APPEAL NO. 93829

Pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act) (formerly V.A.C.S. Article 8308-1.01 *et seq*.), a contested case hearing was held in (city), Texas, on August 26, 1993, (hearing officer) presiding as hearing officer. He found that the designated doctor's impairment rating of seven percent was not contrary to the great weight of the other medical evidence and determined that the maximum medical improvement (MMI) date was April 23, 1993, with a seven percent whole body impairment rating. The appellant (claimant) urges that the designated doctor failed to use the "Guides to the Evaluation of Permanent Impairment, Third Edition, Second Printing, 1989" (AMA Guides) and failed to give her a complete and thorough evaluation. The claimant asks that she be awarded an impairment rating of 18% or 15% as rated by, respectively, a Functional Assessment and Restoration Center and her treating doctor. The respondent (carrier) argues that the decision of the hearing officer was not against the great weight and preponderance of the evidence and that the great weight of the other medical evidence did not outweigh the report of the designated doctor.

DECISION

Finding the evidence of record sufficient to support the decision of the hearing officer, we affirm.

Not in dispute was the fact that the claimant sustained a compensable back injury on (date of injury), when she was helping to lift a patient who had fallen. The only issue at the hearing was the correct impairment rating. The hearing officer's statement of evidence adequately and fairly sets forth the facts in the case and is adopted for purposes of this decision. The records show that the claimant was 50 years old at the time of the incident, is 4 feet, eleven inches tall and weighed 214 pounds. The early medical records indicate the claimant had lumbosacral strain and a series of x-rays of the lumbosacral spine was unremarkable with an MRI showing degeneration at the L3 and L5-S1 levels. Surgery was determined to be inappropriate. On May 28, 1992, a medical report shows that a (Dr. G) found no evidence of spondylosis or spondylolisthesis, decreased T2 signal intensity to L3-4, L4-5, and L5-S1 level with moderated L3-4 subligamentous disc herniation and mild L4-5 and L5-S1 protrusion, moderate L3-4 thecal effacement, otherwise mild narrowing at L3-L4, no other evidence of nerve root compression, mild anterior extradural defects, low pain threshold, chronic pain syndrome, and increased functional overlay during the examination process. On December 12, 1992, the claimant's treating physician gave her a prospective date of MMI of February 1, 1993, with a "15% whole body partial permanent impairment," based upon all of claimant's various medical problems. On March 4, 1993, the date the Commission designated (Dr. M) as the designated doctor, the claimant went to the Functional Assessment and Restoration Center where in a report signed by SG, O.T.R. she was given an 18% impairment rating for the lumbar spine. (Although the initial report indicates that the wrong version of the AMA Guides was used, a 1990 edition, this was later corrected by the Center). According to the testimony of the claimant, her examination with Dr. M, the designated doctor, took about three hours and involved three people and included

range of motion (ROM) evaluations. Dr. M's report indicates the various ROM testing performed and indicated that "Cybex EDI ROM testing will be obtained for appropriate impairment purposes." Later in the report he indicates that "ROM evaluation by Cybex EDI yielded invalid results." Dr. M rendered an impairment rating of seven percent based upon Table 49 of the impairment guides and did not render any impairment for ROM. His report indicates he used the appropriate impairment guides as provided by Section 408.124. That section of the Labor Code provides that the "Guides to the Evaluation of Permanent Impairment, third edition, second printing dated February 1989" published by the American Medical Association be used.

The report of a designated doctor is accorded presumptive weight and the impairment determination is based upon that report unless the great weight of the other medical evidence is to the contrary. Section 408.125(e). The hearing officer found that the designated doctor's report is not contrary to the great weight of the other medical evidence. Given the prospective nature of the reported MMI rendered by the treating doctor, neither the MMI date nor the impairment rating was valid to establish either. Texas Workers' Compensation Commission Appeal No. 93259, decided May 17, 1993. As the hearing officer observed, there is nothing to indicate that the report from the Functional Assessment and Restoration Center was rendered, adopted or incorporated into any doctor's report or evaluation. The hearing officer quite apparently did not find this to be medical evidence measuring up to a great weight standard to overcome the presumptive weight of the designated doctor's report. The hearing officer is the sole judge of the relevance and materiality of the evidence and of the weight and credibility to be given the evidence. Section 410.165(a). We do not find a sufficient basis to challenge that determination. We have repeatedly held that a designated doctor's report is accorded presumptive weight and that it takes more than a mere balancing of the other medical evidence to overcome that presumptive weight. Texas Worker's Compensation Commission Appeal No. 92412, decided September 12, 1992; Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1993. The hearing officer determined, and we agree, that the designated doctor's report was not overcome by other medical evidence in this case. Accordingly, the decision is affirmed.

Stark O. Sanders, Jr.
Chief Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Gary L. Kilgore
Appeals Judge