APPEAL NO. 93750

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). Following a contested case hearing held in (city), Texas on July 28, 1993, hearing officer (hearing officer0 issued a decision holding that the appellant (hereinafter claimant) reached maximum medical improvement (MMI) on April 7, 1993, with a nine percent impairment rating as found by the designated doctor. The claimant contends on appeal that the designated doctor's report was incomplete as it did not, unlike the report of claimant's treating doctor, include any impairment for claimant's radicular bilateral leg pain. Claimant also contends that the designated doctor acted in an unprofessional manner. The respondent (hereinafter carrier) acknowledges the untimeliness of its response, but asks that it be considered because carrier was not aware at the time it received claimant's appeal that the document filed by claimant was a request for review. Due to the untimeliness of carrier's response, however, we will not consider it.

DECISION

The decision and order of the hearing officer are affirmed.

The claimant, who testified with the assistance of a translator, stated that he was injured on (date of injury), while assisting in carrying a 950-pound roll of carpet in the course of his employment with (employer). The roll of carpet slipped, struck claimant on the shoulder, and knocked him to the floor. He experienced numbness in his legs and back pain, and the following day his employer sent him to (Dr. W).

Dr. W treated claimant conservatively and referred him to (Dr. Z), a neurosurgeon, for evaluation. On April 28th, Dr. Z noted claimant's complaints of numbness down claimant's right lower extremity but stated his leg raises to be negative, and said claimant could bend without much problem. On May 5th Dr. Z noted claimant's lumbosacral and leg pain and difficulty in bending, and referred him for physical therapy. On May 18, Dr. Z said claimant's x-rays showed evidence of some changes at L4-5 and possibly L5-S1 with possible herniation. An MRI of the lumbar spine disclosed a bulging disc at the L5-S1 level, and central right paracentral herniation of nucleus pulposus at the L4-5 level; apparently a free disc fragment impinging on the thecal sac centrally at L3-4; and degenerative disc disease at L3-4 and L4-5. The claimant testified that Dr. Z recommended surgery; while a June 17, 1992, letter from Dr. W states that he had no written report confirming that opinion, Dr. W said that claimant might need surgical correction based on the MRI findings.

At claimant's request Dr. W referred him to (Dr. P), so they could communicate in the same language. Dr. P first saw claimant on June 18, 1992, and diagnosed severe post traumatic lumbosacral pain with sciatic leg pain bilaterally right more than left, and post traumatic L4-5 herniated disc associated with L5-S1. He referred claimant for further tests, including a lumbar myelogram and a post myelogram CT scan. The report noted minimal bulging of the L3 disc, Grade II central disc herniation at L4-5, and minimal degenerative changes with osteophyte formation at L3-4. Dr. P described claimant's condition as "a long

term one which will require combined neurosurgical orthopedic procedure as well as time to improve the significant condition." Dr. P also referred claimant to Dr. B, an orthopedic surgeon, for a second opinion; apparently based upon that doctor's recommendation claimant was continued with conservative treatment.

Dr. P continued to treat claimant through, among other things, medication, exercise, therapy, and weight loss. On February 3, 1993, Dr. P completed a Form TWCC-69 (Report of Medical Evaluation) wherein he certified that claimant reached MMI as of February 2, 1993, with a 15% impairment rating. Apparently because of the difference between Dr. P's report and that of the carrier's doctor, (whose report was not offered into evidence by either party), the Commission appointed (Dr. H) as designated doctor. Dr. H certified MMI as of April 7, 1993, with a nine percent i mpairment rating, based on a herniated nucleus pulposus at one intervertebral level and changes at two others. However, Dr. H did not assign a percentage of impairment based upon range of motion, stating that his examination was "significantly marred by functional overlay," that two attempts at measurement were invalid, and that claimant "has declined to perform further attempts at obtaining valid spinal measurements."

The claimant testified that in his opinion Dr. H was not impartial and not professional. He said at the first appointment Dr. H forced him to bend "more than I could" and then gave him an "erroneous evaluation" of five percent impairment. Claimant said after Dr. H recognized his mistake he re-evaluated claimant, again forcing him to bend, and that he told the claimant he had more than 15% impairment and that he should bend lower. (Claimant said he replied that he just wanted a correct evaluation, based upon the movements he was able to perform.) Following the second visit, claimant said Dr. H called him at home and told him it would be to his benefit to agree to testing for a third time because claimant had a family and he could get more money. Claimant said he declined to do so. He asked at the hearing that Dr. H's report be invalidated and that Dr. P's report be considered.

The hearing officer determined that the great weight of the other medical evidence was not contrary to the report of the designated doctor. Our review of the record does not reveal this determination to be in error. The 1989 Act provides that the report of a designated doctor shall have presumptive weight and that the Commission shall base its determination on MMI and impairment on that report "unless the great weight of the other medical evidence is to the contrary." Sections 408.122(b), 408.125(e). This panel has commented many times upon the "unique position" and "special presumptive status" that the designated doctor's report is accorded under the Texas workers' compensation system, and the fact that overturning such report requires more than a mere balancing of the evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Under the facts of this case, that the designated doctor was unable to get valid range of motion measurements, while claimant's treating doctor apparently was able to do so, does not render the designated doctor's report invalid. As we have stated

before, the American Medical Association Guides to the Evaluation of Permanent Impairment recognize that under certain circumstances these tests will be attempted but the results ultimately invalidated. *See* Texas Workers' Compensation Commission Appeal No. 93488, decided July 29, 1993. We also cannot agree from the evidence that Dr. H acted unprofessionally, or in any other manner that would threaten the integrity of the examination process or otherwise cast doubt upon his report, in requesting that claimant return for a third series of tests. Dr. H's report indicates that he tried unsuccessfully to get the claimant to undergo testing for the third time, but in the face of claimant's refusal proceeded to give him an impairment rating without receiving valid range of motion results. There is no evidence to suggest, other than claimant's statement which the hearing officer was free to discount, that Dr. H was attempting to "negotiate" an impairment rating.

In sum, our review of the record shows that the hearing officer committed no error in accepting the report of the designated doctor. We accordingly affirm the hearing officer's decision and order.

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Lynda H. Nesenholtz
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.
Chief Appeals Judge

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Philip F. O'Neill
Appeals Judge