APPEAL NO. 990916

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 April 7, 1999. The issues concerned whether the appellant, who is the claimant, reached maximum medical improvement (MMI) and, if so, the date and the amount of the claimant's impairment rating (IR). In addition, there were issues as to whether the respondent (self-insured or carrier) waived the right to dispute toe amputations that were conducted and whether the compensable injury extended to and included amputations of four toes of the left foot.

The hearing officer held that the carrier had timely contested the toe amputations within 60 days after it received notice and that the claimant had four toes amputated as a result of the progression of diabetes, an ordinary disease of life, rather than his compensable foot injury of _____. The hearing officer held that the claimant reached MMI on July 29, 1996, with a one percent IR, according to the report of the designated doctor, which was not overcome by the great weight of the contrary medical evidence.

The claimant argues that he proved his case and the doctors who rendered opinions in his behalf would not have risked their reputations by being untruthful. The claimant also argues that he faxed a medical report to the carrier well ahead of the date that the hearing officer determined that the carrier had notice of the amputations. The carrier responds, urging affirmance.

DECISION

Affirmed.

At the beginning, we note that the issue concerning the claimant's extent of injury to his toes, the amputation of which occurred, and the waiver issue are somewhat incorrectly worded. An amputation done for medical reasons represents a form of medical treatment; the "injury" in question was the infection that claimant argued resulted in amputation. Therefore, we will analyze the waiver issue and extent-of-injury issue, not in terms of the treatment rendered, but the injury (infection) thus addressed.

The claimant was working for the self-insured on _____, taking down (fair) kiosks and displays, when he stepped on a nail. Medical records reflect that the claimant had a small piece of wire removed from his left foot and a subsequent infection developed. The claimant agreed that he has had diabetes since 1970 and had been relying on insulin, off and on, since 1993. After development of his infection, his third toe was amputated. Medical records also indicate he had peripheral neuropathy.

Claimant's treating doctor until sometime in March 1997 was Dr. G, a podiatrist. Dr. G's January 23, 1996, note states that the claimant has a well-healed wound on his left foot, post amputation. However, on February 28, 1996, Dr. G noted that both feet had pre-

ulcerative breakdowns. On March 11, 1996, a CCH was held after dispute to the compensability of his 1995 foot injury, and the injury and subsequent infection were found to be compensable. The self-insured did not file a timely appeal and the hearing officer in the hearing on appeal here accepted as compensable the extent of injury at the time of that previous CCH. On July 29, 1996, Dr. M, whose Report of Medical Evaluation (TWCC-69) stated that he was a designated doctor, certified that claimant had reached MMI on that date with a one percent IR (following assessment of a similar IR by Dr. C in June 1996). Dr. M's narrative states that he noted only a large callous on claimant's left foot. No infection is noted.

Claimant said he had been terminated and used all his sick leave and, as a result, he believed he was no longer eligible for insurance benefits, including workers' compensation. He also wanted to treat his diabetes more directly. He therefore began treatment in August 1996 through the (university health center). This was paid for by the (Administration), so the self-insured no longer was receiving bills. On March 3, 1997, Dr. D noted that claimant was being treated for chronic pedal ulcerations secondary to peripheral neuropathy and residual foot deformities. According to the claimant, the wound on his left foot never properly healed and the doctors at the university health center decided that the way to heal his foot was to amputate the remaining toes. Dr. D's letter refers to the foot condition as neuropathic ulceration which would heal and then subsequently recur. On May 12, 1998, Dr. H, a professor at the university health center, wrote that claimant's ulceration and infection resulted from the loss of his third toe and subsequent increased weight bearing under the second, fourth, and fifth metatarsals. Dr. H noted that the residual left foot problems could clearly have developed from his diabetes and foot structure alone, but had been facilitated by loss of the third toe. Dr. H's letter refers to a present infection but does not indicate that an amputation had been accomplished at that point.

The medical records also indicate that the claimant was treated for depression resulting from toe amputation, with hospitalization for treatment in October and November 1997. The date of the removal of the other toes was not clearly developed, with claimant testifying that they were removed in September 1996 (not borne out by medical record), but it appears that claimant also had a right fifth toe amputation in August 1998.

The adjuster testified that the first that the carrier knew of additional problems with claimant's left foot was at a benefit review conference (BRC) on August 19, 1998. The claimant asserted that he claimed the other four toes to the carrier following their amputation. We note that the letter from Dr. H was stamped as received by the carrier on August 19, 1998. Claimant argues that the "fax" line at the top of this letter shows that it was sent to the carrier in May 1998, but it appears that the line on the copy in evidence shows that it was received by an orthopedics and podiatry clinic on July 6, 1998. The carrier disputed the compensability of the four additional toes on August 31, 1998, and refers to that amputation as "recent."

The hearing officer is the sole judge of the relevance, the materiality, weight, and credibility of the evidence presented at the hearing. Section 410.165(a). The decision

should not be set aside because different inferences and conclusions may be drawn upon review, even when the record contains evidence that would lend itself to different inferences. Garza v. Commercial Insurance Company of Newark, New Jersey, 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). It was for the hearing officer, as trier of fact, to resolve the inconsistencies and conflicts in the evidence. Garza, *supra*. This is equally true of medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286, 290 (Tex. App.-Houston [14th Dist.] 1984, no writ). An appeals level body is not a fact finder, and does not normally pass upon the credibility of witnesses or substitute its own judgment for that of the trier of fact, even if the evidence would support a different result. National Union Fire Insurance Company of Pittsburgh, Pennsylvania v. Soto, 819 S.W.2d 619, 620 (Tex. App.- El Paso 1991, writ denied); American Motorists Insurance Co. v. Volentine, 867 S.W.2d 170 (Tex. App.- Beaumont 1993, no writ). In this case, the hearing officer need not believe a medical witness is not credible, but may ascertain from the totality of evidence that development of an infection or condition which is sought to be included as part of the injury represents a natural progression of a disease such as diabetes, rather than of the injury itself. While the opinion of Dr. H could support compensability, it equally supports the finding that the infection leading to amputation of toes arose from the diabetes, rather than the original compensable puncture injury. The break between the infection from the injury and that which developed later can be supported by Dr. G's January 1996 report, as well as the counterpart infection in the right foot. We cannot agree that the hearing officer's determination on extent of injury, and the dependent determination as to MMI and IR, are against the great weight and preponderance of the evidence.

Given that the claimant agreed that his medical treatments were being paid through financial sources other than the workers' compensation carrier, it was up to the claimant to prove that the carrier received written notice of the injury and that the carrier did not timely react to dispute it. The claimant agreed that he first notified the carrier after the amputation. The adjuster indicated that this occurred at the BRC on August 19, 1998. There was no development of evidence as to why the BRC was convened. Given the record here, we cannot agree that the hearing officer's determination that there was no waiver is not supported.

For these reasons, we affirm the hearing officer's decision and order.

_____
Susan M. Kelley
Appeals Judge

CONCUR:

_____
Robert W. Potts
Appeals Judge

_____
Thomas A. Knapp
Appeals Judge