APPEAL NO. 93872

This appeal is considered in accordance with 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*.). On July 19, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding, to determine the issues of whether the claimant, PL, had reached maximum medical improvement (MMI) and, if so, the correct impairment rating to be assigned. The claimant had sustained an injury to his shoulder and back on (date of injury), when he slipped and fell into a four foot hole while employed by (employer).

The hearing was requested by the carrier who had disputed the 15% impairment rating given by the designated doctor. The claimant, at the hearing, did not dispute MMI but asked that the 15% rating be adopted (which was assessed upon a certification of MMI effective March 17, 1993). The hearing officer held the record open to ask the designated doctor several clarifying questions about the elements of his impairment rating. In reply, the designated doctor amended his opinion and retracted range of motion impairment he had given to the claimant, and determined that the claimant had a five percent impairment rating. The hearing officer, after allowing time for both parties to respond, closed the record sometime in August 1993.

The hearing officer determined that claimant reached MMI effective March 17, 1993, with a five percent impairment rating, in accordance with the amended report of the designated doctor, and that the great weight of other medical evidence was not to the contrary.

The claimant has appealed the decision to adopt the designated doctor's report and impairment rating, arguing only three points: 1) that the treating physician's impairment rating of 16% is entitled to greater weight than the opinion of the designated doctor; 2) that the decision to use the designated doctor's report denies the claimant due process of law in violation of the Texas Constitution; and 3) claimant has not reached MMI. The carrier responds by reciting the statutory basis for according presumptive weight to the designated doctor's report and pointing out that the presumption in favor of MMI as reported by the designated doctor has not been rebutted by medical evidence.

DECISION

After considering the record in light of the points of error raised, we affirm the hearing officer's decision.

The claimant testified that he injured his shoulder, neck and back on (date of injury), when he fell head first into a four-foot deep hole during work. He stated that his neck was bent back in the fall. The pain gradually became worse and he left work after four more days. It does not appear from the record that the extent or nature of the compensable injury was disputed by the carrier. Claimant identified (Dr. D) as his treating doctor. Claimant had sustained a prior work-related injury to his shoulder, for which he received arthroscopic and then reconstructive surgery in 1987 and 1988, respectively.

Pertinent medical records relating to the issues of MMI and impairment are as follows:

-Initial Medical Report, January 10, 1992 - Dr. D. Diagnosis of Cervical Plexus compression, cervical myofascitis, and subluxation multiple cervical vertebrae.

-(Dr. W), who claimant testified examined him on referral from Dr. D, states in a March 25, 1992, letter normal cervical range of motion, but painful lower back range of motion and limited shoulder motion. Dr. W states that his working diagnosis is adhesive capsulitis of the right shoulder, and an acute back strain with a recommendation for further testing to rule out possible herniated lumbar disc. Dr. W's letterhead describes his specialty as orthopedic surgery.

-April 13, 1992 - Report of MRI of shoulder indicates no rotator cuff tear or evidence of impingement syndrome. No abnormal signal intensity. No evidence of stress fracture, dislocation, or joint effusion. The head of the humerus indicates a probable "Hill-Sachs deformity".

-April 22, 1992 - Dr. W notes that MRI of shoulder showed no rotator cuff tear but some evidence of impingement. Claimant to have physical therapy and remain off work.

-May 19, 1992 - lumbar spine x-ray, (Dr. I). Impression: degenerative disease at L4-5 and L5-S1. Degenerative changes to facet joints bilaterally at these levels is also noted. Straightening of lumbar spine due to muscle spasm.

-May 20, 1992 - Dr. W notes continued limitation of range of motion of shoulder; results of CT scan of lumbar spine show evidence of protrusion at two levels and stenosis at one level, but does not believe this to indicate herniated disc that is pinching on a nerve.

-June 17, 1992 - Dr. W notes improvement in range of motion of shoulder; diagnosis of acute back strain on top of degenerative changes in lower spine.

-July 30, 1992 – (city) Physical Therapy functional capacity evaluation report, prescribed by Dr. D. Results noted are true pain in back, with some discomfort and disfunction related to shoulder. Decreased flexibility in forward bending, back extension and trunk rotation, and in right shoulder range of motion, and minimal to moderate restriction in neck sidebending and rotation. Test notes indicate that results appear valid.

-September 16, 1992 letter from Dr. W releases claimant to employment effective September 17, 1992. States that claimant has tendinitis and impingement of right shoulder along with bulging disc at L5-S1. Main trouble noted is range of motion in shoulder. Letter notes that "passive" range of motion is almost normal.

-Dr. D referred the claimant to (Dr. WR) for impairment assessment, which was performed October 22, 1992. In a six page report, Dr. WR described how he assessed his impairment. He noted that he did not assess for loss of range of motion for the shoulder (although inclinometer measurements were taken) because he determined that it resulted from previous surgery. Dr. WR stated that he used the dual inclinometer method to measure range of motion, in which three to six repetitions were performed, and the data used only if within 10% or 5 degrees. Dr. WR's report indicates that he reviewed claimant's existing medical records to that point and objective tests and that he had claimant complete a questionnaire relating to activities of daily living. Dr. WR noted that claimant's tightest straight leg raise exceeded his sacral range of motion, which invalidated his lumbar test. Dr. WR indicated that he assigned four percent impairment for soft tissue injury to the neck, eight percent for lumbar spondylolisthesis Grade I, and five percent for cervical loss of range of motion, for a combined whole body impairment of 16%. He certified MMI on October 22, 1992. Dr. D concurred in this report.

-The Texas Workers' Compensation Commission (Commission) appointed (Dr. G) as designated doctor to determine MMI and impairment upon carrier's dispute with Dr. WR's certification.

-December 9, 1992 - report of Dr. G, a board certified orthopedic surgeon. Dr. G notes he is unable to assess due to lack of sufficient medical records provided, and asks that appointment be rescheduled pending receipt of x-rays by (Dr. R).

-December 17, 1992 - X-rays ordered by Dr. G. Results = Mild cervical spondylosis, tendinitis and early joint osteoarthritis in right shoulder, and mild degenerative changes in lumbar spine reported.

-December 21, 1992 - Dr. G unable to certify MMI or impairment. Letter, in summary, notes previous arthroscopic surgery on right shoulder (which reportedly did not do any good, according to claimant). Dr. G notes that he performed range of motion testing using inclinometers. States that he was unable to obtain three consecutive range of motion readings within 10 degrees of variance on cervical or lumbar spine. Straight leg raising test normal. No crepitus or popping evident in right

shoulder. Further notes that it is "possible" that current condition did not result from accident, and probable that some permanent impairment existed in right shoulder prior to accident. Citing the x-ray findings of the spine as indicative of minimal findings, Dr. G opines that Dr. WR's 16% rating is grossly excessive.

-January 14, 1993, letter to carrier from Dr. G, in apparent response to communication from carrier. States that he was unable to get impairment because claimant was obviously ill. States that he would have no problem assessing impairment to right shoulder, and states "without knowing what the impairment. . .was to the shoulder prior to the current accident, I would not be able to give you an apportionment and say how much was related (of patient's current shoulder impairment) to the current accident under consideration."

-March 17, 1993, letter to Commission from Dr. G - MMI certified effective that date, with 15% impairment rating. Stated that claimant's range of motion testing indicated he was not giving full effort, but states an opinion that further postponement of range of motion would be futile because of patient's nonanatomic complaints. Notes that shoulder movement was much improved. Internal rotation was normal. The report lists diagnoses of lumbar spondylosis, neck pain, and ankylosis of the shoulder. Dr. G notes evidence of a prior injury and surgery resulting in decreased range of motion, and that shoulder ankylosis was pre-existing the accident. Notes that claimant's medical condition is essentially unchanged over the past six months. In summary, Dr. G assigned five percent for a specific disorder of the lumbar spine, eight percent for loss of range of motion in the lumbar spine, and two percent for loss of range of motion in the cervical spine. The specific recorded range of motions measurements are not the same as those found by Dr. WR in October 1992; only one lumbar measurement and two cervical measurements were characterized as within 10% or 5 degrees.

The carrier disputed the designated doctor's 15% rating in a TWCC-21 Notice of Refused or Disputed Claim, filed March 30, 1993, in which the nature of the injury was described as shoulder strain. Carrier apparently thereafter sought consultation from its own expert doctor. A letter of May 14, 1993, from (Dr. F) to the carrier, which was not based upon an examination of claimant but was based solely upon review of records, noted that the range of motion deficits in the shoulder that were found by Dr. G in March 1993 warranted an 11% whole person impairment rating. Based upon the notes he was given, Dr. F stated he would not assess an impairment to the back. The letter from Dr. F references notes of Dr. W and the report of Dr. G, but makes no mention of review of any records from Dr. D or Dr. WR.

At the contested case hearing, the attorney for the carrier noted that it had asked the Commission to propound questions to the designated doctor and had seen no action on this. The hearing officer held the record open to ask Dr. G the following:

1 -Whether the shoulder was included in his rating;

2 - Why impairment was assigned for loss of range of motion when claimant's testing was declared invalid;

3 -What the basis was for a five percent specific diagnosis rating; and

4 -Whether claimant's spondylolysis was rated.

By letter dated August 3, 1993, Dr. G responded that he did not include the shoulder condition as it was pre-existing[1]. Dr. G stated that he wished to retract his range of motion percentages assigned to the cervical and lumbar areas, which he conceded were based upon his clinical judgment about the claimant's condition, rather than objective measurements. He explained that further training had educated him to the need to invalidate all range of motion measurements for a part of the spine when any one invalid measurement was made. Finally, in response to the last two questions, Dr. G stated that his five percent rating was given for lumbar spondylolysis as reflected on Table 49, IIB. He did not change his MMI date, but submitted a new TWCC-69 with the revised rating.

Both parties were given a chance to respond. At a telephone conference, claimant acknowledged he had been "seen" twice by Dr. G. He also stated that he had hired an attorney; as a result, the hearing officer held the record open to allow the attorney to review Dr. G's amended report and make a response. Both parties responded, and the record thereafter closed.

WHETHER CLAIMANT REACHED MMI

"Maximum Medical Improvement" is defined, as pertinent to this case, as "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated. . . ." Section 401.011(30)(A). We have stated many times that the presence of pain is not, in and of itself, an indication that an employee has not reached MMI; a person who is assessed to have lasting impairment may indeed continue to experience pain as a result of an injury. *See* Texas Workers' Compensation Commission Appeal No. 93007, decided February 18,

[1]We note that the apparent omission of the shoulder impairment by both the treating doctor's consultant and the designated doctor has not been appealed nor was it complained about at the hearing. It appears that claimant therefore concurs in both doctors' assessment that shoulder impairment did not result from the (date of injury) injury. Therefore, we need not address, as we did in Texas Workers' Compensation Commission Appeal No. 93695, decided September 22, 1993, whether "contribution" was inappropriately factored out of the impairment rating for the "compensable injury."

1993.

Even though considered as an issue at the hearing, the claimant did not argue or present evidence he had not reached MMI. Claimant's own doctor, as well as the designated doctor, certified that he had. The hearing officer's conclusion that MMI was reached on the date certified by the designated doctor is sufficiently supported by the record. (The only evidence against this date is the earlier date of MMI supplied by Dr. WR).

WHETHER CLAIMANT HAS BEEN DEPRIVED OF DUE PROCESS BY ADOPTION OF THE DESIGNATED DOCTOR'S REPORT

The report of a Commission-appointed designated doctor is given presumptive weight. Sections 408.122(b) and 408.125(e). The amount of evidence needed to overcome the presumption, a "great weight," is more than a preponderance, which would be only greater than 50%. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992.

Claimant's point of error on this is not clear, as he does not describe how, or in what manner, he has been deprived of due process in violation of the Texas Constitution. The response to Dr. G's report, that was filed by claimant before the record closed, argued that the "whole procedure of using AMA guidelines" was unconstitutional. To the extent that the point of appeal may be based upon this same contention, we would note that we are bound to carry out the statutes as written, and it is within the province of the legislature or the courts to repeal or invalidate statutes. Texas Workers' Compensation Commission Appeal No. 92094, decided April 27, 1992.

Claimant was given the opportunity to respond to Dr. G's report and did so. There is no indication that a reconvened hearing was sought from the hearing officer.

WHETHER THE OPINION OF THE TREATING DOCTOR AMOUNTS TO A GREAT WEIGHT OF MEDICAL EVIDENCE AGAINST THE DESIGNATED DOCTOR'S IMPAIRMENT RATING

The decision of the hearing officer will be set aside only if the evidence supporting the hearing officer's determination is so weak or against the overwhelming weight of the evidence as to be clearly wrong or manifestly unjust. Atlantic Mutual Insurance Co. v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.).

"Impairment" is defined in the 1989 Act as "any anatomical or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." Section 401.011(23). Further, an impairment rating must be based upon "objective clinical or laboratory finding." Section 408.122(a). That subsection further states that if a finding of impairment is made by a

doctor chosen by the claimant and is contested, a designated doctor must be able to confirm the objective clinical or laboratory findings upon which the finding is based.

Dr. WR's impairment rating process, as reported, appears to have been thorough and conscientious. But, for whatever reason, it was not confirmable on two examinations performed months apart by Dr. G. Dr. G conceded that his attribution of a 10% impairment rating to claimant's back was essentially subjective rather than objective. For this reason, we cannot say that the hearing officer's decision to accord presumptive weight to the designated doctor's report was erroneous insofar as error is claimed based upon deletion of an impairment rating for range of motion deficits. For all these reasons, claimant's points of error are rejected and the hearing officer's decision is affirmed.

Susan M. Kelley
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Philip F. O'Neill
Appeals Judge