APPEAL NO. 93213

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. arts. 8308-1.01-11.10 (Vernon Supp. 1993) (1989 Act). A contested case hearing was held on February 22, 1993, in (city), Texas, before (hearing officer), hearing officer. The appellant, hereinafter claimant, appeals the hearing officer's decision that the claimant reached maximum medical improvement (MMI) on August 6, 1992, with a nine percent whole body impairment rating, as found by the designated doctor. The claimant essentially argues that the designated doctor's report was flawed, and asks that this panel reverse and remand this case for a new hearing. The respondent, hereinafter carrier, contends that the designated doctor's report was properly given presumptive weight; it also objects to certain documents attached to the claimant's appeal which it says raises issues which were not presented at the contested case hearing.

DECISION

We affirm the hearing officer's decision and order in this case.

The claimant, an employee of (employer), suffered a compensable injury to her back and wrist on or about August 6, 1991. She was treated by (Dr. HE), who stated in his report of medical evaluation (Form TWCC-69) that an MRI disclosed small central disc herniations at L4-5 and L5-S1 and degenerative disc disease. He also stated that EMGs revealed evidence of bilateral L5 radiculopathy and left S1 radiculopathy. The claimant underwent physical therapy and work hardening. Dr. HE in his report found the claimant to have reached MMI on July 1, 1992, with a whole body impairment rating of 19%.

At the request of the carrier, the claimant was seen by (Dr. C) on November 22, 1991. On that date Dr. C found claimant to have reached MMI, and assigned a 16% whole body impairment rating.

The Texas Workers' Compensation Commission (Commission) appointed (Dr. HA) as designated doctor to resolve a dispute involving the claimant's correct impairment rating. Following an initial visit on June 2, 1992, Dr. HA summarized his examination and reviewed claimant's medical records. However, he recommended that the claimant "undergo further evaluation, including a bone scan and blood test to rule out the presence of an `arthritity' or other entity which would complicate her recovery." Although he examined her back, he said he had not taken spinal measurements at this visit and stated, "I do not believe she will reach [MMI] until August of 1991 (sic)." He said he would see the claimant again and "render a disability rating after spinal measurements have been made." Dr. HA also completed a TWCC-69 which gave an estimated date of MMI as August 6, 1992.

Dr. HA completed a second TWCC-69 (which bears the dates "08/17/92" and "08/19/92") wherein he found the claimant to have reached MMI on August 6, 1992, and assigned her a nine percent whole body impairment rating based on her lumbar spine. Dr. HA did not assign the claimant an impairment rating based on her wrist, although his June

2, 1992 letter mentions her wrist injury.

At the hearing the claimant's attorney argued that the opinion of Dr. HE as treating doctor is more accurate because he saw the claimant more frequently. He also argued that Dr. HA's reports were not accurate because he did not perform any spinal measurements at claimant's initial visit, nor at a follow-up visit which he said occurred on June 18th. He said Dr. HA only did measurements at claimant's third visit in August of 1992, after which Dr. HA rendered his opinion. The carrier's attorney argued that Dr. HA's actions were not inconsistent with his original opinion that claimant had not reached MMI, and that it would have been improper for Dr. HA to give claimant an impairment rating at that point. He also contended that the reports of Drs. HA and C were not in conflict, and actually corroborated each other, as Dr. C saw the claimant in November of 1991, about three months post-injury, and Dr. HA saw her in June and August of 1992. The claimant, who testified at the hearing about her treatment and her present symptoms, did not testify regarding the visits to the designated doctor.

Attached to claimant's appeal was an affidavit wherein she described the manner in which measurements of her spine were taken at a July 17th visit to the designated doctor. Also attached to the appeal were lumbar range of motion findings, and a September 23, 1992 letter from Dr. HE to claimant's attorney commenting upon the reports of Drs. HA and C. None of these exhibits was presented at the hearing. Claimant's appeal also contends that Dr. HA did not consider the results of claimant's EMG.

The 1989 Act requires this panel to limit its consideration of evidentiary matters to the record developed at the contested case hearing. Article 8308-6.42(a)(1). Our review of the claimant's appeal does not disclose that the affidavit and other written material claimant tenders on appeal constituted evidence which was unknown or unavailable at the time of the hearing or which due diligence would not have brought to light. *See* Texas Workers' Compensation Commission Appeal No. 91132, decided February 14, 1992. Indeed, the documentary evidence predated the contested case hearing, and the claimant was present and available to testify to the facts contained in her affidavit. We will thus limit our appellate review to the evidence and argument adduced at the hearing below.

Turning to the issues on appeal, we note at the outset that the 1989 Act provides that a designated doctor's report shall have presumptive weight, and the Commission shall base its determination on MMI and impairment on that doctor's report, "unless the great weight of the other medical evidence is to the contrary." Article 8308-4.25(b), 4.26(g). This panel has commented many times upon the "unique position" and "special presumptive status" that the designated doctor's report is accorded under the Texas workers' compensation system, and the fact that to overturn such report requires more than a mere balancing of the evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992.

Upon review of the record, we find no reason to overturn the hearing officer's decision in this case. With regard to claimant's argument that Dr. HA did not consider claimant's EMG, we note that his lengthy letter of June 2, 1992 summarized claimant's prior examination, tests, and diagnoses, and stated that the claimant "underwent further evaluation . . . which included an MRI of the lumbar spine." While Dr. HA's letter did not specifically mention an EMG, we cannot say that that fact alone calls into question the hearing officer's decision to accord Dr. HA's opinion presumptive weight. We would add that the claimant did not point out this defect at the hearing, nor did she introduce the EMG report or any other medical reports save for her treating doctor's TWCC-69.

While some disparity existed between the designated doctor's impairment rating and that of the treating doctor and the carrier's doctor, we cannot say it was irreconcilably disparate. We can also discern nothing untoward in Dr. HA's initially declining to do range of motion tests on claimant's spine, based upon his stated opinion that she had not reached MMI at that time. His subsequent TWCC-69 did certify MMI and assigned an impairment rating, and we agree with the hearing officer that no "great weight" of other medical evidence existed to overcome this report. We accordingly affirm the hearing officer's decision and order.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Gary L. Kilgore
Appeals Judge