APPEAL NO. 991072

A contested case hearing (CCH) was originally held on February 2, 1999, under the provisions of the Texas Workers' Compensation Act, TEX. LAB CODE ANN. § 401.001 *et seq.* (1989 Act). The appellant (claimant) requested review and the record of the CCH was not received by the Appeals Panel. In Texas Workers' Compensation Commission Appeal No. 990544, decided April 29, 1999, the Appeals Panel reversed the decision of the hearing officer and remanded for the reconstruction of the record or the forwarding of the record if it was located. The record was located in the City field office and the hearing officer adopted his prior Decision and Order in its entirety without modifications. In that Decision and Order, the hearing officer determined that on April 14, 1998, Dr. W certified that the claimant reached maximum medical improvement (MMI) on April 14, 1998, with a one percent impairment rating (IR); that this was the first certification of MMI and IR; that the claimant received a copy of the first certification on April 28, 1998; that she did not dispute the first certification within 90 days of having received it; that Dr. W did not make a significant error or clear misdiagnosis in rendering the first certification; that the first certification of MMI and IR became final under the provisions of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)); and that the claimant reached MMI on April 14, 1998, with a one percent IR. The claimant again appealed, contending that Dr. W made a significant error or misdiagnosis and requesting that the Appeals Panel reverse the decision of the hearing officer. A response from the respondent (carrier) has not been received.

DECISION

We affirm.

The claimant testified that she injured her ankle on _____; that she went to an emergency room; that Dr. W became her treating doctor; that she told Dr. W that she was not getting better; that Dr. W had a bone scan and a CT scan performed; that Dr. W certified that she reached MMI on April 14, 1998, with a one percent IR; that the claimant received the report of Dr. W sometime in April 1998; that she again told Dr. W that she was not getting better; that Dr. W said that he did not know what was wrong with her foot and prescribed Relafen; that she tried to work in July 1998 and could not because of swelling and pain in her foot; that she changed treating doctors; that she was referred to Dr. A, an orthopedic surgeon, and an MRI was performed; and that Dr. A diagnosed a fracture and performed surgery on November 2, 1998.

In a Report of Medical Evaluation (TWCC-69) dated April 14, 1998, Dr. W certified that the claimant reached MMI on that day with a one percent IR. In an attachment to the TWCC-69, Dr. W states that on January 27, 1998, x-rays revealed an osteophyte on the posterior talus; that the claimant was prescribed anti-inflammatories and pain medication; that she was issued a side kick walker; that she was prescribed physical therapy; that on February 5, 1998, she continued to have pain in her left ankle; that she continued to use crutches and a side kick walker; that Dr. W diagnosed torn lateral collateral ligaments in her

left ankle; that on February 3, 1998, she continued to have pain, tenderness, and swelling in her ankle; that on March 13, 1998, a CAT scan revealed a small two-millimeter bone cyst at the superior corner of the left talus; that on March 21, 1998, the claimant received a nerve block for pain with good results; that on April 3, 1998, a bone scan was normal; and that on April 14, 1998, the claimant demonstrated ability to walk on heels and toes bilaterally, that she had decreased range of motion in the left ankle, and that she had reached MMI with a one percent IR.

A report from Dr. F dated January 21, 1998, stated that x-rays revealed a small punctate calcification or ossification distal to the lateral malleous, small calcaneal spurs, and no fracture. In an Initial Medical Report (TWCC-61) dated January 27, 1998, Dr. W said diagnosed torn ankle ligaments and said that repeat x-rays were performed to rule out a hairline fracture. An x-ray report dated the same day states that there are no fractures, that there was an osteophyte at the posterior talus, and that the assessment was torn left ankle ligaments. In a report of a CT study of the left ankle dated March 16, 1998, Dr. N states that his impression is no evidence for acute fracture or dislocation and a small two-millimeter bone cyst at the superior corner of the talus. In the report of a bone scan dated April 4, 1998, Dr. M says that the findings do not show findings suggesting a left foot stress fracture and that plain films would be helpful concerning a spur and degenerative change. An MRI was performed on October 8, 1998. Dr. H reported that her impression was "osteochondrosis desiccans medial talor dome without evidence for a free osteochondral defect," tendonitis, suggested degenerative change, and thickening of the ATAF ligament. Dr. A performed surgery on the claimant on November 2, 1998. In a letter to the carrier dated November 10, 1998, Dr. A stated that the claimant had surgery for curetage of a traumatic and degenerative cyst of her ankle and that, at surgery, he curetted the cyst, bone grafted it, and removed devitalized cartilage which was catching in the joint. In a report dated November 20, 1998, Dr. A stated that he performed a "debridement, curettage and bone graft of cystic degeneration of the osteochondral fracture on the medial aspect of the left ankle talar bone." He noted that the cyst was quite a bit bigger than it looked on the x-ray and MRI and was probably about 1.5 x 1.5 centimeters.

The hearing officer is the trier of fact and is the sole judge of the relevance and materiality of the evidence and of the weight and credibility to be given to the evidence. Section 410.165(a). The trier of fact may believe all, part, or none of any witness's testimony because the finder of fact judges the credibility of each and every witness, the weight to assign to each witness's testimony, and resolves conflicts and inconsistencies in the testimony. Taylor v. Lewis, 553 S.W.2d 153 (Tex. Civ. App.-Amarillo 1977, writ ref'd n.r.e.); Texas Workers' Compensation Commission Appeal No. 93426, decided July 5, 1993. This is equally true regarding medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). An appeals level body is not a fact finder, and it 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). The attachment to the TWCC-69 of Dr. W states that a CAT scan in March 1998 revealed a cyst

and the operative report of Dr. A reveals that surgery was on a cystic fracture. The hearing officer determined that the claimant failed to meet her burden of proof and did not establish the existence of significant error or clear misdiagnosis. That determination and the determination that the first certification of MMI and IR became final under the provisions of Rule 130.5(e) are not so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986). Since we find the evidence sufficient to support the determinations of the hearing officer, we will not substitute our judgment for his. Texas Workers' Compensation Commission Appeal No. 94044, decided February 17, 1994.

We affirm the decision and order of the hearing officer.

_____
Tommy W. Lueders
Appeals Judge

CONCUR:

_____
Robert W. Potts
Appeals Judge

_____
Dorian E. Ramirez
Appeals Judge