APPEAL NO. 94319

This appeal arises under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On February 28, 1994, a contested case hearing (CCH) was held in (city), Texas, with (hearing officer) presiding as the hearing officer. The disputed issues presented at the hearing for resolution were: (1) has the claimant reached maximum medical improvement (MMI), and if so, what is the date of MMI; and (2) what is the claimant's impairment rating (IR). In her decision signed on February 15, 1994, the hearing officer decided that (claimant) had reached MMI on May 28, 1993, with an IR of zero percent as determined by the designated doctor, (Dr. J). The appellant (claimant) requested a review of the hearing officer's decision because he argued that the designated doctor, Dr. J, adopted another doctor's report on the claimant's wrist injury and that the designated doctor did not even mention the claimant's triangular fibrocartilage injury or "trigger finger." The claimant further disputes the zero percent IR found by the hearing officer. The claimant also argues that the great weight of other medical evidence is contrary to the designated doctor's report. Finally, the claimant requests the reversal of the hearing officer's decision and that we render a new decision in the claimant's favor. The respondent (carrier) argues that the claimant's appeal appears untimely and that the hearing officer's decision on MMI and IR should be affirmed.

DECISION

Determining that the hearing officer's determinations are supported by sufficient evidence, we affirm the hearing officer's decision and order.

First, we address carrier's argument that the claimant's appeal was untimely. We find this argument without merit. The claimant does not state in his appeal when he received the hearing officer's decision, and, therefore, we will apply the deemed date of receipt of five days from distribution by the Texas Workers' Compensation Commission (Commission). *See* Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 102.5(h). According to Commission records, the distribution date of the hearing officer's decision was March 1, 1994, which would make the deemed date of receipt be March 6, 1994. This would give the claimant until March 21, 1994, to timely file an appeal. However, even if the claimant had received the decision on March 1, 1994, as the carrier argues might have happened, then the claimant would have until March 16, 1994, to file an appeal or place the appeal in the mail. The claimant's appeal is postmarked March 15, 1994, and was received by the Commission on March 18, 1994, so the claimant's appeal was timely filed even under the carrier's speculative argument.

The claimant's attorney also submitted an application for attorney's fees with the claimant's appeal. The hearing officer told the claimant's attorney on the record at the hearing that the attorney could submit the application to her. The claimant's attorney said, "Okay." The appropriate course on the attorney's fees is to submit the application to the hearing officer, and an application on attorney's fees should not come to the appeals panel until after a hearing officer has ruled on such application. *See* Rule 152.3(g). We have forwarded the application to the division of hearings of the Commission to decide upon the application.

The parties at the hearing stipulated that the claimant suffered an injury on (date of injury), while he was working for (employer). The parties also stipulated at the hearing that the Commission appointed Dr. J as the designated doctor who reported claimant had reached MMI on May 28, 1993, with a zero percent IR. The only witness to testify at the hearing was the claimant, who was Spanish speaking and testified through translation by an interpreter. The claimant stated that he worked as a grinder at a warehouse for the employer and that on (date of injury), he was injured on the job when he tried to prevent a delicate piece of metal flange from falling. The claimant stated that the piece weighed about 200 pounds and that he had tried to hold it with both his arms and hands. The claimant testified that he had hurt both his right arm and left arm, and that the problem at the hearing was over his left hand and fingers. The claimant stated that his fingers would get numb and that he would not be able to straighten them out. The claimant said his doctor told him that he had "trigger finger." The claimant said that the employer's doctor had put his left arm in a cast and that he continued working with the use of his right hand.

The claimant asserted that he was indirectly referred by the Commission to Hospital. The claimant testified that he had seen an ad on the television for the Commission, but on questioning by the hearing officer, who pointed out that the Commission does not advertise on television, the claimant stated that the ad only mentioned workers' compensation cases and when he called the phone number it was a referral service for doctors. The claimant testified that his cast was taken off his arm at the hospital and there he saw (Dr. JA). The claimant stated that Dr. JA, after having treated him for awhile, referred him to (Dr. G), who then treated the claimant. The claimant testified that Dr. G believed that surgery was needed on the claimant's left hand.

The claimant said he wanted to have surgery but that he has not had surgery because the carrier has not approved it and because he does not have the money to pay for it. The claimant further stated that his left arm is lacking strength and gets very tired, that he cannot hold anything, and that things just fall out of his hand. The claimant also testified that his problem has been getting worse and that it is bothering him at night but that his left wrist has healed up. The claimant testified that he was sent to (Dr. E), carrier's doctor, for an independent medical examination (IME). The claimant testified Dr. E paid more attention to his wrist than to his fingers. The claimant stated that Dr. J, the designated doctor, spent about a half an hour with him and that Dr. J examined x-rays previously taken of the claimant. The claimant testified that he had problems communicating with Drs. E and J but that both had translators. The claimant stated that Dr. J took his hand and had him flex and squeeze his fingers by both stretching and tightening his fingers. The claimant said he did not remember if Dr. J took x-rays or did any other tests on his fingers. The claimant said Dr. JA and Dr. G did more testing of his hand and gave him shots in practically all of his fingers. The shots, the claimant said, helped make movement of his fingers easier. The claimant testified that Dr. JA and Dr. G both conducted more tests on claimant's hand and had him go through more therapy.

In a letter dated September 9, 1993, Dr. JA determined an IR of seven percent, and this included impairment of both his hands and middle fingers. Dr. JA noted that he based

his IR on the "Guides to the Evaluation of Permanent Impairment, 3rd Edition, [second printing, dated February] 1989," published by the American Medical Association (AMA Guides) which is the correct version of the AMA Guides. Section 408.124(b). In a report dated September 3, 1993, Dr. G, who works with Dr. JA, wrote that the claimant had "reached [MMI] as far as conservative modalities are concerned" and that Dr. G would not proceed with surgery because the claimant was denied care by the carrier.

In a medical report dated March 9, 1993, Dr. E wrote that the claimant does not have a "true `trigger finger'." Dr. E, in a Report of Medical Evaluation (TWCC-69) dated June 1, 1993, wrote that he tested both left and right hands, and noted "I do not have any objective findings to substantiate [claimant's] subjective complaints. I find nothing to indicate any permanent impairment of function as a result of his injury of 1992." Dr. E found MMI on May 28, 1993, with a zero percent IR.

The claimant argued at the hearing and on appeal that Dr. J mainly examined his left wrist not his left hand and fingers and that Dr. J did not even mention his trigger fingers. The medical evidence submitted from Dr. J's examination completely contradicts this, and the medical evidence of Dr. J indicates that he centered his exam on the left hand and fingers. In a TWCC-69 dated October 6, 1993, Dr. J, wrote that the claimant, after his left wrist injury occurred, "developed symptoms in the fingers of his left hand (& one digit of the right hand, as well). He was elsewhere diagnosed as having a left wrist sprain and trigger fingers. The current examination by me was negative for findings of either of these two conditions." Dr. J noted that the claimant reached MMI on May 28, 1993, with a zero percent IR. Dr. J also noted with respect to the date of MMI that the claimant reached MMI "at some time in the past & agree that Dr. [E]'s date is probably correct." Dr. J further wrote that "I, on multiple examinations on this date found no evidence of trigger finger/stenosing tenosynovitis." (Emphasis is in the original.) The carrier only presented medical evidence in support of the designated doctor, Dr. J, and the carrier argued that Dr. J's opinion carried presumptive weight and that the hearing officer's opinion should be upheld.

On appeal the claimant argues that the hearing officer should not have given Dr. J's opinion presumptive weight because Drs. JA and G, "in effect, also were doctors designated by the TWCC." The claimant's argument has no merit because the 1989 Act clearly defines a "designated doctor" to be "a doctor appointed by mutual agreement of the parties or by the commission to recommend a resolution of a dispute as to the medical condition of an injured employee." Section 401.011(15). Drs. JA and G were not selected by the Commission, or agreed to by the parties and the dispute arose from Drs. JA's and G's diagnosis versus Dr. E's diagnosis. The claimant's subjective beliefs do not operate to make Drs. JA and G designated doctors.

The 1989 Act requires that the opinion of a designated doctor be given presumptive weight. Sections 408.122(b) & 408.125(e). A "great weight" of other medical evidence is needed to overcome the presumption of the designated doctor's opinion. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. The medical evidence in the present case is conflicting on whether the claimant has reached MMI and

what the correct IR should be. A designated doctor's report should not be overturned unless there exists a great weight of other medical evidence contrary to the report. There is not a great weight of other medical evidence established by the claimant to overturn the designated doctor's report in this case.

Under the 1989 Act, the hearing officer is the trier of fact at the contested case hearing and is the sole judge of the relevance and materiality of the evidence offered and of the weight and credibility to be given the evidence. Section 410.165(a). The trier of fact can believe all or part or none of any witness's testimony because the finder of fact judges the credibility of each and every witness, the weight to assign their testimony, and then resolves the conflicts and inconsistencies in the testimony. Taylor v. Lewis, 553 S.W.2d 153, 161 (Tex. Civ. App.-Amarillo 1977, writ ref'd n.r.e.); Texas Workers' Compensation Commission Appeal No. 93426, decided July 5, 1993, and Texas Workers' Compensation Commission Appeal No. 93155, decided April 14, 1993. As the fact finder, the hearing officer has the responsibility and the authority to resolve conflicts and inconsistencies in the evidence, to assess the testimony of witnesses, and to make findings of fact. Texas Workers' Compensation Commission Appeal No. 92232, decided July 20, 1992, and Texas Workers' Compensation Commission Appeal No. 92657, decided January 15, 1993. The hearing officer can also resolve the conflicts in the medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). In this appeal, the hearing officer had sufficient medical evidence presented by Drs. J and E, to support her findings and conclusions. Where sufficient evidence supports a fact finder's conclusions and his findings are not against the overwhelming weight of the evidence as to be clearly wrong or unjust, then the decision should not be disturbed. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Dyson v. Olin Corp., 692 S.W.2d 456, 457 (Tex. 1985); In Re King's Estate, 150 Tex. 662, 664-665, 244 S.W.2d 660-661 (1951). The hearing officer found that the claimant had not shown that the great weight of other medical evidence is contrary to the designated doctor's report. The hearing officer concluded in accordance with the certificates of the designated doctors that the claimant reached MMI on May 28, 1993, and that the claimant had a zero percent IR.

We determine that the hearing officer's decision is supported by sufficient evidence and is not against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust. In Re King's Estate, 150 Tex. 662, 244 S.W.2d 660, 662 (1951); Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986).

The decision and order of the hearing officer are affirmed.

Stark O. Sanders, Jr.
Chief Appeals Judge

Robert W. Potts
Appeals Judge

Susan M. Kelley
Appeals Judge