APPEAL NO. 93959

This appeal is brought 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 was held on July 6, 1993, and August 16, 1993, with the record closing on October 5, 1993, in (city), Texas, with (hearing officer) presiding as hearing officer. The sole issue at the hearing was whether the appellant (claimant) had disability as a result of an injury in the course and scope of her employment on (date of injury). The hearing officer found that the claimant failed to prove disability. The claimant appeals this determination and asserts that the evidence is "absolutely clear" that her injury resulted in disability and that the respondent (carrier) introduced no evidence to establish that the sole cause of her disability was a condition that existed prior to the injury. The respondent (carrier) in urging affirmance asserts that the claimant has not met her burden of proof that she has disability.

DECISION

Finding the challenged findings and conclusions sufficiently supported by the evidence, we affirm.

There is no dispute that a fellow employee, (JS), inadvertently struck the claimant in the forehead with a stick while both were acting in the course and scope of their employment. Whether that action resulted in disability to the claimant and a requirement under the 1989 Act that the carrier pay temporary income benefits (TIBS) is hotly disputed.

Claimant testified that on (date of injury), she somehow got hit above her left eye with a wooden stick being used by a fellow employee to keep items moving freely on the assembly line. The stick was about the length of a broom handle. She stated that when she got hit with the stick, her head started hurting and she got sick in the stomach, nauseous and dizzy. She said she immediately reported the incident to her supervisor, (EC), who told her to rest in the cafeteria. A coworker, (MS), took her home before the normal end of her shift.[1] The claimant further testified that later that morning she went back to work to report her condition. At work, her blood pressure was found to be up[2] and she was advised that this high blood pressure may be the cause of her dizziness. She went home and returned to work that evening for her normal shift. She worked the entire shift even though she said she still felt dizzy, had headaches and "still threw up, some." On her drive home from work, she blacked out and almost collided with an oncoming truck. The next week she returned to the employer's health clinic where her blood pressure was again taken and reported as high. At this point, she began to think that her problems with headaches, nausea and dizziness may be caused by her high blood pressure.

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[1]The claimant's shift was from 11:00 p.m. to 7:00 a.m.

[2]Claimant admitted that she had been suffering from high blood pressure for the previous 15 years.

The claimant worked until Thursday of the following week when she got too sick to work. She first visited her treating doctor,(Dr. L), for her claimed injury on January 27, 1993. According to the claimant, Dr. L confirmed that her blood pressure was up and told her that, because of this high blood pressure, any time she got hit, her blood pressure would "automatically" go up. She stated that Dr. L told her she had a concussion and gave her headache pills. But she continued with severe headaches, stomach aches and nausea, and got weaker. Dr. L took her off work on January 27, 1993, because she was having "neurologic problems and is unable to carry on activities of daily living."

The claimant was next referred to (Dr. C), a neurologist, who by letter of April 19, 1993, to the claimant states:

> I am the treating neurologist for [claimant's] complaints of headache and dizziness. These complaints have been corroborated objectively by the presence of abnormal electrophysiologic studies of the brain called an electronystagmogram. It is my opinion that there is an unequivocal relationship between her inability to work, her symptoms, and the on-the-job minor head injury of January 1993.

In a later letter of June 2, 1993, to the carrier, Dr. C further states:

> . . . it is possible for a minor head trauma to cause aggravation of preexisting migraine. The disabling feature of [claimant's] symptoms was not only the headache but more the vertigo, another well accepted component of the post concussion syndrome. That symptom and the fact that her migraines have occurred sequentially without much break between has precluded her return to work. Thus far we have not discovered a medicine that would help and still be taken while at work.

He adds: "She has several indications that she exaggerates her symptoms." The claimant stated that Dr. C also diagnosed "postconcussion syndrome" and prescribed about four different medications which cause her to "literally sleep most of the day." She contends that when she takes the medication, she is unable to function in a way where she can make a living; that Dr. C has not released her to return to work; and that she has been off work in this condition since January 21 or 22, 1993, up to the date of the hearing. She admitted that previous to the alleged injury, she on occasion had sinus headaches, none of which were as severe as her post-injury headaches, and that she had not had a headache for two months before the injury. She is currently taking up to six different medications prescribed by Dr. C including sleeping pills, tranquilizers, pain pills, and pills for nausea and dizziness. The claimant denied that she had ever been diagnosed as having migraine headaches or got dizzy or nauseous from high blood pressure before the alleged injury. During 1989 and 1990 the claimant lived in (state) and received medical treatment from the (state) State University Medical Center in (city) for high blood pressure. Medical records from the LSU Medical Center reflect a history of high blood pressure and headaches in the facial and

forehead areas which, as conceded by the claimant, would be a symptom of high blood pressure, but nothing like a migraine headache.

The claimant had also begun seeing (Dr. CH) on July 25, 1991, as a result of a motor vehicle accident. Her visits through November 1992 with Dr. CH disclose continuing diagnoses of hypertension, weakness and fatigue.

(TW), a licensed vocational nurse on temporary assignment with the employer, testified that he sat in on the meeting between the claimant and (WR), the employer's health and safety manager on (date of injury). At this meeting, he observed that the claimant did not talk so much about the accident, but was more angry at the individual who hit her with the stick. The claimant said she was hit on the head, "but she didn't know how bad it was or anything. She said it hurt for a while, but then it was over with." When he examined the claimant's head he found no bruises, lumps or broken skin or "superspinal fluid" in the ears that may have reflected a concussion. The claimant told him she was going to see a doctor, but first wanted to go home and cool down. When the claimant walked out of the clinic, TW did not observe that anything was wrong with the way she walked. She held her head erect. Claimant told him that she had not been taking her blood pressure medicine. TW based his knowledge of postconcussion syndrome on his schooling and five and one-half years work with a hospital rehabilitation unit dealing with closed head injuries. He did not observe that the claimant displayed any symptoms of a concussion.

EC, the claimant's supervisor, testified that he was approached by the claimant in the early morning hours of (date of injury). She was complaining about being struck in the head, but, according to EC, she did not stress that she was in pain, had headaches, or needed to go home. She said her blood pressure was boiling because she felt the employee who struck her had been engaged in horseplay and was making jokes about it. Later in the shift, about 4:30 that morning, she asked for permission to take an extra break because she was still upset about the incident. Her normal shift ended at 7:00 a.m., but she left for home about 4:30 a.m. EC asked MS to drive the claimant home because he did not want to take a chance on another accident if she was really hurt because of her job. According to EC, the claimant worked her usual shift for four or five more days during which time she did not display any signs of injury or complain of headaches, nausea or dizziness. Nor did she appear to have bruises or contusions where she said she was hit. He discussed the incident with JS, the individual who struck the claimant with the stick, and considered the blow to her head to be minor.

JS described the incident that occurred on (date of injury), and which is the basis for the claimant's claim. As he brought the stick back, he did not see the claimant and "accidentally tapped her on the side of the head." He apologized to the claimant after he struck her, but she said nothing and continued working until her break. He continued working with the claimant that day. The claimant did not appear dizzy to him, but she was upset with him. She did not bleed and he saw no cuts on the claimant's forehead as a result of the injury.

WR, the health and safety manager, first met the claimant at about 9:00 a.m. on (date of injury), when the claimant came to his office to discuss the incident. TW was present as noted above. The meeting lasted about one-half hour and, according to WR, 95% of that time was spent discussing how upset the claimant was that "the horseplay that was going on out on the floor." She did not ask to be taken off work, nor for medical assistance. She did not appear to WR to have any noticeable injuries, bruises or contusions to her forehead.

A brain CT study on February 1, 1993, disclosed an area of the right frontal lobe of "uncertain clinical significance." A brain MRI on February 5, 1993, resolved this issue and disclosed no evidence of a "subfrontal process."

Dr. L's progress notes as a result of a January 27, 1993, visit by the claimant reflect that his examination of the claimant showed no evidence of trauma. A brain stem auditory evoked response completed on May 14, 1993, was normal. Dr. C's progress notes for a May 19, 1993, visit state:

> [Claimant] comes in holding hand on head [with] eyes closed, holding on to her boyfriend. In spite of these signs, she speaks rapidly in a loud voice and without any hesitation or disruption of thought content. The volume and vigor of her speech is inconsistent with a person with a severe migraine [with] phonophobia.

He also noted a prior history of menstrual migraine.

At the conclusion of the hearing, the hearing officer on his own motion referred the claimant to (Dr. G) whose impression was:

> It is difficult to pin down the etiology of [claimant's] headaches, as well as her complaints of poor memory and overall slowed thought processes. I certainly feel that she may be suffering from post concussive syndrome, but it is impossible to make this diagnosis while she is suffering from a significant hypertensive episode.[3]

The claimant appeals the following determinations of the hearing officer:

FINDING OF FACT

8.The Claimant's inability to obtain and retain employment is not due to her work related injury on (date of injury).

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[3]The record does not reflect why this referral was made. In addition, although copies of Dr. G's report apparently were sent to the parties at the same time the report was sent to the hearing officer, there is no evidence that the hearing officer gave the parties the opportunity to comment on this report. This issue was not raised on appeal, however.

CONCLUSION OF LAW

2.The Claimant failed to prove, by a preponderance of the evidence, that she had disability after January 27, 1993, as a result of her injury on (date of injury).

In support of her position that, contrary to the decision of the hearing officer, the claimant has sustained disability, the claimant asserts:

In every case where a health care provider has reviewed and examined the claimant, there is an indication of post-concussion syndrome and statements regarding the symptoms that [claimant] described as being a natural consequence of that type of injury.

Furthermore, the carrier "has offered no evidence to indicate that the claimant's symptoms are solely related to any kind of condition she might have had prior to this injury."

The claimant in a worker's compensation case has the burden to prove by a preponderance of the evidence that she sustained disability as a result of a compensable injury in the course and scope of her employment. Garcia v. Aetna Casualty and Surety Company, 542 S.W.2d 477 (Tex. Civ. App.-Tyler 1961, no writ). Whether disability exists as a result of a compensable injury is a question of fact and disability can be established by the claimant's testimony alone despite contradictory medical evidence. Texas Workers' Compensation Commission Appeal No. 93854, decided November 9, 1993. The hearing officer, as the fact finder, is the sole judge of the relevance and materiality of the evidence and of its weight and credibility and the inferences to be drawn therefrom. Section 410.165. The hearing officer resolves conflicts and inconsistencies in the medical evidence and judges the weight to be given to expert medical testimony. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). To this end, the hearing officer as fact finder may believe all, part or none of the testimony of any witness. The testimony of a claimant as an interested party raises only an issue of fact for the hearing officer to resolve. Campos, *supra*; Burelsmith v. Liberty Mutual Insurance Company, 568 S.W.2d 695 (Tex. Civ. App.-Amarillo 1978, 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 we will 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 Company, 715 S.W.2d 629 (Tex. 1986).

The evidence introduced in this case to establish disability is ambiguous and conflicting at best. The claimant elected not to appeal numerous findings of fact by the hearing officer. These include a finding that the claimant has a history of hypertension and migraine headaches that are not work related (Finding of Fact No. 4); a finding that there

was no objective evidence (e.g., bruises, broken skin, or lumps on the forehead) to support claimant's subjective complaints of injury (fatigue, dizziness, and headaches) (Finding of Fact No. 5); a finding that an MRI on February 5, 1993, was normal (Finding of Fact No. 6); and a finding that the claimant's subjective complaints are chronic and longstanding before (date of injury). Other evidence from the claimant's treating doctors suggested that claimant exaggerated her symptoms and otherwise acted inconsistent with those stated symptoms. In addition, there was evidence that the fact that the claimant's symptoms appeared to be getting worse reflected not a post-concussion syndrome, but progressive deterioration of pre-existing conditions. Against this evidence, the hearing officer weighed the conclusions of Dr. C that there was "an unequivocal relationship between [claimant's] inability to work . . . and the . . . minor head injury . . ." and that of Dr. L that claimant's symptoms followed the injury on (date of injury), and determined that the claimant failed to prove by a preponderance of the evidence that she had disability as a result of the injury on (date of injury). Having reviewed the record in this case, we are satisfied that there was ample evidence to support these determinations of the hearing officer.

Finally, the claimant reiterated on appeal that the hearing officer declined to subpoena MS to present live testimony. A written statement of MS was in evidence. Although it is not clear whether the claimant asserts on appeal that this was error, we note, as the carrier stated in its response, that the claimant at the conclusion of the hearing specifically withdrew her request for this subpoena. Thus, we do not consider it an issue on appeal and conclude that error, if any was harmless. *See* Hernandez v. Hernandez, 611 S.W. 2d 732 (Tex. App.-San Antonio 1981, no writ) and Texas Workers' Compensation Commission Appeal No. 92409, decided September 25, 1992.

The decision and order of the hearing officer are affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Gary L. Kilgore
Appeals Judge