APPEAL NO. 94203

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq*. On January 11, 1994, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. He determined that appellant's (claimant) impairment rating was as stated by the designated doctor, (Dr. T), who found it to be nine percent. Claimant asserts that the designated doctor did not properly consider claimant's MRI of September 10, 1992, did not refer to all claimant's evidence in his decision, that the carrier "prearranged" the range of motion given claimant by a prior designated doctor, that the designated doctor's decision to invalidate range of motion measurements was error, and that his doctor's, (Dr. Y), impairment rating of 22% is accurate. Carrier replies that the designated doctor's opinion is correct and that the hearing officer should be upheld.

DECISION

We affirm.

The only issue at the hearing was the correct impairment rating. While (Dr. S) was appointed as a designated doctor, his report was not used because claimant reported that Dr. S did not examine him. Thereafter a new designated doctor was appointed; the appeal does not contest the Texas Workers' Compensation Commission (Commission) decision to reject Dr. S's report and appoint Dr. T as the designated doctor. An initial hearing was held on July 21, 1993, at which time the hearing officer decided to assure that the designated doctor had all the medical records necessary in providing an opinion. Claimant does not attack the stipulations entered into, except to say that the hearing officer did not mention some of them, but the record reveals that the ombudsman entered into those stipulations, not the claimant. While not in issue at this time, one who assists has no standing to enter into a stipulation on behalf of a claimant. (One stipulation was that MMI was reached on December 21, 1992, as certified by the treating doctor.)

Claimant injured his lower back while lifting a hot water heater on (date of injury). Some weeks later he developed headaches. Both his own doctor, Dr. Y, and the designated doctor, Dr. T, assign him the same percentage of impairment for both a cervical and lumbar diagnosis based impairment, a total of nine percent. The designated doctor does indicate that he considered claimant's MRI of September 10, 1992, on his report and, as stated, the designated doctor does not differ with claimant's treating doctor about the amounts of impairment warranted as a result of diagnosis. The two differ based on range of motion determinations.

Claimant next asserts that the hearing officer did not mention all his evidence in his decision. Texas Workers' Compensation Commission Appeal No. 93791, decided October 18, 1993, stated that the hearing officer is not required to recite each fact that was considered in reaching his decision. The hearing officer's listing of exhibits does refer to all the documents admitted into evidence. The allegation that the carrier prearranged the range of motion findings of the first doctor appointed as a designated doctor is unsupported by any evidence and is not determinative of the issue before us since that doctor's report

was not used. (We observe that the carrier did make payments of impairment income benefits on the basis of the first designated doctor's rating of 12% and is not seeking recoupment based on Dr. T's rating of nine percent.)

Finally, claimant states that the designated doctor was incorrect in invalidating all range of motion findings. Dr. Y in December 1992 found that claimant's cervical range of motion was "full." In the lumbar area, he noted a two percent impairment in extension, 10% in flexion, zero percent in left lateral flexion, and five percent on right lateral flexion. Dr. Y, after Dr. T did his impairment rating, pointed out that Dr. T assigned no range of motion impairment rating but that Dr. T's own figures in the lumbar area gave five percent for left lateral flexion and three percent for right lateral flexion; Dr. Y acknowledged that straight leg raising did invalidate Dr. T's extension/flexion figures. Dr. Y additionally comments that Dr. T's own records also show two percent, two percent, one percent and one percent ratings in the cervical measurements that Dr. T obtained.

Dr. T's records include his comment about Dr. Y's letter criticizing his impairment rating of the claimant. Dr. T stresses that an impairment rating is required to be a permanent rating, not a transient loss of motion "because of pain or muscle spasm." He pointed out that Dr. Y had tested claimant in October 1992 with a normal range of motion except for left lateral flexion, which Dr. Y then reported as within normal limits in December 1992. (Compare Dr. Y's zero percent impairment for left lateral flexion to the five percent that Dr. Y says Dr. T found when he tested claimant; also note Dr. Y's "full" range of motion in claimant's cervical area.) Dr. T states that claimant had been found also to have a normal range of motion in both cervical and lumbar areas in January 1992. Dr. T states that these inconsistencies allow him to invalidate all range of motion measurements. Finally, Dr. T also states that Dr. Y has measurements in his records of claimant that do not match his conclusions. (Dr. Y does acknowledge that his rating was done according to the "Revised" third edition of the "Guides to the Evaluation of Permanent Impairment," third edition, second printing, dated February 1989, published by the American Medical Association (Guides). When Dr. Y then reviewed his rating, he said he did so under the "Third Edition," without specifying further and said that his rating was unchanged.)

The Guides, in Section 2.0 on page 7, state: "findings should be replicable in repeated examinations. If this is not the case, then the stability of the medical condition is in question, and there is no basis upon which to rate permanent impairment." (Emphasis as written.) This would appear to provide some basis for Dr. T's opinion that prior testing of claimant, resulting in varied results including all areas both cervical and lumbar having been within normal limits, should result in no range of motion impairment. Later, in Section 3.3a on page 72 and 74, measurements of range of motion are discussed in terms of the examination being conducted, number of measurements, and amount of variance, apparently within the examination then being conducted or in a re-examination "at a later date."

Dr. Y criticizes Dr. T for not using the numbers that Dr. T's own examination showed, but does not state that Dr. T erred in interpreting the Guides to allow him to invalidate current

readings by prior range of motion testing. In Texas Workers' Compensation Commission Appeal No. 92570, decided December 14, 1992, the statutory standard of presumptive weight to be accorded the designated doctor's opinion was cited; it was then stated that when there was no medical evidence that the designated doctor had not properly used the Guides, a finding that his use thereof was improper was not sufficient and that case was remanded for clarification. In the case before us, a hearing officer has returned the case to the designated doctor previously. In addition, the designated doctor has made it clear that he interprets the Guides to allow him to look outside his examination for stability of findings in regard to range of motion.

The hearing officer is the sole judge of the weight and credibility of the evidence. *See* Section 410.165. He considered both Dr. Y's and Dr. T's opinions plus all the evidence contained in the record. Without medical evidence that the Guides do not allow a doctor to give no range of motion rating based in part on the fluctuation in ratings previously conducted by others, his decision will not be rejected in this case. We also note that in Texas Workers' Compensation Commission Appeal No. 94149, decided March 16, 1994, a designated doctor's impairment rating which included no range of motion was upheld, even though his testing found some range of motion limitations, because he observed claimant's range of motion to be less limited during other parts of the physical examination.

Finding that the decision and order are not against the great weight and preponderance of the evidence, we affirm. *See* In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

Joe Sebesta
Appeals Judge

CONCUR:

Lynda H. Nesenholtz
Appeals Judge

Gary L. Kilgore
Appeals Judge