APPEAL NO. 991544

On June 16, 1999, a contested case hearing (CCH) was held. The CCH was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). The issues at the CCH were: (1) whether the respondent's (claimant) compensable injury sustained on _____, extends to include "the cervical, headaches and lumbar," and (2) whether appellant (carrier) waived its right to contest the compensability of the claimed injury by not contesting compensability within 60 days of being notified of the injury. Carrier requests that the hearing officer's decision that "claimant's compensable injury sustained on _____ does extend to include the cervical/ cervical sprain/strain; lumbar spine and post traumatic/cervicogenic headaches" be reversed and that a decision be rendered in its favor on that issue. There is no appeal of the hearing officer's decision that "carrier did not waive the right to contest the compensability of the claimed [cervical, headaches and lumbar] injury." No response was received from claimant.

DECISION

Affirmed.

The parties stipulated that claimant sustained a compensable injury on _____. Claimant's testimony was translated by a Spanish-speaking interpreter. Claimant's injury occurred when steel dropped from an overhead crane, hitting claimant in the head. Claimant was wearing a hard hat at the time of the accident. Claimant said he was knocked unconscious until he arrived at the hospital emergency room (ER). It is not disputed that the accident caused a laceration to the claimant's forehead, a laceration to his left thigh, and a fracture of the little finger of his right hand. Carrier accepted compensability for an injury to claimant's left leg, right little finger, and laceration to his forehead. Claimant said that the accident also caused injury to his neck and lower back and resulted in his headaches.

Claimant said that he told the ER doctor what body parts were hurt but that that doctor did not understand him. The ER doctor diagnosed a left thigh hematoma. The ER report does not mention claimant's neck, back, or headaches. Claimant was seen by Dr. FR on September 9, 1997, and Dr. FR noted claimant complained of pain in his head, hands, chest wall, and left thigh. Dr. FR noted that he took x-rays of claimant's skull, left leg, chest, and hands. Dr. FR noted that claimant had a fracture of his right little finger and multiple contusions of the body and that he sutured claimant's forehead laceration and his little finger laceration.

Claimant began treating with Dr. T on October 1, 1997, and Dr. T noted that claimant complained of pain in his little finger, left thigh, and left knee. Dr. T diagnosed claimant as having a laceration of the left quadriceps tendon, possible internal derangement of the left knee, and a stable fracture of the right little finger. Claimant said he told Dr. T about his

neck and back injury and about his headaches. He said that Dr. T speaks a little Spanish but may not have understood all of his complaints.

Claimant was examined by Dr. S on October 29, 1997, and Dr. S gave a date of injury of _____, and diagnosed claimant as having a traumatic head contusion, a laceration of the left frontal area, a cervical sprain/strain, and a left hip contusion and strain. In November 1997, Dr. S wrote that claimant had sustained traumatic injuries to his head, neck, lumbar spine, and left leg, and gave the date of injury as _____. Claimant said that Dr. S speaks Spanish and is his current treating doctor.

On November 19, 1997, Dr. T wrote that claimant complained to him on that day of headache, neck ache, face ache, left knee and thigh ache, back ache and pain in his little finger. Dr. T wrote that he was unable to explain claimant's multiple complaints.

Dr. S referred claimant to Dr. D, an orthopedic surgeon, who noted that claimant complained of headaches and of pain in his head, neck, left knee, and right little finger. Dr. D diagnosed claimant as having a tear of the left quadriceps muscles, a cerebral concussion, post-traumatic headaches, and a healed fracture of the right little finger.

In a letter dated February 24, 1998, the Texas Workers' Compensation Commission (Commission) informed claimant that he was scheduled for an examination with Dr. F with the stated purpose of the examination being "[a]re the claimant's complaints and/or conditions of the neck, low back and headaches causally related to the _____ compensable injury?" Dr. F examined claimant on March 17, 1998, and noted complaints of "headache, neck and right finger, low back and left knee pain." Dr. F wrote that in his opinion "any injury that his sufficiently severe enough to lacerate his face and to injury [sic] his hand and knee at the same time, one could expect that the force could be strong enough to cause his neck and back pain" and that he believed that "some of the delay in diagnosis is related to language barrier." Dr. F recommended that studies be done of claimant's neck and back. In a follow-up report dated August 20, 1998, Dr. F noted that he had reviewed the reports of Dr. RI of lumbar and cervical MRI scans done in April 1998 and Dr. F stated that there is no evidence in the report of any cervical pathology, that in his opinion the cervical region is free of any significant pathology, that the lumbar MRI report mentions mild left retrolothesis at L2-3 as well as a left-sided disc protrusion, that the question of a herniated disc at L2-3 is difficult to interpret, and that "frequently disc herniations are present at this area but does not correlate with the findings of his left sided leg pain." Dr. F then stated that a myelogram with CT or a lumbar discogram at L2-3 would be necessary to further delineate the problem at L2-3.

Dr. B wrote that nerve conduction studies of claimant's lower extremities done in April 1998 were relatively unremarkable. Dr. B also performed nerve conduction studies on claimant's upper extremities and reported several abnormalities. Dr. J examined claimant in April 1998 and diagnosed claimant as having cervicogenic headache, cervical radiculitis, right shoulder sprain, thoracolumbar radiculitis, and injury to the left quadriceps and recommended an EMG and nerve conduction study of the lumbar area and lower

extremities to rule out radiculopathy and peripheral nerve injury, which was done on April 22, 1998.

In a Report of Medical Evaluation (TWCC-69) dated September 8, 1998, Dr. S reported that claimant had reached maximum medical improvement (MMI) on September 8, 1998, with a 14% impairment rating (IR), for impairment of the cervical spine and lumbar spine.

Dr. P examined claimant at carrier's request on November 11, 1998, and he reported that, with regard to the injury to the left thigh and right little finger and the laceration over the left eyebrow, which, he said were the compensable injuries that were reported to him by carrier, claimant reached MMI on November 11, 1998, with a zero percent IR.

In a TWCC-69 dated November 19, 1998, Dr. R reported that she was the designated doctor, apparently appointed by the Commission, and that claimant reached MMI on September 8, 1998, with a nine percent IR. Dr. R assigned claimant impairment for his right little finger, left lower extremity, and cervical spine. Dr. R stated that claimant "almost assuredly suffered a neck injury with a compression of the head and as well may have suffered some low back problems" and that "in an accident of this magnitude causing multiple levels of trauma, this would be consistent with an adequate force to cause injury to the neck and back." Dr. R did not assign any impairment for the lumbar spine because she said that she did not feel that the MRI findings were related to the back injury. Dr. R also stated that claimant's history is consistent with a concussion, which had evidently improved, but that he still has significant headaches. In response to a letter from a Commission disability determination officer, Dr. R wrote that in her medical opinion, she felt that the cervical spine was part of the compensable injury, but that she had been asked to reassess her TWCC-69 to not include the cervical spine as part of the claimant's IR. Dr. R completed an amended TWCC-69 which, she said, assigned claimant a five percent IR for impairment of his left knee and right little finger.

The hearing officer determined that "claimant's compensable injury sustained on _____ does extend to include the cervical/ cervical sprain/strain; lumbar spine and post traumatic/cervicogenic headaches." There is conflicting evidence as to the extent of claimant's compensable injury. The 1989 Act makes the hearing officer the sole judge of the relevance and materiality of the evidence offered and of the weight and credibility to be given to the evidence. Section 410.169. As the trier of fact the hearing officer resolves conflicts in the evidence and may believe all, part, or none of the testimony of any witness. Texas Workers' Compensation Commission Appeal No. 950084, decided February 28, 1995. An appellate level body is not a fact finder and does not normally pass upon the credibility of witnesses or substitute its judgment for that of trier of fact, even if the evidence would support a different result. Appeal No. 950084. When reviewing a hearing officer's decision to determine the factual sufficiency of the evidence, we should set aside the decision only if it is so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Appeal No. 950084. We conclude that the hearing officer's decision is

supported by sufficient evidence and that it is not so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

The hearing officer's decision and order are affirmed.

_____
Robert W. Potts
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Gary L. Kilgore
Appeals Judge