APPEAL NO. 93007

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 through 11.10 (Vernon Supp. 1992). On November 23, 1992, a contested case hearing was held in (city), Texas, with (hearing officer)., presiding, to determine issues relating to whether the respondent, (claimant), had reached maximum medical improvement (MMI), from a hernia injury sustained (date of injury) while employed by (employer). The claimant had two surgical procedures performed to repair the hernia and conditions related to the aftermath of the first surgery. Another issue, the correct impairment rating, was before the contested case hearing officer if he determined that the claimant had reached MMI.

The hearing officer determined that the great weight of medical evidence was contrary to the determination of the designated doctor that the claimant reached MMI effective July 16, 1992, and that assignment of an impairment rating was therefore premature.

The carrier appeals this determination, pointing out areas where the statement of evidence or the findings of fact are not supported by the record, and arguing that presumptive weight should have been given to the designated doctor's report. The claimant responds by arguing evidence, as well as facts not in the record, that he feels support the hearing officer's decision.

DECISION

After reviewing the record of the case, we reverse the decision of the hearing officer and render a decision that the claimant reached MMI on July 16, 1992, with an impairment rating of three percent, as determined by the report of the designated doctor.

Our review is restricted to evidence developed at the contested case hearing. Article 8308-6.42(a). A summary of this evidence follows.

The claimant was injured on (date of injury) when he lifted several heavy boxes while working in the employer's warehouse. At the hospital, he was diagnosed with a hernia located in the groin area. Claimant said he picked (Dr. B), out of the Yellow Pages. Dr. B performed a bilateral laparoscopic inguinal herniorrhaphy with Marlex mesh on April 1, 1992. A second surgery was performed by Dr. B June 5th for lysis of adhesions and appendectomy. On June 12, 1992, a letter from Dr. B to claimant indicates that claimant has lost faith in Dr. B, who offers to care for him during recovery. On June 16, 1992 claimant went to the emergency room of (Hospital) with lower abdominal pain. Much of the writing on the report is illegible but claimant's recent surgery and disinclination to use Dr. B is noted. On June 26, 1992 claimant went to (hospital) with severe pain in his groin. He said he was not doing anything at the time but laying down, following doctor's orders.

At Baylor, claimant was attended by (Dr. A); a medical treatment form indicates a diagnosis of "ilioinguinal nerve entrapment post herniorrhaphy." The claimant said he was referred to a pain clinic by Dr. A, but this was not approved by the carrier. Dr. A then referred claimant to (Dr. SW), who he said was his treating doctor. Dr. SW was a surgeon.

Other medical records indicate that claimant first went to see Dr. SW on June 18, 1992. Claimant also went to see Dr. SW on July 16, 1992 and was referred to a pain clinic. On August 11, 1992 claimant saw Dr. SW; that same day Dr. SW wrote claimant a letter in which he stated that he no longer wished to be involved in his care; the letter notes that he should go back to Dr. B or contact the Texas Workers' Compensation Commission (Commission) to find another doctor. Dr. SW states: "After evaluating your case, I do not feel that I can be of any assistance to you since I am not certain what the nature of your problem is and I am certain that further surgical intervention would be unwarranted at this time. I hope you are successful in finding some assistance with your chronic pain problem." A notation at the bottom of the letter indicates it was mailed certified mail on August 13, 1992.

Dr. SW completed a Commission Report of Medical Evaluation (form TWCC-69), shown as received by the carrier's adjuster on August 17, 1992 which states that claimant reached MMI on July 16, 1992 with an impairment rating of zero percent. The report indicates that, on that date, claimant had an inordinate amount of pain and was referred to a pain clinic. A second TWCC-69 was completed by Dr. SW (for reasons not explained in the record), which is dated September 2, 1992; it states MMI, with no effective date, notes that the date of visit was August 11, 1992, shows zero percent impairment, and states "no medical problems found."

On referral July 16, 1992, from Dr. SW, claimant said he went to see (Dr. BD) at a pain clinic, and was given nerve block shots which did not help him. There are no records from Dr. BD in evidence.

The claimant testified that after Dr. SW discharged him, he got Commission approval to consult with (Dr. F), who told him he had not reached MMI. However, the only records in evidence from Dr. F are two "off work" slips indicating that claimant was seen twice in August. Claimant said that Dr. F referred him to (Dr. AX), a surgeon. He said that Dr. AX has also referred him to (Dr. H), a neurologist, for evaluation. He said that Dr. AX told him he had not had the right kind of surgery for his problem.

A record from (hospital) dated September 22, 1992 shows that claimant came to the emergency room with severe pain and reported that he was unable to drive over to Dr. AX's office because of the pain. The report notes no fever or vomiting, and diagnoses chronic abdominal pain of unknown etiology. "Subjective tenderness" is noted.

A November 4, 1992 letter from Dr. H, in its history, notes only the April 1, 1992 operation. Dr. H notes that his impression is "possible ilioinguinal syndrome;" Dr. H gave him literature about this at the time which was part of the record. This literature states that if therapy does not work to alleviate the pain, surgery is indicated. Dr. H notes that the nerve may be injured during the type of surgery that claimant had. Dr. H also notes that claimant has some left foot weakness "which cannot be accounted for by an ilioinguinal ligament syndrome." Three possibilities are listed, none of which is obviously connected to the hernia treatment, and a "follow-up" EMG is recommended.

On September 8, 1992 the Commission appointed (Dr. O), of the (hospital), as designated doctor to assess MMI and impairment. Claimant stated that he saw Dr. O on October 2, 1992. Dr. O's TWCC-69 report is undated on its face but the narrative attached is dated October 15, 1992. This report shows that claimant reached MMI effective July 16, 1992 with an impairment of three percent as a result of sensory impairment from giving the claimant "the total benefit of the doubt for ilioinguinal entrapment."

Dr. O's report carefully and thoroughly describes how the impairment rating was derived and calculated from the AMA Impairment Guides. (No medical evidence was presented at the contested case hearing to rebut or refute the accuracy of Dr. O's impairment assessment). The report indicates that, at the request of Dr. O, a referral was made to (Dr. S), with whom Dr. O was in practice, for "impairment and disability evaluation." No palpable defect in the supporting structure of the abdominal wall was noted by Dr. S, although there was tenderness. "Extremities and Neurological" are listed as "not specially examined."

Dr. O's evaluation indicates that there was no loss of strength function, and only sensory pain and discomfort were indicated. Dr. O describes why he believes that the claimant has symptom magnification, and felt that he was grossly exaggerating his response, noting inconsistencies between claimant's responses and his reports of pain. Dr. O states that he did an EMG evaluation which was normal. A copy is attached to his report, indicating it was performed October 14, 1992 by (Dr. G), on referral from Dr. O. Dr. G's study indicates that claimant complained of back pain and lower abdominal pain. He concludes:

> Normal nerve conduction study of both lower extremities, no evidence of acute denervation. Motor unit and interference pattern assessment was hampered by poor cooperation. The paraspinal regions showed no abnormalities.

With regard to MMI, Dr. O states "he would be considered at maximum medical improvement because no therapy is helping." Dr. O also notes that claimant was previously determined at MMI by Dr. SW on July 16, 1992. "I certainly cannot disagree with that date." The TWCC-69, completed and signed by Dr. O, certifies an MMI date of July 16, 1992.

Dr. AX completed a TWCC-69 on November 10, 1992 stating that claimant had not reached MMI. His attached narrative gives a brief overview of claimant's treatment, noting that he was hospitalized October 21st to October 23rd; he notes that at that time claimant was seen by two other doctors whose impression was ilioinguinal nerve entrapment. Dr. AX does not describe any objective testing which he himself may have performed, or the results of his examinations. He states that Dr. H will continue to treat claimant for pain, and if, after this treatment, claimant remains symptomatic, "the marlex mesh and hemo clips may have to be removed as a final resort." Dr. AX's TWCC-69, although dated November 10, 1992, states that the date of visit with claimant was September 1, 1992.

Finally, there are two records from (Dr. J), whose indicated specialty is psychiatry and neurology. By letter of November 18, 1992, Dr. J says he saw claimant on the 3rd, 9th, and 16th of that month for Adjustment Disorder with Depressed Mood. Dr. J states that, due to the surgery, claimant developed anxiety, depression, and preoccupation with symptoms, which he says are all normal reactions to surgical complications. An initial medical report from Dr. J, dated November 9, 1992, notes a surgical complication of "nerve entrapment" as the basis for claimant's emotional distress. The report also says, under the referral section, "have discussed with surgeon the need for surgical exploration."

The designated doctor under the 1989 Act is an impartial doctor who is used to finally resolve disputes over MMI and impairment rating. To achieve this end, the report of a Commission appointed designated doctor is given presumptive weight. Art. 8308-4.26(g). Only the great weight of medical evidence can reverse this presumptive status. As the Appeals Panel has stated before, a finding of great weight requires more than a mere balancing or preponderance of the evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. A claimant's lay testimony does not constitute medical evidence that may be considered in determining whether the "great weight" rebuts the presumptive weight accorded to the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992.

We have emphasized that MMI does not, in every case, amount to pain-free recovery. *See* Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993. While MMI may appear to mean complete recovery to the lay person, that is not what it means for purposes of workers' compensation benefits. That term means, under Article 8308-1.03(32)(A) of the 1989 Act, the point at which further material recovery or lasting improvement can no longer be reasonably anticipated, according to reasonable medical probability. When the doctor finds MMI and assesses an impairment, he or she agrees, in effect, that while the injured worker may continue to have consequences, and quite possibly pain, from the injury, the doctor has determined, based upon medical judgment, there will likely be no further material recovery from the injury. Thus, although claimant is unfortunately in pain, this fact alone would not rule out MMI.

We have held that a hearing officer who rejects a designated doctor's report because the great weight of other medical evidence is to the contrary must clearly detail the evidence relevant to his or her consideration, clearly state why the great weight of other medical evidence is to the contrary, and further state how the contrary evidence outweighs the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92690, decided February 8, 1993. The decision of the hearing officer here fails to do this. Also, various findings and discussion of the hearing officer about the report of the designated doctor indicate that he may not have given it the appropriate weight.

In this case, we are troubled by the hearing officer's recitation in the Statement of Evidence that Dr. O did not examine the claimant, but indicates that examination was delegated totally to (Dr. S), Dr. O's associate. This is contrary to the testimony of the claimant, who asserted more than once during the hearing that he saw Dr. O on October 2, 1992 and said he was told by Dr. O that he would have to live with pain because he had reached MMI. As the carrier points out, Dr. O's report also describes tests he performed on claimant. Dr. S's report indicates that he was performing an impairment assessment on referral from, and not instead of, Dr. O. In any event, the designated doctor is not precluded from ordering referral examinations or additional tests to assist him or her in evaluation of MMI and impairment. Texas Workers' Compensation Commission Appeal No. 92627, decided January 7, 1993.

The hearing officer found significant Dr. O's use of the MMI date earlier assessed by Dr. SW. The hearing officer also notes that Dr. O did not evaluate some conditions later found by Dr. H. In our opinion, neither factor warrants discounting the presumptive weight to be given to Dr. O's report.

First of all, the hearing officer's finding that Dr. SW prepared his assessments of MMI after he terminated his professional relationship to the claimant is irrelevant to their validity as certifications of MMI. The TWCC-69s do not, on their face, appear to be based on anything but Dr. SW's treatment of the claimant. Even if viewed as late-filed reports, we have held that the sanction for a late report is an administrative fine, not disallowance of the substance of that report. Texas Workers' Compensation Commission Appeal No. 92132, decided May 18, 1992.

Second, reliance on Dr. SW's report would not, in and of itself, undermine Dr. O's report (in fact, Dr. AX's report, which the hearing officer found to comprise the "great weight" of evidence against Dr. O, documents his own extensive reliance on the findings of others doctors). Although Dr. O adopted Dr. SW's July 16, 1992 MMI date, he has clearly formed an independent opinion that claimant has reached MMI, based upon failure to respond to therapy. The order appointing Dr. O directs the carrier to supply all medical records. Dr. O's report states that claimant, since his operation, has received extensive treatment. We

may thus infer that Dr. O also considered claimant's medical records leading up to his examination. Although the claimant testified that he did not believe Dr. O was given medical records reflecting Dr. F's treatment, these were also not submitted to the hearing officer in this case.

Third, we cannot agree with the hearing officer's findings that the claimant has exhibited symptoms related to medical conditions unrelated to those used by Dr. O in his assessment of claimant's impairment rating. There is no causal link in Dr. H's reports between his speculations about the causes of claimant's foot weakness and his compensable injury, as opposed to another condition not related to the injury. In fact, Dr. H's report notes that the foot weakness is not related at all to the ilioinguinal syndrome. His November 4, 1992 letter is the first time that such weakness is documented in the medical records, a month after Dr. O's examination. Further, Dr. H's report does not indicate an awareness that the claimant had, on October 14, 1992, an EMG including an assessment of his lower extremities that was determined to be normal, which considered that claimant complained about back pain, and which also was performed on the lower extremities.

The only objective, clinical evidence in the record which speaks to the issue of MMI is contained in the designated doctor's report. There is no demonstration that medical conditions demonstrably related to the hernia treatment were not considered by him.

Against this evidence are Dr. F's "off work" statements which do not supply medical evidence about MMI, Dr. AX's report which essentially recaps claimant's medical history and appears to base the "no MMI" conclusion on some evidence not contained in the hearing record, as well as his examination two months prior to the TWCC-69, and Dr. H's diagnosis of "possible" ilioinguinal syndrome and observation of unrelated left foot weakness. This is not, in our opinion, the "great weight" of medical evidence contemplated by Article 8308-4.25(b) to rebut the presumptive weight accorded to Dr. O's report. All in all, we do not find that the hearing officer's reasons for invalidating the presumptive weight of the designated doctor's report to be sufficiently supported by the evidence.

We will reverse the determination of the hearing officer only when it is against the great weight and preponderance of the evidence. Atlantic Mutual Insurance Co. v. Middleman, 661 S.W.2d 182 (Tex. App.- San Antonio 1983, writ ref'd n.r.e.).

Accordingly, we reverse the decision of the hearing officer and render a decision, consistent with the designated doctor's report, that claimant reached MMI effective July 16, 1992 with an impairment rating of three percent, and that impairment income benefits, along with applicable lifetime medical benefits, be paid accordingly.

Susan M. Kelley
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Philip F. O'Neill
Appeals Judge