APPEAL NO. 000277

On January 14, 2000, 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 hearing officer resolved the disputed issues by deciding that appellant's (claimant) compensable injury was not a producing cause of his left ankle and left leg medical problems on and after (date), and that claimant did not have disability resulting from his compensable injury sustained on _____, for the period of October 13, 1999, through the date of the CCH. Claimant requests that the hearing officer's decision be reversed and that a decision be rendered in his favor. Respondent (carrier) requests that the hearing officer's decision be affirmed.

DECISION

Affirmed.

Claimant, who worked as an iron worker for (employer), testified that on _____, he was helping to move an iron beam on a trailer when another 860-pound iron beam struck him in his left leg, injuring his left leg and left ankle. The parties stipulated that on _____, claimant sustained a compensable injury to his left leg and ankle when the beam fell on his leg. Some documents state that the beam rolled onto the claimant's left leg. Claimant was taken to employer's first aid station where he was seen by FW, who is a licensed vocational nurse and employer's safety coordinator. FW treated claimant for a contusion of the left ankle and a laceration above the left ankle. On September 10, 1998, FW took claimant to Dr. R who noted that he saw claimant for a contusion of the left ankle and laceration of the area above the left ankle but made an assessment of right ankle pain and recommended an air cast. A radiologist reported that a left ankle x-ray done on September 10, 1998, showed no fracture or dislocation and stated an impression of soft tissue swelling laterally. Dr. R released claimant to return to work. Claimant said that when he returned to work, he sat in a trailer with his left leg in an air cast and kept his foot elevated for about one and one-half months. On September 17, 1998, Dr. R's assessment was left ankle pain, soft tissue injury, and ligamental injury with no fracture. On October 1, 1998, Dr. R noted that claimant's soft tissue injury to his left ankle was completely resolved and that his left leg skin laceration was resolved. On October 26, 1998, Dr. P, who works in the same health center as Dr. R, noted that he saw claimant for numbness and paresthesia of the left leg. On November 17, 1998, Dr. P wrote that claimant stated that he was doing much better and that if claimant continued to have problems, another x-ray would be done. On August 19, 1999, Dr. P wrote that he last saw claimant on November 17, 1998; that at that time claimant was doing much better; that his movements were within normal limits; and that he was released from his care. FW said that Dr. P orally released claimant to return to work on November 17, 1998; that claimant did not tell her of any left leg complaints after that release; and that claimant did not ask to see another doctor.

Claimant said that in November 1998 he returned to his regular work duties as an iron worker for employer, but that he continued to have left leg problems. He said that when he last saw Dr. R, Dr. R had told him that he would hurt for up to six months due to blood dissipating from a bruise and that he attributed his pain to that. Claimant said that he did continue to complain to FW about his pain and that he told his foreman, RM, and the employer's craft supervisor, LT, that his leg hurt. RM wrote that claimant came to him and said he was ready to go back to full duty and that his leg did not hurt anymore. JY, who is the general foreman, wrote that in the first part of November claimant asked him when they were going to let him go back to the iron work and when he asked claimant how he felt, claimant said that he was doing fine and was ready to go back to the iron work but that he did not have a release. Several of claimant's coworkers' wrote that claimant did not complain about his leg when they worked with claimant and that he said his leg was fine. One coworker wrote that claimant said that sometimes his leg would hurt, but that when he worked with claimant in pre-treatment, claimant never complained that his leg hurt.

Claimant was terminated from employment on March 18, 1999, for a safety violation. LT testified that when he terminated claimant in March 1999 for a safety violation, claimant did not indicate that he was having any problems with his leg. LT said that after claimant resumed his regular duties as an iron worker, he could not recall claimant complaining about his leg. Claimant said that he looked for work after he was terminated from employment. Claimant was rehired by employer on May 5, 1999. FW said an employer nurse gave claimant a physical examination on May 4, 1999. The nurse noted no problems with claimant's lower extremities and claimant did not note any problems with his left leg or ankle on the health questionnaire he completed on May 4, 1999, although FW said that she noted the 1998 injury on that questionnaire. Claimant also indicated on the health questionnaire that there were no aspects of his job duties that he might have trouble performing.

LT said that he met with claimant when claimant was rehired and that he did not recall claimant complaining about his left leg. Claimant worked his regular duties for four days and then quit his job on May 11, 1999, because he was offered a job by another company. LT said that claimant told him that he was quitting because he had found a good job and that he did not recall claimant complaining about his leg at that time. RM noted on the May 13, 1999, status report that claimant quit on May 11th to take other employment and checked that he would rehire claimant; however, LT said that claimant would probably not have been rehired after he quit on May 11th. LT said that at some point he mentioned his own knee problem to claimant. Claimant said that the company he was going to work for told him that he needed a copy of his work release for his August 1998 work injury.

CM, a nurse in Dr. P's office, wrote that on May 11, 1999, claimant called stating that he needed a work release because he was applying for a job, that he had been working regular full-time work since November, and that he was fine and had no problems with his left ankle or foot. Claimant said that he did not tell CM that he was fine and had no problems. FW said that claimant contacted her about getting a copy of his work release and that she told claimant it had been a verbal release and she would help him obtain a

written one. FW noted that claimant told her on May 13, 1999, that his ankle was fine, denied any complaints about his left ankle, and said he needed a copy of the release to obtain other employment. FW and claimant went to Dr. P's office on May 13, 1999, and FW noted that claimant again denied having any problems with his left ankle and told CM that he needed the release to obtain other employment. In a note dated May 13, 1999, Dr. P noted that claimant had been under his care until November 17, 1998, that claimant was sufficiently recovered to resume normal work duties, that claimant was told to return after November 17, 1998, if he had any problems, that claimant never returned, and that he presumes that claimant is doing fine and is released without restrictions.

Claimant said that his new job did not "pan out" because he would have had to relocate. Claimant also indicated that he did not pass an employment physical or stress test with the new company. JB, who works for employer, wrote that on May 25, 1999, claimant called him and asked for the carrier's name and informed JB that he needed further medical treatment for his August 1998 leg injury because he was released prematurely. CM wrote that claimant called her on May 27, 1999, and said that he was having problems with his left leg and needed a referral to Dr. S. In July 1999, CM wrote that claimant called and said that he had never been seen by Dr. P, but that she explained that she had documentation verifying that he was seen by Dr. P.

Claimant said that he did not seek re-employment with employer when he did not get the new job, indicated that there were two companies he had tried to get a job with and that both jobs fell through, and said that he has been seeking employment. He said that if his leg gets fixed, then he will be able to work. He said that by the time he got his written release from Dr. P, one job had been filled. Claimant said that he has continuously had problems with his left leg since the day of his injury in August 1998.

Dr. W saw claimant on June 14, 1999, for complaints of left leg pain and noted the work injury of August 1998 and that claimant said that he had had no pain-free period since that injury. Dr. W noted that x-rays taken on June 14, 1999, of claimant's tibia demonstrated a periosteal reaction which may be post-traumatic in origin and recommended a bone scan and nerve conduction studies (NCS). Dr. W referred claimant to Dr. T, who saw claimant on June 23, 1999, for complaints of persistent left ankle and leg pain following his 1998 work injury. Dr. T noted that claimant said that he had had pain every day since the injury. Dr. T noted that a bone scan showed mostly changes of arthritis, but that there were some local changes in the ankle and foot. Dr. T wrote that claimant's pain seems to be typical of neuropathic traumatic pain and that his impression is that claimant has a legitimate injury and recommended an electromyography (EMG).

Dr. S saw claimant on July 13, 1999, and wrote that claimant's initial x-rays showed evidence of osteopenic changes of the distal fibula and changes in the area of the syndesmosis and that clinical evaluation is consistent with a traumatic injury to the syndesmosis of the left distal fibula and tibia and with the traumatic injury to the sensory branch of the superficial peroneal nerve. Dr. S wrote that claimant should continue in a non-working capacity and recommended an NCS. Dr. S wrote on July 20, 1999, that

claimant told him that he had had persistent problems with his left leg. Dr. S also wrote that he thinks that claimant's returning to work as an iron worker aggravated his condition and that claimant should have been put in a cast and perhaps even considered for surgical intervention. Dr. S noted that he gave claimant an injection for pain relief and put him in a fiberglass walking cast. Dr. S removed the cast on August 10, 1999, and wrote that after the _____, injury, claimant was diagnosed with a ligament injury and should have been placed in a non-weight bearing cast for six to eight weeks to allow the syndesmosis to heal but that was not done and claimant was left with chronic pain of the syndesmosis and the superficial peroneal nerve pathology. Dr. S noted in October 1999 that claimant does not have a medical release for employment.

The benefit review officer had claimant examined by Dr. H for the purpose of addressing whether claimant's current left ankle and leg problems are a result of the _____, injury and claimant's work ability. Dr. H examined claimant on October 1, 1999, and noted that claimant told him that he has continued to have pain every day since his injury. Dr. H wrote that claimant has a complex case of a soft tissue injury with nerve injury and scar tissue formation at the ankle joint resulting in loss of motion and that claimant may need injections of the peroneal nerve and possible arthroscopic surgery for any impingement syndrome of the ankle. Dr. H wrote that he feels that claimant's current left ankle and leg problems are a direct result of the _____, injury, noting that claimant continued to have problems, and that claimant's work ability from July 13, 1999, to the present was extremely limited due to the pain and discomfort of his left lower extremity.

Claimant underwent an EMG on November 16, 1999, and Dr. T wrote that that study showed chronic neurogenic motor unit potential changes indicative of past damage in the superficial peroneal innervated muscles below the knee consistent with the injury described by claimant and that it appeared that claimant continues to have neurogenic pain from a left superficial peroneal nerve trauma. Dr. T stated that claimant has a legitimate injury. Dr. S wrote in November 1999 that claimant continues to have problems with his left leg and is unable to work and that the EMG findings are secondary to a traumatic soft tissue crush injury to the foot and are related to his work injury.

The hearing officer made findings of fact and concluded that claimant's compensable injury of _____, was not a producing cause of his left ankle and left leg medical problems on and after June 14, 1999, and that claimant did not have disability resulting from his compensable injury sustained on _____, for the period of October 13, 1999, through the date of the CCH. The 1989 Act makes the hearing officer the sole judge of the weight and credibility to be given to the evidence. Section 410.165(a). As the finder of fact, the hearing officer resolves conflicts in the evidence and determines what facts have been established from the conflicting evidence. Texas Workers' Compensation Commission Appeal No. 950084, decided February 28, 1995. A fact finder is not bound by the testimony (or evidence) of a medical witness where the credibility of that testimony (or evidence) is manifestly dependent upon the credibility of the information imparted to the medical witness by the claimant. Rowland v. Standard Fire Ins. Co., 489 S.W.2d 151 (Tex. Civ. App.-Houston [14th Dist.] 1972, writ ref'd n.r.e.). The hearing officer noted in his

Statement of the Evidence, that he determined that claimant had very little credibility because he had told so many people so many different things and that claimant had not had continual pain from November 1998 through May 1999 and had given Drs. S, T, and H erroneous information about having had continual pain since his injury. An appellate level body is not a fact finder and 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 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:

_____
Alan C. Ernst
Appeals Judge

_____
Tommy W. Lueders
Appeals Judge