OPINION ENTERED: JUNE 21, 2012

CLAIM NO. 201001592

STELLA ASHBURN PETITIONER

VS. **APPEAL FROM HON. CHRIS DAVIS, ADMINISTRATIVE LAW JUDGE**

CLARK COUNTY BOARD OF EDUCATION,
MICHAEL HEILIG, M.D.,
CLARK REGIONAL HOSPITAL,
CLARK REGIONAL PHYSICAL THERAPY,
ALEXANDER MOGILEVSKI, M.D.,
JOHN MASTERS, M.D.,
SCOTT JENKINS, M.D.,
and HON. CHRIS DAVIS,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION AFFIRMING

* * * * * *

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

SMITH, Member. Stella Ashburn ("Ashburn") appeals from the January 6, 2012 Opinion and Order rendered by Hon. Chris Davis, Administrative Law Judge ("ALJ"), dismissing her claim. The ALJ determined Ashburn failed to prove a work-

related injury. Ashburn also appeals from the ALJ's January 27, 2012 order overruling her petition for reconsideration.

Ashburn filed her Application for Resolution of Injury Claim on December 29, 2010, alleging she was injured on August 20, 2008 and September 18, 2008 while employed by the Clark County Board of Education ("Clark County"). She described the occurrence as follows:

> "August 18, 2008: Student hugged my neck strongly; September 18, 2008: could not turn my neck, swollen on shoulders, by physically having to mobilize a student daily to all classes, specials, skills, field trips, playground; also required diaper changing as well."

She listed the body parts injured as "Neck, left shoulder, right shoulder back limbs (arms and legs), hips, balance, face, nerves and muscles throughout the body, and vertebras, thoracic, sciatic with bursitis."

Ashburn testified by deposition on March 30, 2011 and at the formal hearing held November 9, 2011. Ashburn, who is 59, has a high school education and has worked as a receptionist, secretary, janitor, lunchroom monitor, and teachers' assistant. She began working for Clark on August 14, 1994 as a lunchroom monitor. She later became an instructional assistant for students with special needs. As an instructional assistant, Ashburn was present with the students in class and on the playground.

In the fall of 2008, she was assigned to a kindergarten student who was not toilet trained. When it was time to change the student's diaper, the child would hug her around the neck. After one week, Ashburn became physically tired and developed pain in her arms, legs, and hips. She also developed sciatica, numbness and difficulty balancing. She spoke to the physical education teacher to find ways to work with the student without having pain. On September 18, 2008, Ashburn's neck "locked up". After speaking with a teacher, an accident report was completed and she sought medical attention at an immediate care center. Ashburn continued to work with the same student until October 2008 when she was taken off work.

Ashburn returned to work in January 2009, and was assigned to the second grade class. Ashburn stated there were not enough chairs at times and she had to stand during classes, causing pain in her arms and legs.

Ashburn testified she continues to have weakness in her arms and legs and pain in her shoulders. She also stated she has problems with balancing and numbness in her lower leg. Ashburn stated she is able to stand for approximately 30 minutes, sit for less than 60 minutes, and walk less than 30 minutes. She did not believe she could return to any of her prior jobs. Ashburn indicated she continues to treat

with Dr. Heilig. She is also performing home exercises and receiving injection treatment for her neck and shoulder.

Clark submitted medical records from Terry L. Troutt, M.D., who had treated Ashburn prior to the alleged work injuries. Dr. Troutt examined Ashburn on September 22, 1999 for complaints of bilateral wrist and hand pain with tingling in the fingers. In May 1999, he diagnosed mild demyelinating median neuropathy bilaterally. Dr. Troutt stated Ashburn would benefit from surgery.

Dr. Troutt saw Ashburn again in May 2001 for complaints of right thigh pain and pain in the buttocks and hip after a fall on a wet floor. Ashburn also reported low and upper back pain and numbness in the middle of her back. X-rays of the lumbar spine found hyperlordosis of the lumbosacral curve and congenital partial lumbarization of S1. Dr. Troutt also noted sclerotic facet arthrosis of the lumbosacral spine. The thoracic spine study revealed mild degenerative spurs in the lower thoracic spine. X-rays were negative in the sacroiliac joints as were hip x-rays. Ashburn was diagnosed with thoracic sprain and right hip strain.

In July 2001, Dr. Troutt noted Ashburn had right low back pain and occasional pain in the proximal thigh and right lower extremity. He diagnosed degenerative joint

disease with evidence of congenital partial lumbarization of S1; associated lumbosacral sprain/strain; sprain/strain of the right hip and right leg, and decondition/functional decline.

Clark submitted records from Winchester Chiropractic documenting treatment from November 2002 through January 2003. Ashburn had received spinal adjustments, electrical stimulation, traction, and ice therapy and had been diagnosed with pelvis segmental dysfunction, back pain, and spondylolisthesis.

Clark submitted records from Clark Regional Medical Center where Ashburn had sought treatment for complaints of pain as early as 2004. A right knee x-ray taken January 2, 2004 revealed no acute findings. A lumbar x-ray on August 27, 2005 revealed hyperlordosis of the lower lumbar spine associated with facet joint arthrosis. Left hip x-rays taken September 3, 2005 revealed slight bony hypertrophy of the superiorolateral left acetabulum, degenerative changes and mild scoliosis in the lower lumbar spine. A left knee MRI on January 18, 2007 revealed degenerative changes and narrowing of the medial compartment, degenerative changes in the patellofemoral joint; degeneration with intrasubstance signal within the menisci; and possible small osteochondral defect in the medial femoral condyle.

Ashburn presented to Clark Regional Medical Center on October 6, 2008 for complaints of neck pain. She returned on December 13, 2008 with complaints of back pain that went through her chest. Cervical spine x-rays revealed mild degenerative changes. Ashburn was admitted to the hospital with a primary diagnosis of unspecified chest pain and secondary diagnoses of pain in the thoracic spine, cervicalgia, pain in the shoulder joint, carpal tunnel syndrome, lesion of ulnar nerve, disturbance of skin sensation, obesity, and thoracic spondylosis without myelopathy. Ashburn was discharged on December 14, 2008 after cardiac etiology for chest pain was ruled out. She was restricted from work until January 5, 2009.

Ashburn returned to the emergency room on April 18, 2009 with complaints of left shoulder pain. She had limited range of left shoulder motion with tenderness to palpation in the AC joint and anterior shoulder.

Clark submitted records from Kathryn Jones, M.D., who examined Ashburn on August 25, 2005 for low back, left buttocks, and hip pain. Ashburn also reported tingling in the middle of her spine between her shoulder blades. Dr. Jones treated Ashburn again on October 3, 2006 for left knee pain after a fall. Ashburn returned on November 3, 2006 with knee pain and restricted range of motion. Ashburn also

reported new back pain. Ashburn was seen on June 4, 2007 for a rash due to medication, muscle spasm or nerve twitching in the back of her neck and upper back, and pain with no significant MRI findings. On March 19, 2008 and April 16, 2008, Ashburn was seen with near syncope episodes.

On September 26, 2008, Ashburn reported she strained her back on August 20, 2008 while lifting a child. Dr. Jones found normal range of shoulder and neck motion. Ashburn reported pain between her shoulder blades. On examination, Dr. Jones found no tight muscles or contractions. Dr. Jones assessment was neck and shoulder strains. She restricted Ashburn to no lifting over 10 pounds. On October 29, 2008, Ashburn complained of neck pain radiating into her arms and mid back and pain from her abdomen through to her back. Ashburn returned on January 2, 2009 with complaints of neck and back pain. On physical examination, shoulder and neck motion were within normal range. Dr. Jones restricted Ashburn from working until January 5, 2009. On January 30, 2009, Ashburn was seen for anxiety, depression and shoulder pain. She was ordered to continue physical therapy and released to return to full duty as of February 2, 2009.

Ashburn submitted a one page report from Medworks with her application. Ashburn was examined on September 18, 2008

and was noted to have neck and shoulder pain from repetitive lifting. Ashburn complained of neck and left shoulder pain for several days as well as tingling in her back. On examination, she had left and right paraspinal tenderness of the cervical spine. X-rays of the cervical spine were negative. She had normal range of motion bilaterally in her shoulders and no motor or sensory deficit. She was diagnosed with cervical strain and bilateral shoulder strain. Ashburn was restricted to no lifting, pushing or pulling greater than 10 pounds.

Both parties submitted medical records from Michael R. Heilig, M.D. Dr. Heilig examined Ashburn on November 10, 2008 for complaints of cervical and back pain. Ashburn's cervical spine range of motion, sensation, reflexes and strength were intact. Ashburn reported tingling and numbness in her left upper extremity to her elbow and had right upper extremity complaints. Ashburn was diagnosed with cervical pain and left upper extremity radiculopathy.

Ashburn returned on November 24, 2008. An MRI revealed degenerative changes from C7 through T1. Ashburn reported cervical and thoracic spine pain. Dr. Heilig ordered an upper extremity EMG which revealed right carpal tunnel syndrome and bilateral cubital tunnel syndrome. On February 20, 2009, Dr. Heilig diagnosed cervical and thoracic spine

strain, bilateral cubital tunnel syndrome, and right carpal tunnel syndrome. A left shoulder MRI in June 2009 revealed mild impingement and rotator cuff tendinitis. Ashburn received an injection in the left shoulder.

On March 8, 2010, Ashburn reported pain and stiffness in her cervical and lumbar spine as well as left shoulder pain. Dr. Heilig indicated she had reached maximum medical improvement ("MMI") and released her to perform modified activities. Ashburn returned on July 9, 2010 with complaints of left shoulder, cervical and lumbar pain, and numbness in her left lower extremity. Ashburn received injections in her left shoulder and hip. Ashburn returned in August 13, 2010 stating the injections helped her left shoulder and left hip pain. She reported cervical pain was causing her to have headaches. She was seen on September 8, 2010 for cervical pain. Dr. Heilig noted she had been to the emergency room since the last office visit. On October 11, 2010, Dr. Heilig administered injections for the right shoulder and cervical spine. Dr. Heilig determined Ashburn was at MMI and ordered bilateral upper extremity EMG's which revealed bilateral cubital tunnel syndrome and right carpal tunnel syndrome. On December 13, 2010, Dr. Heilig noted the recent cervical MRI revealed facet arthritis from C3 through

C5. He referred Ashburn to Dr. James for pain management and ordered lumbar x-rays.

Dr. Heilig saw Ashburn on January 31, 2011 for right shoulder pain, left hip pain, joint pain, stiffness and weakness, and numbness from the neck to the lip. On physical examination, Ashburn had tenderness to palpation of the cervical spine. Her cervical spine strength, sensation, and reflexes were intact. Her thoracic/lumbar spine examination revealed intact range of motion, tenderness to palpation, and positive straight leg raising tests. The right and left shoulders had positive AC joint compression tests. Ashburn's hips were tender to palpation. Dr. Heilig administered injections to the right shoulder and left hip. He diagnosed cervical spine facet arthritis, bilateral cubital tunnel syndrome, right shoulder arthrosis and impingement, left shoulder impingement and rotator cuff tendinitis, bilateral hip greater trochanteric bursitis and right hip sciatica, degenerative disc disease of the lumbar and thoracic spine, and right carpal tunnel syndrome.

In May 2011, Ashburn reported right shoulder pain and bilateral Achilles tendon pain. Dr. Heilig administered an injection that provided some relief. On June 15, 2011, she received additional injections to the left cervical spine and lumbar spine.

In a November 7, 2011 letter, Dr. Heilig indicated Ashburn reached MMI in June, 2011. He restricted her from overhead and repetitive motion activities and from lifting greater than 15 pounds. Dr. Heilig concluded Ashburn's neck and shoulder conditions were related to her work injury.

Clark County submitted the report of Henry Tutt, M.D., who examined Ashburn on March 26, 2009. Ashburn reported neck pain, bilateral shoulder pain, upper thoracic paraspinal muscle pain and right sided interscapular tingling. Dr. Tutt stated Ashburn had an essentially normal musculoskeletal and neurological examination. Dr. Tutt concluded:

> In the opinion of the undersigned, this claimant, Stella Ashburn, is deconditioned, not well muscularly developed, and likely sustained muscular strain/sprains, transient myofascial injuries, relative to the activity described as occurring in late August 2008. There is no evidence that she sustained any alteration of the structural integrity of her cervical or thoracic spines as a result of that activity. She is considered, relative to the strain/sprains, to have reached maximum medical improvement and to require no further treatment. This lady is now 56–years–of–age and is simply facing the symptoms associated with the natural process of aging/living and without pursuing some physical fitness and conditioning and some simple strengthening exercises, she is susceptible to strains and sprains with activities both work–related and related

> to the activities of daily living and is only recommended to pursue some strengthening and fitness exercises and programs.

Dr. Heilig indicated Ashburn had reached MMI and did not require further medical treatment. He concluded Ashburn did not have a permanent impairment rating and required no restrictions relative to be alleged work injuries.

Clark submitted records from Central Kentucky Radiology. A June 19, 2009 MRI of the left upper extremity revealed mild medial and lateral arch acromial impingement and mild rotator cuff tendinosis without a tear. A December 8, 2010 cervical MRI showed straightening of the cervical spine with loss of normal lordosis, possibly due to muscle spasm and/or hyperextension/hyper flexion injury. The C3–4 level demonstrated bone spurs narrowing of the left neural foramen. The right foramen was normal. There was no focal herniated disc or central canal stenosis. The C4–5 level demonstrated bone spurs narrowing the left neural foramen associated with facet arthropathy. There was no focal herniated disc, and the central canal and right foramen were normal.

William S. Jenkins, D.M.D., M.D., examined Ashburn on June 17, 2009 for numbness in her face. Ashburn had “no facial swelling or asymmetry and TMJ's were non-tender

bilaterally." Dr. Jenkins found no identifiable cause for the numbness and recommended Ashburn see her primary care physician for possible referral to a neurologist for a brain MRI to rule out intra–cranial lesions.

Clark County submitted the medical report of Philip F. Corbett, M.D., who examined Ashburn on April 20, 2010. Ashburn reported pain and numbness in her left jaw, neck pain, shoulder pain, and tightness in the chest. On examination, Dr. Corbett found full range of motion in the cervical spine, decreased sensation in the distribution of the left trigeminal nerve, tenderness over the trapezius, tenderness over the AC joint, limited glenohumeral motion of the left shoulder, decreased grip strength, and full range of motion in the wrists and elbows. Dr. Corbett diagnosed adhesive capsulitis of the left shoulder with significant restriction. Based upon a functional capacity examination ("FCE") report, Dr. Corbett concluded Ashburn was limited to lifting no greater than 25 pounds.

Dr. Corbett indicated he focused his examination on Ashburn's shoulder and not the thoracic spine. Dr. Corbett stated adhesive capsulitis of the shoulder can be caused by blunt trauma, a complication of surgery, diabetes, or unknown causes. Dr. Corbett assigned a 5% impairment rating, pursuant to the American Medical Association, Guides

to the Evaluation of Permanent Impairment, ("AMA Guides"), Fifth Edition, due to restricted shoulder range of motion.

Dr. Corbett testified by deposition on August 1, 2011. He noted Ashburn stated a child had pulled on her left shoulder. Dr. Corbett stated his opinion regarding causation at the time of his report was based upon what Ashburn told him, including that she had no prior injuries or problems with the use of her shoulder and that all her problems were initiated by the episode of August 20, 2008.

Dr. Corbett indicated he had reviewed the report of Dr. Bilkey, who examined Ashburn 14 months after Dr. Corbett's examination, which showed dramatically improved range of motion.

Rick Pounds, M.S., performed an FCE on June 18, 2010. Pounds found no significant performance inconsistencies during the evaluation. He determined Ashburn met all requirements to perform light level work.

Peter Kirsch, M.D., performed a utilization review of records on March 18, 2011. Dr. Kirsch concluded Ashburn suffered an injury to her neck, upper back, and shoulders consistent with a sprain/strain. He further opined Ashburn returned to her pre-injury status within three months of the date of her injury. He noted that no specific objective injury pathology was identified. Accordingly, he did not

believe requested physical therapy for the cervical and lumbar spine was medically necessary or appropriate for the work injury.

In a May 16, 2011 report, Dr. Kirsch stated that, based on his review, the carrier should deny a request for Valium as not appropriate for the injury.

Ashburn submitted the medical report of Warren Bilkey, M.D., who examined Ashburn on June 14, 2011. Ashburn reported pain in her neck radiating into her shoulders and upper limbs, lower limb weakness, pain in her hips, headaches, bilateral wrist pain, and sensory loss of the right upper limb. Dr. Bilkey noted Ashburn had normal lumbar and thoracic spine curves. Her right shoulder was protracted. She had limited range of neck motion and active range of motion of her trunk was mildly restricted symmetrically in all planes. Ashburn had normal AC and SC joint mobility, normal hip range of motion, weakness in both flexors and extensors, positive Tinel's over the left ulnar nerve, and loss of horizontal abduction of both shoulders. Dr. Bilkey's impression was as follows:

> Ms. Ashburn had 2 injuries. She had the onset of chronic neck pain, shoulder pain with pain radiation into the upper limbs and with weakness affecting both lower limbs in response to the repetitive lifting and transferring of students that she worked with. This was

> a gradually progressive process over several months. During that time, she had a separate injury to the neck when one of the kids hugged her neck too firmly. This aggravated her chronic condition such that she required medical treatment as of 9/18/08. Significant ongoing pain has persisted in spite of efforts of conservative treatment. Surgical pathology has been ruled out. Ms. Ashburn has not been able to resume her pre-existing work duties.
>
> In my opinion, the above diagnoses are due to the work injuries dated 8/20/08 and 9/18/08. The evaluation and treatment procedures which have been carried out appear to have been reasonable, medically necessary and work injury related. There is no evidence that Ms. Ashburn had an active impairment affecting any of these body regions prior to the 8/20/08.
>
> In my opinion, the 8/20/08 work injury aggravated a problem which started with repetitive work activities culminating in the 9/18/08 work injury. As stated, this occurred over several months of time. The specific injury to the neck occurred during that time and aggravated her ongoing condition.

Dr. Bilkey indicated Ashburn appeared to be at MMI and placed her in cervical DRE category II pursuant to the AMA Guides, Fifth Edition, assigning a 7% whole person impairment and an additional 3% whole person impairment related to shoulder pain, headache and hip pain for a total 10% whole person impairment attributable to the work injury. Dr. Bilkey assessed no impairment for shoulder range of

motion. He disagreed with Dr. Corbett's opinion, noting the primary injury was not a significant shoulder injury with adhesive capsulitis but rather “a cervical spine injury with resulting muscle limiting shoulder motion”. He noted passive abduction of the shoulders to be 180° and this, along with full rotation, would rule out adhesive capsulitis. Thus, the impairment rating was related to the neck and resulting muscle spasm and not due to a primary derangement of the shoulder.

The ALJ made the following findings relevant to this appeal:

> In analyzing this claim the Administrative Law Judge has reviewed all the evidence in this claim, as summarized above. The Administrative Law Judge has also reviewed the parties’ briefs and arguments.
>
> As should be evident from the above, seventeen page, [sic] summary the Administrative Law Judge has carefully considered the parties[’] arguments and evidence as a whole. I take note of the fact that the Plaintiff, to the extreme credit of counsel, has carefully and narrowly limited their request for relief to that which is reasonable. I take note of the fact that some temporary total disability and medical benefits were paid. I also take note of the fact that, taken alone, the mechanism of injury described by the Plaintiff could, in some circumstances, be reasonably related to the diagnosis and 7% impairment rating assigned by Dr. Bilkey.

Dr. Bilkey himself is highly respected by the undersigned. Likewise Dr. Corbett assigned a work–related impairment rating, albeit for a diagnosis different from the one provided by Dr. Bilkey. Further, as far as the medical evidence is concerned, the Plaintiff certainly has a long history of medical treatment, primarily with Dr. Heilig. Dr. Heilig certainly thought enough of the Plaintiff's complaints to continually restrict her from work and to offer at least initial treatment and examination.

With all that being said the undersigned is compelled by his own analysis and weighting [sic] of the evidence to come to the conclusion that I affirmatively disbelieve and do not accept any of the Plaintiff's allegations regarding the onset of symptoms, what caused the symptoms, the evolution of the symptoms and her current, objective medical condition. This is not to say that the Plaintiff is, from a subjective viewpoint, dishonest or a liar. This is to say that, objectively, no reliance can be placed on her testimony or subjective beliefs.

It is true that people with a long history of unverified complaints can get hurt at work. It is true that those who have difficulty objectively viewing their current symptoms may, nonetheless, have some symptoms. However, when taken as a whole, this Plaintiff has a history of difficulty objectively assessing her condition and her current condition is entirely subjective.

Not only is the above conclusion based on my own observations but the medical record as a whole supports this finding. The Plaintiff, through the years, has

> alleged a wide variety of symptoms and signs. She has been treated, referred, released and returned to start the cycle over again so many times, without any "permanent" diagnosis or serious treatment, that it supports the theory that her conditions and allegations are not objectively fact-based.
>
> Based on the foregoing, and in reliance on Dr. Tutt and Dr. Kirsch, I find that the plaintiff does not, and did not, have any work–related condition, either temporary or permanent and her claim is dismissed accordingly.
>
> Although the undersigned believes that such a conclusion is contrary to the law should any party argue that a finding of a temporary injury is compelled by the evidence I would find the Plaintiff at maximum medical improvement no later than March 26, 2009, the date Dr. Tutt placed her at MMI.

Ashburn filed a petition for reconsideration, arguing there was no evidence to support the ALJ's finding she did not sustain either a temporary or permanent injury. Ashburn argued it was error for the ALJ not to award, at a minimum, benefits based upon the report of Dr. Corbett, Clark's IME physician. Ashburn raised essentially the same arguments she now raises on appeal to the Board.

The ALJ overruled the petition for reconsideration without making additional findings.

On appeal, Ashburn again argues there was no evidence to support the ALJ's finding she did not suffer a work-

related injury. She notes the ALJ cited Drs. Tutt and Kirsch in making that finding. However, Ashburn notes Dr. Tutt's examination was limited to the neck condition and he did state she suffered a strain/sprain injury. She further notes Dr. Kirsch reported she suffered an injury. Ashburn argues it was an error for the ALJ to not award, at minimum, benefits based upon Dr. Corbett's opinion. She notes Dr. Corbett's evaluation was limited to the shoulder, but he did assign a 5% impairment rating for that condition. Ashburn contends the carrier improperly engaged in "doctor shopping" by obtaining the opinion of Dr. Kirsch after Dr. Corbett, the employer's IME physician, had rendered his opinion. Ashburn argues the opinion of Dr. Kirsch is not substantial evidence since he did not examine her. Thus, she contends his opinions do not constitute objective medical findings. Further, she notes Dr. Kirsch's opinion should have been limited to questions of reasonableness and necessity since he was conducting a utilization review. Ashburn contends he should not have addressed causation or extent of disability. Ashburn requests that the Board reverse the ALJ and remand this matter for the award of permanent partial disability and medical benefits for the shoulder condition.

Ashburn, as the claimant in a workers' compensation case, bore the burden of proving each of the essential

elements of her cause of action. Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Since Ashburn was unsuccessful in her burden of proof, the question on appeal is whether the evidence is so overwhelming, upon consideration of the record as a whole, as to compel a finding in her favor. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984).

"Compelling evidence" is evidence which 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 weight, credibility 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 all reasonable inferences to be drawn from the evidence. Miller v. East Kentucky Beverage/ PepsiCo, Inc., 951 S.W. 2d 329 (Ky. 1997). The ALJ may reject any testimony and believe or disbelieve various parts of the evidence, regardless of whether it comes from the same witness or the same adversary party's total proof. Magic Coal Co. v. Fox, 19 S.W.3d 88 (Ky. 2000). Mere evidence contrary to the ALJ's decision is not adequate to require reversal on appeal. Transportation Cabinet v. Poe, 69 S.W.3d 60 (Ky. 2001). In order to reverse the decision

of the ALJ, it must be shown there was no substantial evidence of probative value to support his decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

Certainly, where, as in the case *sub judice*, a claim is based largely on subjective complaints, the credibility of the claimant is crucial. As pointed out above, the ALJ, as fact-finder, is free to pick and choose from the evidence whom and what to believe. Since the ALJ expressly stated he found Ashburn's testimony to have no credibility, he was free to reject any and all of the claimant's testimony as untruthful, including those statements regarding the occurrence of an injury at work. The ALJ specifically rejected Ashburn's testimony as to "any of the Plaintiff's allegations regarding the onset of symptoms, what caused the symptoms, the evolution of her symptoms and her current objective medical condition." The ALJ set forth reasons, grounded in the claimant's testimony and long history of treatment, why he found her testimony was not credible. Moreover, the ALJ was in a unique position to gauge the demeanor of the claimant at the hearing. The ALJ acted within his authority, and his decision is supported by substantial evidence.

Additionally, medical evidence from Dr. Tutt indicated there was no evidence Ashburn sustained any alteration of

the structural integrity of her cervical or thoracic spine as a result of the work activity. Dr. Kirsch noted there was no significant objective injury pathology identified. The ALJ was well within his role as fact-finder in choosing to rely on the opinions of Dr. Kirsch. Dr. Bilkey, Ashburn's own evaluating physician, was not convinced there was a significant shoulder injury. The ALJ was simply not convinced there was sufficient objective evidence to support a finding Ashburn's work was the cause of her conditions.

The assessment of the claimant's credibility against the other evidence is within the exclusive province of the ALJ as fact-finder. Whittaker v. Rowland, 998 S.W.2d 79 (Ky. 1999). The evidence in this claim falls far short of compelling a finding in Ashburn's favor. We cannot say the ALJ's finding was so unreasonable as to constitute an abuse of discretion or otherwise warrant reversal on appeal. *See* KRS 342.285.

Accordingly, the January 6, 2012 Opinion and Order and the January 27, 2012 order ruling on Ashburn's petition for reconsideration rendered by Hon. Chris Davis, Administrative Law Judge, are hereby **AFFIRMED**.

ALL CONCUR.

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