

## APPEAL NO. 992942

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). On August 18, 1999, a hearing was held, after which the presiding hearing officer determined that respondent/cross-appellant (claimant) sustained a compensable injury on \_\_\_\_\_; that notice was given to employer within 30 days; and that claimant has had disability from January 29, 1999, to the date of hearing on August 18, 1999, but that claimant's heart condition which resulted in heart surgery on March 12, 1999, was not part of the compensable injury. Appellant/cross-respondent (carrier) asserts that there is no compensable injury since claimant's diabetes is an ordinary disease of life and is the "sole cause" of his condition, adding that the amputation of claimant's left leg was not "the" result of any injury at work. Carrier also states that there is no aggravation injury since claimant did not obtain medical care when offered. Carrier takes issue with comments by the hearing officer addressing the condition of the left leg versus the right leg prior to the \_\_\_\_\_, injury and says that medical evidence must show a relationship between the "severe injury" and claimant's employment. Carrier states that disability should not be found because the cellulitis and amputation did not result from the compensable injury. Carrier finally states that the date of injury should have been earlier than \_\_\_\_\_, and then claimant's notice would not have been timely. Claimant asserted that his congestive heart failure resulted from the news on \_\_\_\_\_, that he would need to have more surgery to his leg; claimant also objects to the omission of one of his exhibits by the hearing officer. Both carrier and claimant filed responses.

## DECISION

We affirm.

Claimant worked for (employer) on \_\_\_\_\_. He testified that he was an operations manager at a bentonite mine. He also testified that he has been a diagnosed diabetic (non-insulin dependent) since 1987. He has also had diagnosed hypertension since January 1998, one year prior to the events considered at this hearing.

Claimant testified that on \_\_\_\_\_, he was working among a pile of scrap iron when he felt a piece of steel "poke" his left ankle; it was said to have bled a little, and claimant added that he put peroxide on the wound and bandaged it; he also added that he then paid little attention to it because scratches were said to be a common part of such work.

The hearing officer's Statement of Evidence refers to an examination of claimant by Dr. G on January 15, 1999, before the injury in question, which the hearing officer says reflected "unhealed sores on his right leg but the left leg appeared to be doing fine." There is a reference to the January 15, 1999, visit, but the notes of the actual visit were not provided. On \_\_\_\_\_, Dr. G, claimant's family doctor, provided a history relative to a hospital admission, in which he wrote that he saw claimant on January 15, 1999. At that time, Dr. G said, claimant had lost weight (the context indicated that this was a positive), his

blood pressure was "excellent," his pulse was improved, and he had "no dyspea." Then, while all of the above statements were positive statements, Dr. G did not preface his next sentence to contrast it to the previous sentences; he merely wrote, "all of his scabs over his lower legs had not healed and his respiratory system was clear." (Emphasis added.) Even taking the sentence as it is, it says that scabs had not healed, not that there were open sores or any indication of infection or swelling; it also said that "all" scabs on his lower legs were not healed. This reference does not warrant a comment that differentiated the right leg from the left, although this reference did not say that scabs on both legs were not healed. In addition, Dr. G saw claimant on December 11, 1998 (a note of that visit is in evidence), and said, "right lower leg-wound healing," with no reference to the left leg. On November 20, 1998, Dr. G had noted that a sore on the right leg "isn't healing." Carrier also placed in evidence a copy of a January 22, 1999, letter from claimant to Dr. G (one day after the alleged steel "poke" in the left ankle) in which claimant talks of looking for a different job and being interested in getting his blood pressure under control; he said nothing of any leg sores, problems, or infection. There is some evidence that would support a comment that prior to the \_\_\_\_\_, injury there was evidence that claimant's unhealed scabs were on the right rather than the left leg.

Claimant further testified that on January 26, 1999, he began to feel as if he had flu and went to (city 1) to seek medical care. He saw Dr. S. Claimant was found to have a severe infection (cellulitis) on his left ankle and was advised to admit himself to the hospital then. Claimant said he did not want to be admitted because of his work and because he wished to get a second opinion from his doctor in (city 2), Dr. G. He did obtain a shot of antibiotics for his infection at that time. On January 29, 1999, claimant saw Dr. G and was admitted to a hospital in (city 2). He had his left leg amputated on January 31, 1999. The admission note for the January 29, 1999, admission relates a history of "two week worsening of left leg swelling that began as a scab."

Carrier cites Texas Workers' Compensation Commission Appeal No. 93416, decided July 8, 1993, as saying that an aggravation resulting from refusing medical care is not compensable. That case, however, did not deal with a specific physical injury, such as the alleged "poke" or scratch at work as in the case under review. In addition, in Appeal No. 93416 care was evidently delayed for months, whereas here the time lapse was three days. In addition, Appeal No. 93416 does not indicate that any medical care was undertaken at inception, whereas here there is evidence that claimant received antibiotic treatment for his infection on January 26, 1999, but not in the manner or to the extent recommended by Dr. S. We do not consider Appeal No. 93416 to control this case and render claimant's injury to be not compensable. Carrier also cited Texas Worker's Compensation Commission Appeal No. 94257, decided April 18, 1994, which dealt with over use of a thumb splint possibly leading to a neck injury. This appeal simply affirmed a determination of no compensable injury.

The carrier says that claimant's injury occurred in October when Dr. G's notes say claimant said his scabs resulted from "banging his legs going up steel stairs," or in November when Dr. G noted that claimant was "much better" but "has a sore on right lower leg that isn't healing." Dr. G also noted in November that he "dressed left lower leg." The

hearing officer is the sole judge of the weight and credibility of the evidence. See Section 410.165. The date of injury is a factual determination. The hearing officer could conclude that the left leg condition did not arise in October or November 1998, but that claimant did scratch or poke his left ankle at work on \_\_\_\_\_. In this regard, claimant testified that he reported the puncture to Ms. C and Mr. M at work; the hearing officer could consider that no affidavit or any testimony was provided from either employee denying that claimant reported his injury. In addition, carrier's Payment of Compensation or Notice of Refused/Disputed Claim (TWCC-21) states that carrier first received written notice of injury on February 1, 1999, from "[Mr. M]-CFO" . A statement from Mr. R, the president of employer, identified Mr. M as the "CFO" of employer. Mr. R's statement also said that when he visited claimant in the hospital after his leg was amputated, claimant told him he had "banged his leg" but could not say "when, where, or how." Claimant's statement of February 9, 1999, says that he remembered scratching his left ankle on the "old steel," but claimant said he could not say when it happened. Although that statement was given less than 20 days after the alleged injury, claimant could not remember when it happened; nevertheless, he testified on August 18, 1999, that it happened on \_\_\_\_\_. The hearing officer's finding of facts show that he believed claimant's testimony as opposed to his statement of February 9, 1999, or as opposed to the hospital admission record of January 29, 1999, which related a two-week history of development from a scab; as fact finder he could so choose. The determination that the date of injury was \_\_\_\_\_, is sufficiently supported by the evidence and as a result, notice was timely provided to employer.

Dr. D, who did some surgery after the amputation to better situate the wound for a prosthesis, said in a form dated July 7, 1999, that the date of the accident was \_\_\_\_\_; that claimant's left ankle sustained a puncture wound from scrap metal; and that the injury was related to diabetes; he also wrote, "patient received puncture wound left ankle on \_\_\_\_\_ while at work. Wound became infected . . . ending with left below knee amputation." Dr. D also provided a statement on July 14, 1999, which said that claimant sustained an injury at work. He added, "this wound led directly to necrotizing fasciitis which resulted in his last below knee amputation. . . . The amputation was the direct result of the necrotizing fasciitis which was sustained due to an injury of his foot while at work." There is medical evidence connecting the "severe injury" to claimant's work. While carrier provided an unsigned opinion (not an unsigned record made at the time of treatment) from a peer review doctor, even that doctor's answers were somewhat confusing. A question was asked:

In your opinion, given the provided medical information, do you believe the lesions were caused by or accelerated by an on the job incident? If not, what do you believe caused the lesions? Could they be the result of normal activities of daily living?

The unsigned opinion stated:

No. It is my opinion that complications of diabetes mellitus and chronic cutaneous ulceration with chronic cellulitis caused the lesions. Yes, they could be the result of normal activities of daily living.

The hearing officer could question whether the unsigned doctor was saying that the disease caused the lesions or that some unknown "activity," (but not the disease) of daily living caused it. He could compare that opinion to that of Dr. D which took into account the diabetes and did not reject that condition, but stated that the scratch also had a part in the progress of a severe injury. The evidence did not require the hearing officer to find that claimant's diabetes was the sole cause of his condition.

The evidence sufficiently supports the determination that the claimant compensably scratched himself on \_\_\_\_\_; that this injury progressed to cellulitis which caused an amputation; and that this sequence caused claimant's disability.

While claimant attacks the determination that the heart condition is not compensable, saying that it occurred after he got the bad news of more surgery on his leg, Section 408.008 addresses heart attacks and provides a separate standard for determining compensability compared to other injuries or diseases. Under Section 408.008, a determination must be made that the specific event related to work was a substantial contributing factor rather than the natural progression of a preexisting heart condition. On \_\_\_\_\_, Dr. G noted that claimant was admitted on that day with chest pain. He noted claimant's enlarged heart and said he is now in "congestive heart failure." He added, "I suspect he has been in some degree of heart failure for some time." On March 12, 1999, claimant had heart surgery. It found him to have "severe, diffuse atherosclerotic occlusive coronary artery disease." Among other things the operative report spoke of the posterior descending coronary artery as being "totally obstructed"; the main coronary artery was "calcified"; serial lesions were also noted. Bypass surgery was done. The medical records sufficiently support the determination that claimant's heart condition results from the "natural progression of coronary artery disease which was discovered but not caused by the angina attack on \_\_\_\_\_."

While claimant objects to the exclusion of one document related to Dr. G, that document was excluded on a question of timely exchange which is a matter for the hearing officer to determine. In addition, it dealt with opinions about the leg injury and not the heart condition. We find no reversible error.

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).

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Joe Sebesta  
Appeals Judge

CONCUR:

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Robert W. Potts  
Appeals Judge

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Dorian E. Ramirez  
Appeals Judge