

APPEAL NO. 991599

This appeal arises pursuant to the Texas Workers' Compensation Act of 1989, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). On June 29, 1999, a hearing was held. She (hearing officer) determined that appellant (claimant) sustained a compensable injury (facial contusion, right periorbital hematoma, and injury to teeth), but did not have disability. Claimant asserts (in two appeals timely filed) that there was sufficient evidence to find more extensive injuries and implies that, because the hearing officer is not a physician, she should not “discredit the medical”; claimant also said that respondent (carrier) did not contend part of claimant's injuries were not related to the fall and asks that “head injury” and “blurred vision” be added to her compensable injuries; she states that she had disability for an extended period except for two days at work, adding that she asked the doctor to let her go back to work. Carrier replied that the decision should be affirmed.

DECISION

We affirm, as modified.

Claimant worked for (employer) as a real estate agent. On _____, she fell, striking her head on a cement sidewalk outside a model home. While carrier had cited Texas Workers' Compensation Commission Appeal No. 980631, decided May 14, 1998, for the proposition that not all idiopathic falls are compensable, that appeal specifically stated that no instrumentality of the employer was involved in the reported injury, which was a knee “pop” and give-way while that claimant walked in a straight line; there was no collision with the floor or any other instrumentality, in contrast to the facts set forth in the case under review.

Claimant states that carrier did not contend that certain injuries were not related to the fall, but only asserted that an idiopathic fall was not compensable. The Appeals Panel has ruled that just because a carrier does not address the appropriate reason for an appeal that does not preclude a reversal on some other basis (see Texas Workers' Compensation Commission Appeal No. 991330, decided August 9, 1999); there was no issue that the carrier's controversion did not include whether claimant sustained any injury as a defense.

In addition, a hearing officer does not need to be a physician to reach factual determinations whether based on medical or lay evidence. See Section 410.165 and Texas Workers' Compensation Commission Appeal No. 970834, decided June 23, 1997. Western Casualty and Surety Company v. Gonzales, 518 S.W.2d 524 (Tex. 1975), and Charter Oak Fire Insurance Company v. Gonzales, 736 S.W.2d 931 (Tex. App.-Beaumont 1987, writ ref'd n.r.e.). The hearing officer is the sole judge of the weight and credibility of the evidence.

Claimant, in stating that she was more extensively injured, also says that her neck was in an “awkward position” when she fell, striking her face, and that her arms were “trapped” under her body, with her knee also striking the cement. Whether or not there was

evidence to indicate other injuries is not the test on review; the test is whether the decision, which basically found injury in the facial area, is against the great weight and preponderance of the evidence.

The evidence showed that claimant was taken to an emergency room (ER) in (City), Texas, on the day of the fall. The ER record shows that claimant presented with a bruised area about her right eye and provided a history of a fall. Her neck was not tender and range of motion (ROM) was said to be painless. Her extremities were reported as showing no evidence of trauma with normal ROM. Claimant evidently did report nausea and "trouble concentrating," with a headache. Her cranial nerves were said to be normal. A CT scan showed "right periorbital soft tissue swelling without acute intracranial abnormality or orbital fracture. No other abnormalities demonstrated." The ER "impression" was "fall, facial contusion with periorbital hematoma"; claimant was instructed to rest for "Monday-Tuesday" and return to work on "Wednesday."

Claimant evidently worked from Thursday through Sunday because she answered a question that asked if her working days were Thursday through Monday by saying, "not through Monday."

Claimant then saw Dr. G on December 14, 1998. He mentioned that claimant had damaged her teeth. He noted that claimant had "inability to think for a few hours" and pain in her face. On December 14, 1998 (a Monday), Dr. G appears to have signed a short note saying that claimant may return to work. His progress note of December 15, 1998, said that she was released from work beginning January 18, 1999. (He also appears to have signed another short note that claimant may return to work on January 29, 1999.)

Claimant thereafter saw an ophthalmologist, Dr. C. He indicated that he thought she had a concussion by saying, in regard to intermittent blurring of vision, "I think when she is . . . over her concussion, she will be able to focus well enough."

Claimant began seeing Dr. VB, D.C., in April 1999. He took claimant off work on April 13, 1999, and noted injuries to her arm, shoulder, knee, and neck. He ordered several tests, including an MRI of the cervical spine which showed straightening of lordosis, mild loss of disc height, a disc bulge at C5-6, and osteophytes. An electroencephalograph showed no abnormalities. An MRI of the head showed "normal noncontrasted MR evaluation of the head." An MRI of the left shoulder showed "no evidence" of rotator cuff tear but "capsular hypertrophy of the AC joint causes impingement syndrome."

A neurological consultation by Dr. W on April 22, 1999, stated that claimant had a "mild cerebral concussion," a cervical strain, a left shoulder sprain, "situational anxiety," and "posttraumatic vertigo," but these assessments were made before the studies reported above. However, in May 1999, after the MRI of the brain and cervical spine, Dr. W still assessed "mild cerebral concussion" but changed cervical strain to cervical radiculitis. Claimant also had a neuropsychological evaluation in late May and June 1999. It showed "essentially intact neurocognitive abilities in most areas assessed" and also said, "[i]t appears that [claimant] has largely recovered from her concussion from a cognitive

standpoint, as we do not see compelling evidence of neurologically based deficits at this time.”

While another fact finder could have considered the above medical opinions as indicative of a somewhat different outcome than did this hearing officer, that is not a basis upon which to overturn factual determinations. The Appeals Panel will only reverse a hearing officer on a factual determination when it is against the great weight and preponderance of the evidence. While a fact finder may give weight to problems reported and studies performed in weeks or months after an accident (several doctors reported that claimant had a “concussion”), that does not mean that a hearing officer may not give significant weight to the problems assessed in the first, or very early, medical visits after an accident. In this instance, the hearing officer specifically states in her Statement of Evidence that she considered the results of studies performed in regard to claimant. While injury may be found without verification by objective medical evidence, the hearing officer may always consider results of objective medical evidence. See Texas Workers’ Compensation Commission Appeal No. 92300, decided August 13, 1992. The test reports in this case do not compel any hearing officer to find that a brain injury occurred. In fact, the hearing officer may give weight to the MRI of the brain, which was normal, and to the CT scan taken on the day of injury. She may also give weight to the observation at the ER that claimant’s extremities showed no evidence of trauma. The determination that claimant sustained a facial contusion, right periorbital hematoma, and injury to her teeth (while the hearing officer’s finding of fact says “tooth injury,” her Statement of Evidence shows that claimant sustained a “chipped tooth and a lost filling”) is not against the great weight and preponderance of the evidence. To the extent necessary, the decision is reformed to reflect “teeth injury” as opposed to “tooth injury.”

The hearing officer’s determination that disability was not incurred is not inconsistent with the limited injury she found. It is consistent with an interpretation that the ER record said claimant should only miss two days of work (Monday and Tuesday) and with Dr. G’s note that said claimant could return to work on December 14, 1998. While claimant said she did not work on Monday and appears not to have regularly worked on Tuesday or Wednesday, the injury occurred on _____, a Friday, and the ER records of that date may be subject to an interpretation that the ER considered claimant to be off work on Saturday and Sunday, as are many patients, and therefore did not need to restrict claimant on those days. Nevertheless, the hearing officer’s determination of no disability is supported by medical evidence in the record. Other medical evidence, including that of Dr. G, indicates that claimant had disability which varied in length, but that does not mean the hearing officer had to choose an opinion from that evidence over the ones she chose. The determination that claimant had no disability is also not against the great weight and preponderance of the evidence.

Finding that the decision and order are sufficiently supported by the evidence, we affirm, with the modification that “tooth injury” be read as “teeth injury.” See In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

Joe Sebesta
Appeals Judge

CONCUR:

Gary L. Kilgore
Appeals Judge

Dorian E. Ramirez
Appeals Judge