APPEAL NO. 990016

Following a contested case hearing (CCH) held on December 9, 1998, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer, resolved the disputed issues by determining that the respondent (claimant) sustained a compensable injury to her left shoulder, lower back, and left knee in addition to the injury to her right upper thigh and both shins on _____, and that she had disability from May 13 through May 14, 1998, and from June 8, 1998, through the date of the hearing. The appellant (carrier) has appealed these determinations for insufficiency of the supporting evidence. The file does not contain a response from claimant.

DECISION

Affirmed.

The parties stipulated that claimant sustained a compensable injury to both shins and bruised her upper thigh on _____ (all dates are in 1998 unless otherwise stated).

Claimant testified that she has worked as a nursing assistant for 13 years; that she became employed by (employer) in October 1997 and was assigned to work at (the clinic) as a unit clerk in the patient file room; and that on _____ a wheel came off a buggy loaded with x-ray files she was pushing, the buggy tipped over, and she tripped over it and fell to the floor and "hit everything," mostly on the left side. She said she reported the incident and was seen at the clinic's urgent care department where she only complained of her shins and upper thigh because they were "stinging at that time" and that the doctor at the clinic took her off work for the remainder of her shift and for the following day. The clinic record of _____ stated the diagnosis as contusions of both shins and right upper thigh. Claimant indicated that she later began to experience pain in her left shoulder, the left side of her back, the left knee, and the buttocks. Claimant said she was next off work for two days, to attend a family funeral; that when she returned to work, she did not go to the occupational clinic on May 18th because she had been told she had missed too much work and would be let go if she missed any more; that she was "harassed" for attending a job fair at the clinic; that she resigned from the clinic assignment; and that she informed the employer that she was not available for another assignment because of her pain. She stated that she was referred to Dr. G by her attorney; that Dr. G took her off work because of her pain and stiffness when she first saw him on June 8th; and that Dr. G has not released her to return to work.

Dr. G's June 8th report recites the history of claimant's fall over the x-ray cart; states the diagnosis as lumbar sprain, internal derangement of left shoulder, and internal derangement of left knee; and indicates a course of conservative treatment. In evidence is Dr. G's June 19th report stating that claimant will be disabled from work for six months. Another June 19th report added to the diagnosis probable torn meniscus and rule out lumbar herniated nucleus pulposus (HNP). Also in evidence are several work status reports of Dr. G keeping claimant off work from July 13th through December 29th. Dr. G's

July 13th report indicated that an MRI of the left knee had been requested because claimant was still very symptomatic. Dr. G's October 27th report states the diagnosis as lumbar strain versus lumbar HNP, rule out impingement syndrome versus rotator cuff of the left shoulder, and internal derangement of the left knee, rule out meniscal tear. At the hearing, the carrier expressly offered the MRI to claimant, who did not accept it, asking why the offer was being made "after all this time."

Claimant further testified that at the suggestion of a Texas Department of Human Services representative, she resigned, on June 3rd, from employment with the employer so as to qualify for family aid benefits because she had no income after leaving the clinic job and was not well enough to take another assignment from the employer. Claimant further testified that, presently, her shins, right knee, and shoulder are okay but that she continues to have pain, though reduced and intermittent, in her low back as well as pain in her left knee.

Ms. PD testified that she is the employer's human resources manager; that claimant only mentioned her shins and thigh when she called to report the accident; that on May 21st, Ms. AD of the clinic called and asked that claimant be relieved of her assignment for excessive absences and attending the clinic's job fair; and that she called claimant on May 21st, relieved her of her assignment, and asked her to come to the employer's office for computer skills testing and that claimant never mentioned her injury during that conversation. Ms. PD further stated that claimant came in on May 26th and said she was sore but did not say she could not accept a new work assignment and, in fact, said she needed work. She said that while there, claimant picked up her child without apparent difficulty, was not limping, and did not ask to see a doctor. Ms. PD further stated that on July 1st, claimant called to say she needed a letter of resignation for family aid benefits.

Claimant's June 16th Employee's Notice of Injury or Occupational Disease and Claim for Compensation (TWCC-41) states that the injury included her low back, entire left side of body, both knees, and both shins. The carrier's Payment of Compensation or Notice of Refused or Disputed Claim (TWCC-21), dated June 26th, accepted only the thigh and leg.

The August 26th report of Dr. P, who examined claimant for the carrier, stated the diagnosis as left shoulder strain/contusion, lumbar spine strain, and left knee contusion and he commented on evidence of somatization and the absence of objective evidence of left knee structural damage. Dr. P's August 31st Report of Medical Evaluation (TWCC-69) certified that claimant reached maximum medical improvement (MMI) on August 26th with an impairment rating of "0%." On October 16th, Dr. P wrote that claimant may well have had the onset of pain about the regions of her shoulder, lower back and knee, that her description of the injury is compatible with the areas of her complaints, and that there has been "no marked injury" demonstrated in any of these areas to date.

The October 23rd report of Dr. D, the designated doctor, stated the diagnosis as lumbosacral strain, resolving, and internal derangement of the left knee. He further stated that claimant is improving significantly, that her previous left shoulder difficulty is now

nonexistent, that she is not having any problem with her hands, and that she does have a positive "McMurray's" in the left knee and needs an MRI. He opined that claimant has not reached MMI.

On November 9th, Dr. P responded "no" to carrier questions asking whether on August 26th he had seen any objective evidence of an injury to claimant's left shoulder, lower back, right knee, and left knee and to whether he had seen objective evidence of any condition which would prevent claimant from working.

The scope of claimant's _____ injury, beyond the injury to the shins and thigh which the carrier accepted, was a question of fact for the hearing officer to resolve. The hearing officer is the sole judge of the weight and credibility of the evidence (Section 410.165(a)) and, as the trier of fact, resolves the conflicts and inconsistencies in the evidence including the medical evidence (Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ)). The hearing officer found that on _____, while in the course and scope of her employment, claimant sustained an injury to her left shoulder, left knee, and low back, in addition to contusions to both shins and her thigh, and that due to this injury, she was unable to obtain and retain employment at wages equivalent to her preinjury wage beginning on May 13th through May 14th and from June 8th to the present (CCH date). We are satisfied that these findings are not so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). It is well settled that as a general rule, a claimant's testimony alone may be sufficient to prove both a compensable injury and disability. The hearing officer could credit not only claimant's testimony but the corroboration evident in the medical records.

The decision and order of the hearing officer are affirmed.

_____
Philip F. O'Neill
Appeals Judge

CONCUR:

_____
Susan M. Kelley
Appeals Judge

_____
Thomas A. Knapp
Appeals Judge