APPEAL NO. 93831

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act) (formerly V.A.C.S. 8308-1.01 *et seq.*). On August 18, 1993, a contested case hearing (CCH) was held in (city), Texas, with (hearing officer) presiding as hearing officer. The issues to be determined at the CCH were: a) when did claimant reach maximum medical improvement (MMI); and b) what is claimant's impairment rating. The hearing officer determined that the appellant, claimant herein, reached MMI on February 9, 1993, with a nine percent impairment rating in accordance with the designated doctors report which is not contrary to the great weight of other medical evidence.

Claimant contends that her treating doctor's assessment of 27% impairment is more accurate, that the designated doctor changed his impairment rating of claimant because he was angry, that the great weight of other medical evidence is contrary to the designated doctor's report and requests that we review the hearing officer's decision and find in her favor. Respondent, carrier herein, did not file a timely response and it will not be considered.

DECISION

The decision of the hearing officer is affirmed.

The claimant filed a timely appeal on September 16, 1993. Carrier filed a Motion to Permit Late Filing of Response to Appellants Appeal, filing its response on October 6, 1993, which is more than 15 days after claimant's appeal was received by carrier. There is no provision in either the 1989 Act or the Commission Rules which authorize the Appeals Panel to extend filing deadlines. Consequently carrier's response was not timely filed and will not be considered. Claimant's response to carrier's response will also not be considered.

It is undisputed that claimant injured her back on (date of injury), while employed by (employer), the employer. Claimant apparently was seen by a (Dr. H) for a period of time and was then referred to (Dr. S). There are no reports from these doctors in the record of the CCH although claimant submits a page 2 of a report by Dr. S dated January 15, 1992. As it was not submitted at the CCH and made part of the record we decline to consider it on appeal in that our review of the evidence is limited to the record developed at the hearing. Section 410.203(a); Texas Workers' Compensation Commission Appeal No. 92092, decided April 27, 1992. Eventually, claimant began treatment with (Dr. L), M.D., based on the recommendation of a friend. Dr. L, in an Initial Medical Report and narrative dated March 5, 1992, recounted in patient's history a discharge from hospitalization on January 6, 1992, with a diagnosis of "lumbar disc bulges and fibromyositis," and that claimant was sent to a work hardening program in February 1992. Dr. L states in his report, confirmed by claimant's testimony, that claimant stopped the program after two and a half days "because of increasing pain in her neck and back." An MRI scan of the sacroiliac joints on May 1, 1992, was normal. Dr. L placed claimant on anti-inflammatory agents and analgesics.

Apparently, as a result of Dr. L's report, claimant in May 1992, was sent to (Dr. FL),

M.D., carrier's medical examination order doctor. Dr. FL in a Report of Medical Evaluation (TWCC-69) and narrative dated May 21, 1992, certified MMI on 5-21-92 with nine percent whole body impairment with a diagnosis of "back complaint." Dr. FL comments he believes claimant "is magnifying her symptoms." Dr. FL notes that "[p]atient does not have any objective findings in the diagnostic studies done on her . . . not sure that anything medical science has to offer this patient is going to make much difference." Dr. FL bases his impairment rating of nine percent ". . . on her complaints of pain."

Apparently claimant went back to Dr. L and in a subsequent report dated "December 16, 1993 (sic should be 1992)" Dr. L shows how he did extensive computer assisted range of motion (ROM) tests. Dr. L states "[t]est data reveals that the patient has limited range of motion in all of the primary movements." Dr. L concludes "[i]t is likely that the anomalies seen on the graphs are due to physiological abnormalities."

Subsequently (Dr. W), M.D., was appointed as a Commission-selected designated doctor. In a TWCC-69 and accompanying narrative report dated February 9, 1993, Dr. W certified MMI on February 9, 1993, with a 13% whole body impairment rating. Dr. W's report contained charts on how he arrived at the 13% impairment rating. Dr. W's physical exam found claimant's condition essentially normal with an impression:

1)History of a cervical strain.

2)Lumbar radicular syndrome with bilateral leg pain.

3)Probable functional overlay.

Subsequently claimant returned to Dr. L who by TWCC-69 and narrative report dated March 31, 1993, certified MMI on "3-31-1993" with 27% whole body impairment. The narrative report refers to the "computerized biomedical evaluation" previously done on May 28, 1992. Dr. L discusses his findings at length and concludes "[i]n my opinion, the patient has a problem of the bulging discs, but more so a fibromyalgia, that is the basic cause of her continued disability." Dr. L also states ". . . no impairment has been given with regards to the cervical spine." Dr. L also states he used the "Guides for Evaluation of Permanent Impairment, AMA Third Edition Revised, page 98, table 60."

Apparently a benefit review conference (BRC) was conducted or some proceeding where a disability determination officer (DDO) was of the impression that claimant was complaining that Dr. W, the designated doctor, had not personally examined claimant. Claimant at the CCH denies saying this and testified she only said Dr. W's examination was different than that of the other doctors. In any event, the DDO asked or sent claimant to Dr. W for a re-evaluation. Claimant testified that when she got to Dr. W's office, Dr. W was talking on the telephone with someone at the Commission and was angry that he had been accused of not examining claimant. Dr. W proceeded to re-examine claimant and by TWCC-69 and narrative report dated April 21, 1993, certified claimant reached MMI on

February 9, 1993 (the same MMI as his previous report) with nine percent whole body impairment (compared to 13% in his previous report). Dr. W states in his report:

> We were told by the members of the boards that the patient claimed we did not exam her which is untrue. In talking to this patient, she apparently went back to see [Dr. L], her treating physician. [Dr. L] and the patient state that the following occurred. [Dr. L] apparently gave this patient an impairment rating on 3-31-93 of 27%. This was based according to his report on 7% due to the MRI reading of three bulging discs which gives 7%, 10% loss due to flexion, 5% loss on extension, 3% on right lateral flexion and 2% on left lateral flexion which equates to 27% . . . . When faced with the fact that the board had stated I did not examine her, the patient admitted to me and also to PB who was present during the history and the exam on this patient at this visit that she did not tell the board that, that we did examine her but that she did not understand parts of the report which she had just alluded to above.

Dr. W proceeded to re-examine claimant and stated:

> First of all I feel that the multi-level bulging discs which the patient and [Dr. L] alluded to are not pathological. As a matter of fact on the myelogram they were visualized but in the post myelographic CT scan which is far more accurate, only the 5-1 bulge was noted and it was small. There was no evidence of any herniations or annular tears. MRI's and bone scans were all normal.
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> It may be of interest to note that I gave a rating to the cervical spine and the lumbar spine in my first impairment rating and feel that they should be given in this case. It is my understanding the other observers have not rated the cervical spine. On the basis of this, my impairment rating via 1989 AMA Guidelines is as follows: IIB, cervical spine 4%, range of motion normal 0%; lumbar spine IIB, 5%, range of motion invalid.

Claimant returned to Dr. L who in a report dated August 5, 1993, correcting the reference to the AMA Guides Revised made in his report of March 31, 1993, stated the tables in both the revised and 1989 versions "are identical," and "[t]herefore, there is no reason that the values that are given should not be taken into consideration. . . ." Dr. L reaffirms his ". . . total impairment of 27% for the whole person."

The hearing officer accepted Dr. W's amended report, determined claimant reached MMI on February 9, 1993, with a nine percent impairment rating and that the great weight

of the other medical evidence is not contrary to the "Revised TWCC 69" of the designated doctor. Claimant timely appealed contending Dr. L's "computerized biomedical evaluation" and "comprehensive testing' with the 27% impairment rating constituted the great weight of other medical evidence contrary to the report of Dr. W's revised report. Claimant contends Dr. W was angry because he believed he had been accused of not examining claimant.

Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992, discusses the reason for the designated doctor procedure, which is to resolve disagreement between various medical reports and medical practitioners concerning reaching MMI and assessing an impairment rating. Succinctly the report of a designated doctor selected by the Commission pursuant to Sections 408.122(b) and 408.125(e) "shall have presumptive weight and the commission shall base (MMI and an impairment rating) on that report unless the great weight of the other medical evidence is to the contrary, in which case the Commission shall adopt the impairment rating of one of the other doctors." We read this language to require more than a mere balancing of the evidence. In the area of MMI and impairment ratings, where there is a dispute regarding medical evidence, an attempt is made under the statute and rules to designate an independent doctor to finally resolve these matters. It is for this reason that "presumptive weight" is specifically accorded the designated doctor's report. Therefore, it is not just equally balancing evidence or a preponderance of evidence that can outweigh such report, but only the "great weight' of other medical evidence that can overcome it.

This panel has previously held that it is permissible for a designated doctor to amend his report for proper reason. Texas Workers' Compensation Commission Appeal No. 93328, decided June 2, 1993. In this case the designated doctor, at the request of the Commission as a result of Claimant's comments, re-evaluated claimant, considered Dr. L's evaluation and report, expressed his opinion that the bulging discs were not pathological and, on re-evaluation continued to give a rating on the cervical spine even though ". . . the other observers have not rated the cervical spine." As carrier noted at the CCH, Dr. W's revised impairment rating is quite similar to Dr. FL's rating. Having previously held that a designated doctor could amend his report, that the revised report was in response to the Commission's request to re-evaluate claimant and given that the revised report was prepared within a relatively short period (2 1/2 months) of the initial submission and before the CCH, we find sufficient evidence to uphold the hearing officer's finding that the designated doctor's revised report was not contrary to the great weight of the other medical evidence.

As previously indicated the designated doctor's report occupies a unique position under the worker's compensation system and we have held that no other doctor's report is given such a special presumptive status. Texas Workers' Compensation Commission Appeal No. 92255, decided July 27, 1992; Texas Workers' Compensation Commission 92366, decided September 10, 1992. The medical evidence in this case is basically conflicting as to the claimant's degree of impairment. (We note that Drs L, FL, and W have all found MMI to have been reached, although on different dates.) The designated

doctor is of the opinion that the bulging discs are not pathological, that there is no evidence of any herniations or annular tears and that the MRI's and bone scans were all normal. Both Dr. W's findings and impairment rating is supported by Dr. FL's report. Conversely Dr. L apparently is of the opinion that although claimant has bulging discs the basic cause of her problem is fibromyalgia and the other doctors failed to give sufficient weight to what Dr. L felt was significant loss of ROM based on his computerized biomedical evaluation. We view this as conflicting medical opinion in the nature of balancing Dr. L's report with Dr. W's opinion and given the state of the evidence we agree that Dr. L's reports, notwithstanding the computerized biomedical evaluation, does not constitute the "great weight" of the other medical evidence contrary to Dr. W's revised report.

Finding that the determinations of the hearing officer were not so against the great weight and preponderance of the evidence as to be manifestly wrong or unjust, (In re King's Estate, 244 S.W.2d 660 (Tex. 1951); Pool v. Ford Motor Company, 751 S.W.2d 629 (Tex. 1986) the decision of the hearing officer is affirmed.

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Thomas A. Knapp
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.
Chief Appeals Judge

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Gary L. Kilgore
Appeals Judge