APPEAL NO. 931082

On April 28, 1993, a contested case hearing was held in (city), Texas, with the record being closed on November 1, 1993. (hearing officer) presided as the hearing officer. The hearing was held under the provisions of 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*.). The issues at the hearing were maximum medical improvement (MMI) and impairment rating. The hearing officer determined that the appellant (claimant) reached MMI on August 24, 1992, with a 13% impairment rating as reported by (Dr. O), the designated doctor chosen by the Texas Workers' Compensation Commission (Commission). The hearing officer decided that the claimant is entitled to 39 weeks of impairment income benefits (IIBS) based on the 13% impairment rating (three weeks of IIBS for each percentage of impairment). The claimant disagrees with the hearing officer's determinations of the date of MMI and impairment rating. The respondent (carrier) responds that the decision is supported by the evidence.

DECISION

The decision of the hearing officer is affirmed.

The claimant was not represented by an attorney at the hearing and he declined assistance from an ombudsman.

The claimant sustained an injury to his neck and back on or about (date of injury), when some heavy boxes fell on him while working for his employer. On August 30, 1991, the claimant's treating doctor, (Dr. R), a chiropractor, anticipated that the claimant would reach MMI on September 19, 1991. A CT scan of the claimant's lumbar spine done on October 1, 1991, revealed broad based moderate bulges at the L3-4 and L4-5 levels, a postcentral herniation at the L5-S1 level, and degenerative facetal joint changes bilaterally at the L5-S1 level. A CT scan of the claimant's cervical spine done on the same day revealed neural foraminal narrowing from the C3-4 level to the C6-7 level with associated prominent degenerative disc bulge at the C5-6 level and prominent posterocentral osteophyte at the C7-T1 level. Dr. R referred the claimant to (Dr. W) who reported on October 16, 1991, that the claimant's neurological examination was normal and stated that "although they [x-rays and reports] described a herniated disc, I think clinically he really does not exhibit that."

At the request of the carrier, the claimant was examined by (Dr. C) on February 24, 1992. In a narrative report of the same date, Dr. C said the claimant "should reach MMI in six months." The claimant said he did not see Dr. C after the February 24, 1992, examination. In a signed but undated Report of Medical Evaluation (TWCC-69), Dr. C reported that the claimant reached MMI on August 24, 1992, with a six percent impairment rating.

In a report dated March 10, 1992, Dr. R said he did not think surgery was indicated, that the claimant needed a "disposition," and recommended that the claimant see (Dr. H) for

a "functional capacity test."

In a narrative report dated March 17, 1992, which is signed by Dr. H and by a physical therapist, it was reported that the claimant had a 32% impairment rating, consisting of ratings for specific disorders of the lumbar and cervical regions and ratings for decreased range of motion of the lumbar and cervical regions. Dr. H testified that he did not give the claimant a physical examination, but that the claimant was given a "functional capacity exam." Dr. H further stated that Dr. W referred the claimant to him and that in the referral process Dr. W had stated that the claimant had reached MMI.

On November 20, 1992, the Commission selected Dr. O as the designated doctor to determine whether the claimant had reached MMI, the date MMI was reached, and the percentage of impairment. In a signed but undated TWCC-69, Dr. O reported that the claimant reached MMI on August 24, 1992, with a 13% impairment rating. An accompanying report revealed that the impairment was for specific disorders of the lumbar and cervical regions, but that no impairment was given for decreased range of motion because it had been determined that the claimant had invalidated range of motion testing for both the cervical and lumbar areas. The report also noted that the claimant had demonstrated six positive "Waddell signs" which indicated he was a "symptom magnifier." The claimant testified that he was not examined by Dr. O, and he could not recall the names of the doctors that had examined him at Dr. O's office. Dr. H testified that he didn't "have a problem" with the date of MMI certified by Dr. O. Dr. H also testified that, although he disagreed with Dr. O's impairment rating, he would not say that the rating was incorrect. According to Dr. H, the difference between his impairment rating of 32% and Dr. O's rating of 13% is attributable to different interpretations of the effect of range of motion testing that is invalidated on a determination of impairment rating as set forth in the Guides to the Evaluation of Permanent Impairment published by the American Medical Association.

Dr. R also referred the claimant to (Dr. K), who, in a narrative report dated January 21, 1993, reported that the claimant had a 32% impairment rating which was all attributable to limited range of motion of the lumbar, thoracic, and cervical regions. Dr. K did not mention MMI. However, in a letter dated March 10, 1993, Dr. K stated that the claimant "is approaching [MMI] at this time."

On March 15, 1993, Dr. R wrote that he did not agree with Dr. O's determinations of MMI and impairment rating, that the claimant was still benefiting from continued care, and that he, Dr. R, believed that Dr. K "is more accurate as to his disability percentage."

At the hearing held on April 28, 1993, the hearing officer expressed concern over the claimant's testimony that he had not been examined by Dr. O, the designated doctor, and recessed the hearing, indicating at that time that the Commission might schedule another appointment for the claimant to be examined by Dr. O. By letter dated May 5, 1993, the Commission ordered the claimant to again be examined by Dr. O for the purpose of determining whether the claimant had reached MMI and, if so, the date on which MMI was reached, and impairment rating.

In a narrative report dated May 21, 1993, Dr. O stated that he did a physical examination on the claimant on May 21, 1993, that the claimant still had a 13% impairment rating for specific disorders of the lumbar and cervical regions, that the claimant had again invalidated range of motion testing for both the lumbar and cervical areas, and that the claimant had reached MMI on August 24, 1992.

The hearing officer determined that the claimant reached MMI on August 24, 1992, and that the claimant has a 13% impairment rating as reported by Dr. O, the designated doctor. The hearing officer further determined that the other medical evidence did not overcome the presumptive weight to be given to the report of the designated doctor.

The 1989 Act provides that where a designated doctor is chosen by the Commission, the report of that doctor shall have presumptive weight, and the Commission shall base the determination of MMI and the impairment rating on that report unless the great weight of the medical evidence is to the contrary. Sections 408.122(b) and 408.125(e). We have commented many times upon the "unique position" and "special presumptive status" the designated doctor's report is accorded under the 1989 Act, and the fact that no other doctor's report, including that of a treating doctor, is entitled to such deference. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992; Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992. We have also held, to overturn a designated doctor's report requires the great weight of the other medical evidence to be against it, which involves more than a mere balancing of the evidence. Appeal No. 92412, *supra*. Furthermore, we have held that a date of MMI may be certified as having been reached at a point in time prior to the time the designated doctor evaluates the claimant when medical records sufficiently support that finding. Texas Workers' Compensation Commission Appeal No. 93674, decided September 17, 1993.

In the instant case, Dr. C anticipated that the claimant would reach MMI by August 24, 1992, Dr. O found that the claimant had reached MMI on August 24, 1992, and Dr. H did not disagree that the claimant had reached MMI by August 24, 1992, inasmuch as Dr. W had told him the claimant had reached MMI in March 1992. While there is a difference of opinion in regard to impairment rating, based mostly on the validity of range of motion measurements, the hearing officer could consider the fact that Dr. H acknowledged that he had not physically examined the claimant when evaluating him for impairment and could further consider the accuracy and thoroughness of the reports of the doctors in determining whether the great weight of the medical evidence was contrary to the report of the designated doctor. Having reviewed the record, we conclude that the hearing officer's decision is supported by sufficient evidence and is not against the great weight and preponderance of the evidence.

The decision of the hearing officer is affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Gary L. Kilgore
Appeals Judge