APPEAL NO. 93716

On April 30, July 8, and July 16, 1993, a contested case hearing was held. The first session took place in the (city) field office, the last two sessions by agreed teleconference. The presiding hearing officer was (Hearing officer). The disputed issues were whether claimant (claimant) who is the appellant, had reached maximum medical improvement (MMI) and, if so, the percentage of her impairment, relating to injuries she sustained in a fall on (date of injury), while employed by (employer). The hearing officer gave presumptive weight to the report of the designated doctor, and found that claimant reached MMI on September 29, 1992, with zero percent impairment.

The claimant's appeal is not entirely clear. It does, however, assert that the hearing officer's decision was wrong, and argues evidence which she feels demonstrates that she has not reached MMI and has impairment. Claimant appears to contend that her injured left knee has not been considered. She argues that the designated doctor's report was wrong because he did not have all of her medical records. She appears to dispute that she had examinations by a radiologist from whom reports are in evidence, or from the designated doctor. She argues that the insurance carrier has waived its right to make comments at the hearing or on appeal. The insurance carrier responds that the evidence supports the hearing officer's decision, and that the report of the designated doctor must be given presumptive weight unless the great weight of other medical evidence is to the contrary.

DECISION

We affirm the decision of the hearing officer.

The claimant's testimony, given primarily in narrative form, concerned many matters that were important to the claimant, regarding what she believed to have been unfair treatment from the employer and the insurance carrier. It was clear that claimant felt that the insurance company had not paid medical bills which were due. Because the only two issues considered by the hearing officer, in accordance with TEX. LAB. CODE ANN. § 410.151(b), were whether claimant had reached MMI and, if so, her impairment rating, we focus on that testimony and those exhibits that have to do with these issues.

Claimant was employed by employer and injured herself when she fell on (date of injury). The claimant indicated that she had injuries to her back, neck and left knee. (She also indicated that she felt an ear infection resulted from her employment, because she did not have an ear infection when she started working for the employer).

The claimant identified her health care providers as (Dr. A),(Dr. T), Dr. P), (Dr. S), and (Dr. SE). She was also seen by (Dr. E) as doctor for the carrier, and was examined by (Dr. M) as designated doctor by the Texas Workers' Compensation Commission (Commission). At the hearing, statements of the parties indicated that they had agreed at a benefit review conference that claimant should be examined by a designated doctor appointed by the Commission. Claimant testified that she had been treated for rheumatoid

juvenile arthritis since age seven. Claimant said she had a second fall in March 1992, (not while employed by employer) which she felt was due in part to carrier's bad conduct related to her claim. Claimant was briefly represented by attorney WB, but he withdrew from representing claimant at her request on June 23, 1992.

An October 1991 report from Dr. A noted that she complained of considerable left knee pain from her August fall. Dr. A noted that there was no swelling or no limitation of range of motion, and that her x-rays were negative. A December 3, 1991 letter from Dr. A indicated he had seen claimant once, and that he felt her ear infection was not related to her August injury. An x-ray report from the radiology department at Hospital, dated September 1, 1991, stated an opinion that "narrowing of the joint space suggests internal degenerative changes. No acute bony injury is evident." A later report dated March 31, 1992 records an impression of "no acute bony abnormalities with some degenerative change noted of the lateral compartment." This same report does state that this "may" represent "old trauma residuum."

Dr. E 's report indicated that he examined claimant on March 5, 1992, and determined that she reached MMI as of that date, with a zero percent impairment. Dr. E opined that she could have some rheumatic components in her knees, and that he tried to reassure her that he found no major clinical manifestation of injury. Claimant disputed that Dr. E had examined her, although she indicated she was in his office from half an hour to an hour. She stated that she filled out a questionnaire for him and they discussed her answers to the questionnaire and she did not undress nor was she given an examination.

Dr. M was appointed apparently as a result of claimant's dispute over Dr. E's opinion. Dr. M examined claimant on September 29, 1992. Although claimant complained at the hearing that the carrier had not included her neck and back as part of her injury, Dr. M's report (and claimant's testimony) indicated that he did include as part of his examination her neck, her back, upper left arm and shoulder, and head, as well as her knee. Claimant testified that Dr. M's examination lasted about an hour and she was undressed. Dr. M found full range of motion for cervical and lumbar spine. He stated that bilateral knee range was "physiologic bilaterally." He noted that claimant was able to squat while resting her arms on the examination table. He noted normal cervical and lumbar MRIs had been performed. Dr. M's report indicated that he found a significant subjective component to claimant's pain. His report indicated that an EMG had previously been initiated on claimant but not completed because of her intolerance of pain. He determined she reached MMI. He recommended, however, that the EMG test be completed (to "unequivocally rule out any neuropathic involvement affecting the lower extremity based on subtle reflex differences on examination") and a functional capacity test performed for impairment evaluation.

Claimant testified that she did not at first return to Dr. M when requested to do so because she had signed permission for only one examination. The Commission contacted claimant by letter dated November 16, 1992, urging her to return to Dr. M's office for the functional capacity test. A report from Dr. M dated January 5, 1993, stated that his office

had been in contact with claimant several times to urge her to return but she had not until that date. This report indicated that claimant had related to Dr. M's office that she was recommended for knee surgery by Dr. SE and that she had an Excedrin overdose in October resulting in her going to the emergency room. The notes indicated that she refused the EMG unless sedated first. The report also indicated that claimant presented herself on January 5, 1993, and brought with her a "Criminal Conspiracy Complaint" addressed to Dr. M and the OSHA Commission (a copy of this was not in the record). Dr. M then stated that he believed her complaints at that point were primarily psychiatric, that her injury sustained on (date of injury) had not been of tremendous significance, and he completed a TWCC-69 form finding that claimant reached MMI on September 29, 1992, with a zero percent impairment.

The only records from Dr. SE are an operative report and a report dated July 14, 1992. The July 14th report indicated that Dr. SE found from x-rays that she had bone rubbing on bone in the left knee, which he opined were from cartilage degeneration. (The history on this report does not note any discussion relating to claimant's fall in August 1991 or in March 1992). Claimant had arthroscopic surgery on her left knee on November 23, 1992, during which time a synovectomy was performed, a small amount of chondromalacia shaved, and excess fluid drained. Claimant testified that this surgery had greatly improved her knee. None of the records of Dr. SE opine (one way or the other) about any link of this condition to trauma. Claimant in her appeal appears to assert that she does not feel that Dr. SE's report is entirely accurate in its description of her condition.

"Maximum medical improvement" is defined, as pertinent to this case, as "the point after which further material recovery from or lasting improvement to an injury can no longer be reasonably anticipated, based on reasonable medical probability." Section 401.011(30)(A). We have stated that the presence of pain is not, in and of itself, an indication that an employee has not reached MMI; a person who is assessed to have lasting impairment may indeed continue to experience pain as a result of an injury. *See* Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1993.

"Impairment" is defined in the 1989 Act as "any anatomical or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." Section 401.011(23). Further, impairment must be based upon "objective clinical or laboratory finding." Section 408.122(a).

The report of a Commission-appointed designated doctor is given presumptive weight. Sections 408.122(b), 408.125(e). The amount of evidence needed to overcome the presumption, a "great weight," is more than a preponderance, which would be only greater than 50%. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992.

In response to claimant's contention that Dr. M did not have all of her records, we note that Dr. M did examine all of the parts of the body that claimant said were affected by her fall on (date of injury). He was aware that she had seen Dr. SE. He also examined her knees and noted her specific complaint relating to her knee. In any case, whether Dr. M had the operative report of Dr. SE, the hearing officer had it before him and thus had the opportunity to determine whether it amounted to a "great weight" of evidence against the designated doctor's opinion.

The hearing officer is the sole judge of the relevance, the materiality, weight, and credibility of the evidence presented at the hearing. Section 410.165(a). The decision should not be set aside because different inferences and conclusions may be drawn upon review, even when the record contains evidence that would lend itself to different inferences. Garza v. Commercial Insurance Co. of Newark, N.J., 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). 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.).

Relating to claimant's contention that there has been a waiver, we see nothing in the record indicating that the carrier has in any way given up its right to appear as a party in the dispute over MMI and impairment.

In considering all the evidence in the record, we cannot agree that the findings of the hearing officer are so against the great weight and preponderance of the evidence as to be manifestly wrong and unjust. In re King's Estate, 244 S.W.2d 660 (Tex. 1951). As a result we affirm the hearing officer's determination.

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Susan M. Kelley
Appeals Judge

CONCUR:

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Joe Sebesta
Appeals Judge

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Lynda H. Nesenholtz
Appeals Judge