APPEAL NO. 93626

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On June 16, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The parties agreed the following issue was before the hearing officer:

Does [Claimant] have a 0% impairment rating in accordance with the 21 December 1992 report of Dr. P, a Commission designated doctor.

The hearing officer determined that the designated doctor's report had presumptive weight and that claimant reached maximum medical improvement (MMI) on December 14, 1992 with a zero percent impairment rating. Appellant, claimant herein, contends the hearing officer erred in accepting (Dr. P) assessment, that (Dr. M) rating is more accurate and that the great weight of the other medical evidence is contrary to the designated doctor's rating. Respondent, carrier herein, responds that the decision is supported by the evidence and requests that we affirm the decision.

DECISION

The decision of the hearing officer is affirmed.

The fact that claimant, a 37 year old employee of (employer), the employer, had sustained a back injury on (date of injury), is not disputed. Claimant testified he first saw (Dr. C) and treated with him for a period of time. After claimant was released to return to work claimant began seeing Dr. M. At some point carrier requested claimant see (Dr. F). Eventually Dr. P was appointed by the Commission as a designated doctor. Claimant testified that Dr. P only saw him for about 10 minutes, took some x-rays, did not conduct very comprehensive range of motion tests and did not use "meters" on him. Claimant also testified he received some physical therapy from (WW) and from (Centre).

Dr. C, the first treating doctor, by report dated October 15, 1991, notes claimant "has failed to improve" and suggested "an epidural steroid." In a January 9, 1992, report Dr. C indicates "patient underwent epidural steroid administration" and is "50% better." Claimant at that time remained under active treatment. In a report dated February 6, 1992, Dr. C reports he used a "computerized key functional assessment" which revealed "invalid representation of (claimant's) physical capabilities" which indicated claimant has "manipulated the results of the assessment." Dr. C indicates that in four months of conservative therapy claimant has made no improvement and that Dr. C has nothing further to offer. Dr. C returned claimant to "regular job" with a 25 pound lifting restriction on "2/6/92."

Claimant next saw Dr. M. Dr. M submitted reports dated March 5, 1992, and April 27, 1992, showing additional epidural steroid injections and suspected herniated lumbar disc at "L-4-5" and/or "L5-S1." In a Report of Medical Evaluation (TWCC-69) and narrative

dated January 27, 1993, Dr. M certifies MMI on "12/10/92" with a seven percent whole body impairment rating noting how he reached that figure using the "AMA Guides to the Evaluation of Permanent Impairment" (AMA Guides).

At carrier's request, claimant saw Dr. F "to determine nature and extent of injury." By report dated October 6, 1992, Dr. F noted a normal MRI, claimant's progress in treatment with Dr. C and Dr. M and stated "I do not find any abnormality herein, which would be associated per se with the asserted injury event of 8-29-91. . . ." Dr. F opines claimant ". . .has long since reached (MMI and) . . .no permanent partial functional impairment." Dr. F states "the return to work by Dr. C was probably also a generous (MMI) date."

Claimant was then examined by the designated doctor, Dr. P, who by TWCC-69 and narrative report dated "12/21/92" certified MMI on "12/14/92" with zero percent whole body impairment. In the narrative Dr. P relates claimant's complaints, results of his physical examination to include straight leg and sciatic stretch testing, review of the MRI, discogram, and post discogram CT and concludes there is no "evidence of objective abnormality."

The record also contains an "Ergos Evaluation Summary Report" from WW and work release from Centre not inconsistent with the listed doctors' reports. Claimant refers to a (Dr. T) who did x-rays, discograms and a lumbar myelogram for Dr. M on March 23, 1992. Dr. T's impression was claimant's back was essentially normal with the exception of a "Questionable small partial posterior tear at the L4-L5 level. . . (and) small posterior herniation at the L5-S1 level."

As indicated, the hearing officer reviewed the medical records as noted in his findings of fact, and concluded that Dr. P, as a Commission designated doctor "whose report is entitled to presumptive weight under Article 8308-4.25 and 8308-4.26 (now Sections 408.122(b) and 408.125) and therefore (claimant) has reached (MMI) with a 0% impairment rating as of 14 December 1992." Claimant disagrees but offers only his lay testimony, and the reports discussed above, as medical evidence contrary to that of the designated doctor.

In Texas Workers' Compensation Commission Appeal No. 93442, decided July 12, 1993, we noted that the ultimate determination of impairment, if any, must be made upon medical and not lay evidence. Texas Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992. We have frequently noted the important and unique position occupied by the designated doctor under the 1989 Act. *See e.g.* Texas Workers' Compensation Commission Appeal No. 92555, decided December 2, 1992; Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. We have just as frequently stated that a "great weight" determination amounts to more than a mere balancing or preponderance of the medical evidence. Appeal No. 92412, *supra*. We are satisfied here of the correctness of the hearing officer's having accorded presumptive weight to the designated doctor's report upon determining that the great weight of the other medical

evidence was not to the contrary. The 1989 Act provides that the hearing officer, as the fact finder, is the sole judge not only of the relevance and materiality of the evidence but also of its weight and credibility. Section 410.165(a). Not only did Dr. P determine that claimant had a zero percent impairment, but he is in large part supported by Dr. C and Dr. F. Aside from claimant's lay testimony, only Dr. M assesses claimant with any impairment.

The challenged findings and conclusions are not so against the great weight and preponderance of the evidence as to be manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 751 S.W.2d 629 (Tex. 1986).

The decision of the hearing officer is affirmed.

Thomas A. Knapp
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Gary L. Kilgore
Appeals Judge