APPEAL NO. 990218

Following a contested case hearing (CCH) held in Fort Worth, Texas, on December 12, 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 appellant (claimant) is not entitled to supplemental income benefits for the 15th and 16th compensable quarters. Claimant has appealed these determinations, asserting that the medical evidence established that he had no ability to work during the filing periods for these quarters. The respondent (carrier) urges in response that the evidence is sufficient to support the appealed findings and conclusions.

DECISION

Affirmed.

The parties stipulated that on _____, while employed by (employer), claimant sustained a compensable injury; that he has a 15% impairment rating and commuted no portion of his impairment income benefits; and that the filing periods for the 15th and 16th quarters were, respectively, from March 21 to June 19, 1998, and from June 20 to September 18, 1998.

The following findings of fact have not been appealed and have become final by operation of law (Section 410.169): that claimant did not return to work during the relevant filing periods and did not seek employment; that claimant did not contact the Texas Workforce Commission or the Texas Rehabilitation Commission during the relevant filing periods; that claimant alleged he had no ability to work due to pain, emotional problems, and inability to concentrate; that in a typical day, claimant gets up at 9:00 a.m., eats breakfast, and sits to watch TV for six to eight hours; that claimant has not considered part-time employment "because he does not tolerate people very well"; that claimant is presently receiving Social Security disability benefits and is fully aware that those benefits would end if he returns to work; that claimant has not discussed going back to work with his doctors; that at the CCH, claimant alleged that he must use a cane for ambulation; that a video surveillance tape of claimant (filmed on June 11, 1998) shows that claimant is capable of ambulating without a cane, able to bend at the waist, and able to check a riding lawnmower while resting on his right knee; that claimant drives himself to therapy and drove himself to the CCH (a one-hour drive); that on January 29, 1998, claimant underwent a functional capacity evaluation (FCE) which showed he is capable of performing "medium-duty" level work with restrictions; that claimant sustained a very serious injury with long-lasting physical effects; and that during the relevant filing periods, claimant did not return to work as a direct result of his impairment.

Claimant testified that he worked for the employer as an aircraft assembler from 1985 until he was injured on _____, when he pushed on a heavy workbench weighing

approximately 1,000 pounds; that prior to that time he was an aircraft mechanic in the Navy for 12 years; that he has not worked since May 1, 1992; that he is a high school graduate; that he had a prior work-related injury in 1990 for which he had a one-level cervical fusion procedure; that he has low back pain which radiates into his left leg for which he takes pain medication which has side effects; that on an average day his pain level is a six to seven on a 10-point scale; and that in February 1998 he was recommended by his current treating doctor, Dr. AD, for participation in Dr. V multi-discipline pain management program, which was to include psychological counseling, but the carrier did not authorize it. Claimant further testified that he has depression and anxiety, for which he takes medication, but no longer sees a psychologist since Dr. L stopped seeing workers' compensation patients. Dr. L's report requesting reconsideration of the denial of additional individual therapy sessions is dated January 23, 1995. Claimant further stated that he has no self-esteem owing to his inability to do the things he used to do and has no quality of life due to his pain and depression; that he attempted suicide in 1993 and since his injury has had four marriages and three divorces, and that he does not socialize because he "can't deal with people any more." He further stated that in a typical day, he arises at 9:00 a.m., after his wife has gone to work and eats breakfast prepared by his mother-in-law; sits in a recliner chair and watches TV; and occasionally goes outside for fresh air. He said his wife and parents-in-law take care of the house. He acknowledged that he can drive. He also acknowledged receiving Social Security disability benefits which he calculated to equate to $5.73 an hour and said he would lose those benefits if he returned to work. Claimant maintained that he cannot perform any type of work because of his pain and depression, asserting that both Dr. D and Dr. V have opined to that effect. He said he did not even consider part-time work because of his pain and psychological frame of mind, stating "I don't tolerate people very well."

Claimant's medical records reflect that on January 27, 1995, he underwent "an uncomplicated micro discectomy L4-5 left" by Dr. B and that his final diagnosis included bulging degenerated/ruptured disc L4-5 left; hysterics; inadequate personality; and narcotic-seeking behavior.

The January 29, 1998, FCE report of Dr. S noted claimant's normal gait while ambulating as well as his having a limping gait and walking with a cane and stated that the Arcon isometric lift stations revealed mostly valid studies and good effort by claimant which would recommend a medium-duty-return-to-work level with a 50-pound maximum weight lift and frequent carrying of objects weighing 25 pounds. Dr. S further reported that the dynamic portion was more difficult for claimant to be fully cooperative and the results were mostly invalid. He stated that bending and stooping should be limited to one to two hours per day; that operating heavy machinery, high torque tools, or vibratory tools is contraindicated; and that claimant may return to work subject to the restrictions.

Dr. AD wrote on April 3, 1998, that he received a letter from Dr. S stating that he feels that claimant can return to medium duty. Dr. AD said it is his clinical opinion that claimant's return to work is impossible based on his knowledge of claimant's inability to sit

or stand for any length of time and poor attention span secondary to his use of narcotic analgesics. He said that claimant is totally disabled and he doubts claimant will ever return to the workforce.

A June 5, 1998, lumbar spine MRI report stated that there was no evidence of acute or recurrent disc herniation, but there was moderate annular bulging and posterior spurring at the L2-3 level and mild left ventral epidural fibrosis at the L4-5 level

A quite brief July 11, 1998, surveillance video shows claimant in a yard bending over at the waist, getting down on his hands and knees and doing something with a riding lawnmower, and rising again. He is also seen walking around without a cane and carrying a garden hose.

An August 11, 1998, FCE report, signed by three physical therapists, stated that claimant had a cervical fusion at C5-6 in September 1991 (apparently for his 1990 injury) as well as the laminectomy and discectomy at L4-5 by Dr. B; that claimant had physical therapy from January to June 1997 as well as injections; that functional assessment reveals material handling tolerances are consistent with a sedentary work classification category; and that claimant was not even capable of lifting an 11-pound box from knuckle to shoulder level. The report further stated that it is expected that claimant will not be able to return to a sedentary-level position at this time and that he is restricted to approximately 10-15 minutes of sitting, five minutes of standing, and less than 0.1 mile or one minute of walking. The report concluded that claimant "is not even able to perform at a sedentary level due to the complications associated with his injury and his inability to tolerate any portion of the work capacity evaluation."

According to the August 18, 1998, report of Dr. PD, claimant was referred to him by a Texas Workers' Compensation Commission benefit review officer for a required medical examination (RME). Dr. PD's report contained an extensive overview of claimant's post-injury treatment and stated the impression as chronic post-surgical low back pain syndrome; nonorganic psychological overlay with symptom magnification; and psychiatric documentation of personality disorder with passive/ aggressive and histrionic features. Dr. D twice commented on claimant's sitting comfortably in a chair throughout the interview. Dr. D noted that his review of the FCEs of January 29 and August 11, 1998, showed a marked discrepancy in lifting capacity and that there was a discrepancy in claimant's sitting time at the later FCE and at Dr. D's interview. He felt that the discrepancy "primarily is due to overlying psychological factors with an increased perceived level of pain," and that "symptom magnification was obscuring any attempt at objective testing by FCE." Based on his own observation of claimant during the history taking and physical examination, Dr. PD felt that claimant "would at least be able to tolerate a sedentary type job where he could work at waist level" with sitting for no more than 30 minutes before being able to take five-minute stretching breaks. Dr. D concluded that claimant "is not totally disabled but can perform limited gainful employment, most likely in a sedentary type category."

Dr. AD wrote on October 13, 1998, that while he agreed with Dr. PD that claimant does have some psychiatric problems leading to psychological overlay, he does dispute that claimant "is employable." Dr. AD stated further that he would never employ claimant, cannot imagine that anyone else would employ him with these problems, and regards him as "the living definition of disability" who should be retired.

In closing argument, the carrier's representative asked the hearing officer to observe that claimant sat as a witness for approximately 40 minutes, only twice changing position, and sat at the hearing for an even longer period. However, this information was not adduced into the hearing record as evidence.

The Appeals Panel has held in Texas Workers' Compensation Commission Appeal No. 931147, decided February 3, 1994, that if an employee established that he or she has no ability to work at all, then seeking employment in good faith commensurate with this inability to work "would be not to seek work at all." Under these circumstances, a good faith job search is "equivalent to no job search at all." Texas Workers' Compensation Commission Appeal No. 950581, decided May 30, 1995. The burden of establishing no ability to work at all is "firmly on the claimant," Texas Workers' Compensation Commission Appeal No. 941382, decided November 28, 1994, and a finding of no ability to work must be based on medical evidence or "be so obvious as to be irrefutable." Texas Workers' Compensation Commission Appeal No. 950173, decided March 17, 1995. *See also* Texas Workers' Compensation Commission Appeal No. 941332, decided November 17, 1994. A claimed inability to work is to be "judged against employment generally, not just the previous job where the injury occurred." Texas Workers' Compensation Commission Appeal No. 941334, decided November 18, 1994. The absence of a doctor's release to return to work does not in itself relieve the injured worker of the good faith requirement to look for employment, but may be subject to varying inferences. Appeal No. 941382, *supra*. Whether a claimant has no ability to work at all is essentially a question of fact for the hearing officer to decide. Texas Workers' Compensation Commission Appeal No. 941154, decided October 10, 1994.

In addition to the dispositive legal conclusions, claimant appeals factual findings that he underwent a second FCE on August 18, 1998, which shows he is capable of performing sedentary-type work; that he had some ability to work with restrictions; and that during the relevant filing periods, claimant did not attempt in good faith to obtain employment commensurate with his ability to work.

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)). As an appellate reviewing tribunal, the Appeals Panel will not disturb the challenged factual findings of a hearing officer unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust and we do not find them so in this

case. While Dr. PD's examination of August 18th might be more correctly described as an RME than as an FCE, we do not regard the substance of the finding itself to be inadequately supported by the evidence. The hearing officer could credit the opinions of Dr. S and Dr. PD that claimant had some ability to work, albeit Dr. S's January 28, 1998, report preceded the March 21, 1998, 15th quarter filing period by nearly two months.

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Gary L. Kilgore
Appeals Judge

Tommy W. Lueders
Appeals Judge