APPEAL NO. 92312

On May 15, 1992, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The record was reopened June 5, 1992, to allow the hearing officer to take official notice of documents in the files of the Texas Workers' Compensation Commission (Commission); both parties were given opportunity to object. Objections filed by appellant contending that the documents were factually inaccurate were overruled. The hearing officer adopted the report of a designated doctor, (Dr. R) and determined that the claimant, (claimant), the appellant herein, had achieved maximum medical improvement (MMI) as of February 21, 1992, and had a zero percent impairment rating, as a result of a compensable injury sustained (date of injury). At the hearing, the appellant contended that Dr. R was not an agreed designated doctor, and stated that he agreed to see Dr. R based upon the impression that he would only conduct an independent medical examination. The hearing officer determined the parties had agreed that Dr. R would be the designated doctor to resolve a conflict over the existence of MMI and impairment between the appellant's doctor and the respondent's doctor (who had examined the appellant in accordance with Article 8308-4.16).

Appellant asks for reconsideration by the Appeals Panel on two main grounds. First, he argues that neither he nor his attorney agreed to examination by a designated doctor, and that their understanding was that Dr. R would perform an independent medical examination. He argues that by now, his chiropractor, (Dr. I), is his designated doctor. He further notes that the adjuster for the respondent directly contacted him and did not go through his attorney with regard to his appointment with Dr. R. Respondent replies that the decision of the hearing officer is supported by the evidence.

DECISION

After reviewing the record, we affirm the determination of the hearing officer.

The appellant was injured on (date of injury), when he was working on scaffolding and jammed his neck on the underside of a ledge. Although initially treated at an employer-referred clinic, he ended up seeking treatment from Dr. I, a chiropractor suggested by the foreman where he worked, on April 18, 1991. Dr. I testified at the contested case hearing, and stated that his diagnosis was acute cervical dysfunction and damage to the soft tissues supporting the spine. Dr. I began extensive treatment of appellant, and was still treating him at the time of the contested case hearing. It was Dr. I's opinion that the appellant had not reached MMI. He stated that he did not perform impairment ratings using the Impairment Guides required in the 1989 Act, and typically referred such assessments, which typically take time to perform. Consequently, Dr. I would not give an opinion as to an impairment rating for appellant.

Dr. I agreed that the appellant had improved substantially over the course of his treatment, with the frequency and severity of symptoms subsiding significantly. When asked to describe current restrictions on appellant's ability to function, Dr. I stated that

appellant was able to perform activities of daily living. He stated that he could not, however, do more than very light lifting where this function would involve lifting the arms above the shoulders, for a sustained period of time. Other than this, Dr. I stated that there really weren't any restrictions. He testified that appellant would continue to improve under his treatment. Both Dr. I and the appellant agreed that Dr. I had encouraged appellant to do activities at home, including yard work, but not to push it. Dr. I characterized a videotape showing appellant doing yard work as not inconsistent with his testimony regarding the appellant's limitations, and his advice to the appellant.

The appellant had been examined by a doctor for the respondent, (Dr. E), who rendered a report, on the Report of Medical Evaluation (TWCC-69), that appellant had reached MMI as of September 6, 1991, with zero percent whole body impairment. Appellant agreed that a benefit review conference had been set in December but called off for reasons that he states were never explained to him. He indeed testified that he didn't know why the benefit review conference was called to begin with and that he did not discuss this with his attorney. He testified that he just figured that the Commission and the respondent had a reason for calling it off. Notes from the claim file that were put into evidence indicate that the conference was cancelled so that a designated doctor could be agreed upon.

On the matter of representation by counsel, the appellant stated that, at the time of the first scheduled benefit review conference, as well as at the April 1992 conference that was actually held, his attorney was available for consultation and representation if he needed it. His attorney did not, however, appear at the April 1992 benefit review conference.

A letter from (Ms. P), the adjuster for respondent, to (Mr. T), the attorney for the appellant, dated December 16, 1991, says that she was advised of his representation of appellant by the benefit review officer, as well as the fact that the benefit review conference was cancelled because the attorney did not receive proper notice of it. She goes on to state "Mr. [Benefit Review Officer] has requested that we agree on a designated doctor. The carrier would be in agreement for your client to be seen by a neurosurgeon." (Mr. T) is then asked to contact her as soon as possible.

A December 18th letter from Ms. P to (Mr. T) starts off "[t]his letter will confirm our telephone conversation of December 18, 1991, in which we agreed to appoint (Dr. R) as the designated physician." The letter then advises the time of the appointment scheduled for January 21, 1992. A January 31, 1992 letter to the attorney from Ms. P indicates that it confirms the agreement to appoint Dr. R as designated doctor to examine appellant and, pursuant to the examination on January 21st, she purports to forward a copy of his report.

Dr. R examined the appellant, performed additional tests in February, and then completed a TWCC-69, finding that appellant had reached MMI on February 21, 1992 and had zero percent whole body impairment. This report was apparently made known to the benefit review officer at the April 10, 1992 benefit review conference.

Appellant, under questioning by his attorney, stated that he recalled a conversation

that the two had to the effect that Dr. R would not be a designated doctor but was strictly for another opinion. Appellant stated that he went to Dr. R hoping that he could get help and find out what was wrong with him. Initially in the hearing, appellant stated that Dr. R was neither his choice nor a designated doctor. The hearing officer pointed out that the designated doctor and choice of doctor were two different concepts. The appellant's attorney assured the hearing officer that he understood the function of the designated doctor, but that he had never agreed under any circumstance to a designated doctor, and complained that the respondent was unable to produce evidence, such as a certified mail card, to prove that correspondence had been either mailed to or received by him. The hearing officer commented that (Mr. T) argument and assertions concerning the agreement would not be taken as testimony.

The December 16th and 18th letters, and claims file notes, were received by official notice after the record was reopened by the hearing officer. An attorney for appellant (not Mr. T) replied that appellant and his attorney verbally agreed to an examination by Mr. R that they thought was intended just as an independent medical examination, and that the letters were "factually inaccurate." There was no contention, however, that the documents were not received by appellant's attorney.

Appellant testified that he was contacted directly by Ms. P (not through his attorney) about the time and date of Dr. R's examination. The date this contact occurred was not established in the record. However, appellant testified that he had initiated contact with Ms. P on some occasions to ask questions related to his claim. There was no evidence that Ms. P is an attorney.

Maximum Medical Improvement means the earlier of the expiration of 104 weeks from when benefits begin to accrue, or "the point after which further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated, based on reasonable medical probability." Article 8308-1.03 (32). This will not, in every case, mean that the injured worker is completely free of pain or impairment, or that the injured worker is able to return to the prior occupation. Evidence of impairment must be based on objective clinical or laboratory findings. Article 8308-4.25(a). The mechanism for resolving conflicts in issues over MMI or impairment is resort to an independent "designated" doctor. *See* Articles 8308-4.25, 4.26. 8.05. When a designated doctor is appointed by agreement of the parties, his determination carries presumptive weight on the issue of whether MMI has been reached, Article 8308-4.25 (b). The presumption underpinning the designated doctor's report can only be set aside if the great weight of <u>medical</u> evidence is to the contrary. Lay testimony about the nonexistence of MMI will not overcome the presumption accorded to the designated doctor.

Under the circumstances developed in this record, there is sufficient evidence to support the hearing officer's determination that Dr. R was agreed upon as the designated doctor. An insurance carrier may seek to have a doctor who is not a designated doctor examine a claimant only once in a 180-day period under Article 8308-4.16 (b). The statute further provides that any subsequent examination must be conducted by the same doctor unless the Commission approves another. Both of these provisions would have been

violated if Dr. R were intended to act as a "Section 4.16" doctor rather than a designated doctor.

There are at least three letters in the record that were sent to appellant's attorney that refer to Dr. R as a designated doctor. The evidence indicates that Dr. R's examination came after an apparent disagreement over (Dr. E's) MMI assessment. As noted by the hearing officer, the procedures undertaken by the parties as evidenced by the documents in the record parallel those set forth in Texas W.C. Comm'n, 28 TEXAS ADMIN. CODE §130.6 (Rule 130.6) with respect to selection of a designated doctor. While we are concerned that there is no direct evidence whether persons from the Commission verified the existence of the agreement as provided for in Rule 130.6 (d), it does not appear that Dr. R was appointed by a Commission order as would have been the case absent an agreement. Rule 130.6 (d). Given all the evidence, the hearing officer's inference that an agreement was made for Dr. R to serve as designated doctor is sufficiently supported. Whether the adjuster directly contacted the appellant at any given time to tell him about the appointment does not negate the existence of an agreement.

We conclude that the hearing officer's determination that the great weight of medical evidence did not overcome the presumptive weight accorded to Dr. R's assessment is supported by the record. 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 Co. v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.).

There being sufficient evidence to support the decision of the hearing officer, we affirm.

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Susan M. Kelley
Appeals Judge

CONCUR:

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Robert W. Potts
Appeals Judge

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Joe Sebesta
Appeals Judge