APPEAL NO. 990043

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on November 10, 1998. He determined that the appellant (claimant) sustained a compensable laceration injury above the left eye on _____; that the compensable injury did not include a left forehead, left shoulder, chest, neck, upper back, left hand, left forearm, left hip, and left leg injury; and that the claimant did not have disability due to the compensable laceration injury. The claimant appeals the adverse determinations, contending that they are against the great weight and preponderance of the evidence. The respondent (self-insured) replies that the decision is correct, supported by sufficient evidence, and should be affirmed.

DECISION

Affirmed.

The claimant worked as a firefighter for the self-insured. He testified that he was on duty asleep at the firehouse on _____, when he woke to go to the bathroom. As he walked to the bathroom in the dark, he said, he stubbed his toe on a bedpost. This propelled him forwards and he fell on his left arm and forehead. He said he felt pain in his arm, head, and neck. He crawled to the bathroom where he noticed blood on both sides of his face and felt nauseous. He further testified that he had been suffering from an upper respiratory infection and a large loss of bodily fluids. After the fall, he said, he became dizzy and began seeing double. An ambulance was called and transported him to an emergency room (ER).

The ambulance report reflects complaints on the left side of the neck. ER records reflect complaints of headache, neck and chest pain. Dr. J, the attending physician and later the treating doctor, diagnosed a syncopal episode.[1] Cardiology and neurology consultations were obtained the same day. Dr. F, the cardiologist, reported normal sinus rhythm and doubted that the fall was syncopal. He also noted some nonspecific changes in the claimant's electrocardiogram. Dr. G, the neurologist, reported a normal brain CT scan with neck discomfort. His impression was coronary artery disease with posterior myocardial infarction "per cardiology" and "recent fall with hypotensive event" secondary to the coronary artery disease and myocardial infarction. The claimant was discharged from the hospital on April 21, 1996, with a diagnosis of myocardial infarction and cerebral stroke.[2] On May 15, 1996, the self-insured filed a Payment of Compensation or Notice of Refused or Disputed Claim (TWCC-21) in which it disputed this claim on the basis that the fall was caused by "heart problems" and was not in the course and scope of employment.[3]

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[1]The meaning of other entries on this report was not apparent.

[2]The claimant did not contend that either of these conditions was compensable.

[3]An Employee's Notice of Injury or Occupational Disease and Claim for Compensation (TWCC-41) stating the nature and extent of the claimed injury was not in evidence. The Employer's First Report of Injury or Illness

According to the claimant and the testimony of his wife, the claimant complained repeatedly to Dr. J about a swollen left hand and painful forearm, but Dr. J provided no treatment for this condition, nor did he mention it in his medical records. The claimant has not worked since the injury and retired on July 31, 1997.

It was not clear from the evidence what transpired from the date of the claimant's discharge from the hospital (other than angioplasty in May 1996) until approximately one year later on April 18, 1997, when the claimant submitted to an independent medical examination by Dr. V. In his report of this date, Dr. V stated that the purpose of his examination was "to determine if the claimant suffered a stroke which caused his fall on _____ or if the claimant's fall . . . caused a stroke or brain injury." The report mentions the eyebrow laceration, and that the claimant's history reflected that he "hit the concrete floor with the left side of his face and left arm. His neck popped back." None of the other injuries now claimed to have been caused by the fall are addressed. In Dr. V's opinion, "there is very little medical evidence that suggests that the cerebella injury is a direct result of his fall. . . . The MRI findings as well as [claimant's] presentation, however, do strongly suggest that he suffered an acute cerebellar accident on or around _____. This cerebellar vascular accident was more likely a result of a hypertensive event resulting from his myocardial ischemic/infarction rather than a direct result of his fall."

The claimant then saw Dr. M, D.C., beginning July 16, 1997. He reported the "most dominant symptom is dull, aching, spastic and throbbing pain in the upper back on the left side" that radiated into the left arm and hand. The claimant also reported low back pain on the left, left hand pain, and headaches. In a report of September 23, 1997, Dr. M diagnosed lumbar sprain/strain, neck sprain/strain, brachial neuritis or radiculitis, muscle spasm, and wrist sprain/strain and concluded that "this injury is consistent with the nature of the accident that the patient has suffered." Dr. M wrote a letter on June 8, 1998, "to explain the sequence of events preceding [claimant's] workers' compensation injury of 4/11/96." He found that "based on all information reviewed [claimant] fell as a result of tripping over the corner of a bed, which secondarily caused the so called heart attack . . . or stroke." He felt that the claimant's testimony "should be enough to process this claim." Dr. M also testified at the CCH that the claimant's wrist trauma was left untreated for a year; by then scar tissue built up; and this caused the wrist to heal improperly locking it in the wrong position. He further said that in reaching his conclusions, he did not review any other medical reports. He felt that the claimant's lumbar and neck sprains had resolved and that the claimant on occasion still has radiculitis.

The claimant had the burden of proving that he sustained the claimed injuries. Johnson v. Employers Reinsurance Corporation, 351 S.W.2d 936 (Tex. Civ. App.-Texarkana 1961, no writ). Whether he did so was a question of fact for the hearing officer to decide. Texas Workers' Compensation Commission Appeal No. 93449, decided July 21, 1993. The claimant's testimony at the CCH was devoted almost exclusively to his claimed left hand and forearm injury, with little if any discussion of the other claimed injuries. The

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(TWCC-1) described the compensable injury as an eyebrow laceration.

hearing officer considered the evidence and determined that the claimant established only a compensable eyebrow laceration as a result of the fall on _____. Although the claimant insisted that he repeatedly mentioned his swollen left hand to Dr. J, Dr. J did not treat or address this condition, and there is no mention of this complaint in Dr. J's records. This and the other alleged injuries are discussed for the first time by Dr. M in his report a year later. Dr. M admitted that in reaching his opinion on causation, he was relying solely on the history given him by the claimant. Although arguably the claimant's testimony alone, if found credible, would have been sufficient to establish the claimed injuries, the hearing officer could still properly look to the existence of confirming medical evidence, particularly where, as here, there was a year-long gap in the medical records and no mention of these injuries until Dr. M's examination of the claimant. *See* Texas Workers' Compensation Commission Appeal No. 941303, decided November 10, 1994. On appeal, the claimant argues that his evidence met his burden of proof and established the compensability of the claimed injuries. Pursuant to Section 410.165(a), the hearing officer is the sole judge of the weight and credibility of the evidence. In his role as fact finder, the hearing officer could accept or reject in whole or in part any of the evidence. Texas Workers' Compensation Commission Appeal No. 93819, decided October 28, 1993. He did not find the claimant or Dr. M persuasive in attributing all the claimed injuries to the claimant's fall. We will reverse a factual determination of a hearing officer only if that determination is so against the great weight and preponderance 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, 635 (Tex. 1986). Applying this standard of review to the record of this case, we decline to substitute our opinion of the credibility of the respective witnesses for that of the hearing officer. Rather, we find the evidence sufficient to support the determination of the hearing officer that the claimant's compensable injury included only a laceration of the left eyebrow.

The claimant also had the burden of proving disability. Disability is defined as the "inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage." Section 401.011(16). This too was a question of fact for the hearing officer to decide and could be proved by the claimant's testimony alone if deemed credible. Texas Workers' Compensation Commission Appeal No. 93560, decided August 19, 1993. The hearing officer considered the evidence and did not conclude that the eyebrow laceration caused any disability. He further noted, as the claimant conceded, that no doctor, not even Dr. M, issued any off-work statements. Dr. M explained this by saying he did not realize he should. In any case, the hearing officer apparently concluded that the nature of the compensable injury was slight and did not cause disability. Under our standard of review, we affirm this determination.

For the foregoing reasons, we affirm the decision and order of the hearing officer.

_____
Alan C. Ernst
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

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Gary L. Kilgore
Appeals Judge