APPEAL NO. 990269

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On January 11, 1999, a hearing was held. He (hearing officer) determined that the initial impairment rating (IR) of seven percent provided to appellant (claimant) by Dr. S dated February 13, 1997, became final under the provisions of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)). Claimant asserts that she did not receive treatment for her neck and questions the hearing officer's ability to make a "fair judgment." Respondent (carrier) replied that the decision should be affirmed, stating that claimant's comments about the hearing officer were "inappropriate."

DECISION

We affirm.

Claimant testified that she slipped and fell while working for (employer) on _____, injuring her right shoulder and neck. She began medical treatment with Dr. H in January 1995. The initial IR in question was performed in February 1997 by Dr. S after Dr. H referred claimant to him for an IR.

The parties stipulated that claimant sustained a compensable injury on _____, that Dr. S's IR of seven percent, signed on February 13, 1997, was the first IR provided claimant, that claimant received written notice from the Texas Workers' Compensation Commission on February 28, 1997, and that claimant disputed the initial IR on July 25, 1997.

Claimant's appeal states that Dr. H did not do any "real testing" until after she saw Dr. S. We will consider claimant's appeal to be that she received inadequate medical care and that her condition at C6-7, where surgery was performed in March 1998, was misdiagnosed. Medical exhibits claimant provided begin in June 1997 after her examination by Dr. S. None of these medical documents contain any language that could be considered critical of the initial IR, or indicative of inadequate treatment or a misdiagnosis. On the contrary, Dr. R, on July 23, 1997, wrote that he first saw claimant in April 1996, for persistent neck and shoulder symptoms. He then stated, "she was appropriately evaulated and worked up, including cervical epidural steroid injection, physical therapy, EMG, and selective nerve root block at C7." Dr. R's next sentence continued the thought by saying, "at this point, it was clear that she needed a C6-7 disc evaluated with discography . . . (h)er MRI scan did reveal a small disc herniation at C6-7." Dr. R then said he tried to get approval for a discogram but it was denied. He next said, "(t)he patient then was referred to a neurosurgeon, [Dr. G], in June 97, six months since her last visit with me . . . . " Dr. R then indicated that Dr. G also recommended a discogram. Writing this letter in July 1997, Dr. R said that he is now claimant's treating doctor, and as such, he was requesting a discogram.

Dr. R's comments provide corroboration for Dr. S's reference to a cervical MRI that was in existence prior to one made in June 1997. Claimant testified that there was no MRI made before she saw Dr. S in February 1997, but Dr. S referred to a cervical MRI, provided on August 16, 1996, and Dr. R referred to a cervical MRI showing a small C6-7 disc herniation as the basis for his past attempt to get a discogram approved. Dr. R, as stated, next said that claimant "then" was referred to Dr. G in June 1997, "six months since her last visit with me." (Dr. R in effect said that he had last seen claimant in December 1996 or January 1997--we note that his recitation of events includes references to MRI testing having been done and cervical injections having been provided as of that time in December 1996 or January 1997.)

As Dr. R stated, claimant was referred to Dr. G in June 1997. Dr. G noted at that time that claimant had received epidural injections for her neck pain. He noted neck range of motion (ROM) to be good, with an unremarkable sensory exam and a normal motor exam. He then summed up by saying, "this is a difficult case with no clear etiology of her pain. Her MRI scan does show a bulging disc at C6-7, which may be causing discogenic type pain." (Emphasis added.) Dr. G also called for a discogram.

Dr. S, in his report provided in February 1997, states that statutory maximum medical improvement was reached on January 12, 1997. He noted the injuries to her shoulder and neck, specifically alluding to a cervical MRI conducted in August 1996 which "revealed a small central and left disc herniation at C6-7." Dr. S then referred to trigger point injections by Dr. H and epidural injections by Dr. R. He added that his office also did electrodiagnostic studies on the day of the examination which showed no abnormality. Her cervical ROM was within normal limits. There was some shoulder ROM limitations. He assigned four percent IR for minimal cervical degenerative changes and three percent for the shoulder ROM. Dr. S did not think that claimant would improve with surgery. (Surgery at C6-7 was performed in March 1998; medical records thereafter do indicate that it improved claimant's condition.)

The hearing officer is the sole judge of the weight and credibility of the evidence. *See* Section 410.165. With the absence of any medical opinion indicating a misdiagnosis or inadequate treatment having occurred prior to or at the time claimant was seen by Dr. S, and with the information provided by Dr. S, Dr. G, and Dr. R, the hearing officer was provided sufficient evidence to conclude in his Statement of Evidence and Findings of Fact that claimant did not receive improper or inadequate treatment and that there was no clear misdiagnosis. With the parties stipulating claimant's date of receipt of the IR and her subsequent dispute to be over 90 days later, the only requirements set forth by Rule 130.5(e) were met.

Factual determinations are the responsibility of the hearing officer. The Appeals Panel will not overturn a hearing officer's factual determinations, such as that inadequate care and misdiagnosis were not shown, unless those determinations are against the great weight and preponderance of the evidence. As stated hereafter, those determinations were not against the great weight and preponderance of the evidence.

Claimant's appeal primarily addresses what she considers to be the hearing officer's conduct, described as "rude." She states he is "not capable of making fair judgments." Our review of the record, including claimant's testimony and the medical records, does not point to sufficient evidence to support a decision in claimant's favor, had one been made, that would have been affirmed on appeal. Whether or not claimant perceived rudeness, the record does not show that any rudeness, or other allegation against the hearing officer, resulted in a determination that was improper since the determination followed the evidence presented in this case. The determination that the initial IR became final is sufficiently supported by the evidence.

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:

_____
Robert W. Potts
Appeals Judge

_____
Tommy W. Lueders
Appeals Judge