APPEAL NO. 931097

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act) (formerly V.A.C.S., Article 8308-1.01 *et seq.*). A contested case hearing (CCH) was held on October 27, 1993, in (city), Texas, with (hearing officer) presiding as hearing officer. The issues at the CCH were: 1. did the appellant (claimant herein) have disability; 2. if so, for what period; 3. if so, to what temporary income benefits (TIBS) was the claimant entitled; 4. had the claimant reached maximum medical improvement (MMI); 5. if so, on what date; 6. if so, what is the claimant's impairment rating; and 7. should the Benefit Review Conference Agreement of June 17, 1993 (BRC agreement), be set aside so that the claimant is not bound by it.

The hearing officer ruled that the BRC agreement should not be set aside, that the claimant reached MMI on July 9, 1993, with a whole body impairment rating of zero percent, that the claimant had not suffered any disability as result of this injury, and that consequently the claimant was never entitled to TIBS. The claimant attacks a number of the findings of fact made by the hearing officer and requests that we reverse his decision and remand the case. The respondent (carrier herein) files a request that it be allowed to file a late response to the claimant's request for review.

DECISION

Finding sufficient evidence to support the decision of the hearing officer and no reversible error in the record, we affirm the decision and order of the hearing officer.

The claimant timely filed a request for review which the carrier states it received on December 6, 1993. The carrier states that due to an internal error the request for review was not brought to the attention of the handling adjuster and the carrier's attorney until January 6, 1994. On January 7, 1994, the carrier mailed a request to the Texas Workers' Compensation Commission (Commission) asking that Appeals Panel grant it permission to file a response within such time as appears appropriate to the Panel. In its request the carrier states that it finds no statutory provision or prior Appeals Panel decision which would allow the late filing of a response under these circumstances, but states that it desires to file a response and requests that the Appeals Panel grant an exception to the filing deadline.

Section 410.202(b) states in relevant part as follows:

> The respondent shall file a written response with the appeals panel not later that the 15th day after the date on which the copy of the request for appeal is served

The Commission has interpreted this statute in its agency rules, Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 143.4(c)(1) and (2), which provide that a response made under this section shall be presumed to be timely filed if it is:

> (1)[m]ailed on or before the 15th day after the date of receipt of the appellant's request . . . and

(2)received by the commission or other party not later than the 20th day after the date of receipt of the appellant's request.

We have previously held that an untimely response will not be considered. *See* Texas Workers' Compensation Commission Appeal No. 92079, decided April 14, 1992; Texas Workers' Compensation Commission Appeal No. 92611, decided December 30, 1992. We have interpreted the statute and the rule to extend the time for filing a response when the appellant fails to serve the respondent with its request for review. Texas Workers' Compensation Commission Appeal No. 91120, decided March 30, 1992. We have also held that where the respondent files a timely response but it is not considered by the Appeals Panel due to clerical error on the part of the Commission, we will consider such response, jurisdiction permitting. *See* Texas Workers' Compensation Commission Appeal No. 93835(A), decided November 23, 1993. We have refused prior requests to extend time to file a response. *See* Texas Workers' Compensation Commission Appeal No. 93831, decided October 29, 1993; Texas Workers' Compensation Commission Appeal No. 93967, decided December 12, 1993.

We understand that in an imperfect world clerical error cannot be eliminated. We also understand that any filing time limit is arbitrary by its nature. However, such deadlines are essential to make any adjudicative system workable. A party must bear the consequences of its failure to meet procedural deadlines due to its own clerical error. The Panel has held itself to this same standard. *See* Texas Workers' Compensation Commission Appeal No. 92236, decided July 8, 1992. We deny the carrier's request to file an untimely response. We will review the points raised on appeal.

The hearing officer sets out the evidence in this case in detail in the section of his decision and order entitled "Statement of Evidence." We adopt this statement of the evidence for purposes of our decision. To briefly summarize, the claimant began to work for the employer on September 1, 1992. On (date) the claimant was involved in a motor vehicle accident unrelated to his employment for which he saw (Dr. G), D.C. The claimant testified that Dr. G never treated any low back problems from this accident as there were none. Dr. G's records indicated that on October 28, 1992, the claimant told Dr. G that he did not want treatment to his low back because he was going to file an injury claim with his group health insurance.

At the hearing the claimant testified that he was injured at work while lifting boxes on (date of injury), and reported his injury to his supervisor the same day. One of the claimant's supervisors testified that the claimant did not report his injury until (date). The claimant consulted Dr. G for this alleged injury on (date), according to Dr. G's records. Dr. G also stated that he told the claimant that he could not detect a new injury and could only treat him for his old (motor vehicle injury). The claimant then went to see (Dr. B), D.C., who diagnosed the claimant with a low back strain and released the claimant to return to light duty on December 29, 1992. The carrier paid TIBS for this period.

A witness from the employer testified that the employer made a *bona fide* light duty job offer to the claimant by phone which was confirmed in writing. The claimant stated in his response to interrogatories that he received this light duty job offer on December 31, 1992. The claimant did not return to work pursuant to this offer (although he did return to work with the employer on light duty in August 1993 at the same wage). The claimant saw a (Dr. H), D.C., who the claimant testified told him not to work. Dr. H treated the claimant until he sold his practice to (Dr. S), D.C., who released the claimant to light duty work in August 1993, and to full duty work in September 1993, finding he had attained MMI, but stating that another doctor needed to rate the claimant's impairment.

The claimant and the carrier agreed at a Benefit Review Conference (BRC) in March 1993 that (Dr. O), M.D., would determine the issue of disability. The claimant was seen on April 15, 1993, by (Dr. B), M.D., an associate of Dr. O's who examined the claimant and certified on a Report of Medical Evaluation (TWCC-69) signed by both Dr. B and Dr. O that the claimant had reached MMI on the date of the examination with a zero impairment rating. At a BRC on June 17, 1993, the claimant and carrier entered into another agreement since the claimant had seen Dr. B, rather than Dr. O as agreed earlier. In this agreement the claimant and the carrier agreed the claimant would see (Dr. C), M.D., a doctor suggested by the claimant, to determine the issue of MMI. Dr. C examined the claimant on July 9, 1993, and found the claimant to have reached MMI as of the date of his examination with zero percent impairment.

The claimant had a lumbar MRI at the direction of Dr. S on June 2, 1993. The radiologist who performed the MRI stated that the MRI showed a herniated disc at L4-5. The carrier asked Dr. B to review the films of the MRI, and he read them to show a bulge rather than a herniation. Dr. C commented in his report concerning this MRI, "MRI findings are compatible with his occupation and age, and do not correlate with any clinical evidence of disfunction in my opinion." The claimant attached additional medical reports to his request for review.

First, we note that we will not generally consider evidence not admitted into the record, and offered for the first time on appeal. Texas Workers' Compensation Commission Appeal No. 92255, decided July 27, 1992. To determine whether evidence offered for the first time on appeal requires that the case be remanded for further consideration, we consider whether it came to appellant's knowledge after the hearing, whether it is cumulative, whether it was through lack of diligence that it was not offered at the hearing, and whether it is so material that it would probably produce a different result. Texas Workers' Compensation Commission Appeal No. 93111, decided March 29, 1993; Black v. Willis, 758 S.W.2d 809 (Tex. App.-Dallas 1988, no writ). In the present case the medical report attached by claimant to his request for does not meet this test.

Most of the complaints of the claimant deal with the hearing officer's factual findings. To review these complaints we must apply the proper standard of appellate review. Section

410.165(a) provides that the contested case hearing officer, as finder of fact, is the sole judge of the relevance and materiality of the evidence as well as of the weight and credibility that is to be given the evidence. It was for the hearing officer, as trier of fact, to resolve the inconsistencies and conflicts in the evidence. Garza v. Commercial Insurance Company of Newark, New Jersey, 508 S.W.2d 701, 702 (Tex. Civ. App.-Amarillo 1974, no writ). This is equally true regarding medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286, 290 (Tex. App.-Houston [14th Dist.] 1984, no writ). The trier of fact may believe all, part, or none of the testimony of any witness. Taylor v. Lewis, 553 S.W.2d 153, 161 (Tex. Civ. App.-Amarillo 1977, writ ref'd n.r.e.); Aetna Insurance Co. v. English, 204 S.W.2d 850 (Tex. Civ. App.-Fort Worth 1947, no writ). An appeals level body is not a fact finder, and does not normally pass upon the credibility of witnesses or substitute its own judgment for that of the trier of fact, even if the evidence would support a different result. National Union Fire Insurance Company of Pittsburgh, Pennsylvania v. Soto, 819 S.W.2d 619, 620 (Tex. App.-El Paso 1991, writ denied). When reviewing a hearing officer's decision for factual sufficiency of the evidence we should reverse such decision only if it is so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986).

The hearing officer's Finding of Fact No. 25 was as follows:

The [c]laimant was severely lacking in credibility.

The claimant complains that his credibility was not in issue at the CCH. What he fails to understand is that as a witness his credibility, even if not stated as one of the issues in the hearing, becomes a matter for the hearing officer to consider and one on which he may make findings. *See* Section 410.165(a).

The claimant also complains of the hearing officer's Finding of Fact No. 5, which states as follows:

On October 28, 1992, the [c]laimant told Dr. [G] that he did not want to be treated in the low back area because he was going to file an injury claim with his group health insurance.

The claimant points out that he testified that this was not true. The source for this finding is Dr. G's records. Clearly, the hearing officer chose to believe Dr. G and his office staff rather than the claimant. Under the standard of review outlined above, this is within his province.

The claimant disputes Finding of Fact No. 9 in which the hearing officer states:

The claimant did not notify his supervisor [of the injury] until (date).

The claimant points out that he testified that he notified the supervisor on (date of injury). The supervisor testified that there was no report of the injury until (date), and here again the hearing officer is the judge of the credibility of the evidence.

Finding of Fact No. 12 states as follows:

The claimant insisted that he was in great pain, but he refused to let the doctor treat him unless it was a workers' compensation claim, saying that this was a whole new ballgame.

Again there was a dispute between the claimant's description of events and Dr. G's records. Again the hearing officer, well within discretion, chose to make his findings based on Dr. G's records.

The claimant attacks Finding of Fact No. 16 wherein the hearing officer found that the employer made a *bona fide* offer of employment, stating that the offer was not a *bona fide* offer because it had not been approved by the employer's home office in Pennsylvania. There is no requirement under the 1989 Act that a *bona fide* offer be approved by the employer's home office and there was no evidence in the record that the person who extended the offer, and who testified live at the CCH, did not have authority to do so.

The hearing officer's finding that both Dr. O and Dr. B found MMI on April 15, 1993, and zero percent impairment is supported in the record. It is not relevant whether the issue at the March BRC was disability or not. Clearly MMI and impairment are in issue at the present CCH.

The claimant does not deny that he agreed with the carrier that Dr. C would be an agreed designated doctor. He contends that at the time he agreed he did not realize that Dr. C would be so "biased." It is obvious that the claimant is unhappy with Dr. C's opinion which is unfavorable to him. The expression of an unfavorable medical opinion hardly supports a charge of bias and there is absolutely no evidence in the record to support this assertion.

The hearing officer found that the claimant suffered no disability as result of his alleged injury. The claimant says that his disability is proven by the fact he is in pain. There is ample evidence in the record to support the finding of the hearing officer.

Finally the hearing officer finds no good cause to set aside the BRC agreement. The claimant alleges that it should be set aside because of Dr. C's "dishonesty." Again the claimant is making an assertion unsupported by evidence. We find nothing in the record to cause us to overturn the finding of the hearing officer.

The claimant disputes the zero percent impairment rating found by the designated doctor. This rating is based upon the opinion of an agreed designated doctor whose

opinion the hearing officer is required by law to adopt. Section 408.125(d). Further, it was consistent with the opinion of every other doctor who has expressed an opinion as to impairment.

Finding the assignments of error of the claimant to be without merit, we affirm the decision and order of the hearing officer.

Gary L. Kilgore
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Philip F. O'Neill
Appeals Judge