APPEAL NO. 93768

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held on August 2, 1993 in (city), Texas, before hearing officer (hearing officer). The appellant, hereinafter claimant, appeals the hearing officer's determination that claimant reached maximum medical improvement (MMI) on May 28, 1993 with a six percent whole body impairment, as certified by the designated doctor. The claimant contends the hearing officer erred in accepting the report of the designated doctor who, he claims, is not an orthopedist or neurosurgeon, examined claimant very briefly, and did no more than "rubber stamp" the findings of a doctor whose opinion is not entitled to presumptive weight. The claimant further alleges that his employment status was not an issue and as such the hearing officer erred in making findings regarding such status. The respondent, hereinafter carrier, prays that the hearing officer's decision be affirmed.

DECISION

We affirm the decision and order of the hearing officer.

The claimant testified that on (date of injury), as he was driving spikes on a railroad track, he felt something pop in his neck. He was originally seen by Dr. B, who later referred him to (Dr. KD). The record shows that Dr. KD first saw claimant on January 13, 1992, and stated his assessment of neck and radicular pain with evidence clinically of a radiculopathy; he recommended a myelogram followed by CT scan. On February 3rd he wrote that the myelogram showed "bilateral neuro foraminal narrowing at C6-7 from osteophytic spur with a ventral defect at C6-7;" his letter of that date indicates he discussed surgery (cervical fusion) with claimant. However, in a June 25, 1992, letter Dr. KD stated that he had prescribed physical therapy for claimant and did not believe surgery was indicated (although by April 6, 1993 he said he was still considering it an option). In an August 7, 1992, letter Dr. KD said he was referring claimant to (Dr. BL) for a second opinion, but no report from that doctor was made part of the record. On May 5, 1993, Dr. KD reported that an MRI showed extensive degenerative disease at C3-4 and C4-5 with some spondylitic spurs at C6-7, and that an EMG and nerve conduction velocities revealed polyradiculopathy chronic in the left arm; he stated that "[f]or now, he [claimant] still would not like to have surgery." Claimant testified that he originally put Dr. KD off with regard to surgery because he wanted time to donate his own blood; he said that he did not decide against surgery but rather that Dr. KD determined he could do nothing more for claimant. He said Dr. BL told him the same thing.

In an undated Report of Medical Evaluation (Form TWCC-69) Dr. KD certified that the claimant reached MMI on November 23, 1992, with a six percent impairment rating. On May 17, 1993, the Commission appointed (Dr. H) as designated doctor to determine MMI and impairment rating. On June 1, 1993, Dr. H signed a TWCC-69 certifying that claimant reached MMI on May 28, 1993, with a six percent impairment. The claimant testified that Dr. H examined him for only 10 or 15 minutes, during which time he required claimant to

turn and stretch his neck, walk on his heels and toes, and push against Dr. H's arms. Claimant said he did not know whether Dr. H had seen his medical records.

At the time of the hearing claimant had begun treating with (Dr. GD), to whom he had been sent by his attorney. On May 25, 1993, Dr. GD summarized claimant's complaints of pain and the results of the studies performed to date; he noted that claimant had been assigned a six percent impairment and said "I have no idea if this is correct." However, he stated that "a physical impairment for the two disc lesions would be in the 15 percent (sic) of his body." Dr. GD also said he would not recommend surgery at this time as he did not believe claimant would get much improvement thereby.

The hearing officer found claimant to have reached MMI on a date and with an impairment rating consistent with Dr. H's report. Her discussion of the evidence stated that "[a] review of the medical evidence introduced at the contested case hearing indicates that it not (sic) sufficient to constitute the great weight of contrary medical evidence which is necessary to overcome [Dr. H's] certification." On appeal the claimant contends the hearing officer "summarily" reached such conclusion; that Dr. H did no more than "rubber stamp" his approval of Dr. KD's certification, which is not entitled to a presumption of correctness; and that the hearing officer did not even discuss Dr. GD's report.

As the hearing officer indicates, the 1989 Act provides that the report of a designated doctor appointed by the Commission 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). The Appeals Panel has held that the statute accords the designated doctor's report a "special presumptive status," and overturning such report requires more than a mere balancing of the evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. We find nothing to indicate that the hearing officer, in reaching her decision, failed to consider all the medical evidence in the record, including the report from Dr. GD. We note certain similarities between the medical reports in evidence, such as the fact that the treating and designated doctors assigned the same impairment rating, and the fact that Dr. GD appeared to concur that surgery was not recommended. Upon review of the record, we cannot say that the hearing officer was in error in determining that the "great weight of the other medical evidence" did not outweigh the report of the designated doctor. Further, while Drs. KD and H assigned the same rating, we do not believe the evidence shows Dr. H "rubber stamped" the other doctor's report, in the sense of not performing his own, independent evaluation. We observe that Dr. H certified MMI on a date six months subsequent to Dr. KD. However, we also observe that it would not necessarily be error for one doctor to concur in another's findings, so long as it was based upon his own evaluation of the claimant. *See, e.g.*, Texas Workers' Compensation Commission Appeal No. 92627, decided January 7, 1993.

Finally, the claimant contends that the hearing officer erroneously made a finding of fact which states that "[o]n (date of injury), claimant was employed by (employer);" he states that this was not an issue before the hearing officer and he has not consented to any determination of this issue. The record from the contested case hearing indicates that claimant's employment status was not disputed by either party, but that no stipulation as to this fact was elicited. However, the record contains evidence in support of this finding, which--like evidence of coverage on the employer's part--is a fundamental one and a prerequisite to any decision concerning the compensability of an injury. We find no error in the hearing officer's finding.

Based on the foregoing, the decision and order of the hearing officer are affirmed.

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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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Susan M. Kelley
Appeals Judge