APPEAL NO. 931182

This appeal is considered in accordance with 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*.). On November 15, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The issues to be determined at the contested case hearing were the date on which claimant, RH, who is the appellant, reached maximum medical improvement (MMI), the correct impairment rating to be assigned to the claimant, and the extent of claimant's period of disability. The hearing officer determined that the claimant reached MMI effective June 21, 1992, and had an impairment rating of nine percent, in accordance with the report of the designated doctor. The hearing officer determined that the great weight of other medical evidence was not contrary to his report. The hearing officer determined that claimant had disability from the period of April 30, 1991, through June 21, 1992, and thereafter, when she attributed claimant's inability to obtain and retain employment at her pre-injury wage to "something other" than the compensable injury.

The claimant has appealed, pointing out that the designated doctor stated that claimant reached MMI in December 1992, and that the great weight of contrary medical evidence showed that claimant had not yet reached MMI. Claimant further argues that great weight of other medical evidence is not the sole standard for overturning the designated doctor's report in the case of a designated doctor who acts unethically or improperly. The claimant attacks the finding that her inability to work after (date of injury), was due to something other than the compensable injury. Finally, the claimant maintains that the great weight of other medical evidence is that claimant's impairment exceeds the nine percent assigned by the designated doctor. No response was filed.

DECISION

We affirm the hearing officer's decision.

The claimant stated that she was employed by the employer, (employer)., and was in training at a store for a manager position. Beginning the second day, she was asked to scoop ice cream. Claimant who stated she was 5' 2" tall, said that the ice cream was rock hard, she used a square scoop to scoop it, and that she began having pain in her shoulder, arm and neck as a result. She said that the scooping motion caused her to twist her back and bend low. Claimant said that on (date of injury), she had severe pain upon scooping the ice cream which exceeded what she had before. She did not work after that date.

Claimant had seen a number of doctors, beginning with her family doctor, (Dr. T). Dr. T referred her to a number of doctors' whom she stated she saw once or twice. According to claimant, pain medication and physical therapy she received in the ensuing months were prescribed primarily by Dr. T, while she was consulting with various doctors.

The brief summary of some of the medical records in evidence is as follows:

-Cervical MRI, May 18, 1991. Reported impression as essentially normal,

questionable mild C6-7 bulge.

-(Dr. L), identified by claimant to be a neurologist, diagnoses cervical strain with superimposed anxiety. On September 24, 1991, Dr. L examined her again and stated that she had essentially normal neck and low back motion, and that motor, sensory and reflex examination were unremarkable. He commented upon reviewing an August EMG which he stated was normal, and recommended a referral to Dr. W, an orthopedic doctor.

- (Dr. LA), a doctor for the carrier who examined claimant on (date of injury), under a medical examination order, found that she reached MMI as of that date with a nine percent impairment rating. Dr. LA noted that she had been seen by a number of physicians, none of whom had found anything seriously wrong. Previous diagnoses cited in his report essentially find that claimant had a cervical strain, and that she had a small bulge at C5-6. Although Dr. LA gave claimant nine percent, the discreet elements of his impairment rating are not described. Within his report, he stated that her range of motion limits appeared to result from muscle guarding rather than structural changes. He nonetheless gave her nine percent for continued complaint of pain to the neck and lower back.

-(Dr. O), whom claimant stated was a chiropractor, began seeing her in February, and, according to his records, rendered treatment on an average of every three days from February 12 through May 19, 1993. Although the notes describe slow but steady improvement, claimant appeared to report to Dr. O with essentially continuous pain throughout her spine. Dr. O notes fairly constantly that claimant had not reached MMI. Dr. O's initial medical report stated an intent to treat her for three weeks at three times per week and, if there was not marked improvement at that time, to release her for a psychological profile. His diagnosis was severe muscle spasm and soft tissue inflammation. He stated that all orthopedic tests were positive.

- (Dr. M), the designated doctor, determined also that claimant reached MMI effective (date of injury). Dr. M examined claimant July 1, 1993. In a July 1, 1993, letter which is the first stage of his report, Dr. M refers to Dr. LA as having found MMI in "12/92." His diagnostic impressions are recorded as chronic right lumbar radicular syndrome with non-organic signs and questionable L-5 deficits, chronic right cervicothoracic syndrome with probable mild right TOS, and adjustment disorder with mixed emotional feature. He indicated that claimant was focusing on "quick fix" surgical treatment. Throughout the report, Dr. M noted that claimant had marked and extreme non-organic signs. His July 1,

1993, letter indicated that Dr. M would hold off on an MMI determination should claimant wish to participate in rehabilitation, which he characterized as her last remaining medical option to improve or cure her condition. He stated that he gave her the names of several programs, and said that he would recommend she be given another 10 weeks of temporary income benefits to give her a rehabilitation opportunity. He stated in this letter that he did not believe she would be interested in taking advantage of this, and stated that her view of her medical situation was unrealistic. Dr. M stated in a subsequent July 15, 1993, letter, that "[o]n the basis of the fact that patient has had an adequate soft tissue healing period, and is not (in my opinion) a surgical candidate and has indicated no interest in participating in tertiary rehabilitation, the patient has now reached MMI." Dr. M gave a nine percent rating for specific disorders of the cervical and lumbar spine; he found range of motion invalidated.

-MRIs of cervical and lumbar spine, March 9, 1993: normal cervical spine, mild annular disc bulge at L4-5, L5-S1 "without evidence of effacement of nerve roots or thecal sac."

-June 11, 1993 EMG test, (Dr. TM). Study "suggests the patient has an active right radiculopathy."

At the contested case hearing, claimant stated that the examination at Dr. M's clinic had lasted a total of three hours. She said that some of Dr. M's assistants assumed that she was a patient in the regular rehabilitative treatment offered there. She testified that she felt that Dr. M concluded her problems were psychological and this was one reason she opted not to go through the therapy offered by his clinic. When directly asked twice by the hearing officer is Dr. M stated that his MMI outcome was contingent upon her participation in his clinic program, the claimant was either nonresponsive or unable to testify as to any direct statements from Dr. M to this effect. She testified that Dr. M said he would "address" MMI after she had gone through "the program."

Claimant indicated that she stopped seeing Dr. T because he did not assist her with disputing Dr. LA's impairment rating, although she said Dr. T neither accepted nor disputed that report himself.

Claimant also consulted with (Dr. W). No records from Dr. W are in evidence, although his records are characterized by Dr. LA as diagnosing cervical and thoracic strain, degenerative disc disease at C5-6, and lumbar radicular syndrome.

Claimant testified that she felt she had basically not improved, and may have grown worse, since (date of injury), although she had some improvements after her treatments by other doctors. There was testimony from both claimant and her husband concerning her limited ability to do housework without assistance, although both testified as to her actual

performance of housework, albeit with some pain.

"Impairment" is defined in the 1989 Act as "any anatomic or functional abnormality of loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." Section 401.011(23). Further, impairment must be based upon "objective, clinical or laboratory finding" and, where assigned by a doctor chosen by the claimant, must be confirmable by a designated doctor. Section 408.122(a).

"Maximum Medical Improvement" is defined, as pertinent to this case, as "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated . . ." Section 401.011(30)(A). We have stated many times that the presence of pain is not, in and of itself, an indication that an employee has not reached MMI; a person who is assessed to have lasting impairment may indeed continue to experience pain as a result of an injury. *See* Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1993.

The report of a Texas Workers' Compensation Commission-appointed designated doctor is given presumptive weight. Sections 408.122(b), 408.125(e). The amount of evidence needed to overcome the presumption, a "great weight," is more than a preponderance, which would be only greater than 50%. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992.

We cannot agree that the hearing officer was wrong in not finding that the great weight of other medical evidence was against Dr. M's report. The weight of the medical records indicated that claimant's injury was by and large a back strain. The objective symptoms upon which claimant's impairment rating was based were characterized as generally mild. We do not agree that Dr. M's report determined that claimant reached MMI in December 1992; his reference to that date clearly appears to be a clerical error because it stated (erroneously) that Dr. LA had found MMI then.

Concerning Dr. M's report with respect to his recommendations that claimant go through therapy, with his clinic offered as an option, we note that at the hearing, claimant's attorney argued that while Dr. M had not done anything improper, his actions were questionable. There was no evidence that Dr. M made participation in his particular clinic the determining factor in her MMI. If anything, such statements in his letter indicate a desire to give claimant a further chance notwithstanding the objective evidence that she had already reached MMI. The letters in question speak for themselves and the hearing officer evidently did not agree that Dr. M's opinion as to claimant's objective condition was tainted. On appeal, claimant's attorney now opines that a designated doctor's report can be set aside if he is shown "to have engaged in unethical or improper procedures," again without

specifically pointing to evidence that the doctor in this case acted improperly with respect to his recommendation of further therapy for claimant. As the record fails utterly to demonstrate that either unethical or improper procedures were used by the designated doctor in this case, the hearing officer cannot be said to have erred by according presumptive weight to his report.

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.). This was not the case as to the determinations as to date of MMI and impairment, nor, in our opinion, as to her findings on disability. The definition of disability makes clear that it must result from the compensable injury. Section 401.011(16). Generally, we believe that a hearing officer who finds as fact that claimant's inability to obtain and retain employment at wages equivalent to the pre-injury wages is due to "something other" than a compensable injury should state specifically what the "other" is. However, we note here that the medical evidence supports the hearing officer's apparent conclusion that other factors at some point overcame the effect of claimant's injury on her ability to work. While we believe that the doctors involved in her care did not intend to trivialize claimant's pain, it appeared that most of her physicians were concerned that she was in some ways magnifying the effect of this pain on her ability to work as indicated by her objective condition. Because temporary income benefits are not due when a claimant has reached MMI, Section 408.101(a), the failure to specifically state what other factors, rather than the injury, caused the inability to work, would be at best harmless error.

The determination of the hearing officer is not against the great weight and preponderance of the evidence, and we affirm her decision.

Susan M. Kelley
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Gary L. Kilgore
Appeals Judge