APPEAL NO. 94182

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). At a contested case hearing held in (city), Texas, on January 25, 1994, the hearing officer, (hearing officer), giving presumptive weight to the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission), determined that the appellant (claimant) reached maximum medical improvement (MMI) on February 5, 1993, with a whole body impairment rating (IR) of seven percent. In essence, claimant's request for review challenges the sufficiency of the evidence to support the hearing officer's determinations. In its response, the respondent (carrier) requests first that the Appeals Panel disregard the numerous attachments to claimant's appeal as not being a part of the record developed at the hearing, and then asserts the sufficiency of the evidence to support the hearing officer's determinations.

DECISION

Affirmed.

Claimant, the sole witness, testified that she was employed by (employer)., as a driver/warehouse assistant whose duties included lifting 50 pound boxes of merchandise in the warehouse and delivering them to customers. On the date of claimant's injury, (date of injury), she said she made a delivery to a store and while lifting a box weighing approximately 65 pounds from a dolly, the left end ripped, three left hand fingers caught inside the box, the box's contents and thus the weight shifted to the left end jerking claimant's left arm and shoulder. She said this accident injured the left side of her neck, and the three fingers, hand, wrist, elbow, arm and shoulder on her left side. Claimant also maintained that her back was injured at the time but that it hurt less than the other parts of her body. Claimant said she first saw her family doctor, (Dr. L). Dr. L's report of claimant's initial visit of September 15, 1992, mentioned complaints of pain in her left shoulder and hand and diagnosed left shoulder strain and tendinitis of her fourth and fifth fingers on her left hand. According to his records, on September 24, 1992, Dr. L referred claimant to a hand specialist, (Dr. ER), who then became her treating doctor.

Dr. ER's report of claimant's first visit on "9-30-92" diagnosed acute synovitis/ tenosynovitis of claimant's wrist with possible carpal tunnel syndrome (CTS). His examination revealed no deformity, discoloration or swelling of her left upper extremity and she had no limitation of range of motion (ROM) of her shoulder, elbow, forearm, wrist or hand. Dr. ER did note minor degenerative changes in the left hand and wrist of claimant, who was then 51 years of age, and commenced a course of conservative treatment. Claimant insisted that she told both Dr. L and Dr. ER that her back had also been injured, notwithstanding that neither doctor's records so reflected. Other medical records did indicate claimant had had lower back surgery in 1983.

According to claimant, Dr. ER at first recommended surgery for decompression of nerves in her left elbow and wrist but later changed his mind, instituted conservative treatment, and told her she would have to learn to live with her condition. She said she had some swelling in her left hand and arm and numbness from her three fingers on up to her shoulder. Dr. ER's records indicate that in November 1993 claimant complained of increased left arm pain and lack of improvement, and that Dr. ER decided to have her seen by a hand surgeon since she had failed to improve with what he considered appropriate and adequate conservative treatment. On January 13, 1993, Dr. ER advised claimant that he concurred with the recommendation of (Dr. S) that claimant undergo a carpal tunnel and ulnar tunnel release and his notes revealed that claimant also concurred. A February 2, 1993, report to (Dr. F) reported on the results of a physical examination as well as electromyography (EMG) and nerve conduction studies to investigate complaints of pain and

numbness in claimant's left arm. The report stated that there was no evidence of CTS, minimal evidence of a left ulnar nerve neuropathy, and no conclusive evidence of a radiculopathy.

Claimant stated that she treated with Dr. ER until sometime in February 1993 when he indicated she had reached MMI and assigned her an IR. According to Dr. ER's Report of Medical Evaluation (TWCC-69), he determined that claimant reached MMI on February 5, 1993, with an IR of 36% for her left upper extremity. Dr. ER's TWCC-69 further stated that given the results of claimant's recent EMG and nerve conduction studies which showed improvement, the proposed surgery was not indicated and was cancelled. Dr. ER also stated that claimant should be retrained for work which would not aggravate her condition. Claimant testified that the carrier called her advising it disputed Dr. ER's IR and assessed an IR of three percent.

According to an April 9, 1993, report of Dr. S, claimant returned to him on April 5, 1993, and he felt she would not reach MMI until she had the surgical decompression he recommended in December 1992. This report indicated that the carrier was being requested to authorize the surgery. According to claimant, Dr. S scheduled the surgery but later cancelled it and refused to reschedule it. Claimant stated that Dr. S informed her that "it was too complicated" and that he no longer wanted her as a patient. She said he recommended she see a particular doctor in (city) but that she did not want to see a doctor outside (city).

In evidence were a June 3, 1993, TWCC-69 and detailed narrative report from (Dr. B) which reported the results of his physical examination of claimant as well as the results of a comprehensive evaluation protocol. Examinations and evaluations took place on May 25 and June 3, 1993, apparently at the behest of the carrier. According to Dr. B's report, claimant reached MMI on February 5, 1993, with an IR of zero percent which he specified was based on the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). *See* Section 408.124. Dr. B's report also stated that he reviewed the 36% IR determined by Dr. ER and was unable to determine how it was established in that it did not appear to be in accordance with the AMA Guides.

Claimant said she next commenced treatment with (Dr. RR) in July 1993. According to claimant, Dr. RR had all of her medical records, asked her questions, and had her twice raise and hold out her arms and hands in different positions for measured periods of time after which he recommended she begin the normal use of her arms. She said she tried it for nine days but the pain increased and she dropped objects. Dr. RR's report of July 23, 1993, indicated that he reviewed her extensive medical records including the most recent EMG showing improvement of her left elbow ulnar nerve irritation improvement. He concluded that claimant did not need surgery, that she should seek job retraining, and that she "sustained no significant disability from this injury and I do think she has reached [MMI]." Dr. RR signed a TWCC-69 on July 31, 1993, stating that claimant reached MMI on "2-05-93" with an IR of zero percent.

Claimant testified that in September 1993, she commenced treatment with (Dr. W) who performed various tests and recommended surgery on her elbow. At the time of the hearing, Dr. W was apparently still claimant's current treating doctor. She testified that Dr. W determined that she reached MMI on November 30, 1993, with an IR of five percent for her elbow only. She stated she was not sure she agreed with Dr. W on her having reached MMI, however, because of her continued inability to lift with her left arm. Dr. W's September 7, 1993, report, listed claimant's "present problems" as pain in her left neck and left arm, and lower back pain and some pain in her left leg and her "chief complaint" as pain and numbness in her left arm. Dr. W's assessment was cervical spondylosis and pronounced cubital ulnar neuropathy. An October 25, 1993, record

showed that Dr. W presented claimant with a proposal for elective surgery to release her ulnar nerve at the left elbow. According to Dr. W's November 22, 1993, report, however, claimant declined surgery and asked Dr. W to address her problem with back and left buttocks and thigh pain which she indicated she had had for the past year. Dr. W reported he could not do so without obtaining various diagnostic studies which he requested claimant obtain. Dr. W's November 30, 1993, report stated that the carrier would not authorize lumbar spine diagnostics, that given claimant's declination of surgery she had reached MMI, and that assignment of an IR would require goniometric measurements. Dr. W's January 24, 1994, letter to the carrier advised that he assigned claimant an IR of five percent for her left upper extremity which he observed was similar to the four percent given by the designated doctor, (Dr. H), and that while he did not disagree with Dr H's additional three percent rating for claimant's cervical ROM, he was not inclined to provide that additional rating without a better understanding of the underlying cervical pathology.

The September 13, 1993, TWCC-69 of Dr. H, the designated doctor, together with his detailed narrative report, stated that claimant reached MMI on February 5, 1993, "when her medical progress plateaued," and that he assigned her an IR of seven percent consisting of four percent for her left upper extremity and three percent for her cervical ROM. Dr. H explained that because of claimant's chronic pain complaints and Dr. W's diagnosis of possible left arm reflex sympathetic dystrophy, a psychological pain inventory was performed by (Dr. RS) which revealed that claimant had a significant predisposition to use conversion symptomology as a means of dealing with conflicts or avoiding responsibilities and that her physical complaints were magnified. Claimant testified that when she saw Dr. H on September 13, 1993, he performed a physical examination and also took measurements, that his staff also took measurements, and that some of the psychological evaluation was accomplished on that date and later on September 16th. Claimant commented that her examinations on both dates were quite lengthy. Claimant maintained, both at the hearing and in her appeal, that her psychological evaluation was unwarranted since she did not have head or brain injury. She contended that Dr. H's impairment evaluation was unduly influenced by such unnecessary psychological testing pointing out that certain references in Dr. H's report to claimant's being "irresponsible," "a hypochondriac," and "socially immature" were also in the Dr. RS's psychological evaluation report. The Appeals Panel has held that "a designated doctor can appropriately consider and rely on tests, exams, data, medical reports, etc., performed by others in arriving at his final evaluation in a given case." Texas Workers' Compensation Commission Appeal No. 93095, decided March 19, 1993.

Claimant's basic position at the hearing was that she had not yet reached MMI and therefore that any purported determination of her IR was premature. Claimant apparently continues to take this position on appeal though she seems to indicate agreement with Dr. ER's 36% IR in asserting it should be adopted because the carrier, after first disputing Dr. ER's IR, later "cancelled" the dispute and had her examined by a doctor the carrier selected. The documents in evidence did not reflect carrier's having canceled its dispute of Dr. ER's 36% IR. However, claimant's request for review contained numerous documents which, although apparently in existence before the hearing, were not in evidence and thus will not be considered on appeal. The Appeals Panel has often stated that its review is confined to the record developed at the hearing and that new evidence will generally not be considered for the first time on appeal absent certain unusual circumstances. *See e.g.* Texas Workers' Compensation Commission Appeal No. 92444, decided October 5, 1992, and Texas Workers' Compensation Commission Appeal No. 92459, decided October 12, 1992. Claimant's appeal also contains numerous assertions several of which relate to the adequacy of the designated doctor's examination. Claimant also contends that Dr. H's order for her psychological evaluation, the results of which she disagrees with, was unwarranted and that Dr. RR's report was meritless.

Section 410.165(a) provides that the hearing officer is the sole judge of the weight and credibility to be given to the evidence. It is for the hearing officer, as the trier of fact, to resolve conflicts and inconsistencies in the evidence (Garza v. Commercial Insurance Co. of Newark, New Jersey, 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ) including expert medical evidence (Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ)). We are satisfied that the evidence sufficiently supports the hearing officer's determinations of claimant's MMI date and IR and we find no merit to claimant's contentions regarding the adequacy of the designated doctor's evaluation and his obtaining of pain profile information to consider in reaching his determinations.

Section 401.011(30)(a) defines MMI 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 408.122(a) provides in part that "[a] claimant may not recover impairment income benefits unless evidence of impairment based on an objective clinical or laboratory finding exists." The 1989 Act provides for resort to a designated doctor as the mechanism for resolving conflicts over MMI and impairment. The report of a designated doctor selected by the Commission is entitled to presumptive weight regarding MMI and the 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. H's report. *See* Sections 408.122(b) and 408.125(e).

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.

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, 244 S.W.2d 660 (Tex. 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:

Lynda H. Nesenholtz
Appeals Judge

Thomas A. Knapp
Appeals Judge