APPEAL NO. 001218

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on May 2, 2000. With regard to the issues before him, the hearing officer determined that the appellant's (claimant) _____, compensable injury does not include the neck, left carpal tunnel syndrome (CTS), depression, or any other condition, illness, or injury; and that the claimant reached maximum medical improvement (MMI) on March 15, 1999, with a zero percent impairment rating (IR). The claimant appealed, summarizing the evidence supporting her position in detail. Basically, the claimant argues that the doctor that she saw initially misdiagnosed her condition and that the designated doctor improperly invalidated range of motion (ROM) impairment based on his observations and was "taking out his frustration . . . on the claimant's [IR]." The claimant requests that we reverse the hearing officer's decision and render a decision in her favor. The respondent (carrier) responded to the claimant's appeal and urged affirmance.

DECISION

Affirmed.

The claimant testified that on _____, she sustained certain injuries carrying a 50-pound stack of paper bags. The claimant testified that she felt immediate pain from her neck, through her left shoulder and left arm into her left hand and fingers. There is some dispute how much the stack of paper bags weighed and other factors. The hearing officer questioned the claimant in detail regarding the mechanics of the incident. The carrier has accepted liability for a compensable left shoulder injury. The issue agreed to from the benefit review conference was an extent-of-injury issue of whether the compensable injury included the neck and left CTS. At the CCH, other conditions, including depression, were raised and were subsequently addressed by the hearing officer.

The claimant apparently continued to work after _____, until apparently June 18, 1997. During that time, the claimant testified that she sought medical care at a hospital emergency room but no records of that visit were offered. The first documented care is by Dr. D, who in a progress note dated June 20, 1997, noted complaints of left shoulder pain "since carrying boxes of paper on her shoulder on _____." The claimant's history was taken through an interpreter, an MRI was ordered, and a diagnosis of left shoulder pain of unknown etiology was made. No other complaints were noted and Dr. D noted exaggerated symptoms. Dr. D, in a progress note of July 9, 1997, noted that the MRI showed a tear of the "supraspinatus" and ordered an arthrogram. On August 6, 1997, Dr. D noted that the arthrogram was negative for a rotator cuff tear, had a diagnosis of "[l]eft shoulder contusion" and commented "[h]er symptoms are out of proportion to her mechanism of injury on clinical examination."

The claimant next began seeing Dr. KH on September 2, 1997. Initially, Dr. KH diagnosed "adhesive capsulitis left shoulder" and prescribed "extremity manipulation along

with physical modalities." Subsequent progress notes from September 5 through October 14, 1997, expanded that diagnosis. Dr. KH referred the claimant to Dr. C, who in a report of December 30, 1997, noted complaints of "[n]eck, left shoulder and left arm pain." Dr. C diagnosed cervical discogenic pain, left shoulder subacromial impingement, rotator cuff tear and left CTS. Dr. C performed surgery on March 27, 1998, to repair the rotator cuff tear.

Eventually, the claimant was referred to Dr. Mc, for evaluation. In a report dated February 17, 1999, Dr. Mc recites that the claimant "was lifting a 20-pound bag" and claimant's medical history; observes she "appeared depressed"; and comments that:

It is my opinion that her neck complaints are likely secondary to the left shoulder injury and the left wrist complaints could also be secondary to the left shoulder injury. Dr. Mc certified that the claimant was at MMI (the parties stipulated, correctly or not, that the claimant reached MMI on March 15, 1999) and assessed a 13% IR based largely on left upper extremity (LUE) loss of ROM and left shoulder crepitis which resulted in a 22% LUE or 13% whole body IR. Dr. Mc's IR was disputed and Dr. MH, was appointed as the Texas Workers' Compensation Commission (Commission)-selected designated doctor. Dr. MH apparently saw the claimant two times, one on May 5 and the second time on June 15, 1999. In a Report of Medical Evaluation (TWCC-69) dated June 14 and narrative dated June 17, 1999, Dr. MH recited the claimant's history, commented that the claimant denied any anxiety, depression or suicidal ideations (denied by the claimant at the CCH that she said anything like that to Dr. MH) and diagnosed a degenerative joint disease of the left shoulder, post acromioplasty of the left shoulder, and "[s]ymptom magnification." Dr. MH noted that the claimant could not "achieve full abduction in the standing position on the left so I laid her down to do internal and external rotation in a supported and partially abducted position." Dr. MH went on to comment:

> Observationally, [the claimant] was noticed leaving the facility with her left arm in complete extension and swinging at her side as she walked towards the car. This being unsupported which is contrary to how she maintained her posture in the examination room. She is noted as actually driving herself and her daughter to the appointment. Upon entering the car she did close the door with her right arm reaching across but was able to freely lift the left arm and manipulate it through the seat belt and utilize her left arm in controlling the steering wheel.

The claimant sought to explain those observations at the CCH. Dr. MH assessed a zero percent IR, explaining:

> [The claimant] has refused further intervention. Her subjective signs and symptoms were entirely out of proportion with the objective findings and are inconsistent based on known anatomy. While [the claimant] may have some physical problems, I am unable to detect any residual problems due to her extreme symptom magnification and possible feigning of her condition. Because she has refused intervention, I believe she can be released to a

> home exercise program. Because [the claimant] has refused medical intervention, I do not believe that any further care is necessary. Therefore, she is placed at [MMI], and because of her noted inconsistent behavior I placed her with 0% whole person impairment.

Dr. KH responded to the designated doctor's report by letter dated August 20, 1999, and the Commission forwarded that letter to the designated doctor by letter dated October 13, 1999. Dr. MH responded by letter dated November 9, 1999, agreeing that the claimant may have "recurrent pain and altered biomechanics" but that the claimant

> so grossly exaggerated her responses that it made it virtually impossible for me to obtain accurate measurements, and thus give an accurate impairment. . . . [The claimant] appears to have willfully exaggerated her responses which, again made it virtually impossible to render an accurate rating. Along with other noted inconsistencies and a positive Minkoff (which is lack of physiological response to pain) is why I awarded her 0% whole person impairment.

The claimant was subsequently referred to Dr. WH, a clinical psychologist, by her attorney. Dr. WH, in a report dated April 13, 2000, commented that the claimant's "performance suggests . . . depressive symptoms as a result of her sustained work related injury" and found no evidence of "malingering in testing."

The claimant, in her appeal, cites the reports of Dr. D, Dr. KH, Dr. C, and Dr. G and references what the various doctors said. With regard to the depression, the claimant references Dr. Mc's comment that the claimant "appeared depressed" and Dr. WH's report. The claimant also contends that Dr. Mc's report constitutes the great weight of other medical evidence contrary to the designated doctor's report and that Dr. MH did not follow the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) because he assigned a zero percent IR based on his observation of watching the claimant walk to her car. The claimant contends that the disorder of her left shoulder for which surgery was performed should be "given a specific disorder [IR] in Table 49 of the [AMA Guides]." We note that Table 49 of the AMA Guides deals with specific disorders of the spine and is not applicable to the shoulder.

Regarding the extent-of-injury issue, that is a factual determination for the hearing officer to resolve based on the evidence before him. We are fully cognizant that the claimant contends that Dr. D misdiagnosed the claimant and that other later reports which suggest other injuries should have been given greater weight. However, with the evidence in conflict, 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). While a claimant's testimony alone may be sufficient to prove an extent of injury, the testimony of a claimant is not conclusive but only raises a factual issue for the trier of fact. Texas Workers' Compensation Commission Appeal No. 91065, decided

December 16, 1991. 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). In a case such as the one before us where both parties presented evidence on the disputed issues, the hearing officer must look at all of the relevant evidence to make factual determinations and 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 judgement 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). Only were we to conclude, which we do not in this case, that the hearing officer's determinations were so against the great weight and preponderance of the evidence as to be manifestly unjust would there be a sound basis to disturb those determinations. 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). Since we find the evidence sufficient to support the determinations of the hearing officer, we will not substitute our judgement for his. Texas Workers' Compensation Commission Appeal No. 94044, decided February 17, 1994.

Similarly, regarding the IR, Section 408.125(e) provides that the report of the Commission-appointed designated doctor has presumptive weight which can only be overcome by the great weight of other medical evidence to the contrary. In this case, the designated doctor stated that the claimant willfully exaggerated her responses during the examination and was later observed using her left arm completely contrary to the behavior displayed in the doctor's office. To the extent that Dr. MH considered his observations in assessing his IR, this was a factor for the hearing officer to consider. Certainly the claimant testified at length regarding what she said and did as opposed to what the designated doctor recorded. The hearing officer considered the relevant evidence and determined that the great weight of other medical evidence was not contrary to the designated doctor's report. The claimant cited two Appeals Panel decisions for the proposition that a designated doctor could not base his determination of an IR on observation of the claimant. However, in both cases, we affirmed the hearing officer's decision as not being so against the great weight and preponderance of the evidence as to require reversal. Similarly, in this case, we will reverse a factual determination of a hearing officer only if that determination is so against the great weight and preponderance of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Pool, *supra*. Applying this standard of review to the record of this case, we decline to substitute our opinion for that of the hearing officer.

Upon review of the record submitted, we find no reversible error. We will not disturb the hearing officer's determinations unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. King, *supra*. We do not so find and, consequently, the decision and order of the hearing officer are affirmed.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Gary L. Kilgore
Appeals Judge

_____
Dorian E. Ramirez
Appeals Judge