

APPEAL NO. 991671

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. He (hearing officer) closed the record on July 15, 1999, and determined that appellant (claimant) did not show that he was unable to work at all and was therefore not entitled to supplemental income benefits for the first compensable quarter. Claimant asserts that his doctor said that he had no ability to work relative to the filing period in issue and that the underlying facts of his condition support that conclusion. Respondent (self-insured) replied that the decision should be affirmed.

DECISION

We affirm.

Claimant worked for (employer), on _____, when, he testified, he hurt his back and neck lifting baskets filled with "parts" onto carts. He had fusion surgery of the cervical spine in September 1997. The parties stipulated that claimant's impairment rating (IR) is 17%, that he commuted no benefits, and that the filing period for the first quarter began on December 22, 1998, while the quarter itself began on March 23, 1999.

Claimant had a functional capacity evaluation (FCE) in February 1997 which said that he could do medium work. As stated, however, he thereafter had surgery (fusion) at C4-5 in September 1997. Since that surgery, the record contains no FCE. After the surgery, in March 1998, Dr. G noted that claimant was "real pleased" with the results of the operation. Since that time, claimant testified, he "got worse just before" March 1999. He had called Dr. F in the latter part of 1998 about his depression, and he thereafter saw Ms. E, a licensed professional counselor. Claimant also testified that he had last seen Dr. F in March 1998 prior to seeing him again in March 1999, adding that he did physical therapy at home during the intervening time. He added that in the months since March 1999 (the end of the filing period) Dr. F has had added studies performed and now believes that additional surgery will be necessary.

In March 1998, Dr. F provided a Report of Medical Evaluation (TWCC-69) and narrative in which he assigned a 17% IR to claimant. He said therein that claimant "has done very well following his surgery" reporting "ongoing low back pain and pain into his left leg. Referable to his cervical complaints, he has slight neck and left arm symptoms." On March 3, 1999, Dr. F wrote that claimant had developed pain and spasm in the neck "with rotation"; back pain was also said to be intermittent. Reference was also made to psychological care being provided. Some restriction because of pain was noted on cervical range of motion but otherwise claimant was "neurologically intact." Dr. F then said:

He informs me that he has not yet managed to return to work because of the ongoing pain. I have discussed in detail this with him. I have not seen him in the past year. I have no reason to doubt his ongoing symptoms. As far as

certification of no work status, I think a functional capacity examination may be appropriate

Dr. F also said that an x-ray showed the fusion to appear solid, but noted degenerative changes at C6-7. He then noted on March 8, 1999, that claimant complained of stiffness and pain in the neck, particularly on turning to the left. He said he reviewed past records and "in the past he has had a herniated nucleus pulposus and degenerative discs at C6-7 as well on various studies." He added that because of persistent pain, he would get a discogram; he later stated that claimant said the pain is "getting progressively more incapacitating." Below that typed entry is a handwritten entry dated March 24, 1999, which says, "[h]e is currently at 'no work' status - see above for reasons. *" (The March 8, 1999, entry has a * beside the persistent pain/discogram reference.)

The hearing officer had asked that claimant provide the results of studies performed after the last record admitted, which was dated in March 1999. Thereafter, claimant provided a note of Dr. F dated June 23, 1999, which said a discogram had been done which showed the fusion to be solid, but that the C6-7 had a "posterior rupture and concordant pain reproduction." He said that claimant should see Dr. G. Dr. F also said that claimant was "still unable to return to work."

In addition, the record of psychological treatment provided claimant in September 1998 (which then continued into November 1998) said that claimant had been hired by (employer) but was not able to take the job because he would need to drive and his family only had one car. Claimant testified that he inquired about a job but said he was unable to drive because he could not turn his head to the left.

The hearing officer is the sole judge of the weight and credibility of the evidence. See Section 410.165. The hearing officer specifically mentioned in his Statement of Evidence that Dr. F, in early March 1999, considered claimant's assertion that he had not returned to work because of pain by commenting that he had not seen claimant in a year and posited that an FCE may be appropriate. These comments were made without indication by Dr. F that claimant could not work. As pointed out by the hearing officer, Dr. F then said on March 24, 1999, that claimant was in a "no work" status, after only providing a March 8, 1999, report that noted persistent pain and the need to do another discogram, although Dr. F did refer to having reviewed past records which showed a herniated disc and "degenerative discs at C6-7."

The hearing officer may weigh medical evidence and may consider whether medical evidence provides a basis for opinions it gives. See Texas Workers' Compensation Commission Appeal No. 970834, decided June 23, 1997. This is particularly so in an instance such as considered by this hearing officer in which Dr. F had noted various facts and had not provided an "unable to work at all" opinion in early March 1999 and then changed by providing a "no work" opinion in late March after deciding to order a discogram based on persistent pain. This was a factual determination for the hearing officer to make, and the medical evidence, considered together, sufficiently supports the determination that the medical evidence does not show that claimant is unable to do any work of any kind.

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:

Gary L. Kilgore
Appeals Judge

Tommy W. Lueders
Appeals Judge