APPEAL NO. 94178

At a contested case hearing held in (city), Texas, on January 12, 1994, the hearing officer, (hearing officer), took evidence and heard argument on the disputed issues of maximum medical improvement (MMI), impairment rating (IR), and disability. Giving presumptive weight to the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission), the hearing officer determined that the appellant (claimant) reached MMI on January 18, 1993, with an IR of zero percent. The hearing officer also determined, from a preponderance of the evidence, that claimant had disability, as defined in the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.011(16) (1989 Act), from the date of her uncontested compensable injury on (date of injury), through January 18, 1993, but that she did not have disability thereafter through the date of the hearing. Claimant's appeal asserts that the designated doctor and hence, the hearing officer, erred in finding she had reached MMI since she could still benefit from surgery and injections; erred in failing to fully and fairly evaluate her loss of range of motion (ROM) and in invalidating her ROM testing because of prejudice; and erred in failing to give her an impairment rating for her spinal disc problems. Claimant also maintains that the hearing officer erred in failing to find she had disability after January 18, 1993, for the same reasons. The respondent (carrier) filed a response asserting the sufficiency of the evidence to support the hearing officer's determinations.

DECISION

Affirmed.

Claimant was the sole witness at the hearing. The hearing officer allowed claimant to testify from the counsel's table provided she spoke up. However, claimant's testimony was barely understandable due, apparently, to her location relative to the tape recorder microphone, as well as to excessive background hiss or noise on the tape recording itself. The exceptionally poor quality of this tape-recorded hearing record nearly necessitated remand for reconstruction of the record.

Claimant testified that on (date of injury), while working for (employer), a company she said closed its plant sometime after her injury, she injured her back when lifting a heavy box above her head. Relative to the issue of claimant's having disability and the duration of such, claimant testified that she finished her shift on (date of injury), was off work the next three days, and that when she returned to work she was sent home because of her pain and taking of medication. She indicated she has not since attempted to work nor has she applied for work anywhere. She indicated she does not feel she can work because of her pain, notwithstanding that a former treating doctor, (Dr. H), released her to return work on October 12, 1992.

Claimant had the burden to prove by a preponderance of the evidence that she could neither retain nor obtain employment at her pre-injury wage equivalent because of her injury. The hearing officer, whose discussion of the disability issue consisted of one sentence ("Claimant offered sufficient evidence to establish disability."), determined that claimant had

disability from (date of injury), through January 18, 1993, but that her inability to retain or obtain employment from January 19, 1993, through the date of the hearing "was because of something other than the injury. . . ." January 18, 1993, was, of course, the MMI date found by the designated doctor, (Dr. M). The Appeals Panel has had occasion to distinguish between the terms "return to work," "disability," and "MMI" indicating they are not the same. Texas Workers' Compensation Commission Appeal No. 91060, decided December 12, 1991. However, the carrier has not appealed the finding of disability from (date of injury), through January 18, 1993, and thus we need not concern ourselves further with its evidentiary basis.

Claimant's medical records indicate she was seen on July 5, 6, and 8, 1992, by (Dr. G); that she complained of severe mid-back pain radiating to her neck and lower back, as well as of left-sided numbness and weakness; that x-rays revealed loss of disc space at C5-6, according to Dr. G, and normal thoracic spine and narrowing of the disc spaces at L3-4 and L4-5 and slight narrowing at L5-S1, according to the x-ray reports; that a July 13, 1992, MRI revealed small disc space and some tapering of C5 and C6, which appeared "developmental," and no focal herniation or significant bulges of the cervical spine; and that on July 8, 1992, claimant was referred to Dr. H for cervical spine testing and was thereafter treated by him. Dr. H's EMG and nerve conduction studies of claimant's left upper extremity revealed considerable muscle spasm of the left upper extremity and shoulder but no evidence of radiculopathy.

In a September 1, 1992, narrative report which accompanied his Report of Medical Evaluation (TWCC-69), (Dr. C) stated that he examined claimant, then age 45, at the carrier's request; that her extensive EMG was "entirely normal;" that she exhibited a depressive reaction with crying while bending her trunk to touch her toes but had no accompanying paraspinal spasm; that her leg elevations while reclining indicated her response to the bending was "inconsistent and inappropriate;" and that her "give away weakness" in the left upper extremity was contradicted by a cross-check showing normal muscle strength. Dr. C stated that "[i]n summary, this patient has a basically normal exam except for signs of depression and either hysterical or malingering superimposed." Dr. C felt claimant had reached MMI and had no permanent bodily impairment. While he recommended claimant be evaluated for depression, Dr. C felt she had no organic disease. Dr. C's TWCC-69 appeared to state claimant's MMI date as both "unknown" and "9/1/92," and stated her IR as "0% from an organic standpoint."

On September 3, 1992, claimant began to see (Dr. BH) and/or persons in his office, and several diagnostic tests were requested.

Dr. H signed an undated TWCC-69 stating that claimant had "no objective findings" and that she reached MMI on "10/1/92" with "no impairment." Dr. H's October 12, 1992, record stated that claimant had chronic neck pain and was found not to have any medical impairment. Dr. H's impression was "cervical strain and shoulder sprain" and "normal neurologic examination." He indicated he would delay claimant's MMI for about two months and stated: "I do not seen (sic) evidence of permanent impairment and I believe that she

is able to return to full work without restriction at this time." In November 1992 Dr. H recommended no further treatment except for medications. Dr. H's December 15, 1992, record stated that claimant had no motor or sensory deficits, that her strength was "5/5 in the upper extremities," that her neck was "supple" and without "any stiffness," and that "[s]he seems to have reached [MMI] at this point and there is 0 percent disability rating at this stage."

On November 11, 1992, Dr. BH recommended therapy and efforts to obtain a total myelogram and discogram, and on January 1, 1993, recommended additional therapy.

Dr. M, whom the parties stipulated was the Commission-selected designated doctor, signed a TWCC-69 certifying that claimant reached MMI on "01/18/93" with an IR of "0%." In the accompanying narrative report of January 18, 1993, Dr. M indicated he had reviewed the x-rays and MRI reports, Dr. H's records, and Dr. BH's records. Dr. M commented on the "pattern of her bizarre pain drawing," that despite not appearing to be in acute distress, claimant asserted that her pain level was a constant 10 on a 10 point scale, and on her starting to "give way before [he] even touched the examined part." Dr. M recommended conservative treatment and a few weeks in a pain management clinic. He stated that claimant could "work to whatever capabilities she feels she is capable." Noting that both Dr. C and Dr. H had assigned claimant an IR of zero percent, Dr. M stated: "In light of the unusual nature of her complaints and inability to elicit much in the way of objective findings in a patient with a somewhat hysterical presentation I really do not know how to rate her on any specific basis."

Dr. BH's February 11, 1993, record commented that claimant had "positive DSEPs in both the neck and low back," and that Dr. M "seems to be unaware of the research done on the DSEP which shows that permanent nerve damage is occurring when a DSEP is abnormal in the absence of neurologic findings." Dr. BH's March 4, 1993, record stated that a recent myelogram showed a bulge at C4-5, protrusion at T2-3, T3-4, T4-5, and spondylosis of the lower thoracic vertebrae together with bilateral foraminal stenosis at L3-4, L4-5, and L5-S1. Dr. BH's April 15, 1993, record stated: ". . . [claimant] has DSEP which document (sic) nerve damage. [Dr. M] is obviously wrong in his assessment. Furthermore, [Dr. W] and his group have been barred from doing second and third opinions on my patients because of bias and I find that this entire situation is absolutely unfair to [claimant.]" There was no explanation in the record of the acronym "DSEP" nor was there evidence that Dr. M was a member of Dr. W's group. Dr. BH's July 1, 1993, record indicated he felt claimant had three or four levels of disc involvement in her low back, that he wanted an MRI to sort out the fourth level, and that based on that information differential injections should be done and a surgical decision made. Dr. BH's August 5, 1993, record indicated he would administer some epidural injections.

Dr. BH's September 16, 1993, record stated that "[Dr. M] seemed in no hurry to re-review her findings . . ." and that Dr. BH was "going to make an attempt to get [Dr. M] to take some action in her case." Dr. M's letter of September 13, 1993, stated that he reviewed the myelogram and post-myelogram CT reports of February 18, 1993, and that he felt the

findings constituted "a pattern indicative of a degenerative lumbar spine;" and that his review of the April 22, 1993, discography "is simply indicative of degenerative change. . . . " Dr. M further noted he had reviewed Dr. BH's "clarification letter" and stated that claimant "has a global complaint of numbness which does not follow any dermatome and I do not believe any sensory impairment can be determined and I still do not believe that an obvious pain generator has been identified for her." Dr. M concluded that he still felt that surgery was not indicated but rather that a pain management program with psychiatric assessment was warranted noting that claimant was entitled to continued medical care after reaching MMI. Dr. BH's letter of October 28, 1993, expressed his disagreement with Dr. M's September 13th letter in several particulars and indicated he felt the surgery option should be pursued after epidural steroid injections were undertaken to identify the disc that was the pain generator.

Claimant's position was that she had not reached MMI because she still had pain and might yet have surgery. She disagreed with Dr. M's report because she said he did not have the myelogram and discogram test results when he wrote his report and because he interpreted such reports differently than did Dr. BH. The report of a Commission-selected designated doctor is entitled to presumptive weight regarding an injured employee's MMI and IR unless the great weight of the other medical evidence is contrary to his or her determinations and we do not find such to be the case with Dr. M's report. *See* Sections 408.122(b) and 408.125(e). We are satisfied that the evidence sufficiently supports the hearing officer's determinations. Dr. C, Dr. H, and Dr. M all opined that claimant had reached MMI with no permanent impairment and we cannot say that the differing opinions of Dr. BH constituted the great weight of the other medical evidence. The following observations made in Texas Workers' Compensation Commission Appeal No. 94182, decided March 24, 1994, seem appropriate for this case:

> The Appeals Panel has said that the designated doctor occupies an important and unique position as an agent of the Commission under the 1989 Act. *See e.g.* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. The Appeals Panel has also observed that an injured employee's having reached MMI will not in every case mean that such employee is completely free of pain or impairment, or that such employee can return to his or her prior occupation. *See* Texas Workers' Compensation Commission Appeal No. 92312, decided August 19, 1992, and Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1993. In Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993, the Appeals Panel noted that reaching MMI does not necessarily mean complete recovery and the absence of pain, and stated: "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." In Texas Workers' Compensation Commission Appeal No. 92312, *supra*, the Appeals Panel further noted that lay testimony concerning the

nonexistence of MMI will not overcome the presumptive weight accorded a designated doctor's report. The Appeals Panel has also held that the report of a designated doctor should not be replaced "absent a substantial basis to do so" (Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993) and we find none in this case.

Claimant testified, essentially, that she was not working because of her pain. The Appeals Panel has held that disability can be proven by the testimony of a claimant alone and that objective medical evidence is not required. *See e.g.* Texas Workers' Compensation Commission Appeal No. 91083, decided January 6, 1992; Texas Workers' Compensation Commission Appeal No. 92030, decided March 12, 1992; and Texas Workers' Compensation Commission Appeal No. 92083, decided April 16, 1992. The Appeals Panel has also observed that while doctor reports returning an injured employee to work are evidence to be considered on the issue of disability, along with the employee's testimony and other evidence, they do not, in and of themselves, effectively end disability. *See e.g*. Texas Workers' Compensation Commission Appeal No. 92206, decided July 6, 1992. The issue of disability is one of fact for the hearing officer, as the fact finder, to decide. Dr. H released claimant to return to work on October 12, 1992, and, as of January 18, 1993, Dr. M felt claimant could do whatever work she felt was within her capability. Further, as noted, Dr. C, Dr. H, and Dr. M all felt claimant had no permanent impairment. With the evidence in this posture, we cannot say that the finding that claimant did not have disability after January 18, 1993, is against the great weight and preponderance of the evidence.

We do not find the hearing officer's determinations to be so against the great weight and preponderance of the evidence as to be manifestly wrong or unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986). Consequently, there is no sound basis on which to disturb the hearing officer's decision.

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Gary L. Kilgore
Appeals Judge

Alan C. Ernst
Appeals Judge