APPEAL NO. 000251

This appeal arises pursuant to Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on January 11, 2000. The hearing officer found that during the qualifying period for the 13th quarter for supplemental income benefits (SIBS) the claimant (respondent) was unable to do the lifting required in the job she had when she was injured, that her unemployment was a direct result of her impairment from the compensable injury, that she had no ability to work, that reports from Dr. M describe the claimant's medical condition and adequately explain why she was unable to work, that reports from Dr. B and Dr. S stating that the claimant is able to perform work with restrictions do not show the claimant is able to return to work because they do not adequately address her need to avoid further injury to her back, and that the claimant attempted in good faith to obtain employment commensurate with her ability to work and concluded that she is entitled to SIBS for the 13th quarter. The appellant (carrier) appealed, urged that the determinations of the hearing officer are so against the great weight and preponderance of the evidence as to be clearly wrong and unjust, and requested that the Appeals Panel reverse the decision of the hearing officer and render a decision that the claimant is not entitled to SIBS for the 13th quarter. The claimant responded, urged that the evidence is sufficient to support the decision of the hearing officer, and requested that it be affirmed.

DECISION

We affirm.

The disputed issue of entitlement to SIBS for the 13th quarter was decided under the provisions of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.102(d)(3) (Rule 130.102(d)(3)), effective January 31, 1999, which provides:

> Good Faith Effort. An injured employee has made a good faith effort to obtain employment commensurate with the employee's ability to work if the employee:
>
> * * * *
>
> (3) has been unable to perform any type of work in any capacity, has provided a narrative report from a doctor which specifically explains how the injury causes a total inability to work, and no other records show that the injured employee is able to return to work; or . . . .

A report from the designated doctor dated December 13, 1995, states that on April 13, 1994, the claimant underwent a discectomy at L4-5 and a fusion from L3 to the sacrum;

that 12% impairment was assigned for specific disorders of the lumbar spine under Table 49 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides); that flexion and extension range of motion (ROM) tests of the lumbar spine were invalid; that four percent was assigned for left and right lateral flexion ROM of the lumbar spine; and that the claimant's impairment rating (IR) is 16%. Dr. B examined the claimant at the request of the carrier and in a Report of Medical Evaluation (TWCC-69) dated November 10, 1995, reported that the claimant's IR was 15%. In an attachment to the TWCC-69, he assigned 12% impairment under Table 49 of the AMA Guides; stated that lumbar ROM tests were invalid, therefore, he referred to Table 50 concerning ankylosis and assigned three percent impairment; briefly commented on functional capacity evaluation (FCE) results; and stated that from the results of the FCE the claimant was in the sedentary work classification. In a letter dated February 25, 1997, Dr. M said that the claimant injured her back and underwent lumbar spine surgery in April 1994; that she suffered nerve damage and continues to have pain into her back, hips, and legs; that she still has burning and numbness into her lower extremities; that she is totally disabled and has a permanent disability; and that she will not be able to return to gainful employment. Dr. M made similar reports later in 1997 and in 1998. In a letter dated October 6, 1997, Dr. W said that he saw the claimant on that day; that she gave a history since he last saw her in October 1995; that she said she had been experiencing pain across her lower back and down to both great toes; that he reviewed the report of a September 2, 1997, MRI; and that he recommended a myelogram with CAT scan. On November 18, 1997, Dr. W reported that he had reviewed the results of the tests and recommended therapy rather than further surgery.

In a return-to-work statement dated May 6, 1999, Dr. M indicated that the claimant should not return to work; that the claimant was taking pain medication that might affect her ability to work; and that she would never be released to return to work. In a letter dated July 6, 1999, Dr. M gave a brief history of the claimant's treatment and wrote:

> She continues to have pain, problems, weakness and neurological dysfunction. She had a MRI scan showing postoperative change involving the L4 and L5 levels. There was multilevel disc desiccation and mild degenerative spondylosis involving L3-4 through L5-S1, more so than in the upper lumbar region. The patient did have minimal posterior central bulging of the L5-S1 and L2-3 discs. There was minimal encroachment into the proximal interior aspect of the L2-2 exiting neuro foramen bilaterally.
>
> The patient continues to have neurological pain. She has not responded to conservative care. She continues to have weakness and difficulty. I do not expect her to make improvements in the future and have permanent problems.

On August 16, 1999, Dr. M wrote:

> This is a patient who has had surgery on her back, she had a Lumbar laminectomy and Fusion. She has nerve damage and continued pain. She was seen by her neurosurgeon, [Dr. W], he made additional diagnosis of Disc Degeneration and displacement at L2-3, L3-4 and L5-S1. She continues to have pain and neurological symptoms, [Dr. W] has not suggested any new surgery.
>
> The patient is disabled, she's unable to return to any type of work. She will continue to have problems in the future.

A page that appears to be from a Specific and Subsequent Medical Report (TWCC-64) from Dr. M dated October 11, 1999, states that the claimant has limited ROM; that she still has pain in her back, hips, and legs; and that x-rays taken that day indicate she has good alignment of the fusion, that it looks like she is stable, and it looks like the fusion is doing well. In a letter to the attorney representing the claimant dated November 2, 1999, Dr. M wrote:

> The patient continues to have pain, problems, and difficulty. She continues to have pain into her back, hips, and legs. She continues to have neurological symptoms. She continues to have weakness and chronic pain.
>
> The patient is completely and totally disabled. She will be unable to return to gainful employment. She continues to do poorly and we do not expect her to improve in the future.
>
> The patient at this point in time is taking pain medication and muscle relaxants. She would be unable to work and perform any type of duties while taking this medication. If she does any kind of work with her back, this will aggravate her condition. She will get worse. She will have more numbness, tingling, and weakness into her back.
>
> The patient cannot sit for extended periods of time. She cannot do any stooping, lifting or bending. She cannot do any kind of picking up objects. She should protect her back. She should brake [sic] up her days. She should do some laying down, some sitting and some standing. She is disabled from returning to any type of work.

Dr. S examined the claimant at the request of the carrier. In a letter dated April 11, 1999, he provided a brief history and wrote:

At present the lower back pain is constant, pain medications and muscle relaxants help her somewhat. There are bilateral leg pains, worse on the left and the left leg gets numb sometimes.

She has had physical therapy and has been taking a derivative of codeine and Soma daily. Enclosed medical records are reviewed. We note that epidural steroids were tried and she states that these helped only temporarily.

EXAMINATION: She is advised to move within range of comfort. Postoperative incision is well healed.

Examination of the lumbar spine: Lumbosacral spine shows good alignment. There is no evidence of muscle spasm on static examination. On dynamic examination, forward flexion is to 30 degrees. Extension is to 0 degrees. Lateral flexion to the left and right is 10/10 degrees. Total sacral motion is 20 degrees. There is paralumbar suxcular spasm and she reports more discomfort on extension. Straight leg raising test is negative at 70 degrees bilaterally. Foraminal compression test is equivocal bilaterally. Femoral nerve stretch test is equivocal bilaterally. Leg strength appears equal. Motor examination shows excellent strength. There is no evidence of atrophy. There is no evidence of dermatomal sensory deficits. Reflexes, knee jerks 2+, bilaterally; ankle jerks 1+, bilaterally. There is no evidence of pathological reflexes. Examination of the vascular system reveals good pedal pulses and both calves are soft. No edema present. Both hips move fully.

* * * *

RECOMMENDATIONS: The patient could only return to light semi-sedentary type of work. Restrictions are as follows: No lifting over 15 lbs. No bending, stooping, or twisting. No work on unprotected heights.

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. 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). The hearing officer considered the medical evidence presented on the three provisions in Rule 130.102(d)(3) and made factual determinations favorable to the claimant on each of them. He briefly commented on medical reports and did not summarize or quote from them in his Decision and Order, but he did make findings of fact that indicate his rationale for determining that the three criteria in Rule 130.102(d)(3) were met. The Appeals Panel

must consider all of the relevant evidence to determine whether the factual determinations of the hearing officer are so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. Texas Workers' Compensation Commission Appeal No. 941291, decided November 8, 1994. 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 could 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 appealed factual determinations of the hearing officer 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, 224 S.W.2d 660 (1951); Pool v. Ford Motor Company, 715 S.W.2d 629, 635 (Tex. 1986). In so holding, we do not hold that for a report of a doctor to show that the injured employee is able to return to work it must contain comments addressing each comment of a narrative report from a doctor which specifically explains how the injury causes a total inability to work. 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:

Joe Sebesta
Appeals Judge

Gary L. Kilgore
Appeals Judge