APPEAL NO. 93789

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE § 401.001 *et seq*. (1989 Act). A contested case hearing was held on August 4, 1993, in (city), Texas, before hearing officer (hearing officer) to determine the single issue of claimant's impairment rating. The claimant, who is the appellant in this action, seeks our review of the hearing officer's determination that the claimant's impairment rating was zero percent as determined by the agreed designated doctor. The carrier responds that the hearing officer's decision should be affirmed.

DECISION

We affirm the hearing officer's decision and order.

Claimant testified that he injured his neck and back on (date of injury), while working as an elevator operator for an oil field company, (employer). He said he first went to a hospital for treatment, then later was seen by employer's doctor. (These medical reports were not in evidence.) He said the carrier sent him to see(Dr. K), who on May 7, 1991, stated his impression that the claimant had a lumbosacral sprain and possible degenerative disc disease at L5-S1; he recommended that claimant undergo physical therapy and be referred to an orthopedic surgeon. On

May 29th, claimant was seen by (Dr. Ki), who diagnosed apparent sprains of the neck and back and who stated that he believed the claimant had been "overcome by an emotional fixation on his neck and back musculature. . . . In my opinion he now has no disability and will have no permanent disability as a result of whatever injury he sustained in the mishap occurring on (date of injury)."

Claimant began treating with (Dr. S), who ordered tests including a July 31, 1991, MRI of the lumbar spine which disclosed a possible L5-S1 herniation, but said there was so much motion present that this could not be confirmed. (Reports of other tests and studies, including x-rays, a cervical MRI, myelogram, CT scan, and EMG were not in evidence although they are referred to in several doctors' reports.) Dr. S also referred claimant to the (city) Functional Assessment and Restoration Center for evaluation. A February 24, 1992, report from the center summarized the results of claimant's evaluation and assigned him a 41% whole body impairment rating. Dr. S adopted these findings and certified claimant as having reached maximum medical improvement (MMI), but did not assign a date.

At the carrier's request, the claimant was seen by (Dr. M) on May 26, 1992. Dr. M stated his assessment of claimant as chronic cervical and lumbar musculoligamentus injury, C-5 disc protrusion, and L-5 disc dysfunction. Although he discussed the possibility of a functional component to the claimant's symptoms, he stated that in his opinion the claimant was "not faking any of his complaints." The hearing officer found that Dr. M assigned the claimant a 13% impairment rating.

Because the carrier disputed the impairment rating assigned by Dr. S, the Texas

Workers' Compensation Commission (Commission) on August 12, 1992, appointed (Dr. St) as a designated doctor. The claimant testified that he was never examined by Dr. St and indeed never saw her; that his examination was conducted entirely by her associate, (Dr. C), who on August 27th filed a lengthy report summarizing his examination of claimant and his review of claimant's medical records. Dr. C stated his conclusion that claimant had no physical impairment but that his "psychological impairment appears to be quite severe," and he recommended that a psychological evaluation would be helpful in attempting to arrive at an impairment rating. The claimant testified that he was very uncomfortable with Dr. C's manner of dealing with him. He also stated that he subsequently underwent psychological evaluation, although no reports are in evidence. In a letter dated November 11, 1992, Dr. St stated that claimant's psychological findings suggested that he had a schizoid personality disorder, and that patients with this disorder show symptom magnification in the form of inappropriate physical symptoms. She concluded, "[i]n view of [claimant's] psychological profile and in view of his lack of objective physical findings, I think that [claimant's] cervical range of motion studies must be invalidated. X-ray studies do not indicate any abnormalities, specifically a herniated disc, nor is there substantial evidence of any other objective findings." Dr. St found that claimant reached MMI on August 27, 1992, with a zero percent impairment.

At a benefit review conference on January 11, 1993, the claimant and carrier executed an agreement whereby claimant would see a mutually agreed-upon doctor for another impairment rating to resolve that issue. (The hearing officer's discussion of the evidence states, "it is clear that the parties recognized a problem with the designated doctor's determination because an agreement was made . . . to send [claimant] to a mutually agreed upon doctor for another impairment rating. . . ." The hearing officer characterized the second doctor as "agreed to subsequent to a defective designated doctor's report.") On February 26, 1993, claimant was examined by (Dr. H), who completed review of claimant's medical records and studies on (date of injury). Dr. H's report noted normal x-rays, EMG, myelogram, and lumbar CT scan; it finds the lumbar MRI to be essentially within normal limits, with a small protrusion of "no real clinical significance;" and it notes minimal bulging on the cervical myelogram with no sign of herniation, and characterizes this study as normal. Stating that there was no evidence of disc herniation or need for surgery, and that in Dr. H's opinion any restriction of claimant's motion was voluntary, he certified MMI as of February 25, 1993, with a zero percent impairment.

At the hearing the parties stipulated that claimant reached MMI on March 17, 1992. The hearing officer found that Dr. H was an agreed designated doctor whose determination on an impairment rating is conclusive and binding; therefore, the hearing officer concluded that claimant's whole body impairment rating as a result of his compensable injury was zero percent. On appeal, claimant challenges this finding and conclusion, stating that the great weight of the medical evidence does not support Dr. H's impairment rating, as claimant's treating doctor assigned a 41% impairment rating and Dr. M found a greater than zero percent impairment. Further, claimant argues, Dr. H's report was based upon the report of Dr. C which he says should not have been reviewed by Dr. H because Dr. C was not the appropriate evaluating physician and because the claimant's testimony supports a

conclusion that Dr. C's evaluation could not be objective due to claimant's extreme distrust of that doctor.

Claimant does not challenge the hearing officer's finding that Dr. H was a designated doctor agreed to by the parties; accordingly, that finding will stand. The 1989 Act, Section 408.125(d), provides that if a designated doctor is chosen by agreement of the parties to determine impairment rating, the Commission "shall adopt the impairment rating made by the designated doctor." This is distinguishable from the situation where the Commission appoints a designated doctor, whose report is then entitled to presumptive weight unless the great weight of the medical evidence is to the contrary. Section 408.125(e). Under the facts of this case, it was not necessary for the hearing officer to consider medical evidence to the contrary of Dr. H. *See* Texas Workers' Compensation Commission Appeal No. 92608, decided December 30, 1992. While this panel has held that the sufficiency of a report by an agreed-upon designated doctor can nevertheless be considered, *see e.g.*, Texas Workers' Compensation Commission Appeal No. 93001, decided February 19, 1993, it was not improper for Dr. H to consider Dr. C's report when making a determination on impairment rating. While Dr. C was not a designated doctor, and his opinion was not entitled to presumptive weight, it was certainly medical opinion that Dr. H could appropriately consider. We note also that Dr. H's report indicates he reviewed and considered medical opinions in addition to Dr. C's, including reports of Dr. S, Dr. K, Dr. Ki, Dr. M, and Dr. St, as well as that of the physical therapist who rendered the 41% impairment rating. Under the facts of this case, the hearing officer properly adopted Dr. H's impairment rating.

Finally, the claimant alleges error in the hearing officer's finding of fact that claimant injured his back while at work on (date of injury), stating that claimant also injured his neck on the same date. While claimant's testimony and the medical reports include complaints and examination of claimant's cervical, as well as lumbar, spine, the hearing officer's statement is harmless error, as the issue of extent of claimant's injury was not before the hearing officer.

The decision and order of the hearing officer are affirmed.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Thomas A. Knapp
Appeals Judge