APPEAL NO. 001515

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 June 6, 2000. The hearing officer determined that the respondent (claimant) had disability resulting from the injury sustained on _____. The appellant (carrier) appealed on sufficiency grounds and that the findings of fact misstated the date of injury as January 13, 2000, when the correct date of injury was _____. The claimant replied that the hearing officer's decision was supported by sufficient evidence and should be affirmed but agreed that the findings of fact should reflect a date of injury as _____, rather than the January 13, 2000, date found by the hearing officer.

DECISION

Affirmed as reformed.

The carrier contends the hearing officer erred in determining that the claimant had disability from August 9, 1999, through the date of CCH on June 6, 2000. The claimant testified that she sustained an injury to her abdomen and lower back on _____, while lifting and moving boxes to a storage area in furtherance of her duties as an apartment leasing agent for the employer. She was treated by Dr. V in (City 1) on January 18, 1999, who suspected an incisional hernia and on January 21, 1999, recommended exploratory surgery.

A pelvic CT scan was performed on January 28, 1999, which was interpreted as normal by Dr. P. The claimant was returned to work by Dr. V on March 8, 1999, with instructions to return if the pain persisted. She returned to Dr. V on March 30, 1999, with continued complaints of abdominal pain. Dr. V returned the claimant to light- duty work with a restriction of no lifting over 15 pounds and no frequent use of stairs.

The claimant was examined by Dr. C at the request of the carrier on April 6, 1999. Dr. C's narrative of April 13, 1999, reflects that the claimant presented with a history of onset of burning pain in her right lower abdomen at the site of a previous hysterectomy scar which radiated throughout the abdomen. The claimant also developed a burning sensation in the low back as well. The claimant recited a history of back pain to Dr. C as of the date of injury but asserted the abdominal pain was considerably worse than the back pain. Dr. C diagnosed a probable tear of the right half of the lower abdominal scar without specific hernia being palpable and a resolving mild low back strain without evidence of radiculopathy.

The claimant changed employers in May 1999 but continued to work as an apartment leasing agent. She contended the new job did not require her to walk or climb stairs as much as she did at her previous employment. The claimant continued to be treated for abdominal complaints by Dr. V who reiterated that exploratory surgery was necessary. On June 29, 1999, a pelvic CT scan was ordered by Dr. V.

Records reflect that the claimant appeared at the (Hospital 1) on July 21, 1999, where a pelvic ultrasound was performed and interpreted as normal. On July 22, 1999, abdomen and chest x-rays were taken and reported as negative. On July 23, 1999, another abdominal and pelvic CT scan was performed and interpreted as normal with no evidence of acute appendicitis. Dr. V issued the claimant a release on July 26, 1999, taking her off work through August 9, 1999.

The claimant presented to (Hospital 2) in City 1 on July 28, 1999, for a pain management consult. The intake records reflect that multiple workups for complaints of abdominal pain had all been negative. The claimant was admitted for evaluation of pain and pain control and discharged with instructions to follow up with Dr. V and Dr. L for subsequent trigger point injections.

The claimant did not return to work after August 9, 1999, and moved to (City 2) in August 1999. She testified that Dr. V never intended for her to return to work after August 9, 1999, and the release was issued pending surgery.

On August 24, 1999, the claimant presented to (Hospital 3) in (City 3) with complaints of chest pain, fatigue and general pain over her whole body. The intake records reflect that the claimant had a history of pericarditis and lupus and had received a steroid injection earlier in the day for pain. As part of the general physical examination, the claimant's abdomen was checked and was found to be non-tender with no organomegaly (enlargement). The claimant was treated and released. Chest x-rays and an EKG were interpreted as normal with no evidence of cardiopulmonary disease.

On September 1, 1999, the claimant returned to Dr. V in City 1 with complaints of nausea, dizzy spells, fever, and pain in her right lower back. She was sent back to Hospital 2 for a possible urinary tract infection and renal pelvis (pyelo) problems and/or acute appendicitis. The claimant presented to the hospital and was released with a discharge diagnosis of acute gastroenteritis. No hospital intake records were offered by the parties.

The claimant testified that she moved back to City 1 in November, 1999, and was examined by Dr. V sometime during this month. There are no office records of this visit. Records from Dr. V dated December 9, 1999, reflect that the claimant appeared for a follow-up on her abdominal wall injury and possible hernia. She was taken off work for one month. The claimant returned on January 7, 2000, and Dr. V ordered a surgical consult and continued her off work for another month. On January 12, 2000, the claimant was referred to another physician for chronic pain management. The claimant was treated and kept off work by Dr. V through March 6, 2000, pending surgical approval. The claimant was scheduled to return in three weeks.

On March 6, 2000, the claimant signed an Employee's Request to Change Treating Doctors (TWCC-69), which was approved by the Texas Workers' Compensation Commission on March 9, 2000. The claimant testified that she made the change to Dr. LO

at the referral of her attorney because Dr. V could not get the abdominal surgery approved. Additional x-rays of the claimant's cervical and lumbar spine were taken on March 24, 2000, and were interpreted as unremarkable. An MRI of the lumbar spine was also performed on March 24, 2000, and interpreted as unremarkable. Dr. L referred the claimant to Dr. A for pain management.

A narrative from Dr. A dated May 24, 2000, reflects that EMG/nerve conduction studies performed on May 9, 2000, did not indicate any evidence of neuropathy or radiculopathy and that he had concerns for chronic myofascial pain. The claimant was to follow-up in one month or on an as needed basis.

The carrier contended that the hearing officer misstated the date of injury as January 13, 2000, in Finding of Fact Nos. 1b, 2, and 3 and the correct date should read _____. The claimant also urged that the correct date should be _____. We agree and reform the clerical error in these findings of fact to reflect the proper injury date as _____.

The carrier also contended that the claimant's compensable injury was limited to an abdominal injury. Section 410.151(b) provides that an issue not raised at the benefit review conference (BRC) or that was not resolved at the BRC may not be considered at the CCH unless the parties consent or good cause existed for not raising the issue at the BRC. The issue as to whether the injury extended to the claimant's lower back was clearly tried by the parties by consent and there was no objection urged by the carrier during the CCH when the hearing officer asked the claimant whether she had injured her lower back. The carrier offered into evidence the narrative report from Dr. C, who opined that the claimant had, as of April 6, 1999, a resolving mild lower back strain. This evidence was sufficient to support the hearing officer's determination that the claimant had injured her low back and abdomen while working for the employer. Since there was no stipulation by the parties that the claimant had sustained a compensable injury, a finding was required on the issue of compensability prior to making the ultimate disability determination. The hearing officer did not err in finding that the claimant sustained an injury to her lower back and abdomen.

"Disability" means the "inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage." Section 401.011(16). The claimant testified that she was off work from August 9, 1999, through the date of the CCH on June 6, 2000, due to her injury and that she did not believe she could return to work pending surgery. The claimant offered work release slips from Dr. V from December 9, 1999, through March 6, 2000. This evidence supports the hearing officer's disability determination.

Section 410.165(a) provides that the hearing officer, as finder of fact, is the sole judge of the relevance and materiality of the evidence as well as the weight and credibility that is to be given the evidence. It was for the hearing officer, as trier of fact, to resolve the inconsistencies and conflicts in the evidence. Garza v. Commercial Insurance Company

of Newark, New Jersey, 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). 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 trier of fact may believe all, part, or none of the testimony of any witness. Aetna Insurance Company v. English, 204 S.W.2d 850 (Tex. Civ. App.-Fort Worth 1947, no writ). We affirm as reformed the hearing officer's finding of a compensable lower back and abdominal injury to have occurred on _____, and the determination that the claimant had disability from August 9, 1999, through the date of the CCH as a result of the injury sustained on _____.

Kathleen C. Decker
Appeals Judge

CONCUR:

Elaine M. Chaney
Appeals Judge

Judy L. Stephens
Appeals Judge