APPEAL NO. 94142

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on January 11, 1994, in (city), Texas, with (hearing officer) presiding as hearing officer. The issues remaining on appeal from the hearing were whether the appellant (claimant) reached maximum medical improvement (MMI) and what was his correct impairment rating (IR). A third issue, whether the respondent (carrier) was relieved of responsibility to pay for treatment by (Dr. S) because of the claimant's failure to follow Texas Workers' Compensation Commission (Commission) guidelines when changing treating doctors, was resolved favorably to the claimant by agreement of the parties.[1] The hearing officer determined that the claimant reached MMI on June 2, 1993, with a five percent IR as reported by (Dr. G), the Commission-selected designated doctor, and that the great weight of the medical evidence was not contrary to Dr. G's report. In his appeal, claimant asserts that Dr. G's report is defective because it did not assign an IR for loss of motion of the lumbar spine, that it improperly adopted a date of MMI from another doctor's report and that a final determination of MMI and IR cannot be made until further diagnostic tests, therapy and valid range of motion testing are completed. In addition, the claimant contends that the conduct of the hearing was unfair. The carrier replies that the report of Dr. G is entitled to presumptive weight, that the decision of the hearing officer is supported by sufficient evidence, and that the hearing officer conducted the hearing with impartiality.

DECISION

Finding the evidence sufficient, we affirm the decision and order of the hearing officer.

It is not disputed that the claimant injured his lower back on (date of injury), in the course and scope of his employment as he was unloading boxes. He continued to work until the following April and apparently saw several treating doctors who are referred to in the testimony and in various medical reports admitted into evidence. However, the earliest written report of medical treatment in evidence at the hearing was a report of an MRI examination of the lumbar spine done on March 23, 1993, at the request of a (Dr. W). Both the lumbar spine and spinal canal were found to be normal. The claimant next saw (Dr. Y), an orthopedic surgeon, who on May 4, 1993, observed that "[e]xamination reveals the patient is in distress with his pain, but impresses me as symptom magnification. . . . Range of motion of the lumbar spine could not be established due to the patient showing a significant amount of pain mannerism and muscle spasm." Dr. Y's initial diagnosis (before seeing the report of the MRI) was chronic lumbosacral strain and "conversion reaction to pain." At a follow-on visit of May 11, 1993, Dr. Y reviewed the MRI report and saw no

[1]At the hearing, the parties agreed that the carrier would pay for reasonable and necessary care provided by Dr. S as a result of the claimant's injury in the course and scope of employment. Nonetheless, the claimant raised questions about the carrier's willingness to pay for particular items of care both at the hearing and again on appeal. This latter issue was not properly before the hearing officer and any dispute about it will not be considered by the Appeals Panel. *See* Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 133.305 (Rule 133.305) and Texas Workers' Compensation Commission Appeal No. 93524, decided August 5, 1993.

evidence of disc herniation. The claimant "appeared to be in a very stiff position. Range of motion could not be carried out due to a significant amount of muscle spasm or pain mannerisms." He referred the claimant to a pain clinic for evaluation and treatment. At an office visit on May 28, 1993, Dr. Y observed that the claimant was "still having pain in the lumbar spine with limitation of motion in all directions," and continued the claimant in a pain clinic program. On June 3, 1993, Dr. Y received a letter from (Dr. K), the codirector of the pain management program, in which Dr. K advises that:

> we are now releasing [claimant] from the clinic because of noncompliance. . . . He has refused most pool activities, stating that the chlorine made him ill. Yesterday, after complaining of pain and being instructed to continue on with his Program, he left the clinic without authorization. It is felt that with little motivation, frequently being tardy and inconsistencies in performance, there is slight chance for improvement and we recommend return to work for this patient.

The claimant testified that he left the pain clinic because the activities there were hurting him too much and his complaints were ignored. After his discharge from the program, he testified he was called by Dr. Y's office and told he was dismissed from Dr. Y's care. On June 3, 1993, Dr. Y completed a Report of Medical evaluation (TWCC-69) in which he assigned a five percent IR for the lumbar spine and gave a date of MMI of June 2, 1993. The only explanative narrative was a statement on the TWCC-69 that the claimant "was not cooperative in the pain clinic" and a statement that the MRI of the lumbar spine was normal. According to the claimant, May 28, 1993, was the last time he was seen by Dr. Y.

The hearing officer, in a finding of fact not appealed by either party, found that Dr. G, an orthopedic surgeon, was a Commission-selected designated doctor. In a TWCC-69 of September 15, 1993, Dr. G assigned an IR of five percent and found the date of MMI to be June 2, 1993. In an accompanying narrative report, he describes the results of various tests given to the claimant, including walking on toes and heels (which he considered normal) and notes that the claimant "will not squat because of complaints of pain." The claimant also complained of pain to light touch over the spine and lumbar area. With regard to range of motion testing, Dr. G stated:

> When [claimant] is performing straight leg raising test, he pushes to the examining table with the heel that is being tested, so he is fighting straight leg raising right from the start and I feel that his range of his lumbar spine is invalid due to the fact that he did not do a maximal effort. Though he tries to think that he does a maximum amount of effort, he is straining, grunting throughout the examination, trying to impress upon me how much pain he is in.

He considered the claimant's March 23, 1993, normal MRI and diagnosed a history of low back strain, absent deep tendon (patellar and achilles) reflexes and diminished sensation to pinprick. His five percent IR was based on a specific disorder of the spine, unoperated with

six months of medically documented pain. In his testimony about his examination by Dr. G, the claimant said he was unable to squat or to walk on his toes or heels even though Dr. G said the heel and toe tests were normal. He said he made a maximum effort on the other tests, but could not do any of them because of the pain. He does not believe that Dr. G examined him properly and denied that Dr. G did range of motion testing, but on cross-examination admitted he did not know what range of motion testing was.

The claimant's current treating physician is (Dr. S), also an orthopedic surgeon. He first examined the claimant on October 11, 1993, and diagnosed chronic lumbosacral strain, radiculitis in both lower extremities, left radiculopathy, chronic myofascitis and "pain overlay with low pain threshold." He recommended further diagnostic testing and "advanced" physical rehabilitation. Based on this examination and another one on December 29, 1993, Dr. S reviewed and critiqued Dr. G's TWCC-69. Dr. S concluded that the claimant does have "significant range of motion limitations . . . [and] . . . antalgic gate." He suggested that range of motion testing should be repeated. He also noted that Dr. G failed to mention a dermatomal sensory latency study on the lower extremities which "revealed the presence of left S1 radiculopathy." He recommended re-evaluation after further tests and that the date of MMI "should be delayed until after the [claimant] had undergone 6 weeks of well-supervised work hardening/reconditioning program."

The 1989 Act provides that where a designated doctor is chosen by the Commission, the report of that doctor shall have presumptive weight, and the Commission shall base the determination of MMI and IR on that report unless the great weight of the other medical evidence is to the contrary. Sections 408.122(b) and 408.125(e). The Appeals Panel has commented many times on the "unique position" the designated doctor's report is accorded under the Texas workers' compensation system, and the fact that no other doctor's report, including that of a treating doctor, is entitled to such deference. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992; Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992. We have also previously discussed the meaning of "the great weight of the other medical evidence to the contrary" and have held that it is not just equally balancing the evidence or a preponderance of the evidence but only the great weight of the other medical evidence that can overcome the presumptive weight given to the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 931125, decided January 26, 1994. Whether the great weight of the other medical evidence is contrary to the opinion of the designated doctor is normally a factual determination. Texas Workers' Compensation Commission Appeal No. 93459, decided July 15, 1993.

The claimant contends that Dr. G's report is not entitled to presumptive weight because the additional diagnostic and repeat range of motion testing recommended by Dr. S has not been done and therefore, Dr. G's report is premature.[2] In Texas Workers'

[2]Claimant also asserts that Dr. G improperly relied on the report of Dr. Y for his selection of a date of MMI and IR. Dr. G was permitted to review other available medical reports. Texas Workers' Compensation Commission Appeal No. 93095, decided March 19, 1993. Whether he properly relied on these reports requires expert evidence and cannot be determined on the basis of the claimant's lay testimony. *See* Texas Workers' Compensation

Compensation Commission Appeal No. 931106, decided January 11, 1994, the Appeals Panel observed that "in the evaluation of a spinal injury for the assignment of an IR, consideration must be given not only to specific spinal disorders . . . but also to the existence and extent, if any, of abnormal [range of motion] and neurological deficits." However, the Guides to the Evaluation of Permanent Impairment, 3d Edition, 2d printing, February 1989 (Guides), which are mandated for use under Section 408.124 of the 1989 Act, do not require valid range of motion test results before an IR can be assigned for a back injury. *See* Texas Workers' Compensation Commission Appeal No. 92494, decided October 29, 1992. Indeed, the 1989 Act does not contemplate that these critical determinations of MMI and IR be delayed indefinitely with the expectation that eventually all relevant test results will be available for consideration. As we said in Texas Workers' Compensation Commission Appeal No. 94053, decided February 23, 1994:

> However, it has never been the Appeals Panel's mandate that the trier of fact hold a case open indefinitely, affording the designated doctor unlimited opportunities to correct errors or re-evaluate the claimant, while the parties' cases hang in the balance.

In the case before us, ROM testing was attempted twice by Dr. Y in May 1993 with invalid results because of symptom magnification. Dr. G was similarly unsuccessful for the same reason in September 1993. We do not believe that as a matter of law, further ROM testing was necessary before Dr. G could assign an IR with a zero percent rating for loss of ROM. *See* Texas Workers' Compensation Commission Appeal No. 94004, decided February 11, 1994.

The hearing officer is the sole judge of the relevance and materiality of the evidence and of its weight and credibility and the inferences to be drawn therefrom. Section 410.165. The hearing officer resolves conflicts and inconsistencies in the medical evidence and judges the weight to be given to expert medical testimony. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). To this end, the hearing officer as fact finder may believe all, part, or none of the testimony of any witness. The testimony of a claimant as an interested party raises only an issue of fact for the hearing officer to resolve. Campos, *supra*; Burelsmith v. Liberty Mutual Insurance Company, 568 S.W.2d 695 (Tex. Civ. App.-Amarillo 1978, no writ). An appeals level body is not a fact finder, and does not normally pass upon the credibility of witnesses or substitute its own judgment for that of the trier of fact, even if the evidence would support a different result. National Union Fire Insurance Company of Pittsburgh, Pennsylvania v. Soto, 819 S.W.2d 619, 620 (Tex. App.-El Paso 1991, writ denied). When reviewing a hearing officer's decision we will reverse such decision only if it is so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Pool v. Ford Motor Company, 715 S.W.2d 629 (Tex. 1986). In the case under consideration, Dr. G prepared a comprehensive report of tests done and addressed the entire range of symptoms described by the claimant. The hearing officer gave the weight

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Commission Appeal No. 92395, decided September 16, 1992.

he considered appropriate to the claimant's contrary contention that Dr. G did not do all the tests he described in his report. Dr. S was of the opinion that more testing was necessary before a correct date of MMI could be given and IR assigned. The hearing officer was charged with determining whether the great weight of the other medical evidence was contrary to Dr. G's report. He did this on the evidence before him. Having reviewed the record in this case, we conclude that the hearing officer properly accorded presumptive weight to the report of the designated doctor and that his determination that the claimant's correct date of MMI is June 2, 1993, and his correct IR is five percent is supported by sufficient evidence and is not so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust which is our standard for review.

Regarding the claimant's persistent pain, we believe it worthwhile to repeat our observations in Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993:

> It has become clear that many claimants do not understand how they can reach "maximum medical improvement" when they still continue to hurt and suffer from an injury. "Maximum medical improvement" appears to mean complete recovery to the ordinary person. But that is not what it means for purposes of workers' compensation benefits. That term . . . means the point at which further material recovery or lasting improvement can no longer be reasonably anticipated, according to reasonable medical probability. When the doctor finds MMI and assesses an impairment, he agrees, in effect, that the injured worker is likely to continue to have effects, and quite possibly pain, from the injury. However, he has determined, based upon his medical judgment, that there will likely be no further substantial recovery from the injury [citation omitted].

The claimant also contends in his appeal that he was denied a fair hearing. He asserts that the hearing officer showed favoritism to the carrier's attorney by greeting her and engaging her in casual conversation "while completely ignoring me, and not even saying one single word to me." He also takes issue with the hearing officer's characterization of his testimony in his decision and order as "vague" concerning the specifics of his examination by Dr. G. He states that the reason for this was that he is unable to read and comprehend words and definitions above a certain level due to his lack of education. Therefore, when questioned about words he did not understand or when referred to doctors' reports while testifying, he was at an unfair disadvantage. Furthermore, he contends that his fiancee, (Ms. M), was improperly not allowed to testify on his behalf.

Our careful review of the record reveals that the hearing officer conducted the hearing not only with fairness and impartiality, but also with respect for all the parties. His description of the claimant's testimony as vague on certain particulars cannot be fairly construed as an attempt to disparage the claimant, but to express the relative weight he gave that testimony in arriving at his findings of fact. The claimant agreed to and did present the testimony of Ms. M by means of a stipulation of expected testimony. This

procedure is permitted under Rule 142.9. In the stipulation, Ms. M clarified what hospital the claimant originally went to and that he did make a request to change treating doctors when he became dissatisfied. Also in her stipulation was testimony that the claimant did not have problems with his treatment by Dr. Y except for his discharge from Dr. Y's care after he was removed from the pain clinic program. At the hearing, the claimant was not restricted from offering any other matters in the stipulation nor did he raise an objection at the hearing that this procedure was unfair or that he was prevented from including anything in the stipulation. In his appeal, no additional specific matters that Ms. M would have testified to were identified other than the general assertion that she would have testified "to help clear up some of the misunderstandings that were taking place." We find no merit in the claimant's assertion that the hearing officer lacked impartiality in the conduct of this hearing or that error was committed in receiving the testimony of Ms. M by way of stipulation.

The decision and order of the hearing officer are affirmed.

Alan C. Ernst
Appeals Judge

CONCUR:

Lynda H. Nesenholtz
Appeals Judge

Thomas A. Knapp
Appeals Judge