APPEAL NO. 980056

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 et seq. (1989 Act). On October 31, 1997, a contested case hearing was held. She (hearing officer) determined that appellant's (claimant) injury did not extend to L3-4 and that his initial impairment rating (IR) became final under Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)). Claimant asserts that medical evidence shows that the injury includes L3-4 and adds that a substantial change of condition results in the initial IR not becoming final. Respondent (carrier) replies that the decision should be affirmed.

DECISION

We affirm.

Claimant worked for (employer) on _____, when he slipped and fell at work injuring his back. An MRI taken in May 1994, almost one year after the accident, indicated disc bulging and desiccation at L4-5 with a small ventral disc herniation. An L5-S1 disc herniation was shown indicating that the thecal sac and S1 nerve root were affected. This MRI then stated:

> At L3-4 level, the central spinal canal, neural foramen, and lateral recesses appear normal bilaterally.

No other reference to L3-4 was made by the 1994 MRI.

According to (Dr. S) letter of April 16, 1997, he performed surgery on claimant on March 13, 1995, to decompress L4, L5, and S1. In 1997, he called for another MRI. Prior to surgery, Dr. S in February 1995, described claimant's problems at L4-5 and L5-S1 and refers to "highly stenosed L4, L5 and S1 nerve roots and spinal stenosis" saying that surgery would be performed. A neurosurgical consult from (Dr. R) in August 1994 had referred to the 1994 MRI as showing a herniation at L5-S1, "acquired central spinal stenosis," a small spinal canal, and a bulging disc margin. No mention of L3-4 was made by Dr. R.

Claimant saw (Dr. F) on March 18, 1996. Dr. F appears on the same letterhead as Dr. S. On March 18th Dr. F called for x-rays to assure stability of claimant's spine and on March 25, 1996, commented that the spine appeared stable. He then signed a Report of Medical Evaluation (TWCC-69) saying that claimant reached maximum medical improvement (MMI) on September 27, 1995, with 11% IR. There is no indication in the documents in evidence that the initial IR was ever disputed. Claimant did not testify. The carrier provided evidence that a report of the initial IR was sent to claimant on April 8, 1996.

Whether or not Dr. F was ever the treating doctor does not control, because an initial IR by any doctor may become final.

An MRI of May 2, 1997, relates that the L3-4 disc has a "mild broad based spondylotic" bulge, that there is canal narrowing, and there is "borderline stenosis." (Canal stenosis was also shown at L2-3.) On May 8, 1997, Dr. S wrote to the carrier that the MRI showed foraminal narrowing at L3, 4, and 5 with spinal stenosis "at the level where the operation was stopped last time at L3-4." He added that this is an exacerbation of his___injury. On June 9, 1997, Dr. S wrote that the MRI showed, "mild posterior indentation upon the dural sac at L3-4." He also said "I am unable to account for the patients findings on the basis of this study."

Then on August 25, 1997, Dr. S wrote in reply to the ombudsman, that he had "always mentioned that [claimant] had problems at L3-4 . . . ." He added that the 1995 surgery was not more inclusive because he wanted to keep the surgery limited. He said the L3-4 problems go back to 1994 in the records, that his problem relates to the injury at work, and that he needs further surgery. He opined that MMI was reached on March 17, 1997, with 12% IR.

Claimant saw (Dr. RO) in consultation on August 25, 1997, and Dr. RO opined that the current MRI shows "some stenosis at L3-4" and adds that his symptoms are related to the original injury.

The carrier had (Dr. G) review the medical records. Her reports dated June 12, 1997, and October 13, 1997, indicate that she did not believe the L3-4 problem of 1997 was related to the 1993 injury; she referred to the 1994 MRI and the 1997 MRI. She also commented that she did not agree with Dr. S that the L3-4 had been mentioned in the records she received, referring to 1994 and 1995 records.

The hearing officer is the sole judge of the weight and credibility of the evidence. *See* Section 410.165. There was no evidence that the initial IR was disputed in 90 days. In addition there was no compelling medical evidence indicating that Dr. F had misdiagnosed the claimant at the time of the initial IR in 1996. The evidence of the 1997 MRI and Dr. S's opinion referring to a "mild" indentation at L3-4 after obtaining the 1997 MRI and his observation that he was unable to account for the patient's findings on the basis of the MRI, along with Dr. RO's opinion in 1997 that there is now "some stenosis," does not require the Appeals Panel to overturn the finding of fact that the evidence did not show a substantial change of condition.

The medical evidence, including the MRI of 1994, the opinion of Dr. G, and the other medical records prior to 1997 do not show that the great weight and preponderance of the evidence is against the determination that the claimant's L3-4 condition was not part of the compensable injury and that the compensable injury did not extend to the area of L3-4. While Dr. S did refer to L4 in some records preceding 1997, the hearing officer, based on the medical evidence provided, did not have to consider those references as indicative of

an L3-4 condition as part of the compensable injury. We note that the issue addressed at the hearing involved L3-4.

Finding that the decision and order are sufficiently supported by the evidence, we affirm. *See* In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

Joe Sebesta
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Judy L. Stephens
Appeals Judge