APPEAL NO. 950344

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB.CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held in (city), Texas, on January 26, 1995, to determine the following disputed issues: is the claimant's "condition" an "effect" naturally resulting from the injury of (date of injury), entitling her to reasonable and necessary medical treatment; has the claimant reached maximum medical improvement (MMI) and, if so, on what date; and what is claimant's impairment rating (IR). The hearing officer, (hearing officer), held that the claimant's herniated disk of 1994 is not causally related to or naturally resulting from the injury of (date of injury), that the claimant did not dispute the MMI and IR given by (Dr. G), and that accordingly claimant reached MMI on October 5, 1992, with an IR of 1%.

DECISION

We affirm.

The claimant was employed as a custodian by the self-insured school district (hereinafter "carrier"). She sustained a compensable back injury in (month) of (year) while moving desks and was treated by (Dr. M), who diagnosed low back syndrome, treated her conservatively, and released her to return to work in October. In February of 1990 the claimant began treating with (Dr. G) because of continued pain. On February 7th an MRI disclosed degeneration of the L4-5 and L5-S1 disks with mild bulging at L4-5; no evidence of a herniated nucleus pulposus was found. An April 18th CT scan and myelogram showed minimal bulging at L4-5 and probable disk degeneration with minimal central bulging at L5-S1. On October 26th Dr. G released claimant back to work with restrictions; on December 19th he found she had reached MMI; and on December 26th he released claimant to work with no restrictions (noting that she had returned to work). She contended that she had continued to have back pain since that injury.

The claimant suffered a second compensable injury on (date of injury), when she fell on a trash can and injured her neck, lower back, and wrist. The evidence shows that on December 16, 1991, she saw Dr. G, who stated she continued to have symptoms relating to her lower back. At that time, he prescribed topical ointment. On March 30, 1992, he gave as a history the injury of (date of injury), reported tenderness in claimant's lumbar spine, and ordered a back brace, medication, and further studies. A lumbar spine MRI dated March 30th indicated disk degeneration and mild bulging at L4-5 and L5-S1 with no evidence of herniation. She also began seeing (Dr. E) for a series of manipulations with ultrasound and muscle stimulation.

On (date of injury), the claimant experienced back pain while digging in a garden at work. She again returned to Drs. E and G; on September 2nd the latter noted claimant's complaints of back pain radiating into her leg and neck pain radiating into the shoulder and arm. A lumbar MRI showed minimal bulging of the annulus at the L4-5 level. On September 30 Dr. G stated, "A comprehensive review of this patient's testing includes an MRI which

does not show evidence of disc herniation." He stated she could return to work on October 5, 1992, "at which time she will have reached [MMI]" with a one percent IR. On June 28, 1993, Dr. G completed a Report of Medical Evaluation (Form TWCC-69) giving the MMI date of October 5, 1992, with a one percent IR. The claimant stated that she received Dr. G's TWCC-69 in July of 1993, and that approximately one week later she contacted the Texas Workers' Compensation Commission (Commission) to state that she disagreed with the one percent IR; she said she was told to send papers to the (city) field office and that the matter would be investigated, but that she never heard back from the Commission. Commission Dispute Resolution Information System computer entries show that the claimant contacted the Commission about Dr. G's IR, but that this occurred in July of 1994.

On October 13, 1992, Dr. E scheduled the claimant for a functional capacity evaluation. That report noted that the claimant was currently experiencing no back or neck pain. While stating that claimant manifested some symptom magnification, the report concluded that the claimant was capable of physically performing some of her pre-injury work, and it recommended that she undergo a work hardening program. At the conclusion of that program in January of 1993 claimant was deemed to be capable of performing her pre-injury work.

Although claimant testified that after January 1993 she twice went to an emergency room for treatment of pain, the next medical document in the record is a May 3, 1994 report from (Dr. EX). (The claimant also stated that she had not sought further medical treatment because the carrier would not pay for it.) On that date Dr. EX wrote that claimant had been injured in (year) and had suffered persistent pain since that time. On June 16th claimant was seen by (Dr. P), who noted an injury of (date) (sic), (year) and the fact that a CT scan ordered by Dr. EX showed a very large herniation at L4-5. A later MRI showed degenerative disk disease at L4-5 with moderate sized midline herniation, as well as degenerative disk disease at L5-S1 with mild diffuse bulging.

On July 5th Dr. P initiated the process for approval of spinal surgery; thereafter claimant was seen by (Dr. H) for a second surgical opinion. At the hearing the claimant stated that Dr. H examined her in a rough manner, and his report reflects that the claimant screamed when her leg was elevated at approximately five degrees. He concluded that the claimant had sustained an "uncomplicated muscle strain" and saw no indication that surgery was recommended. He also found "a significant factor of emotional overlay." Dr. P wrote that he disagreed with Dr. H's assessment, and requested that the case go to surgical dispute resolution; however, due to claimant's complaints of continued and serious pain emergency surgery was performed by Dr. P on August 24th.

On October 20th, Dr. P wrote as follows:

> The question has been raised about the natural history of the herniated disc from 1992 to 1994. The patient could have a tear or laceration of the annulus fibrosis in 1992 which was produced by the injury in 1992 and which can come

through the tear over a period of time which accounts for the large disc herniation at the level of L4-L5.

On November 3rd the carrier wrote Dr. H, asking that he comment on Dr. P's letter as to causation; Dr. H responded:

I have reviewed the lumbar MRI study of [claimant] done June 30, 1994. There again is decreased signal intensity of the discs at L4-5 and L5-S1 with a fairly large central bulge or herniation at L4-5. There is no apparent encroachment or displacement of the nerve root on either side.

The findings of this study thus are different from those noted in the earlier studies done February 7, 1990 and September 2, 1992. These changes occurring more than three years after the work related strain are not causally associated with that strain. Furthermore, it should be emphasized that the lesion is central or midline and failing to irritate or displace the nerve root, it almost surely has no clinical significance whatsoever.

And on January 11, 1995 Dr. H wrote:

. . .the findings of lumbar disc degeneration at L4-5 and L5-S1 as noted in the MRI studies done as early as February 7, 1990 represented the gradual effects of wear and tear, required years to develop and were not causally associated with any single traumatic episode or strain. The significant increase in central bulging of the L4-5 disc noted in an MRI study done June 30, 1994, in terms of all medical probability represent the natural progress of this disorder over a period of time. To contend that injury to the annulus fibrosis occurred either with her work related strain of September 24, 1989, (date of injury), or at any other time would be sheer speculation.

In her appeal the claimant challenges the following findings of fact and conclusions of law contained in the hearing officer's decision:

FINDINGS OF FACT

4.The MRI of February 7, 1990, showed no disc herniation; the CAT scan of April 17, 1990, showed no disc herniation; x-ray and MRI examinations of (date of injury), showed no disc herniation; and the MRI of September 2, 1992, showed no disc herniation.

5.The CAT scan of May 3, 1994, was the first to show a disc herniation.

7.The Claimant was not under medical treatment or care from February of 1993 until May of 1994.

8.The medical evidence in the record does not show a causal relationship between the herniated disc and the sprain of (date of injury).

9.The findings of lumbar disc degeneration at L4-5 and L5-S1 as noted in the MRI studies done as early as February 7, 1990, represented the gradual effects of wear and tear, required years to develop, and they were not causally associated with any single traumatic episode or strain.

10.The significant increase in central bulging of the L4-5 disc noted in an MRI study done June 30, 1994, represents the natural progress of this disorder over a period of time.

11.[Dr. G] on June 28, 1993, certified that the Claimant had reached [MMI] as of October 5, 1992, and assigned the Claimant an [IR] of 1%.

12.The Claimant received notice of these determinations early in July of 1993, and she did not dispute them.

13.These determinations became final in accordance with Rule 130.5(e) [Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e)].

CONCLUSIONS OF LAW

2.The Claimant's herniated disc of 1994 is not causally related to or naturally resulting from the injury of (date of injury).

3.The Claimant reached [MMI] on October 5, 1992, with an [IR] of 1%.

The claimant contends that Drs. G and E indicated to her in 1990 and 1992 that she had a herniated disk, and that the May 1994 CAT scan was not the first time this was revealed; that she did seek medical treatment between 1993 and 1994 by going to an emergency room; that the same disks are affected in the injuries and medical records show a causal relationship between the herniation and the (date of injury), injury; that Drs. P and EX believed the herniation resulted from the (date of injury), injury; that she disputed her MMI date and IR timely but that no action was taken by the carrier and the Commission; and that because Dr. G's certification was premature it should be disregarded and a designated doctor appointed.

The hearing officer's decisions as well as his findings and conclusions show that he relied upon evidence showing negative test results following the (date of injury), injury and earlier injuries. To the extent that the hearing officer did not find earlier evidence of herniation, and found that the claimant sought no medical treatment between work hardening in January 1993 (which pronounced her able to return to work) and May of 1994,

he was not obligated to believe the claimant's testimony that doctors had told her she had a herniated disc and that she had twice gone to an emergency room. Further, although Dr. P stated his opinion that there could be a relationship between the (date of injury), injury and the herniation diagnosed in 1994, the hearing officer could choose to rely upon the opinion of Dr. H that no causal connection could be drawn in the absence of speculation. The 1989 Act provides that the hearing officer is the sole judge of the relevance and materiality of the evidence and of its weight and credibility. Section 410.165(a). As such, he is entitled to believe all, part, or none of the testimony of any witness and may resolve conflicts in the evidence, including medical evidence. Burelsmith v. Liberty Mutual Insurance Co., 568 S.W.2d 695 (Tex. Civ. App.-Amarillo 1978, no writ); Garza v. Commercial Insurance Co. of Newark, New Jersey, 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). That the record contains other evidence that would support a different inference is not a sound basis for overturning the decision of the fact finder. Salazar v. Hill, 551 S.W.2d 518 (Tex. Civ. App.-Corpus Christi 1977, writ ref'd n.r.e.). We will not overturn the hearing officer's decision unless it is so against the great weight and preponderance of the evidence as to be manifestly unfair and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986). Upon reviewing the evidence in this case, we decline to do so here.

As to the issues of MMI and IR, Rule 130.5(e) provides that the first IR assigned to an employee is considered final if the rating is not disputed within 90 days after the rating is assigned. The Appeals Panel has held that MMI and IR become intertwined in applying this rule. Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993. While claimant correctly notes that Dr. G's initial determination of MMI was prospective, and hence invalid (*see* Texas Workers' Compensation Commission Appeal No. 93259, decided May 17, 1993), the hearing officer in this case only considered Dr. G's later-filed TWCC-69, which did not give a prospective MMI date. The hearing officer found, pursuant to the claimant's testimony, that she received this document in July of 1993; however, despite claimant's statement that she conveyed her disagreement to someone at the Commission a week later, Commission records indicate this actually occurred approximately one year later. We thus find the evidence sufficient to support the hearing officer's determination that Dr. G's MMI date and IR became final under Rule 130.5(e).

Based upon the foregoing, the decision and order of the hearing officer are affirmed.

____
Lynda H. Nesenholtz
Appeals Judge

CONCUR:

____
Stark O. Sanders, Jr.
Chief Appeals Judge

____
Thomas A. Knapp
Appeals Judge