APPEAL NO. 93295

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq.* (Vernon Supp. 1993) (1989 Act). On December 4, 1992, a contested case hearing (CCH) was held in (city), Texas, with (hearing officer) presiding as hearing officer. The hearing was recessed and reconvened on February 19, 1992. The record was then held open until March 8, 1993, when the record was closed. The only issue announced and agreed upon at the CCH was: "whether the claimant had reached maximum medical improvement (MMI) of his (date of injury) injury." The hearing officer determined that respondent, claimant herein, had not reached MMI for his (date of injury) compensable injury to the date of the hearing officer's decision.

Appellant, City herein, appealed, arguing certain psychiatric evidence should not have been considered and that the designated doctor's opinion should have been adopted. Claimant filed a response alleging that the City's request for review was untimely and in the alternative that the hearing officer's decision is supported by the evidence and requests that we affirm the decision. The City filed a "Response to Claimant's Appeal" contending that "its appeal was timely filed."

DECISION

Finding that the City's appeal was timely filed, for reasons stated below, and further finding that the designated doctor's opinion was not overcome by the great weight of the other medical evidence, we reverse and render a new decision that MMI was achieved on August 6, 1992.

Addressing the claimant's allegation that City's appeal was untimely, we note that the hearing officer's decision was distributed, by mail, on March 24, 1993. The City's request for appeal did not assert when the decision was received and applying the "deemed" date of receipt under Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 102.5(h) (Rule 102.5(h)) the deemed date of receipt would have been March 29, 1993, and the appeal must have been mailed (pursuant to Rule 143.3(c)(1)) no later than April 13, 1993. The City's appeal was dated and postmarked April 14, 1993. In response to claimant's allegation that the City's appeal was not timely filed, the City produced documentation that the hearing officer's decision was not received by "appellant's [City] agent, the law firm of Mullen, MacInnes & Redding located in (city), Texas" until March 30, 1993, thereby making the appeal filed on April 14th timely. Although not necessary for resolution in the case, we will address the City's statement complaining that "[f]or whatever reason, the Hearing Officer's decision was sent there [City agent, law firm located in (city), Texas] and not to the undersigned." First we note the decision was sent to the City at P.O. Box 1562, Houston, TX 77251, and to Summit Risk Management, Inc. in Houston as well as City's law firm in Austin. Also please note Texas Workers' Compensation Commission (Commission) Rule 156.1(c) which states "[a]ny notice from the commission, sent to the designated representative's (city)in address is notice from the commission to the insurance carrier [in this case the self-insured governmental entity]."

As to the merits of the case, it is undisputed that claimant sustained a compensable back injury on (date of injury). Claimant testified he fell down a flight of stairs on that date and was treated for contusions to the leg, back and shoulder. Claimant subsequently saw (Dr. F), who referred claimant to (Dr. T). Claimant testified he was seen by Dr. T one or two times and that Dr. F is still his treating physician. Claimant was referred to physical therapy by Dr. F and subsequently was seen by the (clinic). At some point in time, claimant testified, it was determined he needed psychological counseling. The report of the benefit review conference (BRC) on September 25, 1992 indicates that Dr. T certified MMI on "4-02-92" and assigned a "9% impairment rating." (Impairment is not an issue in the instant case.) The City disputed the impairment rating of Dr. T and claimant disputed the MMI. Consequently the Commission designated (Dr. X), to resolve the dispute. Dr. X examined claimant and certified MMI on August 6, 1992 with a 0% impairment rating. Claimant, at the BRC, asserted Dr. X's ". . . findings were against the great weight of medical evidence per the report of [Dr. F] dated 9/03/92 stating claimant has not reached [MMI]." A CCH was then scheduled.

The CCH was convened on December 4, 1992. At the CCH claimant began testifying about his psychiatric condition, one or more suicide attempts and an attempted admission to a state mental hospital. The City objected to this testimony but the hearing officer determined that the evidence and testimony were relevant and overruled the City's objections. A substantial portion of the December CCH consisted of discussion of how, and who, would get the medical records relating to claimant's psychiatric/psychological condition from the providers. It was finally agreed that the hearing officer, with claimant's permission, would obtain the records, send them to the parties, and make the records hearing officer exhibits. The CCH was recessed and subsequently reconvened on February 18, 1993. At the February portion of the CCH, it was determined that claimant had had a myelogram performed on February 16, 1993 (two days before the reconvened hearing) and that myelogram revealed "(1) bilateral L5 spondylolysis with minimal Grade I spondylolisthesis . . . accentuated in the standing lateral position indicating instability and (2) a central disc bulge indents the thecal sac at the L3-4 level." Dr. F, claimant's treating doctor, in a report dated 2-17-93, stated that in his opinion claimant was "unstable at the L5-S1 level as well as (having) a herniated disc at the L3-L4 level." Dr. F recommended "evaluation for possible spine fusion . . . ." As Dr. X, the designated doctor, had not had an opportunity to review the most recent myelogram and Dr. F's comments, the hearing officer sent the reports and Dr. F's comments to Dr. X "to determine whether these reports changed or modified his finding that claimant reached [MMI] on August 6, 1992." The hearing officer left the record open for Dr. X's response and allowed for written closing statements after Dr. X's response was received and distributed to the parties. Dr. X by letter dated February 22, 1993 stated he had reviewed the reports and stated "I feel that this patient was a symptom magnifier. In May of 92 had normal EMG and NCV. By exam had a normal gait, but would not bend the lumbar spine at all to exam. I stand by the original report."

Claimant's medical evidence at the CCH consisted of an April 10, 1992, report from Dr. F which states Dr. T's 9% impairment "would seem reasonable" and the claimant "needs to be in a pain clinic type setting." In a report dated 11-17-92, Dr. F noted "[i]t is a quandary that the patient has been told that there is nothing wrong with him by several doctors but that the [City] will not accept him back for work because they feel he is not physically fit for work." Dr. F in a handwritten note dated 2-17-93 states claimant "appears to have degenerative disease with spondylolithsesis (sic) of the lumbar spine . . . will probably need a fusion." The myelogram results are attached to Dr. F's February 1993 comments.

The City's medical evidence consists of a May 7, 1992, report from the Hermann Hospital Clinic Neurophysiology Laboratory which showed "[t]his is a normal EMG and nerve conduction study of right upper and left lower extremities. There is no evidence of cervical or lumbo-sacral radiculopathies." A CT Scan on 1-17-92 by (Dr. O) concluded "Unremarkable CT scan of the cervical spine. The accuracy of diagnosis of cervical disc herniation without intrathecal contrast is quite limited." (Dr. P) did an MRI of the cervical spine and by report dated May 21, 1992, noted "normal MRI of the cervical spine." (Dr. S) examined claimant at City's request and by report dated March 30, 1992 stated claimant's ". . . examination is almost impossible. Examination of the neck has so much functional component that I cannot do an accurate exam." Dr. S comments that the "CT scan of the cervical spine done on 1-17-92 was somewhat inferior" and the "MRI of the lumbar spine . . . which again is not the most optimum study, demonstrates a central disc protrusion at L4." Dr. S recommended a work hardening program. Dr. T in an April 2, 1992, report gives a 9% impairment rating but no specific date of reaching MMI. The hearing officer states in Finding of Fact No. 3 that Dr. T certified claimant as reaching MMI on April 2, 1992. This "certification" is also recited in the BRC report, but the April 2, 1992, report in the record available to us makes no such certification of MMI. The City also introduces Dr. X's three page report dated 8-6-92 certifying MMI on 8-6-92 with 0% impairment. Dr. X lists the reports he reviewed including Dr. F's reports of 10/29/91, and 11/18/92, s (Dr. R) reports of 1/27/92 and 1/117/92 (sic), Dr. T's reports of 2/24/92 and 4/1/92, Dr. S's report of 3/30/92, (Dr. B) report of 3/9/92, (Dr. G) report of 4/20/92 and (Dr. L) report of 5/8/92. Dr. X concludes:

> IMPRESSION: based on reports and on this exam I feel this patient has a normal physical exam. The radiological examinations are of terrible qualility (sic). He has no evidence of radiculopathy. There is no atrophy. There is no numbness. I feel he is a symptom magnifier. No further orthopaedic treatment is needed. May benefit from psychological counselling. I find no objective evidence to support his subjective complaints.

Dr. T apparently referred claimant for behavioral testing and in a four hour test on March 9,

1992, Dr. B concludes that claimant ". . . is experiencing significant psychological distress. The distress appears to be manifested in symptom magnification." (Dr. C) in a May 18, 1992, report to the City stated he thought claimant ". . . had two main problems; one was lower back pain secondary to possible nerve root compression/irritation, and the second was cervical back pain of questionable etiology." Dr. C notes that claimant became angry and irritable about the ancillary paper work required, was "rude to our secretaries" and stated he "would not like to come to the [pain center] ever again."

The City's entire testimonial case consisted of the testimony of two private investigators who testified that on an unspecified date and time they observed, and video taped, claimant washing (or as claimant states "rinsing off") his truck and squatting as he appeared to be talking on the telephone. They also testified they observed claimant to be walking without the use of a cane (contrary to his testimony) and that he did not appear to be in pain as he performed tasks associated with washing his truck and boat.

The hearing officer's exhibits included medical records from (ER) reflecting an "overdose of medication" on 10/26/92 and detailing action taken. No mention is made of back or cervical problems and no causal connection to the work related injury was noted. Progress notes from Hospital of October 27 and 28, 1992, indicated depression with the doctor noting "multiple medical problems, by history." The recommendation was the claimant "be stabilized and transferred to an inpatient psychiatric unit." The admitting diagnosis was "Depression S/P suicide attempt, overdose." The (clinic) psychiatric assessment, dated November 4, 1992, states:

> IMPRESSION: Depressive reaction, major affective with suicidal thoughts ideation, and a plan that he will not tell. He has had two overdoses in the past couple of weeks, and I feel he should be hospitalized as soon as possible for further evaluation and treatment. 2) Chronic pain syndrome by history. We will need to get old records to find out what his back status is and what else possible could be done.

Although not clear from the evidence, the hearing officer states the Commission ordered a neuropsychological evaluation by (Dr. P). In his report dated January 15, 1993, Dr. P related the interaction of claimant's medical and psychiatric problems and concluded:

> [Claimant] is most likely engaging in symptom magnification and this makes his medical management quite difficult. His management should be based on objective physical finding and not his subjective complaints. . . . From a neuropsychological standpoint he is not disabled but psychologically at this time he appears to be disabled due to his suicidal ideation and depression."

The hearing officer, in pertinent part, found:

FINDINGS OF FACT

3.Claimant was certified as having reached [MMI] on April 2, 1992 by [Dr. T].

4.Claimant disputed [Dr. T's] finding of [MMI], and has continued to complain of back pain and intermittent left leg numbness to the present time.

5.The Commission appointed [Dr. X] as a designated doctor, and [Dr. X] certified claimant as having reached [MMI] on August 6, 1992 with a "0" percent impairment rating.

6.Claimant has significant psychiatric problems that are causally related to his (date of injury) compensable injury, that are manifested in symptom magnification.

7.Claimant's February 16, 1993 objective myelogram findings are not inconsistent with prior diagnostic report of claimant's lumbar spine, and as recommended by [Dr. F], reveal the need for further treatment to improve claimant's lumbar spine.

8.[Dr. X's] certification that claimant reached [MMI] on August 6, 1992 is against the great weight of the medical evidence relative to claimant's lumbar spine.

CONCLUSIONS OF LAW

3.Claimant has not reached [MMI] of his (date of injury) (sic) compensable injury to the date of this decision.

The City's first contention of error is that the hearing officer's Finding of Fact No. 6 is against the great weight of medical evidence and that there is no objective evidence that claimant "in fact has suffered any psychiatric injury associated with his present claim." We find there is evidence that claimant has significant psychiatric problems and that they are manifested in symptom magnification. In fact Dr. X in his original report of August 6, 1992, and the February 22, 1993, addendum states claimant is a symptom magnifier, as does Dr. B in his report of March 9, 1992. We understand symptom magnification to be exaggeration, or magnification, of various symptoms, such as pain, that claimant is experiencing. However, magnifying his symptoms does not per se make claimant's psychiatric condition causally related to his back injury. We note that Dr. P in his neuropsychiatric evaluation urges claimant's management should be based on objective physical findings and not subjective complaints. As Dr. P notes, this may make claimant's

medical management more difficult, but falls short of establishing a causal relationship. We find no medical evidence that claimant's psychiatric problems are work related or connected to his (date of injury) compensable injury. Claimant's psychiatric condition may cause him to magnify his symptoms and may make medical management more difficult but there is no evidence that the psychiatric condition was caused by the compensable injury. So much of the hearing officer's finding as finds that claimant's psychiatric problems are causally related to his compensable injury is not supported by the evidence.

The City's second contention of error is that claimant "[f]or the first time at the contested case hearing . . . was allowed to present evidence of psychiatric problems without even a showing of (sic) such problems were causally connected to his back injury." The City objected to the introduction of psychiatric evidence on the ground of relevance. We note that the hearing officer is the sole judge of the relevance and materiality of the evidence offered. Article 8308-6.34(e). The hearing officer obviously thought the psychiatric evidence was relevant. We will not say, as a matter of law, that the hearing officer abused her discretion in admitting evidence of a psychiatric nature.

The City's third and fourth contentions of error allege, in summary, that the opinion of Dr. X, as the designated doctor, in accordance with Article 3808-4.25(b) (rather than section 4.26(g) as cited by the City) ". . . shall have presumptive weight, and the commission shall base its determination as to whether the employee has reached maximum medical improvement on that report unless the great weight of the other medical evidence is to the contrary." We note that Dr. X on his initial evaluation specifically listed and considered the comments of Dr. F and Dr. B before certifying MMI on August 6, 1992. The hearing officer in sending the February 16, 1993, myelogram to Dr. X also included Dr. F's comments and one of the psychiatric consultation reports for Dr. X's consideration. Dr. X stated he stood by his original report of an August 6, 1992 MMI certification.

To overcome the presumptive weight of the designated doctor's report the great weight of the other medical evidence must be to the contrary. We have 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." *See* Texas Workers' Compensation Commission Appeal No. 93072, decided March 12, 1993 and Appeal No. 92614, decided June 5, 1992. We have also stated that a hearing officer who rejects a designated doctor's report because the great weight of the other medical evidence is to the contrary must clearly detail the evidence relevant to his or her consideration, clearly state why the great weight of the other medical evidence is to the contrary, and further state how the contrary evidence outweighs the designated doctor's report. *See also* Texas Workers' Compensation Commission Appeal No. 92570, decided December 14, 1992; Texas Workers' Compensation Commission Appeal No. 92690, decided February 8, 1993; and Texas Workers Compensation Commission Appeal No. 93072, *supra*. The hearing officer failed to specifically detail such evidence in her Findings of Fact and Conclusions of

Law. However, she does discuss claimant's February 16, 1993, myelogram results and Dr. F's recommendation "that claimant undergo evaluation for possible spine fusion with instrumentation as well as an exploration of the L3-L4 disc space" in her statement of evidence. We believe this comment falls short of the requirement to clearly detail the evidence relevant to her consideration, clearly state why the great weight of the other medical evidence is to the contrary, and state how the contrary evidence outweighs the designated doctor's report. We are unable to discern how the great weight of the other medical evidence is to the contrary. Even were we to accept the recitation of Dr. F's recommendation regarding the February 1993 myelogram as evidence contrary to the designated doctor's report, this appears to us to merely be weighing and balancing Dr. F's opinion, as the treating doctor, against the opinion of the designated doctor, who had the subject myelogram and Dr. F's comments available for review. We have frequently noted that no other doctor's report, including that of the treating doctor, is accorded the special presumptive status of the designated doctor's report. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992 and Appeal No. 93072, *supra*. Here the treating doctor recommended claimant undergo evaluation for surgery as opposed to the designated doctor's opinion that claimant achieved MMI and that claimant is a "symptom magnifier." Under these circumstances we cannot conclude, as a matter of law, that the designated doctor's opinion has been overcome by the great weight of medical evidence to the contrary.

Finding that the great weight of the other medical evidence is not to the contrary of the designated doctor's opinion, we reverse and render a new decision that claimant reached MMI on August 6, 1992, in accordance with the designated doctor's certification.

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Thomas A. Knapp
Appeals Judge

CONCUR:

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Philip F. O'Neill
Appeals Judge

CONCURRING OPINION

I concur in the result reached herein; however, I would have rendered a decision that

the claimant reached MMI on August 6, 1992, with 0% impairment, in accordance with the designated doctor's certification. Despite the fact that the issue from the benefit review conference was phrased as whether the claimant had reached MMI, a reading of the parties' positions indicates that the issue centered around the reports of Dr. T (who apparently only found impairment) and Dr. X (who found MMI and impairment), versus that of Dr. F, who determined claimant had not reached MMI. The fact that the issue was framed solely as one of MMI may have been a function of claimant's contention that MMI had not been reached, and carrier's contention that Dr. X's report (which found no impairment) was entitled to presumptive weight. Whatever the reason, in the absence of the parties' agreement on an impairment rating, I believe it can only foster confusion and potentially prolong the dispute resolution process to issue a decision and order which purports to adopt one part of a designated doctor's report and remain silent on the remaining part. I note that the Act, Article 8308-4.26(d), provides in part that "[a]fter the employee has been certified by a doctor as having reached [MMI], the certifying doctor shall evaluate the condition of the employee and assign an impairment rating . . . ." I believe what was essentially before the hearing officer in this case were the entire reports of all the doctors who gave opinions, and for that reason this panel should have rendered a determination based on the designated doctor's report as a whole.

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Lynda H. Nesenholtz
Appeals Judge