APPEAL NO. 94227

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq*. On January 10, 1994, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. She determined that respondent (claimant) reached maximum medical improvement (MMI) on June 7, 1993, with 20% impairment, as reported by the designated doctor, (Dr. H). Appellant (city) asserts that the date of MMI is against the great weight of other medical evidence because claimant was only treated for pain and did not improve her condition after February 1993 when (Dr. P) found MMI was reached. Carrier also states that the impairment rating was contrary to the great weight of other medical evidence because claimant invalidated her range of motion testing, which was a significant part of the 20%. Claimant replies that the hearing officer was correct and should be upheld.

DECISION

We affirm.

Claimant was working for the city on (date of injury), when she turned, in response to a call, while picking up a storage box possibly weighing 25 pounds and twisted her back. She notified her employer and saw (Dr. L) from May 5 to July 21, 1992; he diagnosed strain, sprain, and spasms, and referred claimant to (Dr. O), a neurosurgeon. Dr. O found "marked restriction of back dynamics," commented that MRI and CT scan showed degenerative disc disease but no ruptures, and prescribed physical therapy. After a period of therapy with (Dr. B) claimant was released to light duty. She began seeing (Dr. G) who advised her to get a discogram in addition to the MRI and CT scan previously done. The discogram was read as showing tears at L2-3, L3-4, and L4-5. Dr. G, an orthopedic surgeon, recommended against surgery, however, because he thought it could entail a fusion that was too extensive. Dr. G then recommended that claimant see the (city)Spine Group (DSC) for long term care.

(Dr. P) at the DSC referred claimant to admission in a hospital for evaluation of her condition. On being discharged 18 days later at the end of October 1992, she was said to have made "fair" progress in her range of motion, but was "certainly not at maximum medical improvement." On February 22, 1993, Dr. P signed a Report of Medical Evaluation (TWCC-69), which said claimant reached MMI on February 17, 1993, with nine percent impairment. He referred to "Table 53, page 80 II C & F" for "lumbar." Below that entry he noted, "ROM invalid." Attached to that TWCC-69 is a two page document titled "Range of Motion Test for Impairment Rating and Report;" it states that claimant's range of motion is invalid. The last paragraph of this document reads:

6.Whole Body Impairment: 9%

The impairment rating listed above was determined following the procedure as outlined in the Guides to the Evaluation of Permanent Impairment. American Medical Association, Third Edition, Revised 1990.

The Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (Guides) are specified for impairment ratings under the 1989 Act. *See* Section 408.124. The Guides provide no table on page 80; table 53 is found on page 83, but it pertains to the cervical region, not the lumbar. In addition, the attachment to Dr. P's TWCC-69 declares that the Revised 1990 version was used, not the statutorily mandated 1989 version.

In April 1993, claimant had begun to see (Dr. Ba) who noted that she had not had facet joint injections, and stated that she was not at MMI even though said to be at that point by Dr. P. Claimant disputed Dr. P's opinion and Dr. H was appointed as the designated doctor. On July 17, 1993 (after Dr. H, the designated doctor found MMI on June 7, 1993, with 20% impairment), Dr. Ba stated that he agreed with Dr. H as to both MMI and the impairment rating. In June 1993, Dr. Ba had commented in correspondence that he had recommended "facet injections" to "help increase her motion and give her some flexibility without pain."

Dr. H examined claimant in his role as designated doctor on June 8, 1993. On June 20, 1993, he signed a TWCC-69 which said that claimant reached MMI on June 7, 1993 with 20% impairment. He found nine percent for three level severe degenerative changes and 12% for "validated ROM," giving a total of 20% impairment. In his accompanying narrative Dr. H provides two statements that invite question. He states that he used the "AMA Guides, Non-Revised, 1988 version, second printing;" he also says the range of motion was "11%," not 12%. He added in the narrative that claimant validated "all of her lumbar ranges of motion." The Texas Workers' Compensation Commission (Commission) queried Dr. H in regard to his reference to the "1988 version" of the Guides. A person named E. S (ES), on October 11, 1993, replied to the Commission using Dr. H's stationery, stating, "Dr. [H's] Impairment Ratings are by The AMA Guidelines to the Evaluation of Permanent Impairment February 1989 version, Third Edition, Second Printing." (While issue was taken regarding the reference to "1988" and the subsequent clarification, no question was raised as to the reference to range of motion as 11%.)

The hearing officer is the sole judge of the weight and credibility of the evidence. *See* Section 410.165. She could consider that Dr. Ba agreed with Dr. H as to when MMI was reached and that only Dr. P found MMI earlier, in February 1993. She could note that claimant was said not to have reached MMI when discharged from the hospital at the end of October 1992. She could consider that Dr. Ba was of the opinion that facet injections during the April-June 1993 time period were advised for the purpose of improving claimant's condition through increasing her range of motion. There was sufficient evidence in the record to support the hearing officer's decision that the great weight of other medical evidence was not contrary to the designated doctor's opinion as to MMI.

The only impairment rating given other than that of Dr. H was that of Dr. P, who referenced incorrect page and table numbers in one place in his report indicating the 1989 Guides, mandated by the 1989 Act, were not used and in another instance stated that the 1990 revised edition was used. Counsel for carrier argued in detail how invalid ranges of

motion conducted at previous times by other doctors should invalidate the range of motion examinations given by Dr. H; also argued was that Dr. H merely said that the ranges of motion were validated but did not affirmatively show the validation. With Dr. H's medical opinion that his motion studies were validated and with Dr. Ba agreeing with Dr. H's impairment rating, the hearing officer was sufficiently supported in concluding that the great weight of medical evidence was not contrary to the rating given by Dr. H. The hearing officer was not compelled to conclude that because the reply to the Commission's question came from a person at Dr. Ba's office, instead of Dr. Ba (in regard to the 1988/1989 question of the Guides), such reply was void and could be given no weight. The hearing officer was free to consider any evidence contrary to the statement of ES had such evidence been forthcoming; such an answer to a Commission inquiry does not always have to be signed by the doctor to be considered, as does a TWCC-69 when used to certify MMI. In addition the hearing officer could consider that the only other evidence as to an impairment rating was given by a doctor who used an incorrect guideline.

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:

Stark O. Sanders, Jr.
Chief Appeals Judge

Thomas A. Knapp
Appeals Judge