APPEAL NO. 92582

A contested case hearing was held on September 8, 1992 in (city), Texas, with (hearing officer) presiding. The issue was whether claimant suffered disability from May 13, 1991, that was caused by a (date of injury) injury incurred while working at (employer). The hearing officer found that claimant suffered an injury on (date of injury) while in the course and scope of his employment; that a June 5, 1992 doctor's report determined that claimant's MRI showed no objective findings from the (date of injury) injury; and that the injury caused the claimant to be unable to obtain and retain employment at preinjury wages from May 13, 1991 to June 5, 1992. The hearing officer thus concluded that for that period of time the claimant had disability within the meaning of the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq*. (Vernon Supp. 1992) (1989 Act).

In his request for review, the appellant (herein "claimant") alleges the hearing officer erred in his characterization of claimant's compensable injury (Finding of Fact No. 4). He also alleges error in Finding of Fact No. 8 and Conclusion of Law No. 5, that claimant's inability to obtain and retain employment at wages equivalent to his preinjury earnings was limited to the time period of May 13, 1991, to June 5, 1992. Respondent carrier conversely argues that there is sufficient evidence to support the hearing officer's finding that disability ended on June 5th.

DECISION

We affirm the decision and order of the hearing officer.

The claimant was employed by (employer) on Thursday, (date of injury), when he was attacked by a coworker with a hammer. He suffered blows to his neck at the base of his skull and to his forehead. That injury was found to be compensable in Texas Workers' Compensation Appeal No. 92103, dated May 1, 1992.

Following his injury, claimant was taken immediately to the emergency room at (Hospital). His lacerations were stitched and x-rays of his back were taken. The next day, claimant said his hands would not close at all, he was dizzy and he had blood coming from his ears. He went to a hospital emergency room in (city), where his neck was x-rayed, pain medication was prescribed, and he was told he could go back to work the following Monday but that he should return to the emergency room if his symptoms worsened.

Beginning on May 13, 1991, claimant began going to his brother-in-law, (Dr. A), who became his treating doctor. From that exam, Dr. A found limited range of motion in the cervical region and decrease in the right grip and diagnosed acute traumatic cerviocranial syndrome; hypoesthesia--right upper extremity; and segmental dysfunctions--cervical spine. At the hearing, Dr. A also said that all of claimant's lumbar movements produced pain and dizziness. Dr. A's Initial Medical Report filed May 15th stated "Unknown" in response to the blank "Prognosis (Anticipated time frame of treatment)." Dr. A testified at the hearing that he has never released the claimant to return to work. In answer to a question, he said

he believed the claimant to have reached maximum medical improvement, but there was nothing in the record to indicate he had certified maximum medical improvement pursuant to the requirements of the 1989 Act or regulations.

Dr. A continued to treat the claimant, ordering x-rays, MRIs, electromyograms (EMGs), and a digital myogram (DMG), which tests muscle strength. A May 11, 1991 consultation report from the Medical Center Hospital Department of Radiology found no evidence of skull or cervical spine fracture. An April 16, 1992 report found MRIs of the cervical spine and the brain to be unremarkable. Dr. A testified that, given claimant's symptoms, he believed something had been missed in the first study. He therefore asked (Dr. H) to review both MRIs. On July 21, 1992, Dr. H found a two to three millimeter posterior and fixed subluxation of the condyloid process of the skull relative to the lateral masses of C1. Dr. A at the hearing characterized this finding as a two to three millimeter posterior slippage which could cause pressure on nerves and muscles.

(Dr. L) on June 5th examined claimant as part of a neurosurgery consultation referred by Dr. A, and reviewed the April 16, 1992 MRIs. On June 11th he reported that the MRIs were basically normal studies, and that he did not see "any neurosurgical problem here." He prescribed pain medication and recommended that claimant see a medical neurologist to try to get him on some type of therapy regimen. The doctor he referred claimant to, (Dr. V), examined the claimant and on June 23rd stated his impression of post traumatic cervical pain with associated occipital headaches. He recommended use of a TENS unit and cervical exercises.

Dr. L also wrote carrier's representative on August 4, 1992, as follows:

> As you are well aware, I feel [claimant's] problems are primarily muscular in nature. I have referred him to [Dr. V], a neurologist and I have not seen [claimant] since June of 1992. However, if the hopes are that by manipulation under anesthesia, they can get this gentleman's muscular situation to improve, then I would be supportive of limited treatments. However, I would make sure that both the patient and the chiropractor understand that this is just a 1 or 2 treatment modality, not a long term situation.

A May 18, 1992 EMG report by (Dr. S) stated the impression that "EMG and nerve conduction velocities in the upper extremities are normal bilaterally." At the hearing Dr. A said this test was a pin-prick EMG which, contrary to his request, tested the claimant's lower neck rather than his upper neck. After Dr. S told Dr. A she had nothing else to offer, Dr. A recommended a surface paraspinal EMG, which was performed by a technician for Advanced Mobile Diagnostics on August 18, 1992. (Dr. A also stated that additional questions raised by other doctors, including whether claimant was a candidate for manipulation under anesthesia, caused him to recommend the second EMG.) Dr. A explained that a pin-prick EMG "tests specific muscles at their tendonous insertions to read

their millivolt potentials," while a surface EMG uses a microphone over the surface of the spinal area. Dr. A said the second EMG revealed a significant increase in amplitude at the left C3 area, indicating acute muscle spasm. In addition, Dr. A interpreted the results of the DMG (strength test) as showing claimant's right hand 33 percent deficient of the left, which he said was consistent with claimant's complaints of weakness and numbness in his right arm. However, he said a strength test of the lateral neck flexors showed those muscles to be within normal limits.

On June 1st claimant was examined by (Dr. G), an independent medical examination doctor. In a June 5th letter Dr. G said he reviewed the MRI report but had not seen the report of the EMG. He also found sensitivity of range of motion of claimant's neck and tenderness to the entire upper back and occipital region of claimant's skull; however, Dr. G found full range of motion of claimant's neck and upper extremities. His impression was that claimant had multiple symptoms which appeared to be "greatly out of proportion to anything that can be objectively found, or anything that would be expected from the type of injury that he had." He concluded that "[i]t is my opinion that he most likely has no significant disability, medical or neurological problem, related to his original injury." However he recommended that claimant have "stress films" done of his cervical spine, stating that it was conceivable the claimant could have had a ligamentous injury which would not show up on x-rays or an MRI scan. If those tests proved normal, Dr. G said the claimant would be "fit to go back to work whenever he feels like doing so." Dr. A testified that he next sent claimant to Dr. L for stress x-rays and also to find out whether claimant needed surgery. Dr. A also said the report of the stress x-rays was not in evidence, but that Dr. L's August 4th letter showed them to be within normal limits.

Dr. G also signed a Report of Medical Evaluation (Form TWCC-69). In answer to the question "[h]as employee reached maximum medical improvement?" Dr. G responded, "[n]ot certain. [s]een only once." Under the blank "Document objective laboratory or clinical finding of impairment" Dr. G wrote "0 to my knowledge."

Dr. A acknowledged at the hearing that the only objective organic physical basis for claimant's condition came from the DMG, the surface EMG, and a second report on the stress x-rays. He stated that since he received Dr. L's report, he was "back to square one" in dealing with claimant's problems. His recommendation for further treatment was more testing to see whether the claimant was a candidate for manipulation under anesthesia.

The claimant, who has a 10th grade education, testified at the hearing that he continues to have neck pain, his right arm goes numb, and he has a hard time controlling and closing his hand. He has not worked since his injury, except for odd jobs for which he said he has earned about $20. Although he had worked in the past at his father's auto body shop, he said he was not able to do so now and that his father had not paid him for any work. His father, (DS), verified this. Claimant said his job with employer, which paid $4.25 an hour, involved running a forklift and helping to load up customers. He said he could not do that job now because it requires heavy lifting and because of the shaking in his hands.

(CL), a private investigator hired by carrier, testified that he performed surveillance on the claimant, but that he never observed him working.

Claimant's first point of error is that the hearing officer erred, in Finding of Fact No. 4, in describing claimant's compensable injury as only "lacerations of the head." Claimant points to medical records describing the extent of the injury, and notes that the hearing officer's Conclusion of Law No. 4 characterizes the injury as to claimant's neck and head.

We do not agree. The sole issue in this case was disability--that is, whether the previously-determined compensable injury was the cause of claimant's inability to earn wages equivalent to those he had earned before the injury. We do not find the hearing officer's brief description of claimant's injury to be error, especially where, as here, the hearing officer was merely restating a fact that presumably had been determined at an earlier contested case hearing.

Claimant also alleges the hearing officer erred in finding that claimant's inability to obtain and retain employment at wages equivalent to his preinjury earnings was limited to a time period from May 13, 1991, to June 5, 1992 (citing Finding of Fact No. 8 and Conclusion of Law No. 5). We note for purposes of clarity that the hearing officer in Finding of Fact No. 7 states as follows:

7.[Dr. L] reviewed [claimant's] MRI on 5 June 1992 along with the other medical records and determined that MRI showed no objective findings from a 9 May 1991 injury.

Claimant points out that Dr. L did not in any way find claimant to have been injury free on that or any other date, nor did he ever state that claimant was capable of returning to work. He argues that Dr. L's June 11th opinion that both MRIs were normal must be considered in context with his letter reports of June 11th and August 4th which, claimant says, do not conclude that claimant was not continuing to suffer pain and other problems from his injury and indeed recommended further treatment.

Claimant also points out that the Finding of Fact and Conclusion of Law in question terminate disability on June 4, 1992, although no event occurred on that date according to the evidence of record. We note with respect to this argument, however, that the hearing officer's actual decision dates disability from May 13, 1991 <u>through</u> June 5, 1992.

As the Appeals Panel noted in Texas Workers' Compensation Commission Appeal No. 91045, decided November 21, 1991, determining the end of disability within the meaning of the 1989 Act can be a very difficult and imprecise matter, especially given the lack of definitive guidance from the act and regulations. This panel has held that both lay and medical evidence can be considered by the hearing officer in determining whether or not the compensable injury was the cause of a claimant's inability to obtain and retain employment

equivalent to the preinjury wage. *See* Texas Workers' Compensation Commission Appeal No. 92167, decided June 11, 1992. In this case the hearing officer heard both lay and medical testimony and chose to give greater weight to Dr. L's June 5, 1992 opinion than to claimant's testimony or that of his treating doctor. The hearing officer is the sole judge of the relevance and materiality of the evidence offered and of its weight and credibility. Article 8308-6.34(e). It is the hearing officer's responsibility to resolve conflicts in and between the evidence. Texas Workers' Compensation Commission Appeal No. 92069, decided April 1, 1992. Further, any conflicts in testimony of medical witnesses is a matter to be resolved by the trier of fact. Highlands Underwriters Insurance Co. v. Carabajal, 503 S.W.2d 336 (Tex. Civ. App.-Corpus Christi, no writ). We will not overturn his decision unless the evidence on which it is based is so weak against the overwhelming weight of the evidence as to be clearly wrong or manifestly unjust. Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

The decision and order of the hearing officer are accordingly affirmed.

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Lynda H. Nesenholtz
Appeals Judge

CONCUR:

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Susan M. Kelley
Appeals Judge

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Thomas A. Knapp
Appeals Judge