APPEAL NO. 93613

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq*. (Vernon Supp. 1993) (1989 Act). On March 3, 1993, a contested case hearing (CCH) was opened in (city), Texas, with (hearing officer), presiding, and the record was closed on June 25, 1993. The issues at the CCH were: 1. whether the appellant (claimant herein) had reached maximum medical improvement (MMI) and, if so, what was her correct impairment rating; 2. whether the claimant's injury extended to and included her lower back; and 3. whether to approve the claimant's request to change to a third treating doctor. The hearing officer found the claimant reached MMI on November 11, 1992, with a four percent impairment rating based upon a certification by the designated doctor selected by the Texas Workers' Compensation Commission (Commission). The hearing officer also found that the parties agreed to claimant's request for a third treating doctor, but concluded that the claimant's injury did not extend to and include her lower back.

The claimant appeals arguing essentially that she has not reached MMI and that her injury includes an injury to her lower back. The respondent (carrier herein) replies that the hearing officer correctly determined that the great weight of the other medical evidence was not contrary to the designated doctor's report and that there was sufficient evidence to support the decision of the hearing officer finding that the claimant's injury did not extend to and include her lower back.

DECISION

Finding no reversible error in the record, and sufficient evidence to support the decision of the hearing officer, we affirm.

The claimant testified that she was injured on (date of injury), while lifting pots from the floor to the top of a push cart while working in food production for her employer. The claimant testified that she injured her neck, shoulders and back. The claimant offered into evidence a form she apparently filled out for her employer, dated March 9, 1992, which is called "Employee's Report of Injury," and in which she described her injury as "neck and shoulder-back." Another internal employer document entitled "Injury Investigation Report," dated March 10, 1992, on a section labeled "Part of Body Injured" is marked by "back" and "arm."

Medical records show that the claimant was initially seen at a chiropractic clinic on March 8, 1992, by a (Dr. L), D.C. Dr. L initially diagnosed cervical sprain/strain and along with (Dr. G), D.C., began a course of chiropractic manipulations and physical therapy to the cervical and thoracic spine. There is no mention of the lumbar spine in Dr. L's and Dr. G's initial reports.

The carrier's handling adjuster, (Ms. H), testified that on March 26, 1992, she visited claimant's home to take a tape recorded statement from the claimant. Ms. H testified that

the claimant gave her permission to conduct this recorded interview and that during the course of the interview Ms. H and the claimant pointed to various parts of claimant's back. From this pointing, Ms. H testified that the claimant communicated to her that only the middle of the claimant's upper back was injured. Based upon her interview with the claimant Ms. H testified that she refused to pay for any treatment of the claimant's low back, including physical therapy.

The claimant testified that when Ms. H came to her home that she was in pain, confused and nervous. The claimant also testified her state of nervousness had been increased in that just before Ms. H's arrival she had received a telephone phone from one of her supervisors at work. The claimant also testified that she did not draw a distinction in her own mind between the upper as opposed to the low back. It is also clear from the record that the claimant is not a native English speaker and often has difficulty understanding and making herself understood in English.

The claimant testified that Dr. G referred her to (Dr. M), a D.O. and neurologist, who on April 2, 1992, reported that the claimant had neck pain and low pain back pain after lifting a heavy container at work. Dr. M's diagnosis included "lumbar sprain and strain" as well as "cervical sprain and strain." Dr. M ordered Magnetic Resonance Imaging (MRI) of the cervical spine which showed degenerative disc changes at C3-4, C4-5, and C5-6, with a annulus bulge at C5-6 without apparent impingement on the nerve roots or spinal canal. Dr. M's medical reports indicate that he desired to do an MRI of the claimant's lumbar spine. The claimant testified that this was not performed because the carrier refused to authorize payment for it. An EMG and nerve conduction studies were performed on the claimant's left arm; the results were normal. On July 7, 1992, Dr. G completed a Report of Medical Examination (TWCC-69) certifying MMI as of that date and an impairment rating of 16% as a result of "loss of cervical range of motion and upper extremity weakness."

Shortly after this certification, the claimant changed her treating doctor to (Dr. N), D.O., who shortly thereafter referred her to (Dr. MN), a D.O. and rehabilitation specialist. Since the claimant had disputed Dr. G's determinations, the Commission appointed (Dr. W), M.D., and orthopedist, as its designated doctor. Dr. W examined the claimant on October 12, 1992, (according to the testimony of the claimant at the hearing this was the only examination by Dr. W) and on that date stated in a TWCC-69 that the claimant had not reached MMI, but estimated an MMI date of December 15, 1992. In his associated narrative report Dr. W stated in the section labeled "Final Diagnosis": "This patient has degenerative disc disease at C3-4, C4-5, and C5-6. She has a lumbosacral strain as well as a strain of the sacroiliac joints."

Ms. H, the carrier's handling adjuster, wrote Dr. W a letter dated November 3, 1992, which states in part:

I am in receipt of your medical report dated October 12, 1992, on the above claimant.

Your wrote that [claimant] stated that she has not really had any conservative care and that her physical therapy had been refused. I just wanted to point out to you that this is absolutely not true. She received quite a bit of chiropractic manipulations because she refused to go see an orthopedic for several months. When the manipulations were not helping, her chiropractor, [Dr. L], requested that she receive four weeks of aggressive physical therapy to include McKensie exercises. This request was originally denied by the pre-authorization procedure required by the state law. [Dr. L] felt so strongly regarding the need for aggressive PT that I went ahead and agreed to pay for this. He felt that if she did not improve from the physical therapy, that she would definitely be at [MMI]. [Claimant] did proceed with four weeks of treatment and alleged that she had not improved. Do you not feel that she is at maximum medical improvement?

This letter does not indicate it was originally sent to anyone except Dr. W.

On November 11, 1992, Dr. W wrote a letter to Ms. H stating that the claimant needed a "good exercise program, including a vigorous program such as Work Hardening," and on the same date he issued an amended TWCC-69 stating that the claimant had reached MMI on November 11, 1992, with a four percent impairment rating.

At the CCH the claimant presented a statement from Dr. MN dated February 26, 1993, which stated that he did not believe "the patient can be considered maximally medically improved." The claimant also presented a statement from Dr. M stating that "this patient has not reached maximum medical improvement."

On April 21, 1993, the hearing officer, wrote to Dr. W stating in part:

I note that you changed your opinion as to whether or not the [c]laimant had reached [MMI] by virtue of--at least in part--a letter you received on November 3, 1992, from [Ms. H], the [c]arrier's adjuster. As part of the supplemental documentation, I am asking the [c]arrier to provide a copy of that letter for your review. After your review, write and tell me what you considered in determining to change your report from an estimated MMI date of December 15, 1992, to a 4% impairment rating as of November 11, 1992, (i.e., what supplemental medical information was made available to you during that period which influenced, if it did, your decision to modify your report) and what the objective findings were for that subsequent determination.

Finally, the parties agreed at our hearing to include the issues of whether the injury

> sustained by the [c]laimant on (date of injury), extended to and included her lower back (lumbar spine). If the documentation is sufficient for that purpose, please state your medical opinion as to whether or not her injury did extend to and include her lumbar spine.

After this letter by the hearing officer to Dr. W, Ms. H sent a copy of her original letter of November 3, 1992, to all parties.

Dr. W responded to the hearing officer's inquiry in a letter of May 4, 1993, stating in part:

> The so-called change that you talked about was based upon re-examination of the patient. The MMI was changed to December 15, 1992 (sic) because at that time I requested that the patient go to a work hardening unit which would last four-(sic) to six weeks at least, possibly eight weeks, after which would have been some where around December 15, 1992. This patient should be able to return to gainful employment.
>
> The 4% permanent impairment was based upon the cervical spine, which was explained in the report. There was no impairment given on the TWCC 69 Form, in which it was estimated that the patient should be able to return to work as of December 15, 1992. There is absolutely no new information on the patient. This is purely based upon the guidelines for a cervical spine injury, Table 49, Page 73, Section 2B. According to her examination on several occasions, she meets this guideline. That was the basis of the 4% impairment. I did not give any impairment for the lumbosacral spine or lumbosacral injury. The patient has a history of a previous accident to her back and I do not feel that this was anything acute. Consequently, no impairment of the lumbar spine was given.

The question of whether the claimant's injury of (date of injury), includes an injury to her low back is a question of fact. Article 8308-6.34(e) provides that the contested case hearing officer, as finder of fact, is the sole judge of the relevance and materiality of the evidence as well as of the weight and credibility that is to be given the evidence. It was for the hearing officer, as trier of fact, to resolve the inconsistencies and conflicts in the evidence. Garza v. Commercial Insurance Company of Newark, New Jersey, 508 S.W.2d 701, 702 (Tex. Civ. App.-Amarillo 1974, no writ). This is equally true regarding medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286, 290 (Tex. App.-Houston [14th Dist.] 1984, no writ). The trier of fact may believe all, part, or none of the testimony of any witness. Taylor v. Lewis, 553 S.W.2d 153, 161 (Tex. Civ. App.-Amarillo 1977, writ ref'd n.r.e.); Aetna Insurance Co. v. English, 204 S.W.2d 850 (Tex. Civ. App.-Fort Worth 1947, no writ). An appeals level body is not a fact finder, and does not

normally pass upon the credibility of witnesses or substitute its own judgment for that of the trier of fact, even if the evidence would support a different result. National Union Fire Insurance Company of Pittsburgh, Pennsylvania v. Soto, 819 S.W.2d 619, 620 (Tex. App.-El Paso 1991, writ denied). When reviewing a hearing officer's decision for factual sufficiency of the evidence we should reverse such decision only if it is so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex 1986); Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986).

While the claimant testified, and clearly believes, her injury includes an injury to her low back, the hearing officer found that the evidence failed to establish this. While there is other evidence in the record to support the claimant's contention that her low back was injured in the accident, there is some evidence, particularly in the letter of the Dr. W, the designated doctor, to support the findings of the hearing officer. Therefore, although we might have weighed the evidence differently we do not feel that the we can say that the finding of the hearing officer was against the great weight of the evidence. *See* Texas Workers' Compensation Commission Appeal No. 92503, decided October 29, 1992.

As to the issue of MMI and impairment, the opinion of a Commission selected designated doctor is presumptive on these issues and will be set aside only if the great weight of the other medical evidence is to the contrary. *See* Article 8308-4.25 and 4.26. We commend the hearing officer for seeking clarification from the designated doctor. This allowed the hearing officer to weigh the questions concerning the designated doctor amending his report in determining that the designated doctor's opinion was not contrary to the weight of the other medical evidence. As the hearing officer states in his discussion, "[h]is [Dr. W's] response didn't clarify his report a great deal but, even so, there is insufficient evidence to establish that the great weight of other medical evidence is to the contrary." We certainly feel that a doctor's reason for amending a medical report, particularly when preceded by a unilateral communication from a party, should be taken into account when weighing that opinion against the other medical evidence. While based upon Dr. W's somewhat unenlightening explanation for amending his report, and the statements of two other physicians that the claimant had not reached MMI, we might have reached a different result, we must defer to the fact finder. Further, there is other medical support for the designated doctor's finding of MMI in that one of the claimant's earlier treating doctors, Dr. G, had previously found MMI.

What most troubles us about this case is the unilateral communication between the carrier and the designated doctor. We find our following statement in Texas Workers' Compensation Commission Appeal No. 93455, decided July 22, 1993, apropos to the present case:

The nature of the unilateral communication between the carrier and the designated doctor, quoted at length above, could tend to compromise the perception, if

not the reality, of impartiality on the part of the designated doctor in this case. We have commented on this problem in the past. *See* Texas Workers' Compensation Commission Appeal No. 93272, decided May 24, 1993; Texas Workers' Compensation Commission Appeal No. 92595, decided December 21, 1992; Texas Workers' Compensation Appeal No. 93336, decided June 16, 1993. Without the appearance of impartiality the entire designated doctor process may be undermined. We appreciate that a party may need a clarification of a statement by a designated doctor; but that party should communicate its need for clarification to the Commission, with notice of its request to all other parties, and allow the Commission to contact the doctor to request clarification. Using this procedure as well as the discovery procedures available, such as deposition on written questions, provides each party sufficient access to the designated doctor for legitimate communication without potentially compromising the impartiality, or appearance thereof, of the designated doctor.

We could envision a situation where a unilateral communication so compromises the appearance of impartiality of the designated doctor as to require us as a matter of law to hold that his opinion must be disregarded. Our careful review of the medical in its entirety, as well as the hearing officer's seeking of clarification from the designated doctor, leads us to conclude that this is not the proper case to apply this remedy.

The decision of the hearing officer is affirmed.

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Gary L. Kilgore
Appeals Judge

CONCUR:

_____
Robert W. Potts
Appeals Judge

_____
Lynda H. Nesenholtz
Appeals Judge