APPEAL NO. 991464

This case returns for review pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act) following this panel's decision in Texas Workers' Compensation Commission Appeal No. 94511, decided June 15, 1994. That case was reversed and remanded because the record did not include the exhibit containing evidence excluded by the hearing officer, which was the subject of one point of error raised on appeal by the subclaimant health care provider. A hearing on remand was held on August 2 and 29, 1994, before (hearing officer 1), who was the original hearing officer. One witness testified and additional documentary evidence was admitted into the record. Thereafter, (hearing officer 1) left employment with the Texas Workers' Compensation Commission (Commission) and a second hearing officer, (hearing officer 2), was appointed. The decision and order reflects that (hearing officer 2) wrote such decision and order based upon his review of the transcript, the evidence, Appeal No. 94511, and the applicable statutory provisions of the 1989 Act and rules of the Commission. The second decision and order was precisely the same as the first, except that the hearing officer made findings that the documents which were the subject of the remand do not exist in their original form and cannot be reproduced, but that part of the documents which were the subject of the remand, as well as the information contained in such documents, are included in hearing officer exhibits on remand. Otherwise, the hearing officer held that the claimant did not sustain an infection injury in the course and scope of his employment and that the carrier timely contested compensability of the infection; he also held that the hearing officer does not have jurisdiction to decide contractual disputes between the carrier and health care providers.

The appellant, hereinafter "subclaimant," raises numerous points on appeal. It objects to the disputed issues as contained in the hearing officer's decisions; contends that certain disputed issues were omitted; disputes findings of fact and conclusions of law, pointing to evidence in the record which it contends supports its position; and contends that certain findings and conclusions were omitted and that unnecessary conclusions were made. The subclaimant further contends that the hearing officer's decision continues to erroneously omit from evidence certain sealed documents which were excluded at the hearing, and states that the hearing officer thus abused his discretion and his decision should be reversed and rendered in favor of the subclaimant; it also contends that the carrier should be sanctioned for the loss and/or destruction of the missing exhibits, with the result that the subclaimant should be awarded previously unpaid benefits. Finally, although the subclaimant notes that the decision and order was signed by a hearing officer who did not preside over any of the proceedings, the subclaimant does not specifically raise this as reversible error. Therefore, this panel will not consider it among subclaimant's points on appeal. *See* Texas Workers' Compensation Commission Appeal No. 941544, decided December 29, 1994.

In its response the carrier maintains that the hearing officer was correct in determining that the claimant's infection did not occur during the course and scope of his employment and that the carrier timely disputed the causal relationship between the infection and claimant's work-related injury; it also maintains that the hearing officer

answered and addressed all relevant issues pertaining to the issue of compensability and timely dispute and that no further findings and conclusions are necessary. Finally, it contends that its witness produced diary narratives predating February 26, 1993, and also reprinted in its entirety all diary notations as requested by the Appeals Panel.

The appeals file does not reflect that the claimant filed any response to the subclaimant's request for review.

DECISION

Affirmed.

It was not in dispute that the claimant injured his back on (date of injury), while lifting trash cans while working for his employer, a self-insured city (hereinafter carrier). He was seen that evening in the (H Hospital) emergency room; documents from that visit show claimant was diagnosed with acute lumbar paravertebral ligament strain, given medications, and advised he could return to full duty work on October 31st. He was also instructed that his next visit was to be with Dr. G.

On (10 days after the date of injury), the claimant went to (Hospital) emergency room (ER) (hereinafter hospital), complaining of persistent back pain as well as foot pain. The ER report of that date said claimant's primary complaint was increasing back pain but that a secondary problem was that "apparently he was bitten on the left foot by a spider about three days ago;" the report described a large centrally necrotic edematous area over the dorsal aspect of his left foot "that is very characteristic for a brown reclusive [sic] spider bite." Dr. G's initial medical report of a visit of November 4th shows examination for persistent acute lumbar strain; it also states "[h]as unrelated brown recluse spider bite of left foot. Dorsal foot being followed by [Dr. B]." In a note to claimant of the same date Dr. G advised further rest and medication for claimant's back as well as an appointment with Dr. B "to take care of the spider bite on your foot." A specific and subsequent medical report signed by Dr. G on November 10th gave diagnoses of persistent lumbar strain and brown recluse spider bite.

A November 17th report signed by Dr. G shows claimant complaining of worsening of the pain in the mid portion of his back at the L5-S1 area. Dr. G injected pressure points at each lumbar ligament, continued a prescription for muscle relaxants, and advised rest at home. An MRI performed the next day included the following impressions:

1. L3-4 discitis with suggestion of left psoas abscess and epidural inflammatory process anteriorly and on the left side of the spinal canal with thecal sac narrowing.
2. Small central disc herniation at L4-5.

3. Large central disc herniation at L5-S1.

4. Congenital spinal stenosis which is increased by the above

mentioned process at L3-4 along with hypertrophy of the apophyseal joints and disc herniations at L4-5 and L5-S1.

During a November 23rd visit, Dr. G gave a diagnosis of herniated disc and persistent lumbar pain, and stated as a treatment plan "[a]dditional views of MR and needle aspiration of psoas lesions by invasive radiologist." On December 2nd Dr. G admitted claimant to the hospital; the inpatient admission record gives the admission diagnosis as an "unspecified disorder" of the muscle and ligament. The "primary final diagnosis" was given as "psoas abscesses."

Carrier's adjuster, Mr. C, testified that he received the November medical records from Dr. G mentioning a spider bite but that they did not indicate that it was in any way related to claimant's compensable injury. Mr. C's records in evidence indicate he authorized the MRI on November 17th, and that on December 4th he was contacted by a representative of the hospital for authorization of treatment for "HNP-psoas abscess of muscle and spinal inflammation." He testified that he did not know at that time what the condition entailed or how it was related to the back injury, and he began further investigation which included contacting Dr. G and interviewing the claimant.

Beginning on December 15th, a hospital social services representative had several conversations with Mr. C concerning claimant's upcoming discharge and his home health care needs (Dr. G had recommended home IV antibiotic therapy). Mr. C's adjustor's log notes from December 16th and 17th show that Mr. C was considering whether to approve such services. A December 18th entry stated "[Mr. C] will approved [sic] home IV, but states he may not pay." A December 21st note said, "Approval was given for home IV antibiotics." (Ms. H), subclaimant's president, testified that pre-authorization was given by an associate of Mr. C.) Notes also reflect that one of claimant's doctors, Dr. W, coordinated arrangements with subclaimant for home health care, which began upon claimant's discharge from the hospital on December 23, 1992, and lasted, according to Ms. H, until March 9, 1993. Ms. H stated that carrier first began receiving bills from subclaimant on January 7th. Approximately 30 days afterwards, when subclaimant's representative called Mr. C, he stated that he would probably deny the claim and would be sending a Notice of Medical Payment Dispute (Form TWCC-62) which Ms. H stated was received March 26th. According to a transcription in evidence, Mr. C spoke on February 5th with an individual working for subclaimant, to say that carrier was contesting the compensability of the infection.

As indicated in a transcribed interview with Mr. C, the claimant said he believed he was bitten on the toe while he was at home resting from the back injury and that he knew it had to have happened at home because he was "already a week off of work cause of the back." He said on a Friday that he had pain while walking and that his foot had begun to swell when he finally went to the ER some four or five days later. He said he did not actually see a spider bite him but said that a doctor told him that probably was the cause.

On December 18th Mr. C spoke with Dr. G and was told that the claimant had

sustained an infection which settled in his spine after being bitten by a spider. He said Dr. G also said he could not rule out the possibility of claimant's being bitten on the job. Mr. C testified that December 18th was the first time he had an indication that the spider bite could be related to the back injury. On that date he also wrote Dr. G asking him to indicate how claimant's infection was related to the back strain. Mr. C also wrote Dr. W on January 20th, 1993, asking how the diagnosis of psoas abscesses was related to claimant's back strain, and whether there was medical evidence to relate the diagnosis and symptoms with the perceived spider bite.

On January 21st Dr. W wrote Mr. C that he believed claimant's back infection may have been present on (date of injury). He stated that:

> I suspect that [claimant's] foot lesion two weeks later was not a spider bite but rather an infection in an area of trauma. It may also have been an embolic lesion from [claimant's] back infection. In either case, my best judgment is that [claimant] suffered minor trauma, probably at work. He developed an infection at that site or developed bacteremia from that site. Bacteria in [claimant's] blood spread to his back and ultimately resulted in his back infection.

Dr. W also stated that claimant's belief that he had gotten the bite while convalescing at home "does not coincide with the medical history," pointing out that claimant's job required him to work in a type of environment favored by the brown recluse spider. Mr. C contended that this letter was the first written medical evidence which related to or addressed the causal relationship of claimant's back injury to the infection.

Dr. G did not respond to Mr. C's letter until February 22, 1993, when he wrote in part that:

> Claimant's condition . . . is indeed a continuum of problems that all relate to one another. The original back distress was in all likelihood a combination of strain from lifting on a lumbar area involved by a combination of discitis and herniated discs at two levels . . . That minimal evidence of discitis progressed to full blown abscess the origin of which appears to be the psoas muscle where defects were identified but relevance could not immediately be determined. The entire scenario appears to be related to a lesion of the dorsum of his left foot treated before I had an opportunity to assess him . . .

Also in evidence were a portion of diary entries reflecting Mr. C's activities with regard to claimant's claim. A December 18th entry reflects the conversation of that date with Dr. G. That entry stated "[Dr. G] initially thought clmt suffered a simple back strain but after an apparent set back clmt was hospitalized to find out what caoued [sic] his pain. After multiple test [sic] it was determined clmt has infection of spine from spider bite. He did not know when or how clmt was bitten but could not rule out possibility of being bitten on the job. He wants to release clmt to home health care for continual antibody injections."

The diary entries further reflected Mr. C's conversation with claimant on December 18th, as well as his letter to Dr. G of that date. Also on December 18th Mr. C wrote "I updated J of findings she advised OK to authorize home health care for reasonable and necessary related to injury and to get doctor to address how related in writing." A January 13, 1993, entry stated "PPD questionable pending decision on relevancy of spinal infection to strain," and a January 20th entry documents Mr. C's letter to Dr. W, adding that the MRI did not explain the infection and that carrier's staff nurse did not feel that a herniation would cause a psoas abscess.

On January 25th Mr. C wrote his supervisor asking that this case be referred to a consultant for record review to determine whether claimant's hospitalization and treatment were reasonable and necessary for the back strain injury as originally reported. On February 2nd Mr. C received a response from (hereinafter healthcare company); briefly, the unsigned report stated the opinion of a physician advisor that there was no causal relationship between the claimant's diagnosis and the work injury; that the claimant appeared to have had a disc space infection occasioned by a non-work related soft tissue injury of unknown etiology to his foot. The report further noted that no work injury to the foot was documented, no back injury was documented as to the cause of the back pain, and in the physician advisor's opinion, the infectious process caused the back pain and it was not work related. Dr. G responded to the (healthcare company) report by stating that home origination of the spider bite seemed "fanciful at best" and that claimant worked in an "ideal habitat for this . . . spider which had in all likelihood fallen into his shoe as he worked."

The following day, February 3, 1993, Mr. C completed a Notice of Refused/ Disputed Claim (TWCC-21) which stated that payment was refused/disputed for the reason that "Recent peer utilization review indicates psoas abscess osteomyelitis are not causally related to injury alleged by [claimant]. Therefore, the carrier denies liability for injury and treatment." Mr. C stated that this form was mailed to the subclaimant; it was date stamped as received by the Commission on February 4th. In addition, the carrier filed with the Commission its TWCC-62 disputing entitlement to medical treatment.

In March, (healthcare company) was asked to perform an "appeal review," apparently at the request of the hospital. According to a March 17th letter to Mr. C from (healthcare company), the same physician advisor determined that his opinion did not change from his prior recommendations. On May 27th, a (healthcare company) representative wrote that a second level appeal review had been conducted by a different physician advisor, whose opinion on lack of causation was the same, and who said that there was no scenario which would satisfactorily explain the causality of the abscess or the lesion on the claimant's left foot, as there was no history of trauma or foot injury on the job, nor no clear history of bite or wound to the foot which would have provoked the abscess.

On July 27th Dr. G wrote Mr. C to state his impression that claimant's complaint "was likely at all times related to the eventual septic problem that became obvious when sophisticated assessment was carried out . . . If there ever was a strain it was not documentable medically and it remains my opinion that the complaints came as a result of

early discitis preceding the full-blown septic process. The only scenario that makes any sense whatsoever is that of infection resulting from the site of a brown recluse spider bite of the dorsum of the foot. Speculative perhaps when the bite occurred and if it was on the job or not."

At the hearing Dr. BI testified that he was the doctor who performed the review for (healthcare company) in May. He stated that the lesion on claimant's foot could have been caused by a spider bite or from another cause as suggested by Dr. W, although he said that it was unlikely that a bite from a recluse spider would be nonsymptomatic for a period of days. He also said that an abscess of the psoas muscle--which he described as a muscle in the inner portion of the back--can be spontaneous, but usually is seeded from another site. He stated that a basic lumbar strain could not cause a psoas abscess, which would be more likely to arise after a significant trauma, that claimant's medical records showed he had a lifting injury and did not sustain a hematoma, and that even though a lifting injury could cause a disc herniation, he had never seen a herniation become infected. He stated that he disagreed with the opinion of Dr. G that claimant's infection was work related and restated the conclusion contained in his written report that it would be difficult to find causation between the work related back injury and the subsequent infection.

Dr. T testified for the subclaimant. On February 2, 1993, following review of claimant's medical records, he wrote that he did not know whether the foot lesion was caused by a spider bite but that given claimant's occupation it was "just as likely" that a work-related trauma led to the introduction of the staphylococci. He also wrote that regardless of whether the foot lesion was work related the development of an abscess in the back "clearly" was a compensable injury, stating that "Had [claimant] not injured his back, he would have been extremely unlikely to have seeded the area from an abrasion on the foot as innocuous as described." Dr. T basically repeated this opinion during his testimony at the hearing, stating that it was likely that the infection moved from claimant's back which, due to his injury, "probably had fresh blood outside the blood vessels."

WHETHER THE HEARING OFFICER MISSTATED ISSUES AND/OR ERRONEOUSLY ADDED CARRIER'S ISSUES WHILE FAILING TO ADD SUBCLAIMANT'S ISSUES

In the decision and order the disputed issues were set forth as follows:

1. Did the carrier contest compensability on or before the 60th day after being notified of the infection and, if not, is the carrier's contest based on newly discovered evidence that could not have been reasonably discovered at an earlier date.

2. Whether or not the infection injury occurred during the course and scope of his employment, independent of his (date of injury), injury.

3. Is notification from the hospital on or about December 3, 1992, sufficient for purposes of notifying the carrier of a compensable workers' compensation injury.

4. Is the carrier estopped or has the carrier waived the right to deny payments for the services provided by [subclaimant] as a result of advising [subclaimant] on December 23, 1992, that the treatment of [claimant's] back was covered by workers' compensation insurance.

In its appeal the subclaimant contends that the hearing officer restated the second disputed issue after the conclusion of the hearing. The benefit review conference report indicates that there were two disputed issues, the first being identical to that stated by the hearing officer and the second as follows: "did the claimant sustain a compensable injury in the form of an infection on or about (date of injury)." The record further reflects that the subclaimant on January 25, 1994, filed a "Request for Submission of Additional Disputes Not Identified As Unresolved in the Benefit Review Officer's Report," which contained the proposed issue "[w]hether or not the infected [sic] injury occurred during employment, independent of the back strain injury on (date of injury)." The transcript of the hearing reflects that the hearing officer proposed to substitute the subclaimant's proposed issue, with the deletion of the reference to (incorrect date of injury), and that the subclaimant's attorney agreed. Thus, this point of error has no merit.

The subclaimant further argues that the third issue was added after the start of the contested case hearing, was self-serving to the carrier, was never agreed to by the parties and, indeed, the subclaimant objected to the addition of the issue. It further notes that the hearing officer, on the second day of the hearing, announced only two issues. Additionally, the subclaimant contends that the hearing officer refused to allow it to introduce any evidence with regard to the fourth issue, and that the hearing officer erred in refusing to add the issue of equitable estoppel, as requested by the subclaimant.

The transcript of proceedings in this case shows that on February 14, 1994, the day the hearing was first convened, the carrier requested the addition of Issue No. 3 after the hearing officer announced his intention to decide the issue of timely dispute of compensability; this issue was objected to by the subclaimant. However, the subclaimant requested that the hearing officer add the issue of equitable estoppel as contained in its request for submission of additional disputes, to which the carrier objected. The record shows the hearing officer stated that the carrier's request was "intricately intertwined" with the subclaimant's proposed issue, and that "I believe in addressing one, I would wind up addressing both. So I will allow them both to stay in." However, the record also shows that on February 18th the hearing officer purported to clarify his position with respect to the issues requested by the subclaimant and stated he was specifically not adding issues of estoppel or waiver nor taking any testimony thereon.

While it is certainly troubling that the hearing officer first appeared to have added issues requested by the parties, only later to specifically deny subclaimant's request to add

an issue, nevertheless it was the interested party's responsibility to bring such discrepancy to the hearing officer's attention during the course of the hearing. While it is perplexing that Issue No. 4 was still listed as a contested issue in the decision and order, the fact remains that the hearing officer stated on the record that he was not allowing this issue nor any testimony thereon. Further, it is inexplicable why the hearing officer announced the two original issues on the second day of the hearing but, subsequently, allowed carrier's issue (Issue No. 3) to stay in; however, we cannot say the subclaimant was prejudiced by the addition of this issue which, had it been answered affirmatively, would have benefitted the subclaimant. We also note that in resolving Issue No. 1, the hearing officer was compelled to address all communication to the carrier concerning the compensability of the claimant's infection.

As to the excluded issue, Tex. W.C. Comm'n, TEX. ADMIN. CODE § 142.7 (Rule 142.7) provides, in pertinent part, that additional disputes to those identified at the benefit review conference may be added by the hearing officer only on a determination of good cause. *See, generally*, Texas Workers' Compensation Commission Appeal No. 92538, decided November 25, 1992, stating that Rule 142.7(e) applies to such situation, placing the burden of showing good cause upon the moving party, rather than Rule 142.7(c), which concerns a party's response to the disputes identified as unresolved in the benefit review officer's report. Based on the discussion at the hearing of this issue, which involved questions concerning the time period in which the carrier reported denial of coverage and failed to pay 50% of expenses billed, as well as whether its actions constituted a breach of the duty of good faith and fair dealing, the hearing officer determined in essence that those issues were not properly the subject of a contested case hearing. We thus cannot determine that the hearing officer abused his discretion in failing to find good cause to add such issues. Appeal No. 92538, *supra*.

WHETHER THE EVIDENCE SUPPORTED THE HEARING OFFICER'S FINDINGS OF FACT

The subclaimant challenges numerous findings of fact by the hearing officer, by and large those going to the scope of claimant's injury (whether or not the infection was caused by, or naturally resulted from, the original compensable injury) and the dates on which the carrier allegedly received written notification putting the carrier on notice that the claimant had an infection which could be causally related to the original injury. In arguing these points, the subclaimant makes reference to medical and other evidence in the record, and the dates thereof.

As to the first issue, we note at the outset that the 1989 Act defines "injury" to include damage or harm to the physical structure of the body and a disease of infection "naturally resulting" from such damage or harm. Section 401.011(26). Whether the infection in this case naturally resulted from the claimant's back injury involves an issue of causation. While lay witness testimony generally is sufficient to establish causation where, based upon common knowledge, a fact finder could understand a causal connection between the employment and the injury, expert testimony may be required where such

common knowledge does not exist. *See* Hernandez v. Texas Employers Insurance Association, 738 S.W.2d 250 (Tex. App.-Corpus Christi 1989, no writ) and cases cited therein. We believe this case presents such a situation. Further, such causal connection must be established through reasonable medical probability; otherwise, the inference of causation "amounts to no more than conjecture or speculation." Schaefer v. Texas Employers Insurance Association, 612 S.W.2d 199 (Tex. 1981).

The medical evidence in this case is conflicting. It is clear the claimant sustained a back injury at work on (date of injury), and that foot pain was first recorded 10 days later. There is no direct evidence of a spider bite, although several doctors stated that claimant's foot symptoms were characteristic of the bite of a recluse spider. Abscess of the psoas muscle was first suspected following the MRI of November 18, and was finally diagnosed sometime after he was admitted to the hospital on December 2nd. Claimant's treating doctor stated his opinion that this condition was a "continuum of problems" by which a lifting incident at work progressed to discitis which progressed to a "full blown abscess." Dr. W believed the original foot lesion arose from infection in an area of trauma, "probably" suffered at work, which resulted in bacteremia which spread to his back and resulted in the back infection. Conversely, the (healthcare company) physicians did not believe there was a causal connection between the back infection and the injury. One of those doctors, Dr. BI, testified that an abscess of the psoas muscle is usually seeded from another site and that a basic lumbar strain could not cause such abscess, which is more likely to arise after "significant trauma," which, in his opinion, claimant's medical records did not indicate. Dr. T testified that regardless of whether the foot lesion was work related the abscess was clearly a compensable injury, as it would have been "unlikely" for such to have occurred in the absence of a back injury.

The hearing officer, based upon this evidence, determined that the infection was not part of claimant's compensable injury; i.e., that it was not the natural result of his back injury. The 1989 Act provides that the hearing officer is the sole judge of the relevance and materiality of the evidence and of its weight and credibility. Section 410.165(a). As such, the hearing officer resolves conflicts in the evidence and is entitled to disbelieve one expert witness and believe another. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). An appellate body will not overturn the decision of the fact finder unless it is so against the great weight and preponderance of the evidence as to be manifestly unfair and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986). The subclaimant in this case, pointing to expert medical testimony in its favor, contends this is the case. However, upon our review of the evidence we cannot say that the hearing officer's decision was so unsupported by evidence as to require our reversal. As we have noted in the past, the fact that the record contains evidence that could have supported different inferences is not a sufficient basis upon which to overturn the fact finder's decision. Garza v. Commercial Insurance Co. of Newark, New Jersey, 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ).

Notwithstanding whether an injury is compensable in its own right, the 1989 Act provides that if an insurance carrier does not timely contest compensability of an injury, the

carrier waives its right to contest compensability. *See* Section 409.021(c), and Tex. W. C. Comm'n, TEX. ADMIN. CODE § 124.6 (Rule 124.6). The latter provides in subsection (c):

> If a carrier disputes compensability after payment of benefits has begun, the carrier shall file a notice of refused or disputed claim, on or before the 60th day after the carrier received written notice of the injury or death. This notice shall contain all the information listed in subsection (a) of this section, provided that all facts set forth as grounds for contesting compensability shall be based on actual investigation of the claim, and shall describe in sufficient detail the facts resulting from the investigation that support the carrier's position.

Rule 124.1(a) provides:

> Written notice of injury . . . consist of the insurance carrier's earliest receipt of:
>
> (1) the employer's first report of injury;
>
> (2) the notification provided by the commission under subsection (c) of this section [written notification to the carrier from the Commission when a source other than the carrier reports, among other things, an injury which may cause the employee eight days or more or disability or has resulted in an impairment]; or
>
> (3) any other written document, regardless of source, which fairly informs the insurance carrier of the name of the injured employee, the identity of the employer, the approximate date of the injury, and facts showing compensability. [Emphasis added.]

It was undisputed in this case that the carrier filed a TWCC-21 disputing compensability of the infection on February 4, 1993. For such to have been timely, any written notice of injury must have been received by the carrier no earlier than December 6, 1992. It was the finding of the hearing officer that the claims for services from subclaimant, which were first transmitted on January 7, 1993, constituted the carrier's first written notice of claimant's infection injury (while the finding does not so state, we presume that what is meant is that January 7, 1993 was the first date the carrier received written notice that the infection could be related to claimant's original back injury). The hearing officer's finding must be examined in light of the evidence and the fact that, as we have held, the 60 days for disputing compensability should not begin to run until the carrier is "fairly informed" of the four elements specified in Rule 124.1(a)(3). Texas Workers' Compensation Commission Appeal No. 93120, decided April 2, 1993.

In its appeal the subclaimant argues that the hearing officer's finding ignores

substantial documentary evidence beginning November of 1992 that indicates that the claimant's back injury was infected; it also contends that this finding is rebutted by other findings, including the findings that on (10 days after the date of injury), the claimant went to an ER complaining of back pain and a swollen foot "due to an infection," that on December 4, 1992, a hospital employee verbally notified Mr. C that claimant was in the hospital, that claimant was subsequently found to have an infection in the psoas muscle, and that on December 18, 1992, Dr. G verbally advised Mr. C that the infection in claimant's back was the result of a spider bite.

Laying aside the question of whether the verbal notices to carrier's adjuster would suffice (*see* Appeal No. 93120, *supra*; Texas Workers' Compensation Commission Appeal No. 92359, decided September 9, 1992), we note that the December 18th conversation by Dr. G occurred within the 60 days prior to the date carrier filed its dispute. While Mr. C also spoke to a hospital representative on December 4th for pre-authorization, he testified that he did not know how the infection was related to the back injury. As to the documentary evidence received by the carrier prior to December 3, 1992, we note that the first medical report issued following claimant's complaints of foot pain was the (10 days after the date of injury) ER report of an apparent spider bite occurring "about three days ago;" the November 4th follow-up report by Dr. G states the claimant had a spider bite that was "unrelated" to his back pain. Dr. G's specific and subsequent medical report contained two diagnoses and did not indicate the two were related; nor did the MRI report which first identified a possible abscess of the psoas muscle. Claimant's December 2nd hospital admission diagnosis was "unspecified disorder" of the muscle and ligament. We would thus agree with the hearing officer's implicit determination that none of these documents fairly informed the carrier of the purported compensability of the infection so as to constitute a written notice of injury in accordance with the requirements of Rule 124.1.

Because we find the evidence sufficient to uphold the hearing officer's determinations on the issue of compensability and timely dispute by the carrier, subclaimant's point of error that the hearing officer failed to make additional findings and conclusions in support of its position is without merit.

EVIDENCE EXCLUDED BY THE HEARING OFFICER

At the original hearing Mr. C testified while referring to diary entry pages, which the attorney for the subclaimant requested be put into evidence. The attorney for the carrier objected, contending that the material contained information covered by the attorney-client privilege. At the close of the first session of the first hearing, the hearing officer rejected the subclaimant's attorney's proposal that the documents be kept overnight by the hearing officer pending his ruling when the hearing reconvened. The following day the carrier offered into evidence some 2? pages of the material; the hearing officer ruled that the balance of the material contained information that was both privileged and irrelevant; while the remainder was to have been forwarded as an appellate exhibit, it was missing from the appeals file and this panel remanded to allow the hearing officer to secure the documents, to review them to assure that they are the same documents he reviewed at the hearing,

and then to forward them for purposes of this panel's review.

Following additional hearing on remand, the hearing officer received into evidence what carrier's witness, Mr. C, testified were duplications of the documents which had been excluded from the record below; he also testified that to his knowledge the contents of the document had not been altered. The hearing officer also determined, based on carrier's attorney's representation, that the documents no longer existed, nor could they be reproduced, in their original form. The subclaimant contends that the hearing officer's continued failure to forward the documents constitutes an abuse of discretion, and that the carrier should be sanctioned for the loss and/or destruction of the exhibit by being ordered to pay previously unpaid amounts to the subclaimant.

The record indicates that the hearing officer, on remand, was satisfied that the material belatedly produced sufficiently duplicated the material which was the source of contention at the original hearing. Given the limited period of time for which the diary notes were relevant to the issue of timely contest of compensability, as was exhaustively argued during the hearing, we do not believe the hearing officer abused his discretion either in determining that the remaining material was not relevant nor in making a determination that the exhibits upon remand contain the information sought, albeit in a different form. Further, as we have previously held, reversible error is not ordinarily shown in connection with rulings on questions of evidence unless the whole case turns on the particular evidence admitted or excluded. Thomas Construction Company v. Arbs, 692 S.W.2d 926 (Tex. App.-Fort Worth 1985, writ ref'd n.r.e., 700 S.W.2d 919 (Tex. 1985)). Because the issue of timely contest of compensability turned on dates and content of written notification of injury, rather than on the witness's verbal conversations or mental impressions, we cannot say that the exclusion of this evidence would have changed the result. Further, to the extent that the subclaimant would have us, in effect, order sanctions against the carrier, this panel has ruled that an administrative procedure under the Administrative Procedure Act, TEX. GOV'T CODE ANN. § 2001.001 *et seq*. (Vernon 1995), rather than the contested case hearing process, is the appropriate forum. Texas Workers' Compensation Commission Appeal No. 93610, decided September 7, 1993.

The subclaimant also raises as error the failure of the hearing officer to allow the subclaimant to see the contents of a claims file Mr. C referred to during his testimony in order to refresh his memory; the subclaimant refers to TEX. R. CIV. EVID. Rule 612, which states that if a witness uses a writing to refresh his memory for the purpose of testifying, an adverse party is entitled to have the writing produced at the hearing, to inspect it, to cross-examine the witness thereon, and to introduce in evidence those portions which relate to the testimony of the witness. While the rule further provides that the court shall, if it is claimed that the writing contains matters not related to the subject matter of the testimony, inspect same in camera, excise any portion not so related, and preserve for appellate review all portions withheld over objection, the subclaimant contends that the hearing officer did not make a relevancy determination and thus abused his discretion.

The transcription of the lengthy proceedings below indicate that the subclaimant

noted for the record, but did not object to, Mr. C's referring to documents as he testified; two or three of these documents apparently were introduced into evidence. The subclaimant did, however, request that it be able to see the balance of the file to assist it in cross-examination; the hearing officer denied the subclaimant's request to review the entire file based on the fact that the documents referred to by the witness had been introduced. Thus we also find no reversible error based upon this point.

Finally, the subclaimant contends that it followed Commission rules for pre-authorization as evidenced by the Commission's medical providers handbook, and it attaches this document to its appeal. However, the Appeals Panel is limited in its consideration of evidentiary matters to the record developed at the contested case hearing. Section 410.203.

Based upon the foregoing, and finding no reversible error on the part of the hearing officer, we affirm.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Susan M. Kelley
Appeals Judge