APPEAL NO. 002116

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 August 24, 2000. The issues at the CCH were whether Parkinson's disease was part of the respondent's (claimant) compensable injury of _____ (cast as an "extent of injury" question), and whether the appellant (carrier) had waived the right to dispute compensability of this injury by not timely contesting it in accordance with Section 409.021.

The hearing officer determined that there was no waiver by the carrier of the right to dispute the Parkinson's disease, apparently due to the applicability of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 124.3(c) (Rule 124.3(c)) and this issue has not been appealed. The hearing officer further found that the claimant's Parkinson's disease was traumatic in origin and therefore part of his compensable injury.

The carrier has appealed. It argues that the evidence does not establish within reasonable medical probability that the claimant's Parkinson's disease is a compensable "follow-on" injury. The carrier further argues that the hearing officer should have made a finding as to whether the claimant had Parkinson's disease or parkinsonism, and argues that the difference in the two conditions is significant. The carrier disputes that the claimant even sustained a head injury. There is no response from the claimant.

DECISION

We affirm the hearing officer's decision.

The claimant was employed as a security guard by (employer); while making his rounds on _____, he slipped and fell backwards on some ice. He said that he hit his head on a speed bump. The claimant was treated in the emergency room on _____. He was found to have post-traumatic musculo-skeletal pain, right lower extremity pain, and low back pain. The person making notes recorded that the claimant on that date denied neck and head pain.

The claimant's treating doctor early in the course of his injury was Dr. H. The claimant was referred to and treated by Dr. S for low back pain and right knee derangement. Dr. S's report on January 22, 1991, recorded a history of the claimant's falling and hitting his head and low back, and twisting his right knee. He had arthroscopic surgery on his knee on March 22, 1991. The claimant also treated with other doctors simultaneously to Dr. S. The claimant said that shortly after his accident, he began to develop tremors and numbness, symptoms which he had never previously experienced.

On May 6, 1991, the claimant was examined by Dr. F relating to persistent headaches, tremors of his upper extremity, and radicular lower extremity loss of sensation. Dr. F's notes record that the claimant's tremors began about a week after his accident.

Dr. F opined that this could be idiopathic Parkinson's disease or "may be related to his recent head trauma." Dr. F recommended ruling out a subdural hematoma or intracranial tumor. Notes from Dr. F's office state that the claimant's EMG findings are consistent with diabetic neuropathy or polyradiculoneuropathy.

On July 17, 1991, Dr. K noted that the MRI of the head was normal, and that his tremors "may most likely" represent idiopathic Parkinson's disease, although clinical follow-up was recommended. Dr. K stated that the relationship between the claimant's on-the-job injuries and the development of these symptoms was "difficult to clarify."

The claimant undertook treatment by Dr. M in August 1992. Dr. M was a member of the American Academy of Neurology, the American College of Neuropsychiatry, and the American Society of Neuroimaging. Dr. M noted a normal EEG on August 25, 1992. On November 16, 1993, Dr. M wrote a general short letter that he was treating the claimant for posttraumatic-induced Parkinson's disease. The claimant's tremors and headaches were treated with medication. On March 3, 1994, Dr. M noted a mildly abnormal EEG that he said was "most likely as the late effects of head injury. However must rule medication side effects." A narrative report dated this same day recorded a diagnosis of "post traumatic Parkinson's disease."

The carrier apparently sent medical records to a consulting doctor on May 17, 1996; a report reflecting review of such records was written on June 10, 1996, by Dr. SN. Dr. SN noted as part of his report that the claimant was in an automobile accident on June 17, 1991, and a second accident on _____. However, no other evidence was offered or developed concerning these purported accidents. Dr. SN's conclusion was that there had not been a statistically documented relationship between Parkinson's disease and trauma and that this condition was therefore unrelated to "the bump" the claimant sustained when he fell. Dr. SN said that the trauma to the claimant's head was exceedingly mild. It should be noted that Dr. SN's letter also described the claimant's symptoms as "Parkinsonism."

If the carrier reacted to this report, it is not contained in the evidence. In fact, the first Payment of Compensation or Notice of Refused/Disputed Claim (TWCC-21) that the carrier filed is dated as received on September 27, 1999, by the Texas Workers' Compensation Commission. This disputed the claimant's Parkinson's disease due to a report filed by Dr. G, who also testified at the CCH. The TWCC-21 noted that the disease was an ordinary disease of life, that there was no causal relationship between it and the compensable injury, and that there was "no evidence" of trauma to the head that could cause Parkinson's disease.

The claimant was referred to Dr. D, a neurosurgeon, in 1998; Dr. D's October 19, 1998, report noted that the claimant's tremors started two weeks after his injury, which included a "mild" head injury. Dr. D's impression was "severe Parkinsonism, possibly post-traumatic." Dr. D noted that the claimant had an MRI of the brain on August 31, 1998, which was reported as showing decreased signal intensity in one area of the brain. Dr. D said that he would review the MRI himself, and assess its findings, which he said were

"quite unusual" findings in idiopathic Parkinson's disease, making a traumatic origin more likely. On January 4, 1999, Dr. D wrote a letter stating that he had examined the claimant again and reviewed the MRIs of his brain. Dr. D stated that the claimant had not improved over the last year and had gait and swallowing difficulties. Dr. D stated that the MRI findings pointed toward "secondary Parkinsonism," most likely due to head trauma.

Another doctor, Dr. E, wrote a letter on February 16, 1999, to the carrier's adjuster requesting a motorized scooter for the claimant. In March 1999, Dr. E referred the claimant to Dr. V, who wrote a three-page report stating his belief that the claimant had idiopathic Parkinson's disease.

On September 23, 1999, the claimant was examined by Dr. T, a neurologist. Dr. T noted that the claimant was, at that point, wheelchair bound. Dr. T's working diagnosis was trauma-induced parkinsonism. It appears that Dr. T was consulted primarily with regard to recommendations of further treatment for the claimant.

Dr. G testified at the CCH that Parkinson's disease was primarily idiopathic; however, he also stated that it could be traumatic (transcript, page 35), but that a trauma would have to be repetitive or severe. He stated that he concluded that the claimant definitely had a Parkinsonism condition (of which Parkinson's disease would be one form) but that it was due to idiopathic origin. He said he based this upon his determination that the claimant did not have any head trauma, because it was not recorded in the first emergency room record. Dr. G said that he was not aware that there was a history prior to May 1991 that the claimant gave of hitting his head. He said that knowing that the claimant gave a history of hitting his head when he fell earlier than that date would not change his opinion. On cross-examination, Dr. G clarified that he was disputing that there had been trauma to the claimant's brain, as opposed to his head.

Finally, there are two Report of Medical Evaluation (TWCC-69) forms in evidence, both filed by Dr. H. One certified that the claimant had reached maximum medical improvement (MMI) on January 7, 1993, with a 52% impairment rating (IR). Of this, 45% was for impairment to the brain and central nervous system, including a posttraumatic extrapyramidal disorder, and a Parkinson-type tremor is noted. The second TWCC-69 certified MMI on March 1, 1994, with a 28% IR, with 15% assigned to the extrapyramidal disorder. If there was a reaction or dispute by the carrier to either IR, the record has not been supplemented with this.

The carrier, as part of its argument on appeal, asserts that the claimant did not even sustain an underlying blow to his head when he fell. We note that the waiver issue before the hearing officer related to the "claimed injury" of Parkinson's disease or parkinsonism and whether the claimant's fall on _____, was the cause of this syndrome; this is borne out by the benefit review conference (BRC) report, in which the carrier's position on the waiver issue was that the "Parkinson's disease" was idiopathic in nature.

Any dispute that the claimant hit his head when he fell was not expressly carried forward to the BRC or CCH or argued in final argument and cannot be said to have been actually litigated during the CCH. Accordingly, the hearing officer found that the claimant sustained a traumatic head injury.

In this case, we agree that the development of Parkinson's disease or Parkinson symptoms from a blow to the head involved matters beyond common experience, and medical evidence should be submitted which establishes the connection as a matter of reasonable medical probability, as opposed to a possibility, speculation, or guess. *See* Houston General Insurance Company v. Pegues, 514 S.W.2d 492 (Tex. Civ. App.-Texarkana 1974, writ ref'd n.r.e.); Schaefer v. Texas Employers' Insurance Association, 612 S.W.2d 199 (Tex. 1980); Texas Workers' Compensation Commission Appeal No. 92187, decided June 29, 1992; and Texas Workers' Compensation Commission Appeal No. 93774, decided October 15, 1993. However, we would also note that opinion testimony does not establish any material fact as a matter of law and is not binding on the trier of fact. American Motorists Insurance Co. v. Volentine, 867 S.W.2d 170 (Tex. App.-Beaumont 1993, no writ). The hearing officer was still entitled to weigh the conflicting expert opinions presented. The hearing officer could determine not to credit Dr. G's testimony because his opinion was based upon his belief that the claimant did not hit his head.

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, 702 (Tex. Civ. App.-Amarillo 1974, no writ). This is equally true of medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286, 290 (Tex. App.-Houston [14th Dist.] 1984, no writ). An appeals 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. National Union Fire Insurance Company of Pittsburgh, Pennsylvania v. Soto, 819 S.W.2d 619, 620 (Tex. App.-El Paso 1991, writ denied); Volentine, *supra*. We cannot agree that the opinions favorable to the claimant's argument do not rise to the level of reasonable medical probability.

The decision of the hearing officer will be set aside only if the evidence supporting the hearing officer's determination is so weak or against the overwhelming weight of the evidence as to be clearly wrong or manifestly unjust. Atlantic Mutual Insurance Company v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.). We cannot

agree that this is the case here, and affirm the decision and order.

Susan M. Kelley
Appeals Judge

CONCUR:

Kenneth A. Huchton
Appeals Judge

Judy L. Stephens
Appeals Judge