APPEAL NO. 931118

This appeal arises under the (state) Workers' Compensation Act (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq*. (formerly V.A.C.S., Article 8308-1.01 *et seq*.). On November 3, 1993, a contested case hearing was held in (city), (state), with (hearing officer) presiding. He determined that appellant (claimant) reached maximum medical improvement (MMI) on March 24, 1993, with an impairment rating of two percent. Claimant asserts on appeal that the date and amount of rating are both wrong, citing the opinion of his current treating doctor and the pain he still has. The carrier replies that the hearing officer should be upheld.

DECISION

We affirm.

Claimant worked for (employer). On (date of injury), he was moving some boxes on a "hand cart" when the boxes began to slip. He moved to stabilize the boxes when the handle on the cart recoiled and struck him on the right side of the head in the temple area. He was taken to a hospital. A "Cat scan" was done and claimant was kept overnight, returning to work the next day. He then saw (Dr. P) as his treating doctor. Dr. P referred claimant to several doctors, one of whom was (Dr. O). A few months later, claimant was again sent to Dr. O to get a determination as to MMI and impairment. Dr. O stated that claimant reached MMI on March 24, 1993, with three percent whole body impairment based on range of motion limitations. Claimant disputed Dr. O's opinion. (Dr. C) was appointed as the designated doctor, and claimant saw him in June 1993.

At approximately this time, claimant moved from (state) to (state). The hearing in this matter was conducted by telephone with claimant outside the state, but with the ombudsman at the location of the hearing assisting the claimant. Claimant agreed to hold the hearing in this manner and does not raise the location of, or the manner of holding, the hearing as an issue in his appeal.

Claimant was not working at the time of the hearing. He complained at that time that his neck would "sometimes . . . stiffen up on me;" he sometimes gets a "grinding sensation" and "spasms on the right side of my neck." Claimant had continued to work for employer until May 6, 1993, when he was terminated.

He described Dr. C as personally examining him for about 15 minutes. Dr. C took measurements with something that looked like a ruler as claimant rotated his neck. He characterized Dr. O's examination of him for MMI/impairment rating as being more thorough than that of Dr. C.

Dr. C provided a lengthy report as to his examination of claimant. He referred to the CT scan, EMG studies, and ophthalmologist's reports as normal. He referred in his narrative to Dr. O finding MMI on March 24, 1993, and stated that he agreed with that date; the hearing officer could compare this date, which was correctly stated as the one Dr. O had given, to the date of March 24, 199<u>2</u> on the TWCC-69 and conclude that the date in the

narrative controlled over the date on the form, especially since the accident had not occurred as of the 1992 date. Dr. C assigned a two percent impairment rating based on some limitation in range of motion.

After moving to (state), claimant began to regularly see (Dr. Co). Also while in (state), claimant had an MRI of his cervical spine. The report stated that there was a "minimal bulge" at C5-6 posteriorly and called it a "marginal impression." The doctor who ordered the MRI, (Dr. S), a neurosurgeon, describes the "minimal bulge" on the MRI as "not a significant finding." He felt that further medical treatment would not benefit the claimant. Dr. Co was aware of this MRI and did not describe it as indicating more than was described in the MRI report. He stated on August 18, 1993, that claimant had not reached MMI. Then on October 13, 1993, Dr. Co wrote that he felt "Maison's text Applied Spinal Disability is able to more accurately assess [claimant's] situation than the AMA guidelines." Without saying that claimant reached MMI, Dr. Co also said on October 13, 1993, per Applied Spinal Disability, *supra*, that claimant had 10% whole body impairment. On October 14, 1993, Dr. Co notes that he manipulated claimant's cervical spine.

The hearing officer, in finding that the report of the designated doctor was not contrary to the great weight of other medical evidence, had before him the report of Dr. O which was very similar to that of Dr. C, the designated doctor. The MRI that was accomplished after the designated doctor's report, as interpreted by medical doctors, did not present significant new diagnostic information that would require the hearing officer to assure its consideration by the designated doctor. The main evidence contrary to that of the designated doctor was provided by Dr. Co who rejected the AMA guidelines, set forth by the 1989 Act as the criteria for impairment ratings. *See* Section 408.124(b). The hearing officer was not required, in that circumstance, to give Dr. Co's impairment rating any weight. At the time of giving his rating, Dr. Co did not state a date of MMI for the hearing officer to compare to the date given by both Dr. C and Dr. O.

Claimant asserts that he still has pain. (state) Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992, pointed out that MMI does not mean that in every case the claimant will thereafter be free of pain. Compare that case to (state) Workers' Compensation Commission Appeal No. 93119, decided March 29, 1993, where nerve root injury did delay MMI.

The findings of fact and conclusions of law are sufficiently supported by the evidence and will not be overturned by the Appeals Panel. *See* In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). The decision and order are affirmed.

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Joe Sebesta
Appeals Judge

CONCUR:

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Susan M. Kelley
Appeals Judge

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Philip F. O'Neill
Appeals Judge