetes NIDDM, hyperlipidemia, detached left retina with vision loss, hypothyroidism, osteoarthritis, anxiety, menopause, hypertension, and B12 deficiency. Dr. Smith opined Slone's injury caused her complaints. Under "explanation of causal relationship," Dr. Smith stated as follows:

Patient had wear and tear on the wrist over many years causing severe [CTS] and severe pain and numbness in the hands. She sustained repetitive trauma and wear and tear over 32 years causing [CTS] bilaterally. The [CTS] is due to years of keyboarding/typing/clerical duties and is work related."

Dr. Smith assessed a 16% impairment rating and opined Slone has not yet reached maximum medical improvement. However, if Slone opts not to have surgery, the impairment rating would be accurate. Dr. Smith opined

Slone does not retain the physical capacity to return to her former job, and restricted her from typing or manual labor using her hands.

Springleaf filed the medical report of Dr. Gregory Snider, who examined Slone at its' request on October 7, 2015. Dr. Snider reviewed Slone's long work history with Springleaf and her associated job tasks, as well as the medical records. Dr. Snider diagnosed Slone with bilateral median greater than ulnar neuropathies, right greater than left, obesity, diabetes, hypothyroidism and history of B12 deficiency. Dr. Snider provided the following explanation in finding there is no evidence of CTS caused by cumulative trauma related to her employment:

Review of symptoms and exam findings were repeatedly documented as negative over the years for symptoms of neuropathy. Her symptoms did not surface in the record until August 2014, nine months after she last worked and after "canning a lot." Electrodiagnostic studies are not consistent with an isolated median neuropathy (carpal tunnel syndrome), but show a diffuse pattern of neuropathy perhaps more consistent with metabolic problems. She has multiple risk factors for neuropathy, including obesity, diabetes, hypothyroidism, and potentially B12 deficiency. Her symptoms should be steadily improving if they were related to her work activities; however, they are not improving and are reported to be worsening. This is not consistent with

a work-related etiology. In my opinion, Ms. Slone does not have any convincing evidence of "cumulative trauma" in the form of entrapment related to her employment.

Dr. Snider opined Slone could return to her job with Springleaf without restrictions considering only the effects of her neuropathy. He also opined Slone does not have ratable impairment for a work-related impairment for neuropathy.

Finally, Springleaf filed the medical records review report of Dr. Christopher Brigham dated November 2, 2015. He opined Slone's CTS is not work-related. Dr. Brigham also critiqued the opinions expressed by Dr. Smith.

In the January 15, 2016 opinion, the ALJ summarized the evidence, and noted Slone carried the burden of proof on causation. The ALJ provided the following analysis in ultimately dismissing Slone's claim:

In the case at hand, the injury consists of claimed cumulative trauma to the bilateral wrists resulting in Carpal Tunnel Syndrome. Implicit in the finding of a gradual injury is a finding that no single instance of workplace trauma caused an injury of appreciable proportion. Hill v. Sextet Mining Corp., 65 S.W.3d 503, 507 (Ky. 2001). However, to support a finding of a long term exposure to small but ultimately damaging mini-traumas there should be some indication of an ongoing medical process. Here there is none.

Here, the Plaintiff reported to all of the treating and examining physicians that she had performed repetitive typing, keyboarding and handling money for her employer. She avers that this is the source of her Carpal Tunnel Syndrome. She had gradual onset without known injury by history and now suffers from constant tingling and aching. Night splinting with her prescribed wrist splints has not helped. CTS surgery has been advised.

Yet her history shows that she worked for the Defendant/Employer from 11/17/1980 until 12/16/2013 when she went on long term disability not due to CTS, but rather from a detached retina in her left eye which resulted in loss of vision in her left eye.

While she now claims that she suffered from increasing symptoms of CTS over the years, her medical records reveal a different scenario.

Mrs. Slone is not a physician, and while her testimony as to her physical and occupational history is relevant, she cannot render a medical opinion as to the cause of her CTS. When the cause of a condition is not readily apparent to a lay person, medical testimony supporting causation is required. Mengel v. Hawaiian-Tropic Northwest & Central Distributors, Inc., 618 S.W.2d 184 (Ky. App. 1981). Medical causation must be proven by medical opinion within "reasonable medical probability." Lexington Cartage Co. v. Williams, 407 S.W.2d 396 (Ky. 1966). The mere possibility of work-related causation is insufficient. Pierce v. Kentucky Galvanizing Co., Inc., 606 S.W.2d 165 (Ky. App. 1980).

As noted in the treatment records of her primary care physician, Dr. Ratliff, although she made mention of "occasional numbness in her hands" at a visit of 1/13/2011, Mrs. Slone first presented to Dr. Ratliff for bilateral wrist pain on 08/15/2014. She had been treating with him from 3/11/2009 (5 ½ years) and an exhaustive review of those records (which are significant and frequent) indicates that she never complained to her primary care physician of wrist pain or stiffness until nine (9) months after she had left employment. Even the complaint of occasional numbness was a one-time thing, to which no apparent medical response was made.

One cannot tell from his correspondence or reports how Dr. Ratliff determined that she had suffered CTS from 20 years of cumulative trauma when his own records belied such a finding. He apparently made that judgment retrospectively, based on Mrs. Slone's reports and the fact that Dr. Hammock found the condition to be present via his EMG/NCV. But it is interesting that Dr. Ratliff solicited the medical opinion of Dr. Sharma, whose response bears repeating:

I examined Ms. Slone on 12/15/14 for the bilateral hand pain, associated with numbness & tingling for the past 20 years. PMH is also significant for DM. Carpal tunnel syndrome is a common compression neuropathy especially in diabetics. With the history provided by Ms. Slone, I cannot support or refute her claim that her carpal tunnel syndrome is related to the work. It can only be supported by a physician who has examined her over the last 20

years & who can support with examination findings that symptoms became worse during her working years & improved after stopping the work.

Note: PMH stands for "Patient Medical History", while DM stands for "Diabetes Mellitus".

Of course, the only physician in the record who examined Mrs. Slone for any length of time during her employment was Dr. Ratliff and he never noted any symptoms of CTS nor, to be fair to him, did she complain of any until 9 months after she ceased her employment due to a condition caused by her diabetes.

Mrs. Slone also relies on the opinion of her IME physician, Dr. Thomas A. Smith, M.D., a general practitioner practicing in Pineville, Kentucky.

Dr. Smith received a history from Mrs. Slone on August 25, 2015 who alleged "gradual onset of tingling in the hands." She alleged that it got worse over time. Her attempts to relieve the symptom by shaking her hands decreased in effectiveness. She says the condition has gotten worse since the EMG/NCV of 11/13/2014 (11 months post employment). She now believes that it was caused by her 30 years of clerical work. However, she was only a secretary for 10 of those years, but more significantly, a cursory review of Dr. Ratliff's records shows that she was a frequent and thorough reporter of what was going on with her body to her primary care physician. Yet she did not report this very significant phenomenon to Dr. Ratliff.

This is especially significant because Dr. Smith relies upon Dr. Ratliff's

opinion in formulating his own as he clearly stated at the bottom of the first page of his Form 107-I.

With regard to Dr. Smith, he relied almost solely on PMH and Dr. Ratliff's belated opinion as to causation. However, the only medical records he reviewed according to his report were the results of the EMG/NCV performed by Dr. Hammock, although he disagreed with Dr. Hammock's diagnosis of nerve involvement.

Thus, Dr. Smith's conclusion that within reasonable probability the Plaintiff's "repetitive use trauma" and "accumulative trauma" was the cause of her complaints, without stating any basis for that conclusion other than her history and test results, which he must have thought were accurate, can be reasonably concluded to have originated in the fact that he didn't read Dr. Ratliff's treatment records. Further, even if he didn't know of the existence of those records, one would have thought that he would think it curious that the symptoms became active and disabling 11 months after the alleged source of the trauma ceased.

Because of the foregoing, I find the medical opinion of Dr. Gregory T. Snider, M.D. to be the most complete, compelling and persuasive medical evidence in the record as it pertains to Mrs. Slone's claim of work-related CTS. Dr. Snider's diagnosis was bilateral median greater than ulnar neuropathies, right greater than left; obesity, diabetes, hypothyroidism and history of B12 deficiency.

Dr. Snider's opinion mirrors that of treating physician Dr. Sharma (quoted herein above) to the effect that Mrs.

Slone's symptoms should be steadily improving if they were related to her work activities. The fact that by report they are not improving after she stopped work (indeed only commenced 9 months after she stopped work) and are reported to be worsening is not consistent with a work-related etiology. Therefore Ms. Slone does not have any convincing evidence of "cumulative trauma" in the form of entrapment neuropathy related to her employment.

Dr. Snider observed that Mrs. Slone has become disabled because of a vision problem. There is no evidence in the record that she was having any functional difficulty because of neuropathy and there is no indication that she could not have continued working at her regular job duties had her vision problems not arisen.

I therefore concur with Dr. Snider's conclusion that according to the *AMA Guides to the Evaluation of Permanent Impairment, 5th Edition*, any impairment for neuropathy is attributable to non-work-related factors such as obesity, hypothyroidism, diabetes and potentially B12 deficiency. He did not find her to have measurable sensory deficit, at least clinically. He did find her to have some effort-related evidence of weakness as well as signs of thenar atrophy. As pointed out by Dr. Snider, this is not specifically listed as a ratable impairment in the *Guides*.

The report of Dr. Brigham along with supporting documentation was stricken from the record because it was untimely filed. See Order of 12/2/2015. On petition for reconsideration, I ruled that I would consider it as evidence,

which I did. See Order of January 11, 2016. However, I did not consider that it added anything to the medical opinion of Dr. Snider and therefore chose not to rely upon it.

FINDINGS OF FACT
AND CONCLUSIONS OF LAW

. . . .

3. Based upon a preponderance of the evidence, I am persuaded that Mrs. Slone has failed to establish that her CTS was caused by her work. In making that finding, I rely on the medical opinion of Dr. Gregory T. Snider, M.D., which I find to be persuasive for reasons I have articulated in the foregoing "Analysis". In making that finding I also rely on the medical records of her treating physician, Dr. Darlan[sic] Ratliff, and the opinion of her treating physician, Dr. Devesh Sharma, as expressed in his handwritten note back to Dr. Ratliff.

. . . .

Slone filed a petition for reconsideration arguing the ALJ erroneously required her to prove she sought medical treatment while working for Springleaf as part of her repetitive trauma claim. Slone also argued the ALJ should have recognized the objective medical evidence established CTS. In denying her petition, the ALJ stated as follows:

The Plaintiff mistakenly asserts that I have made a finding that a repetitive trauma claim requires some indication of an ongoing medical process while the

claimant is working for the Defendant/Employer. I made no such finding. I did note the medical history of that Plaintiff which demonstrated not only no ongoing medical process, but no symptoms of her CTS until many months after she left employment for a totally separate health issue. Nevertheless, this fact, although relevant and material under the facts of this case, was not dispositive but rather it was the medical opinion of Dr. Gregory T. Snider, M.D., which I found to be persuasive along with the opinion of Plaintiff's treating physician, Dr. Devesh Sharma, M.D.

In this instance, Plaintiff's allegation of error patently appearing on the face of the Opinion and Order is a disagreement with my interpretation of the medical evidence in the record, which is not within the scope of my review under the provisions of KRS 342.281. Francis v. Glenmore Distilleries, 718 S.W.2d 953 (Ky. App. 1986).

On appeal, Slone argues the objective evidence compels a finding of a diagnosis of CTS pursuant to the definitions of injury and objective medical findings, as well as Gibbs v. Premier Scale Co./Indiana Scale Co., 50 S.W.3d 754 (Ky. 2001). Slone points to the EMG/NCV study, Dr. Ratliff's opinion regarding causation, and Dr. Carawan's opinions and findings on examination. Slone asserts the ALJ failed to consider the objective medical evidence and abnormal physical examination supporting the

diagnosis of CTS. Slone also argues, as she did in her petition for reconsideration, the ALJ erred in requiring her to "show she had been treated for her condition over the years that she was working before her condition was diagnosed by Dr. Hammock." Slone asserts the case of Hale v. CDR Operations, 474 S.W.3d (Ky. 2015), holds there is no requirement a Claimant's condition must manifest during any period of employment.

We begin by noting Slone's argument on appeal largely focuses on whether the medical evidence compels a finding of an injury, specifically CTS. It is clear the ALJ acknowledged Slone's diagnosis of CTS, but opined her condition was not caused by her work activities with Springleaf. This is evidenced in the ALJ's findings of fact and conclusions of law, number 3, in which he stated "I am persuaded that Mrs. Slone has failed to establish that her CTS was caused by her work . . ."

With that in mind, as the claimant in a workers' compensation proceeding, Slone had the burden of proving each of the essential elements of her cause of action, including causation/work-relatedness. Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Because Slone was unsuccessful in that burden, the question on appeal is whether the evidence compels a different result. Wolf

Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). "Compelling evidence" is defined as evidence that is so overwhelming no reasonable person could reach the same conclusion as the ALJ. REO Mechanical v. Barnes, 691 S.W.2d 224 (Ky. App. 1985). The function of the Board in reviewing the ALJ's decision is limited to a determination of whether the findings made by the ALJ are so unreasonable based on the evidence they must be reversed as a matter of law. Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000).

Causation is a factual issue to be determined within the sound discretion of the ALJ as fact-finder. Union Underwear Co. v. Searce, 896 S.W.2d 7 (Ky. 1995); Hudson v. Owens, 439 S.W.2d 565 (Ky. 1969). An ALJ is vested with broad authority to decide questions involving causation. Dravo Lime Co. v. Eakins, 156 S.W.3d 283 (Ky. 2003). Where the evidence is conflicting, the ALJ, as fact-finder, has the discretion to pick and choose whom and what to believe. Caudill v. Maloney's Discount Stores, 560 S.W.2d 15 (Ky. 1977). The Board, as an appellate tribunal, may not usurp the ALJ's role as fact-finder by superimposing its own appraisals as to the weight and credibility to be afforded the evidence or by noting reasonable inferences which otherwise could have been drawn

from the record. Whittaker v. Rowland, 998 S.W.2d 479, 481 (Ky. 1999). So long as the ALJ's ruling with regard to an issue is supported by substantial evidence, it may not be disturbed on appeal. Special Fund v. Francis, 708 S.W.2d 641, 643 (Ky. 1986).

In this instance, differing medical opinions exist in the record addressing the cause of Slone's CTS. Dr. Snider's opinions, in conjunction with Dr. Sharma's letter and Dr. Ratliff's records, constitute substantial evidence supporting the ALJ's determination Slone's condition is not casually related to her work activities at Springleaf, and no contrary result is compelled. Dr. Snider reviewed the pertinent medical records, and he diagnosed bilateral median greater than ulnar neuropathies, right greater than left, obesity, diabetes, hypothyroidism and history of B12 deficiency. Dr. Snider opined Slone did not demonstrate her condition was caused by cumulative trauma and provided a detailed explanation in support of his opinion. He noted Slone's symptoms did not appear in the record until nine months after she last worked, the electrodiagnostic studies showed a diffuse pattern of neuropathy more consistent with metabolic problems, her multiple non-work-related risk factors for neuropathy, and

the fact her symptoms have worsened since she stopped working.

The ALJ additionally relied upon the handwritten response from Dr. Sharma, who responded to Dr. Ratliff's inquiry concerning causation. Although Dr. Sharma did not provide a definite opinion on causation, he noted CTS is a common compression neuropathy frequently seen in diabetics. He also noted an opinion in support of work-related CTS "can only be supported by a physician who has examined her over the last 20 years & who can support with examination findings that symptoms became worse during her working years & improved after stopping the work." The ALJ then provided an accurate and thorough review of Slone's treatment history with Dr. Ratliff noting the absence of any symptoms or complaints of CTS, with the exception of the January 13, 2011 visit, until 9 months after she ceased her employment due to an eye condition caused by her diabetes.

We conclude the ALJ correctly understood the evidence before him regarding causation, weighed that evidence, and determined Slone's evidence was not persuasive. Drs. Ratliff, Carawan, and Smith opined Slone's CTS is work-related. On the other hand, Drs. Snider and Brigham opined Slone's CTS is not related to her

job activities. The ALJ, as fact-finder, has full discretion to determine the physician or physicians upon which he relies. If "the physicians in a case genuinely express medically sound, but differing opinions as to the severity of a claimant's injury, the ALJ has the discretion to choose which physician's opinion to believe." Jones v. Brasch-Barry General Contractors, 189 S.W.3d 149, 153 (Ky. App. 2006). The evidence falls far short of compelling a finding Slone's conditions are causally related to her employment with Springleaf. Because Slone failed to meet her burden of proof on this issue, the ALJ properly dismissed the claim.

As a final note, we find meritless Slone's argument the ALJ required her to prove she had treated for her condition over the years she was working and before her condition was formally diagnosed. As explained by the ALJ in the order denying her petition for reconsideration, Slone's medical history with Dr. Ratliff was one of several factors he considered in making his determination. Regardless, the ALJ also noted he ultimately found the opinions of Drs. Snider and Sharma most persuasive on the issue of causation, and explained his reasons. For the foregoing reasons, the ALJ's decision will not be disturbed.

Accordingly, the January 15, 2016 Opinion and Order and the February 24, 2016 order on petition for reconsideration by Hon. Steven G. Bolton, Administrative Law Judge, are hereby **AFFIRMED**.

ALL CONCUR.

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