APPEAL NO. 980051

This appeal § 401.001 et seq. (1989 Act). On December 11, 1997, a hearing was held. He (hearing officer) determined that appellant (claimant's) compensable injury of _____, was a cause of the claimant's right subacromial impingement symptoms but that it was not a cause of the claimant's carpal tunnel syndrome; he further found that the correct impairment rating (IR) was 11%. Claimant asserts that the carpal tunnel syndrome is compensable, citing diagnostic studies and pain he had had; he also states that his IR should be 15%. Respondent (carrier) asserts on appeal that the subacromial impingement is not part of the compensable injury, citing a May 1996 arthrogram; carrier adds that all other determinations of the hearing officer should be affirmed.

DECISION

We affirm.

Claimant injured his right shoulder on _____, when he lifted a battery and turned; he testified that he heard a pop in his right shoulder and felt a sharp pain there. On June 3, 1994, (Dr. P) operated on the right shoulder for "subacromial impingement." In April 1995, Dr. P again operated and noted that there was no significant scarring and "no demonstrable subacromial residual impingement." In July 1995, after claimant had changed his treating doctor to (Dr. K), that doctor noted persistent pain and very limited right shoulder range of motion. He injected the acromial clavicular joint. An arthrogram was performed on April 23, 1996, which gave an impression of "negative for rotator cuff tear."

Claimant argued at the hearing that the arthrogram was really addressing whether there was a rotator cuff tear and not subacromial impingement. Dr. K noted on June 20, 1996, that claimant still complained of his right shoulder although there had been some improvement from physical therapy but added that claimant still had pain "referable to the subacromial arch." He injected the shoulder at that time. In December 1996, Dr. K called for an MRI scan. Dr. K then wrote in January 1997 that the MRI showed "degenerative changes in the acromioclavicular joint causing impingement . . ."

(Dr. W), who reviewed the records for carrier, said that the MRI of 1997 did not show a new injury but an "on-going degenerative process of the A-C joint." While the carrier then argued that the cause of the current subacromial impingement symptoms is degenerative rather than the 1993 injury, the hearing officer as sole judge of the weight and credibility of the evidence (*see* Section 410.165) could interpret the medical evidence to show that the subacromial impingement treated in 1994 had never healed. He could consider that the arthrogram did not show a cessation of the process, as evidenced by the June 1996 note, made within weeks of the arthrogram, which still showed pain in the subacromial arch. The

determination that the compensable injury of 1993 was a cause of the right subacromial impingement symptoms is sufficiently supported by the evidence.

The claimant states that he was diagnosed as having carpal tunnel syndrome. However, his own doctor, (Dr. S), who took over after Dr. K, said in a letter dated October 20, 1997:

> I cannot absolutely claim that his carpal tunnel syndrome is specifically related to the work injury of _____, and would suspect that indeed that in his case the carpal tunnel syndrome that is present is a long-standing, slowly developing issue, particularly in view of the fact that he has not been working
>
> I certainly am sympathetic with your position that the carpal tunnel may not be work related and I am fully willing to concede that point.

(We note that Dr. S also made the point that claimant would not be restored to working status by merely treating part of his problems.) The hearing officer also quoted these statements made by Dr. S. The medical evidence sufficiently supports the determination that claimant's carpal tunnel syndrome is not related to the 1993 injury.

While claimant asks for a 15% IR, there is no 15% IR in the record. (Dr. B) in his Report of Medical Evaluation (TWCC-69) dated November 20, 1996, identified himself as the designated doctor and found maximum medical improvement (MMI) on May 26, 1996, labeling that date as "stat MMI date"; he also assigned an 11% IR. (Dr. B had provided a 13% IR on July 3, 1996, but stated in his narrative that claimant had not appeared for examination, twice, so he used range of motion figures from an exam done in 1995.) The hearing officer's decision to assign presumptive weight to the latter of Dr. B's IR's, which included an examination at the time the IR was provided, is sufficiently supported by the evidence and that latter IR of 11% is not contrary to the great weight of other medical evidence. As stated, there is no medical evidence that the IR should be 15% as requested by claimant.

Finding that the decision and order are sufficiently supported by the evidence, we affirm. *See* In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

Joe Sebesta
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Christopher L. Rhodes
Appeals Judge