APPEAL NO. 950188

On December 22, 1994, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). In response to the issues at the hearing, the hearing officer determined that the appellant's (claimant's) "lumbar condition, her diabetes and hypertension, her gums, teeth, both feet, both arms and deterioration of all muscles are not causally related to her injury of (date of injury);" that the claimant timely filed her claim for compensation with the Texas Workers' Compensation Commission (Commission); that the claimant timely reported her injury to her employer; and that the respondent (carrier) timely contested compensability of the claimant's lumbar injury, and her diabetes, hypertension, gums, teeth, feet, arms and muscle deterioration. The hearing officer decided that the claimant injured her head and neck in the course and scope of her employment on (date of injury), and further decided that the claimant does not have injury to any other part of her body as a result of the compensable injury of (date of injury). The claimant seeks review of the hearing officer's determination on the extent of her injury. The carrier requests affirmance.

DECISION

Affirmed.

We disagree with the carrier's contention that the claimant's appeal is not adequate to invoke the jurisdiction of the Appeals Panel. We read the appeal to question the sufficiency of the evidence to support the hearing officer's determination on the extent of the claimant's injury.

According to medical reports the claimant had neck surgery in 1975 and sustained a work-related injury in 1986 when she fell while climbing stairs and developed chronic low back pain. She suffered another work-related injury in April 1987 when she stooped down and felt severe back pain. She treated with (Dr. E) for the 1987 injury and he diagnosed a low back sprain. In April 1988 (Dr. HU) reported that the claimant was still experiencing chronic low back pain with radiation down her legs and that she had paresthesias of both feet.

The claimant testified that on (date of injury), she fell backwards at work when her chair broke and she struck her head on a shelf and landed on her back. She said she began "aching all over" immediately after the accident. In May 1992 she filed a claim for workers' compensation in which she claimed she injured her neck when her chair broke on (date of injury). At the hearing the claimant claimed that as a result of the accident of (date of injury) she injured her head, neck, lumbar spine, feet, arms, teeth, and gums. She also claimed that the injury aggravated her preexisting diabetes and hypertension and that it caused deterioration of all of her muscles. The claimant has been seen by numerous doctors. On June 2, 1992, Dr. E reported that he had been treating the claimant for her

(date of injury) injury and he diagnosed a neck sprain, head contusion, scapular contusion, and a "sprain or strain back, unspecified." In April 1994 Dr. E stated that surgery and pain had exacerbated the claimant's blood pressure problem and that dietary restrictions and the inability to be mobile had aggravated the claimant's diabetes control.

Dr. E referred the claimant to (Dr. S), who had performed the 1975 surgery, and in May 1992 Dr. S reported that the claimant needed additional neck surgery which surgery was done in June 1992. In September 1992 Dr. S reported that the claimant had pain in her right forearm which he attributed to tendinitis. In a Report of Medical Evaluation (TWCC-69) dated October 13, 1992, Dr. S reported that the claimant reached maximum medical improvement (MMI) on September 23, 1992, with a 10% impairment rating (IR) for impairment of her neck. In November 1994 Dr. S reported that he had "no record of difficulty related to hypertension, diabetes or low back problems."

Dr. S referred the claimant to (Dr. W) who examined the claimant in July 1992 and she noted that the claimant had had neck surgery in June 1992 and she diagnosed the claimant as having myofascial pain syndrome and chronic right C-6 radiculopathy. In a TWCC-69 dated October 19, 1992, Dr. W reported that the claimant reached MMI on October 19, 1992, with a 10% IR for impairment of her neck. In her narrative report Dr. W noted, among other things, a diagnosis of "lumbosacral strain irritability reactive to muscle contracture, overall clinically improving on objective exam." However, she also stated that "the progressing muscle spasming down her back subjectively is not uncommon after procedures and processes such as hers."

On January 29, 1993, (Dr. H) reported that he examined the claimant for an IR and that the claimant has a 47% IR, which he increased to 70% later in his report. It appears that the IR is for impairment of the neck and upper extremities. In March 1993 the claimant changed treating doctors to Dr. H. In April and May 1993 Dr. H reported that the claimant had complaints of pain in the neck, upper back, lower back, and arms, and that the claimant had not reached MMI. A "total myelogram" and CT scan were done in April 1993 and they revealed cervical spondylosis and stenosis, cervical disc bulges, a cervical fusion, and a disc protrusion at L5-S1. In October 1993 the claimant had a lumbar discogram done because of low back pain radiating to her legs. In April 1994 Dr. H stated that "I think she [claimant] has had damage to her low back and her neck as a result of her injury, which has been overlooked." (Dr. A) performed a neurological evaluation of the claimant in July 1994 and his impression was that the claimant has chronic cervical, dorsal, and lumbosacral radicular syndrome, along with chronic headaches, diabetes, and high blood pressure. In August 1994 Dr. H stated that the claimant needs cervical and lumbar surgery.

In October 1994 (Dr. SH) evaluated the claimant for her chronic headaches and he diagnosed bilateral cervical radicular syndrome, bilateral chronic occipital neuritis, lumbar radicular syndrome, diabetes and hypertension. In November 1994, Dr. SH reported that

the injury of (date of injury), did not cause the claimant's hypertension or diabetes, but it has made it more difficult to manage those conditions. Dr. H reported in November 1994 that the claimant's condition is "continually deteriorating, involving her arms, legs and feet." He also stated, "[w]ith reasonable medical certainty, the pain from this patient's injury is worsened by the obstructionism of the carrier and their cohorts is the primary factor in her lack of diabetic and hypertensive control."

The Texas Workers' Compensation Commission (Commission) selected (Dr. O) as the designated doctor to determine MMI and IR and in a TWCC-69 he reported that the claimant reached MMI on October 19, 1992, with a 19% IR for impairment of the neck.

(Dr. L) examined the claimant on February 19, 1994, at the request of the carrier and he reported that he didn't find any "objective findings on her low back exam to indicate that she has a significant low back problem," and that he didn't think the claimant needs any further surgery for her neck or back. He also stated that he agreed with Dr. O's date of MMI and IR. (Dr. D) reviewed the claimant's medical records at the request of the carrier and he reported in October 1993 that the claimant "had no injury to her lumbar spine at the time of the accident (date of injury)." (Dr. G) reviewed the claimant's medical records at the request of the carrier and he reported in July 1994 that the claimant's blood sugar and blood pressure were not under control both before and after the (date of injury), accident. He stated that chronic underlying pain will worsen both hyperglycemia and hypertension to some extent; however, when Dr. G was asked whether continued treatment of the claimant's diabetes and/or hypertension is necessary because of her (date of injury), injury, he responded: "[t]he patient requires treatment for both conditions independent of the injury. This injury neither lessens nor increases the need for treatment."

In November 1994, (Dr. GI), who had given the claimant three cervical epidural steroid injections in 1993, reported that the claimant had preexisting diabetes and hypertension, but that chronic pain possibly could add to those problems because of increased release of epinephrine in response to the pain.

The claimant testified that before her injury of (date of injury) she had perfect teeth but that now her gums are sore and her teeth are rotten. She also said that after her injury both of her arms hurt from her neck to her fingertips, that she has experienced "leg jumping," and that she has numbness in her feet. She said that prior to the (date of injury) accident her diabetes and hypertension were "borderline," but were not out of control, and that the injury aggravated those conditions. She further testified that she injured her "whole back" on (date of injury). (Mr. W) testified that when he met the claimant in December 1992, she had neck and lower back pain.

The claimant disagrees with the hearing officer's decision that she injured her head and neck on (date of injury), but that she does not have injury to any other part of her body as a result of the compensable injury on (date of injury).

The claimant had the burden to prove the extent of her injury. Texas Workers' Compensation Commission Appeal No. 941329, decided November 18, 1994; Texas Workers' Compensation Commission Appeal No. 950084, decided February 28, 1995. There is much conflicting evidence on the issue of the extent of the claimant's injury. The hearing officer is the judge of the weight and credibility of the evidence. Section 410.165(a). As the trier of fact the hearing officer can believe all, part, or none of any witness's testimony, and he or she resolves conflicts in the evidence, including the medical evidence, and determines what facts have been established from the conflicting evidence. Appeal No. 950084, *supra*. 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, *supra*. 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, *supra*. We conclude that the hearing officer's decision is supported by sufficient evidence and is not so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust.

The hearing officer's decision and order are affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Lynda H. Nesenholtz
Appeals Judge