APPEAL NO. 93532

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 through 11.10 (Vernon Supp. 1993). On January 13, 1993 and May 27, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding, to determine the issue of whether the claimant, Ms D, who is the appellant in this case, had reached maximum medical improvement (MMI), and, if so, the extent of permanent impairment as a result of a compensable injury sustained on (date of injury), while claimant was employed by (employer). The hearing officer determined that the opinion of the designated doctor regarding MMI was not contrary to the great weight of other medical evidence, and he accorded it presumptive weight by finding that claimant reached MMI on May 4, 1992. In accordance with Article 8308-4.26(g), he adopted the five percent impairment rating assigned by the agreed designated doctor.

The claimant has appealed this decision, arguing about the thoroughness of the designated doctor's examination, and arguing further that he failed to take into account her neck injury and head condition. The claimant asks that the decision be reversed and that the designated doctor be asked to give her a complete and total new examination. The carrier responds that the decision of the hearing officer is correct.[1]

DECISION

The decision of the hearing officer is affirmed.

The claimant was injured on (date of injury), when a stool on which she was seated broke and she fell backwards, hitting her head and back. The claimant's first treating doctor was (Dr. D). His diagnosis was lumbar and cervical strain. An MRI examination of the lumbar spine, conducted January 24, 1992, showed that claimant had a slightly bulging disc at L5-S1, characterized as a "borderline" abnormality. Dr. D ordered a functional capacity evaluation conducted on the claimant on April 23, 1993. He determined that she had reached MMI effective May 4, 1992, with a five percent permanent impairment rating. The claimant disputed this; thereafter, a designated doctor, (Dr. O), became the designated doctor by agreement between the parties. Such agreement was not disputed and was admitted by both parties.

The claimant also changed treating doctors to (Dr. S) in May 1992, whom she testified said she had not reached MMI.

Dr. O examined the claimant on June 9 and June 23, 1992. This examination, according to his report and attachments, expressly included consideration and examination

[1] The carrier's appeal indicates it was misinformed that a proper tape was not made of the reconvened hearing on May 27th. We would note, however, that the record does include a full tape of the second session.

of her cervical spinal area, as well as her lumbar spine. Claimant also testified that he checked her feet since she complained of occasional numbness. Range of motion tests were not validated. Dr. O determined that the claimant had reached MMI on May 4, 1992, with a five percent impairment rating, which was attributed to the objective injury to her lumbar spine as detected on her MRI. Dr. D released the claimant to light duty. Claimant testified that it was her impression that Dr. O did not review her records. The adjuster for the carrier, (Ms. H), testified that she sent all of the medical records in her possession to Dr. O. Dr. O's report indicated that he reviewed records from Dr. S and Dr. D.

At the first session of the hearing, the claimant testified that a new condition had developed since her evaluation by Dr. O. She testified that she had developed blackouts and seizures. She felt that the condition was related to her injury because she had not had this condition prior to the injury. She stated that the first seizure or blackout occurred in October 1992, and that Dr. S referred her to (Dr. B), a neurologist. Claimant had an appointment scheduled for the day after the hearing. The record was held open to allow claimant to bring forward new medical evidence, and then allow it to be considered by the designated doctor.

At the second session, she testified that she saw Dr. O again, and he ordered an EEG. She testified that Dr. O told her that he couldn't consider her neck at all, and that he conveyed the impression that the EEG wasn't very important. However, she also testified that he told her that he would review the EEG results and would take them into consideration if he possibly could. Claimant testified that she was told by a staff member at the EEG doctor's office that the battery did not work. This point is not mentioned at all in the EEG report by (Dr. M) indicating that the 24 hour EEG was normal. In response to cross-examination, the claimant conceded that Dr. O had run some tests on her neck area. Claimant also told the hearing officer that she had no more blackouts since the previous session of the contested case hearing, although she continued to have headaches.

Dr. B, in a letter dated February 16, 1993, stated that in his opinion the injury at work was not the proximate cause of her seizures if indeed she was having seizures. This letter referred to an abnormal EEG (without further description) and that claimant was a likely candidate to be suffering from "epileptiform" seizures.

The hearing record is commendably full of many medical reports made on claimant during the course of her treatment. They indicate that claimant does not need surgery. They indicate no evidence of radiculopathy. Dr. S opined in February in a letter to Dr. D that he told claimant she would not have complete recovery from all pain on a day-by-day basis. Both Dr. D and Dr. S prescribed physical therapy. X-rays conducted by (Dr. H), a chiropractor, found that the cervical disc spaces were good. Dr. H indicated that claimant's headaches were possibly the result of referred pain. A cranial MRI conducted October 21, 1992, at the request of Dr. S diagnosed a small cyst on the temporal lobe, as well as a small

asymmetrical disc bulge at C5-6. There are no statements in the records from doctors stating that claimant has not reached MMI, nor are there any medical records linking her reported seizures and blackouts to the injury of (date of injury). On December 10, 1992, Dr. B recorded an EEG within normal limits that contained one single abnormal discharge.

The claimant testified that she had not treated with Dr. S or Dr. H since the first session of the contested case hearing in January 1993. She stated that other than Dr. B, no doctor had examined her in that time interval. She stated that one reason she felt she could not work was because Dr. S had advised her not to drive at his last consultation with her, and had not "released" her.[2]

The use of a designated doctor is intended under the Act to assign an impartial doctor to finally resolve disputes over MMI and impairment rating. To achieve this end, the report of a designated doctor is given presumptive weight. Article 8308-4.25(b). Only the great weight of medical evidence can reverse this presumptive status. Article 8308-4.25(b). As the Appeals Panel has stated before, this requires more than a mere balancing of the evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. A claimant's non-medical testimony or evidence about her condition does not alone provide a sufficient basis to overcome this presumption.

When the parties agree on a designated doctor, and the designated doctor agrees that the claimant has reached MMI and assigns an impairment rating, the impairment rating is conclusive. Article 8308-4.26(g); *see also* Texas Workers' Compensation Commission Appeal No. 92511, decided November 18, 1992.

The hearing officer is the sole judge of the relevance, the materiality, weight, and credibility of the evidence presented at the hearing. Article 8308-6.34(e). 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.).

To the extent that claimant's case against MMI depended upon her contention that she had developed a significant new condition, the burden was on her to prove, by a preponderance of the evidence, that this related to an injury that occurred within the course and scope of employment. Texas Employers' Insurance Co. v. Page, 553 S.W.2d 98 (Tex. 1977). A trier of fact is not required to accept a claimant's testimony at face value, even if

[2] Although it was not disputed that claimant received approval from the Commission to change her treating doctor to Dr. S, claimant said that Dr. S's office told her when she called for a return visit that "workers' comp" hadn't approved her visit. The carrier's adjuster, Ms. H, pointed out that she had never denied treatment from Dr. S, and the carrier in fact had paid for her most recent prescription.

not specifically contradicted by other evidence. Bullard v. Universal Underwriters' Insurance Co., 609 S.W.2d 621 (Tex. Civ. App.-Amarillo 1980, no writ). We would observe that chronology alone cannot establish the link between a work-related injury and a condition that manifests itself nearly a year later. The causal connection between a fall and seizures a year later is, we believe, beyond the common experience of most persons such that medical evidence is required to establish the link. *Compare* Texas Workers' Compensation Commission Appeal No. 92331, decided September 1, 1992. The claimant did not bring forward any medical evidence to demonstrate that she had not reached MMI.[3] While we acknowledge that claimant continues to complain of pain, we have before noted that MMI does not mean in all cases that the injured employee will achieve a pain-free status, and, indeed, an impairment could indicate that some lingering effects, including pain, are to be expected. *See* Texas Workers' Compensation Commission Appeal No. 92270, decided August 6, 1992. We note that the record indicates that Dr. S counselled claimant that she would not completely recover from pain. There is essentially no medical evidence in the record to refute the contention of the designated doctor that MMI was reached by claimant on the date initially found by her treating doctor. Dr. O has examined claimant; we will not impose a further requirement that another examination be rendered after the EEG test he ordered. As presumptive weight accorded to his opinion by the hearing officer resulted in a finding of MMI, the hearing officer was therefore required under Article 8308-4.26(g) to adopt the impairment rating assigned by Dr. O as agreed designated doctor.

[3] The Act, Article 8308-1.03(32) states that MMI means the earlier of 104 weeks from the date income benefits begin to accrue, or "the point after which further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated, based upon reasonable medical probability. . . ."

After review of the record, we affirm the hearing officer's decision.

Susan M. Kelley
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Thomas A. Knapp
Appeals Judge