APPEAL NO. 931041

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act) (formerly V.A.C.S., Article 8308-1.01, *et seq*.). A contested case hearing was held on October 28, 1993, in (city), Texas, with (hearing officer) presiding as hearing officer. The sole issue at the hearing was the appellant's (claimant) correct impairment rating. The hearing officer found that the six percent whole body impairment rating certified by the designated doctor who was selected by the Texas Workers' Compensation Commission's (Commission) was not against the great weight and preponderance of the other medical evidence. The claimant appeals this determination asserting that the designated doctor failed to assign ratings to all his injuries as contemplated by the American Medical Association's Guide to the Evaluation of Permanent Impairment, third edition, second printing, February 1989 (AMA Guides). The respondent (carrier) urges that the decision of the hearing officer was correct and should be affirmed. The parties agreed that statutory maximum medical improvement (MMI) pursuant to Section 401.011(30)(b) was reached in January 1993 and was not an issue at the hearing.

DECISION

The decision and order of the hearing officer are affirmed.

The claimant worked as a truck driver. There is no dispute that on (date of injury), he was injured while unloading his truck when boxes of detergent fell on him. On (date), he complained of head, neck and upper back pain to his treating doctor, (Dr. MR). Dr. MR's initial diagnosis was head injury and cervical and thoracic strain. In a follow-up visit of January 23, 1992, he complained of increased pain and numbness in the fingers of both hands. Over the succeeding months, his complaints extended to severe headaches, facial numbness, dizziness, slurred speech and loss of memory and left elbow pain.

The claimant was subsequently seen by numerous specialists and a series of tests were performed.[1] An MRI of the left shoulder on August 9, 1991, showed evidence of a mild impingement of the supraspinatus tendon. A left shoulder arthrogram on July 25, 1991, was normal with no evidence of rotator cuff tear. An MRI of the head on December 9, 1992, was "unremarkable" except for a pineal cyst. An MRI of the cervical spine on February 8, 1991, was negative. (A subsequent MRI of the cervical spine on February 18, 1993, was also negative). An electroencephalogram taken on August 20, 1991, was normal with no evidence of epileptiform activity or evidence for focal or global cerebral dysfunction. An otherwise normal cervical myelogram on January 17,1992, showed a minimal annular bulge at C5-6 with no lesion, which was confirmed by CT scan.

(Dr. S), an MEO doctor, completed an examination of the claimant and review of his medical records on December 1, 1992. In his Report of Medical Evaluation (TWCC-69), dated December 4, 1992, he assigned an impairment rating of six percent based on injury

[1]In this appeal, we need not discuss every statement of every physician involved with the claimant, but only those relevant to the issue of impairment rating.

to the left upper extremity (shoulder). In arriving at this impairment rating, he noted and considered the claimant's complaints of shoulder, elbow and neck pain as well as dizziness, seizures, and numbness in the head and fingers of his left hand. Range of motion was normal except for the left shoulder. He further stated that his evaluation revealed a "considerable variability of response and variability of reaction." As to the claimant's headaches, Dr. S. concludes that since their onset began after the injury with increasing intensity, it is "less likely" that they could be attributed to the injury.

On February 4, 1993, (Dr. O), a referral physician, in a TWCC-69, assessed a nine percent whole body impairment rating. He observed that "I think we are looking at a somatization disorder with (claimant). In reviewing things with him he is almost hypochondriacal." Dr. O reviewed the results of previous tests done on the claimant. With regard to cervical range of motion testing, he found:

> When we did the physical examination, the cervical range of motion was 100% of normal. When we tried to do an inclinometer and he was aware of the evaluation, it was invalid. We could not get 3 readings within 5 degrees in cervical left rotation.

Dr. O noted that the claimant complained of "tingling in the fingertips of the left hand," but was unable to detect neurological deficits by pin wheel or pin prick. Hence, he found no sensory deficit. Strength testing was also invalidated. No muscle spasms were found. With regard to ulnar palsy of his left forearm, Dr. O could find no source in the neck or brain. Thus, Dr. O concluded that he could give an impairment rating only to the left shoulder based on loss of range of motion. He did not believe that claimant had a closed head injury or that he was not knocked unconscious in the accident. He was thus unable to conclude that he had a brain injury for which a rating should be given.

On May 11, 1993, (Dr. H), also a referral physician, in a TWCC-69, assigned a six percent whole body impairment rating based solely on injuries to the cervical spine. No narrative is attached to the report, but Dr. H refers on the TWCC-69 to the several tests done on the claimant.

The claimant was also referred by Dr. MR to (Dr. A), a neurologist, for his complaints of decreased memory, paroxysmal falling episodes without explanation and "excruciating, diffuse" headaches which were alleged to have begun on the date of the injury. His impression was that "[t]here seems little doubt (claimant) suffers from a postconcussive syndrome." He nonetheless found the claimant to be "neurologically intact." As noted above, an electrophysiologic evaluation showed no evidence of focal or global cerebral dysfunction. On January 20, 1992, Dr. A suggested that the claimant be seen at a pain clinic.

The Texas Workers' Compensation Commission appointed (Dr. B), M.D., Medical Director of the (city) Rehabilitation Hospital (rehabilitation hospital), as the designated doctor to determine the claimant's impairment rating. Dr. B examined the claimant on July 8, 1993,

and reviewed the claimant's medical records. Dr. B, noting that many of the claimant's objective examinations showed normal or essentially normal results found that the claimant had some impairment from his shoulder and his neck for which he assigned a whole body rating of six percent.

The claimant, in his request for review states that he sustained a closed head injury as a result of the accident on (date of injury), which resulted in numerous neurological problems, as well as a "cubital tunnel" problem with his left elbow, none of which were factored into his whole body impairment rating by any physician who provided an impairment rating. He attributes this failure to a refusal by the various specialists who examined him to look beyond their own specialties and provide a whole body impairment rating and an apparent unawareness by these rating doctors that the AMA Guides authorize impairment ratings for neurologic problems, specifically, facial numbness, speech impairment, disorientation, blurred vision, inability to concentrate and sensory loss. He offers as evidence in support of his position, his recounting of a conversation he had with a (Dr. D), whom he describes as an editor of the AMA Guides, on how the AMA Guides should be used,[2] and his own account of why he should receive an additional rating for these alleged injuries.

The designated doctor holds a unique position under the 1989 Act. *See* Texas Workers' Compensation Commission Appeal No. 92555, decided September 2, 1992; Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Section 408.125(e) accords the report of the designated doctor "presumptive weight" in regard to impairment. In Appeal No. 92412, *supra*, we pointed out that to outweigh the report of the designated doctor requires more than a mere balancing of the medical evidence or even a preponderance of medical evidence. Rather, such other medical evidence must be determined to be the "great weight" of the medical evidence contrary to the report. We have also held that a claimant's lay testimony does not constitute medical evidence that can be considered in determining whether the "great weight" rebuts the "presumptive weight" of the designated doctor's report. *See* Texas Workers' Compensation Commission Appeal No. 93072, decided March 12, 1993. The claimant contends that neither Dr. B, nor Dr. O, nor Dr. S. were his treating doctors and none had "first hand" knowledge of his medical needs. Hence, in his view, their findings and opinions based on a one hour visit were not valid. Our review of the record indicates that with the exception of Dr. S, an MEO doctor, and Dr. B, the designated doctor, all the physicians whose reports are included in the record were selected by the claimant in consultation with his primary physician, Dr. MR. The reports of Drs. S and B are detailed and address the claimant's neurological complaints. Indeed, the reports of the various physicians are remarkably consistent with the only variance among those providing an impairment rating being Dr. O who gave a nine percent instead of a six percent impairment rating based solely on injury to the upper left shoulder. Under these circumstances, we find sufficient evidence to support the hearing officer's

[2]Claimant, in his appeal, describes Dr. D as the editor of the 4th Edition of the AMA Guides. Section 408.124(b) of the 1989 Act requires use of the 3rd Edition, Second Printing.

decision that the claimant's correct impairment rating is six percent and that the great weight of the other medical evidence did not overcome the "presumptive weight" afforded the certification of the designated doctor.

The hearing officer is the sole judge of the relevance and materiality of the evidence and of the weight and credibility to be given that evidence. Section 410.165. Where there is sufficient evidence to support this determination, there is no sound basis to disturb the decision of the hearing officer. Only if we were to determine, which we cannot given the evidence in this case, that the decision of the hearing officer is so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust would we reverse. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Pool v. Ford Motor Company, 715 S.W.2d 629 (Tex. 1986).

The decision of the hearing officer is affirmed.

Gary L. Kilgore
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Thomas A. Knapp
Appeals Judge