OPINION ENTERED: AUGUST 7, 2012

CLAIM NO. 200877934

DOMINIC HOLLIS — PETITIONER/ CROSS-RESPONDENT

VS.

APPEAL FROM HON. J. LANDON OVERFIELD, CHIEF ADMINISTRATIVE LAW JUDGE

STARNES BAR-B-QUE — RESPONDENT/ CROSS-PETITIONER

and

HON. J. LANDON OVERFIELD, CHIEF ADMINISTRATIVE LAW JUDGE — RESPONDENT

OPINION AFFIRMING

* * * * * *

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

SMITH, Member. Dominic L. Hollis ("Hollis") appeals and Starnes Bar-B-Que ("Starnes") cross-appeals from the Opinion, Award and Order rendered by Hon. J Landon Overfield, Chief Administrative Law Judge ("CALJ") on February 2, 2012, finding surgical procedures proposed by

Dr. Erdogan Atasoy neither reasonable nor necessary, but awarding temporary total occupational disability ("TTD") benefits, permanent partial disability ("PPD") benefits and medical benefits mainly based upon the opinions of Dr. Craig Roberts. The CALJ's February 2, 2012 decision also incorporates the Interlocutory Opinion and Order rendered September 1, 2011, finding the proposed surgical procedures were neither reasonable nor necessary. The parties also appeal the CALJ's Order denying the petitions for reconsideration.

On appeal, Hollis argues it was error for the CALJ to determine the surgical procedures proposed by Dr. Atasoy were not reasonable or necessary given the substantial evidence to the contrary. Starnes, in its cross-appeal, argues it was error for the CALJ to rely upon the opinions of Dr. Roberts in awarding TTD, PPD and medical benefits, since, in his Interlocutory Opinion and Order of September 1, 2011, the CALJ had found much of that testimony not credible.

A recitation of the administrative history is necessary to properly frame the issues before the Board. Hollis filed a Form 101, Application for Resolution of Injury Claim, on March 23, 2009, asserting that on November 1, 2007, as he was moving meat from a pit to a cooker he felt pain in his

right wrist. On November 17, 2007, he alleged an injury to his right foot and ankle as he was loading wood onto a wheelbarrow. Then on February 11, 2008, he allegedly sustained an injury to his right forearm as he was transporting and turning meat.

The claim was assigned to Hon. R. Scott Borders, Administrative Law Judge ("ALJ Borders") on April 29, 2009 for adjudication.

Thoracic outlet syndrome surgery was performed as recommended by Dr. Craig Roberts, the university evaluator appointed by the CALJ. In addition, Hollis's treating physician, Dr. Atasoy continued to recommend additional surgical treatment. The claim was bifurcated with the issue of the compensability of the recommended surgery by Dr. Atasoy to be decided first.[1] On September 1, 2011, the CALJ issued an Interlocutory Opinion and Order finding the surgery proposed by Dr. Atasoy not reasonable or necessary. The CALJ first reviewed the extensive evidence presented summarizing as follows:

> In support of Dr. Atasoy's recommended surgery, Plaintiff introduced the doctor's January 12, 2009 report. Plaintiff also deposed Dr. Atasoy on

[1] By order of CALJ Overfield dated July 23, 2009, the claim was reassigned to ALJ Overfield for further proceedings upon ALJ Borders' appointment as interim chief administrative law judge. Thereafter, at a later date ALJ Overfield resumed responsibilities as chief administrative law judge, but retained this claim for adjudication. The recorded is not clear as when the later transition occurred.

October 20, 2010. In the doctor's report, he diagnosed Plaintiff with right thoracic outlet compression, carpal tunnel syndrome, pronator teres syndrome and myofasicitis. It was Dr. Atasoy's opinion that Plaintiff's condition was related to his work at Defendant Employer. Plaintiff had undergone conservative treatment with a course of physical therapy with instructions for home exercise and medications. The doctor recommended surgery which would consist of a right transcervical anterior and medial scalenectomies; external neurolysis of the brachial plexus (C5, C6, C7, C8 and T1); and decompression of the plexus and subclavian artery and vein.

Dr. Atasoy was of the opinion that Plaintiff had some degree of permanent partial functional impairment but he was unable to determine it at the time of his report. It would be determined once Plaintiff had reached maximum medical improvement. He would place permanent restrictions of no lifting more than 20 pounds maximum, with frequent lifting of 10 pounds with both hands. Dr. Atasoy noted Plaintiff had been off work due [to] his being unable to find anything suitable for his restrictions. Plaintiff had not, in the doctor's opinion, obtained maximum medical improvement.

At his deposition, Dr. Atasoy testified that Plaintiff reported a pulling and jerking injury to the upper extremity in February of 2008. The doctor ordered EMG/NCV studies which were read as normal. There was some swelling and atrophy noted in the right hand. Dr. Atasoy initially believed Plaintiff had signs of carpal tunnel compression and pronator teres compression syndrome. Tests were also

performed on Plaintiff's neck and upper extremity. There was right neck tenderness and upper back tenderness. After examination, physical tests and diagnostic tests, Dr. Atasoy determined Plaintiff had symptoms of right thoracic outlet compression syndrome and right upper back myofasicitis. There was also a question of right carpal runnel [sic] pronator teres syndrome. The doctor was of the opinion that the symptoms were all work related.

Dr. Atasoy performed a right supraclavicular scalenectomy procedure on December 14, 2009, removing some scalene muscle around the brachial plexus nerves. The surgery helped with some of the upper back and neck pain. Dr. Atasoy advised Plaintiff that he would still require surgery on the neck as well as other nearby areas. Plaintiff had been instructed in post-operative exercises and prescribed medication.

Dr. Atasoy was asked what his recommendation had been to Plaintiff for the treatment of the carpal tunnel syndrome. The doctor responded that he had recommended surgery on the carpal tunnel and pronator teres in the cubital tunnel on the right side. Nerve studies had been done twice and although they were normal, Plaintiff continued to have clinical symptoms known as compressions. Dr. Atasoy testified that 10% of people with these problems do not show symptoms on nerve conduction studies. It was his opinion that Plaintiff fell within this group. The surgeries would be performed at the same time at the elbow in the crazy bone area, the upper forearm, and the carpal tunnel area.

Upon cross-examination, Dr. Atasoy testified that while the carpal tunnel involved the wrist, the pronator teres involved the elbow area (the median nerve) and the cubital involved the crazy bone area (the fourth and fifth ulnar nerve). He had determined on a September 23, 2008 office visit that Plaintiff's right thoracic outlet compression was related to his work. Plaintiff's upper back myofasicitis was also related to his work. Asked if the two symptoms were related, Dr. Atasoy testified that if a patient had thoracic outlet compression syndrome, chances of back pain being present were almost always 90%.

Dr. Atasoy testified that 10% of patients will have a negative EMG study but will have clinical symptoms. Of that 10% chances were good for improvement following surgery but there was no guarantee. It was the doctor's opinion that Plaintiff had no other neurologic problems. While he expected Plaintiff to have some improvement in the right hand, it would never become normal. Even with surgery there would still be some loss of hand strength. Following a carpal runnel [sic] release or a pronator teres release, Dr. Atasoy would expect to see some improvement in Plaintiff's symptoms shortly thereafter. He was unable to determine when Plaintiff would see improvement in the hand strength following surgery.

Dr. Atasoy testified that once a patient has thoracic outlet compression syndrome, there was about 40% to 50% chance of them getting a new compression at the carpal tunnel or cubital tunnel. The doctor testified that Plaintiff was having almost similar symptoms on the left side. Once a patient develops thoracic outlet

> compression in one extremity, there is a 50% chance of it developing in the other arm due to only using the one arm. Plaintiff would have to take pain mediation constantly and may be capable of performing some work. He might be capable of lifting 10 to 20 pounds with [sic] right arm. At the time of the deposition, Dr. Atasoy had not seen Plaintiff since June 25, 2010. The grip strength in the right hand was about 40 and the left was 110. In February of 2010 the right hand grip strength was 35 and the left was 80. For Plaintiff's size, since the injury he had lost more than 60% of his grip strength on the right side. That was due to the injury and not from lack of activity. It was 120 at the first examination. At 110 it was slightly down but still within normal limits.

Starnes submitted the November 8, 2008 report of James Goris, M.D., who diagnosed Hollis with carpal tunnel syndrome, shoulder joint pain and nerve injury, not otherwise specified, pronator teres syndrome, and a traction injury of the right upper extremity with pain. He did not believe there was evidence of clear thoracic outlet syndrome; however, it was difficult to rule it out completely. He also concluded the injury to Hollis's upper extremity in the forearm and wrist was work-related.

Dr. Goris opined Hollis did not have the ability to return to full duty work because of its requirement for heavy-duty lifting. He further concluded Hollis's complaints were reasonable compared with the objective

findings. He recommended decompression of the median nerve at the pronator and carpal tunnel as proposed by Dr. Atasoy.

Starnes submitted the July 15, 2009 evaluation of Ross E. Marburger, M.D., who noted Hollis complained of pain in his right wrist, right forearm and right upper back, simultaneously. Hollis also stated that, at the time of the wrist injury, he felt a tingling and popping. Dr. Marburger diagnosed pain in the right limb and determined Hollis was not a surgical candidate for any procedure on the right forearm, wrist or hand.

Dr. Marburger would not disagree with the consensus opinions of other physicians who had concluded Hollis's work contributed to his condition. However, he found no objective pathology to explain the widespread relatively non-anatomic complaints. Dr. Marburger assessed a 3% functional impairment pursuant to the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th Edition ("AMA Guides"). He also concluded Hollis needed no additional medical treatment and was able to return to work without restrictions.

Starnes introduced the January 25, 2010 utilization review report of Daniel Wolens, M.D., who conducted a records review to determine the necessity of the right cubital tunnel release with external neurolysis of the ulnar

nerve with Osborne ligament reconstruction; right pronator teres release with external neurolysis of the median nerve; right carpal tunnel release with external neurolysis of the median nerve; and possible flexor tenosynovectomy and transverse carpal ligament reconstruction. Dr. Wolens recommended denial of the procedures noting that, although Hollis had limited symptoms, nothing in the record could substantiate the recommended procedures.

Starnes submitted the April 19, 2010 utilization review report of Thomas M. Gabriel, M.D. He reviewed the medical records submitted to him and examined Hollis following his right thoracic outlet decompression. He noted Dr. Atasoy reported additional findings and recommended multiple areas of clinical nerve compression about the cubital tunnel and carpal tunnel regions of the right upper extremity. He also noted electro-diagnostic studies of March 31, 2010 had been normal with no evidence of median or ulnar nerve neuropathy on the right side. There were no denervation or re-enervation changes in the C5-T1 distribution on the right. Dr. Gabriel found no objective evidence of any persistent peripheral nerve compression on the right and no evidence to support additional surgical decompression. Noting that he examined Hollis four months after surgery, Dr. Gabriel

determined he was at maximum medical improvement ("MMI") and needed no additional therapeutic intervention.

In his Opinion, the CALJ extensively summarized the report of Dr. Roberts. He stated:

> Plaintiff underwent a university evaluation on November 2, 2009 performed by Dr. Roberts. Dr. Roberts prepared a Form 107-I and, pursuant to statute, that report became part of the evidence in the record. Part of the history Plaintiff related to Dr. Robert[s] was as follows:
>
> > He had the **gradual onset** of right hand and wrist weakness and pain first reported the beginning of November 2007. This was more of a repetitive overuse injury. **He does not recall any one episode of injury.** (Emphasis added.)
>
> Plaintiff also reported the injury of February 2008 in a manner consistent with his deposition testimony.
>
> The physical examination revealed that Plaintiff’s forearms were equal in circumference, there was no thenar or hypothenar atrophy, the range of motion of the wrist and elbow for each arm were identical and the range of motion of the right shoulder was less than 6% reduced when compared to the left shoulder. Dr. Roberts noted that x-rays were taken on the date of his evaluation. The right shoulder films showed type II acromion with as os [sic] acromial. Right wrist x-rays showed no fractures or dislocations. Cervical spine radiographs showed some ossification bilaterally which looked symmetric. There were no fractures. Dr. Roberts

diagnosed Plaintiff with thoracic outlet syndrome, neurogenic. He was of the opinion that the condition was caused by Plaintiff's work. Based on the *Guides*, Dr. Roberts assigned 14% functional whole body impairment for right arm problems. Plaintiff did not have an active prior impairment.

Dr. Roberts noted that he had not been provided a description of the physical requirements of Plaintiff's customary work for Defendant Employer. He noted that Plaintiff lifted 25 to 30 pounds of meat repetitively as well as cut up meat. While the doctor noted that he would place restrictions on Plaintiff, he did not indicate any. He was of the opinion that Plaintiff did not have the capacity to return to the job that he held at the time of the injury. Dr. Roberts was of the opinion that Dr. Atasoy's proposed thoracic outlet syndrome surgery was medically necessary. The procedure would give Plaintiff his best chance to return to work. Plaintiff's permanent impairment would likely change following surgery.

Dr. Roberts supplemented his Form 107-I report on February 1, 2011 with clarification regarding Dr. Atasoy's proposed surgery. He was of the opinion that Dr. Atasoy's proposed right transcervical anterior and medial scalenectomies, external neurolysis of the brachial plexus, and decompression of the plexus and subclavian artery and vein are reasonable and necessary for the cure and relief of Plaintiff's work related condition.

As stated in Plaintiff's brief, the supplemental report from Dr. Roberts resulted from the fact that the doctor's Form 107-I did not address the need for all of the multiple surgeries

> recommended by Dr. Atasoy. It is noteworthy that in both his original Form 107-I and the supplemental report, Dr. Roberts never diagnoses any condition other than thoracic outlet compression and never addresses the surgeries proposed for carpal tunnel syndrome, cubital tunnel syndrome and pronator teres syndrome.
>
> Dr. Roberts' deposition testimony reiterated his findings. He was of the opinion that based on the history and examination of Plaintiff, that Dr. Atasoy's proposed procedures were related to Plaintiff's work injuries and were medically necessary. Asked if there were a percentage of patients who might have normal EMGs and still have carpal tunnel, Dr. Roberts responded that that [sic] was correct.
>
> On cross-examination, Dr. Roberts testified that he was aware of the procedures proposed by Dr. Atasoy when he had performed his examination of Plaintiff. He had examined Plaintiff and found positive Tinel's and positive Phalen's. He had examined the Guyon's canal, cubital tunnel brachial plexus and grip strength. Asked why his examination findings demonstrated the need for the proposed procedures, Dr. Roberts responded that the carpal tunnel surgery would address the median nerve compression of the wrist, which his exam showed, and the cubital tunnel release would address the compression of the ulnar nerve throughout the elbow. He was of the opinion that his exam was really consistent with that.

The CALJ then determined:

> I did not find the medical evidence presented through Dr. Atasoy and Dr. Roberts to be the most credible and

convincing evidence in the record. **I am particularly troubled by the history upon which Dr. Roberts based his opinions, that being of a gradual onset of right wrist symptoms noticed by Plaintiff with Plaintiff not recalling any one episode of injury. This is inconsistent with Plaintiff's testimony and the pleadings. In addition, until his deposition, Dr. Roberts never diagnosed carpal tunnel syndrome, cubital tunnel syndrome or pronator teres syndrome, and never gave an opinion that surgery for those conditions was reasonable and necessary as well as related to Plaintiff's injuries at work. Of course, the findings Dr. Roberts made on his physical examination did not seem to be supportive of problems with Plaintiff's right wrist, right forearm or right elbow.** Dr. Roberts did recommend the thoracic outlet compression surgery which was in fact performed by Dr. Atasoy, the medical expenses for which were apparently at the cost of Defendant Employer's workers compensation carrier. **I have also found the testimony of Dr. Roberts in his deposition to be inconsistent with his Form 107-I and supplemental report. For these reasons, I reject the clinical findings and opinions of Dr. Roberts and find that Defendant Employer has overcome the presumptive weight to be afforded the opinions of Dr. Roberts**. (Emphasis added.)

I am not convinced by the testimony from Dr. Atasoy that, in spite of numerous normal electrodiagnostic examinations, Plaintiff is suffering from multiple neurological problems related to most of the nerves innervating his right upper extremity. I find the most credible and convincing evidence in the record to be that of Dr.

> Wolens, Dr. Gabriel and Dr. Marburger. Based on that evidence, the medical fee dispute must be resolved in favor of Defendant Employer.

The CALJ denied Hollis's petition for reconsideration and a formal hearing was conducted on December 14, 2011. The CALJ rendered an Opinion, Award and Order on February 2, 2012, resolving all issues. After a review of the evidence, the CALJ found Hollis had a 14% impairment rating pursuant to the AMA Guides for his upper right extremity injury based upon the opinions of Dr. Roberts. The CALJ stated:

> **I find the most credible and convincing evidence in the record concerning Plaintiff's functional impairment rating as [sic] result of the stipulated injury to his right upper extremity is that assessed by Dr. Roberts, 14%.** I further find, based on the opinions of Dr. Roberts and Dr. Goris, that, as [sic] result of the February 11, 2008 work-related injury, Plaintiff does not retain the physical capacity to return to the type of work he was performing at the time of his injury. He is unable to perform the type of physical activities with his right upper extremity that, according to his un-rebutted testimony, is essential to the job he was performing for Defendant Employer. Plaintiff, pursuant to KRS 342.730(1)(c)1., is entitled to enhancement of his permanent partial disability benefits otherwise payable under KRS 342.730(1)(b). (Emphasis added.)
>
> Dr. Gabriel, based on March 31, 2010 nerve conduction studies which were reported as normal, declared Plaintiff

> at maximum medical improvement for his right upper extremity injury as of the date of those studies. I find this opinion to be the most credible and convincing evidence in the record concerning Plaintiff's date of maximum medical improvement relating to the February 11, 2008 work-related injury. I further find, based on Plaintiff's testimony and the opinions of Dr. Atasoy, Dr. Goris and Dr. Roberts, that Plaintiff was temporarily totally occupationally disabled from August 24, 2008, the day after he last worked following his right upper extremity injury until the day he reached maximum medical improvement, March 31, 2010.

Hollis filed a petition for reconsideration on February 27, 2012, renewing his previous arguments that there was overwhelming evidence he had sustained a work injury to his wrist and forearm which required additional surgeries to correct the carpal tunnel syndrome, cubital tunnel syndrome and pronator teres syndrome. He took issue with the CALJ's conclusions that Dr. Roberts had based his opinion on a history inconsistent with Hollis's testimony. Hollis noted the CALJ found Dr. Roberts' testimony not credible "due to his not diagnosing the carpal tunnel syndrome, cubital tunnel syndrome and pronator teres syndrome in his initial report." Hollis argued the order appointing Dr. Roberts as university evaluator only requested he comment on the thoracic outlet syndrome.

Hollis additionally argued the CALJ failed to include the reports of Dr. Jefferson, D.O., who diagnosed work-related carpal tunnel syndrome, and Dr. Tus-Min Tsai who had diagnosed work-related thoracic outlet compression syndrome, pronator teres syndrome, and carpal tunnel syndrome. Hollis noted Dr. Goris also diagnosed “carpal tunnel syndrome, shoulder joint pin [sic] and nerve injury, not otherwise specified, pronator teres syndrome, and a traction injury to the upper right extremity with pain.” In the opinion of Dr. Goris, the carpal tunnel was likely due to the repetitive use "aggravated by trauma and the forearm symptoms occurred with the pop at the time of the work injury."

Starnes filed a petition for reconsideration on February 20, 2012 pointing out clerical errors and arguing the CALJ in his Interlocutory Opinion and Award rendered September 1, 2011 found the opinions of Dr. Roberts to be inconsistent and unreliable. Starnes further argued CALJ found Roberts’ testimony to be inconsistent with his Form 107 and therefore he rejected his clinical findings. Yet, in his Opinion, Award and Order of February 2, 2012, the CALJ relied upon those opinions in awarding PPD benefits. Starnes argued these inconsistencies justified changing the award to be more consistent with the opinions of Dr. Marburger. In an Order rendered March 6, 2012, the CALJ

rejected the substantive portions of both petitions for reconsideration.

On appeal, Hollis argues the totality of the medical proof proves the CALJ's conclusions regarding the compensability of the proposed surgeries are clearly erroneous. Hollis identifies evidence which would support a finding in his favor. Hollis notes that, with the exception of Dr. Marburger, every doctor who personally saw and evaluated him diagnosed work-related carpal tunnel and pronator teres syndrome, and concurred with the medical necessity of the surgeries recommended by Dr. Atasoy. Hollis notes the employer’s doctors relied solely on negative EMG studies and one did not examine Hollis. Hollis notes the AMA Guides state 5% of individuals with CTS may have normal electrophysiologic studies.

Hollis further notes KRS 342.315 provides the clinical findings and opinions of the designated university evaluator shall be afforded presumptive weight by an ALJ and the burden to overcome such findings and opinions falls on the opponent of that evidence. Thus, Hollis argues Dr. Roberts’ opinions should be afforded presumptive weight. Hollis asserts Dr. Roberts did not comment on carpal tunnel syndrome, cubital tunnel syndrome or pronator teres syndrome because he was not asked to respond to anything other than

thoracic outlet syndrome. Hollis asserts there is clear and convincing evidence his carpal tunnel syndrome, cubital tunnel syndrome and pronator teres syndrome exist and are work-related. He notes Dr. Jefferson had diagnosed these conditions immediately after the accident. The diagnoses and relation to the work-related injury were confirmed by Dr. Goris, Dr. Atasoy and the university evaluator.

Finally, Hollis argues it was inconsistent for the ALJ to find Dr. Roberts' opinions to be the most credible in regard to the AMA impairment rating while finding his opinion as to the carpal tunnel syndrome, cubital tunnel syndrome or pronator teres syndrome not credible.

Starnes argues the CALJ erred in relying on Dr. Roberts' testimony and reports, which were based on an inaccurate history and had been previously rejected by the CALJ in the September 1, 2011 Interlocutory Opinion and Order. In the earlier decision, the CALJ found the opinions of Dr. Roberts to be inconsistent and unreliable. Specifically, the CALJ stated he was particularly troubled with the history upon which Dr. Roberts based his opinions and the fact that, until his deposition, Dr. Roberts had never diagnosed carpal tunnel, cubital tunnel or pronator teres syndrome. The CALJ further noted Dr. Roberts' testimony was inconsistent with his Form 107 and therefore

rejected his clinical findings. Starnes argues this is now the rule of the case. Starnes contends the evidence upon which the CALJ relied in awarding PPD benefits was precisely the same evidence rejected in denying surgery. Starnes argues the CALJ cannot now rely on the same clinical findings in choosing an impairment rating. Starnes notes Dr. Roberts issued an impairment rating for sensory deficits of the median nerve at the wrist (carpal tunnel) and ulnar nerve (cubital tunnel). Starnes asserts the conditions were the same conditions the CALJ had earlier rejected. Starnes notes the CALJ, in the September 1, 2011 Interlocutory Opinion and Order, ruled he did not believe the testimony or report of Dr. Roberts and rejected both. Starnes contends the CALJ did not state he was only rejecting certain parts of the report and testimony, but rather stated he was rejecting the clinical findings and opinions of Dr. Roberts. Thus, Starnes argues the CALJ's decision regarding the impairment rating should be reversed and the claim should be remanded to the CALJ for a ruling relying on the impairment rating of Dr. Marburger.

It is well established that a claimant in a workers' compensation claim bears the burden of proving each of the essential elements of his cause of action, including entitlement to future medical treatment. Burton v. Foster

Wheeler Corp., 72 S.W.3d 925 (Ky. 2002). Since Hollis was unsuccessful in his burden of proof before the CALJ regarding proposed surgeries, the question on appeal is whether the evidence is so overwhelming, upon consideration of the whole record, as to compel a finding in his favor. 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). As fact-finder, the ALJ has the sole authority to determine the quality, character, and substance of the evidence. Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993). Similarly, the ALJ has the sole authority to judge the weight and inferences to be drawn from the evidence. Miller v. East Kentucky Beverage/Pepsico, Inc., 951 S.W.2d 329 (Ky. 1997); Luttrell v. Cardinal Aluminum Co., 909 S.W.2d 334 (Ky. App. 1995). The ALJ, as fact-finder, 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. Magic Coal v. Fox, 19 S.W.3d 88 (Ky. 2000); Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999). Mere evidence contrary to the ALJ's decision

is not adequate to require reversal on appeal. Whittaker v. Rowland, *supra*. In order to reverse the decision of the ALJ, it must be shown there was no evidence of substantial probative value to support his decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

The record contains conflicting evidence on the question of the reasonableness and necessity of the proposed surgeries. While Hollis is able to identify evidence that could support a finding in his favor, the evidence does not compel a finding in his favor. Hollis' arguments are essentially an attempt to have the Board re-weigh the evidence and reach a conclusion contrary to that reached by the CALJ. We are without authority to do so. *See* KRS 342.285.

The CALJ indicated he was most convinced by the opinion offered by Drs. Wolens, Gabriel and Marburger with respect to the reasonableness and necessity of the proposed surgeries and specifically stated he did not find Drs. Atasoy and Roberts persuasive on this issue. The CALJ considered all of the evidence, weighed that evidence and reached a determination based upon substantial evidence. While the AMA Guides may state 5% of patients may have normal studies and yet have carpal tunnel syndrome, this does not preclude the CALJ from relying on the medical

opinions of the doctors who found multiple normal studies to be significant in forming their opinions. Hollis' argument simply goes to the weight to be afforded the evidence. Likewise, the fact that a doctor has not examined a claimant goes to the weight to be assigned to the evidence.

Since Hollis was successful before the CALJ regarding the extent of his impairment, the issue on appeal is whether the ALJ's decision is supported by substantial evidence in the record. Paramount Foods, Inc. v. Burkhardt, Ky., 695 S.W.2d 418 (1985); Wolf Creek Collieries v. Crum, Ky. App., 673 S.W.2d 735 (1984).

Here, Dr. Roberts in his Form 107 indicated a diagnosis of thoracic outlet syndrome, neurogenic. He assigned a 14% impairment for that diagnosis. Since Dr. Roberts did not diagnose carpal tunnel syndrome, pronator teres syndrome or cubital tunnel syndrome, presumably the entirety of the 14% impairment rating relates to the thoracic outlet syndrome. The CALJ was well within his role as fact-finder in selecting the impairment rating assessed by Dr. Roberts even though he rejected his opinions with regard to the necessity of additional surgery. In his order on reconsideration, the CALJ explicitly stated his rejection of Dr. Roberts' opinions in the September 1, 2011 Interlocutory Opinion and Order was

in regard to the reasonableness and necessity of the recommended surgery. Reasonableness and necessity of the additional surgery was the only issue to be decided in that decision. Thus, the CALJ was not limited by the earlier ruling when determining the appropriate impairment rating. The CALJ properly exercised the discretion afforded him under the law by relying on portions of Dr. Roberts' testimony, and this testimony comprises substantial evidence. Hence, the ALJ's decision cannot be disturbed.

Accordingly, the ALJ's February 2, 2012, Opinion, Award, and Order and the March 6, 2012, Order ruling on the petitions for reconsideration rendered by Hon. J. Landon Overfield, Chief Administrative Law Judge, are hereby **AFFIRMED**.

ALL CONCUR.

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