APPEAL NO. 94256

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on (month) 4, 1994, in (city), Texas, with (hearing officer) presiding as hearing officer. The issues at the CCH were impairment rating and contribution. The hearing officer found that the appellant (claimant herein) had a 13% impairment rating based upon the assessment of a designated doctor selected by the Texas Workers' Compensation Commission (Commission). The hearing officer also found that 46% of this 13% whole body rating (or a six percent whole body rating) was attributable to a prior compensable injury suffered by the claimant. The hearing officer ordered a 46% reduction in impairment income benefits (IIBS) and supplemental income benefits (SIBS). The claimant appeals, arguing that the opinion of the designated doctor should not be given presumptive weight because it was not solely based on the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated (month) 1989, published by the American Medical Association (the statutory Guides). The claimant also contends that the respondent (self-insured employer herein) failed to meet its burden to prove contribution applied. The carrier replies that the opinion of the designated doctor is entitled to presumptive weight and that it proved contribution.

DECISION

Finding sufficient evidence to support the decision of the hearing officer and no reversible error in the record, we affirm.

Claimant testified that he has worked as a bus driver for self-insured employer for 12 years. He testified that during this period he has had 13 on-the-job injuries, none of which have been his fault. In (month year) the claimant testified he sustained an on-the-job injury to his back, neck, arms, legs and feet ((month) injury). The claimant testified that he was treated for the (month) injury for six months, his treatment ending in August of 1992. The claimant testified that he never received an impairment rating or received impairment income benefits for his (month) injury. On September 16, 1992, the claimant suffered another on-the-job injury, injuring his neck and back (September injury). The claimant testified that he was off work for this injury for seven months, returning to work in April 1993.

(Dr. C), the claimant's treating doctor for the September injury, assessed the claimant's impairment rating at 20%. The self-insured employer disputed this rating and the Commission appointed (Dr. O) to be the designated doctor. Dr. O initially assessed the claimant's impairment at 13%. The only difference between the ratings of Dr. C and Dr. O is that Dr. O gave no impairment for loss of range of motion because he determined that the range of motion tests he conducted were invalid.

At a Benefit Review Conference (BRC) in this case, the self-insured raised the issue of contribution from the (month) injury. The Benefit Review Officer (BRO) sent Dr. O medical records from the (month) injury. Dr. O wrote the BRO a letter on January 4, 1993, in which he stated:

In response to your letter dated December 15, 1993, (sic) concerning [claimant], you sent me a lot a (sic) records that I did not have available to me when I rated this patient. Based on these records I would not give the patient 6% impairment in the neck area. I would rate him at a 7% whole person impairment. This is because the data you sent me showed old injury to the C-5/C-6 area in the neck was present prior to the trauma in question. If anything the patient has actually improved since those x-rays were taken. I mentioned in my report that I wasn't too sure this wasn't pre-existing. I had simply given him the 6% but if you look at the old records and look at the present records he actually appears to have improved considerably. Therefore, I would retract the 6% in the cervical area.

The hearing officer determined that since the claimant reinjured or aggravated his cervical spine in the September injury, Dr. O's assessment of 13% impairment was correct. The hearing officer also found that because the six percent impairment to the claimant's cervical spine was due to the prior compensable injury, the self-insured employer was entitled to contribution for that prior injury which the hearing officer computed at 46% (6% divided by 13%). The hearing officer therefore, ordered a 46% reduction in the amount of IIBS and SIBS.

The claimant appeals contending that the designated doctor should not have been given presumptive weight on the issue of impairment rating because he used texts other than the statutory Guides in computing his impairment. The claimant argues that only Dr. C's rating was made pursuant to the statutory Guides and therefore should be adopted.

Section 408.125(e) provides:

If the designated doctor is chosen by the commission, the report of the designated doctor shall have presumptive weight, and the commission shall base the impairment rating on that report unless the great weight of the other medical evidence is to the contrary. If the great weight of the medical evidence contradicts the impairment rating contained in the report of the designated doctor chosen by the commission, the commission shall adopt the impairment rating of one of the other doctors.

We have previously discussed the meaning of "the great weight of the other medical evidence" in numerous cases. We have held that it is not just equally balancing the evidence or a preponderance of the evidence that can overcome the presumptive weight given to the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. We have also held that no other doctor's report, including the report of the treating doctor, is accorded the special, presumptive status accorded to the report of the designated doctor. Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992; Texas Workers' Compensation Commission Appeal No. 93825, decided October 15, 1993.

Whether the great weight of the other medical evidence was contrary to the opinion of the designated doctor is basically a factual determination. Texas Workers' Compensation Commission Appeal No. 93459, decided July 15, 1993. Certainly, the designated doctor is required to use the statutory Guides in assessing impairment. Section 408.124. Dr. O stated in his initial report that in arriving at his 13% rating he relied upon the statutory Guides. Dr. O also stated in his report:

> The data which the AMA Guides is based on which is [Dr. M's] publication, states that there is good test, retest, or liability. When I try to test, retest, or liability I get total invalidation.
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> I checked the patient with a functional assessment. On the University of M's static strength testing model there were 3 out of 7 excessive coefficients of variation. Studies on M's Protocol have shown that 3 or more excessive coefficients of variation are 85% accurate in identifying symptom magnification. A new article in the Journal of Disability has shown that inappropriate horizontal changes are also a good predictor on an exaggerated response. We also did the Jamar Hand Grip and he had 7 out of 10 excessive coefficients of variation with 2 over 20%. While we do not rate using the Third Editions Revised or the Fourth Edition of the AMA Guides, but they are good peer reviewed publications and they both clearly state if you have a variation above 20% the patient is not giving you their best effort.

In this case, the hearing officer specifically made a finding of fact that the designated doctor assessed the claimant's impairment following the statutory Guides. Section 410.165(a) provides that the contested case hearing officer, as finder of fact, is the sole judge of the relevance and materiality of the evidence as well as of the weight and credibility that is to be given the evidence. It was for the hearing officer, as trier of fact, to resolve the inconsistencies and conflicts in the evidence. Garza v. Commercial Insurance Company of Newark, New Jersey, 508 S.W.2d 701, 702 (Tex. Civ. App.-Amarillo 1974, no writ). This is equally true regarding medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286, 290 (Tex. App.-Houston [14th Dist.] 1984, no writ). The trier of fact may believe all, part, or none of the testimony of any witness. Taylor v. Lewis, 553 S.W.2d 153, 161 (Tex. Civ. App.-Amarillo 1977, writ ref'd n.r.e.); Aetna Insurance Co. v. English, 204 S.W.2d 850 (Tex. Civ. App.-Fort Worth 1947, 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 for factual sufficiency of the evidence, we should 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 Co., 715 S.W.2d 629, 635 (Tex. 1986).

While Dr. O's comments are potentially ambiguous and could possibly be interpreted to indicate reliance on material other than the statutory Guides, we certainly do not think this possibility amounts to the great weight and preponderance of the evidence and thus, cannot hold the hearing officer erred in finding that Dr. O based his IR on the statutory Guides. Dr. O says his rating was based on the statutory Guides and not the other texts to which he refers. Nor would we find as a matter of law that merely referring to other texts, in and of itself, constitutes assessing an impairment rating not in accordance with the statutory Guides.

The claimant also argues that the hearing officer erred in applying contribution because the carrier failed to prove contribution properly. The claimant contends that for purposes of contribution an impairment on which the contribution is based must have been assessed at the time of maximum medical improvement from that injury, not after the second injury for which contribution is sought. We find no such requirement in Section 408.084. The claimant's reliance on Texas Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992, is misplaced in that that case primarily deals with the assessment of an impairment rating and only marginally with contribution in applying Section 408.084 (holding it is benefits, not the impairment rating, that are adjusted in computing contribution). In the present case, the hearing officer's computation of contribution is consistent with our earlier opinions on the matter. *See* Texas Workers' Compensation Commission Appeal No. 93272, decided May 24, 1993; Texas Workers' Compensation Commission Appeal No. 93695, decided September 22, 1993; Texas Workers' Compensation Commission Appeal No. 94155, decided March 30, 1994. We do observe that the determination of contribution is for the hearing officer who is not bound by the opinion of any doctor, including the designated doctor. *See* Texas Workers' Compensation Commission Appeal No. 93889, decided November 17, 1993.

The claimant's equitable argument raises some concern. It might seem a harsh result to preclude the claimant from being fully compensated for impairment because of a previous compensable injury resulting in permanent impairment for which he was never compensated in the first place. In the present case, however, there is no indication in the record that the claimant is precluded from seeking the IIBS attributable to his (month) cervical injury. In fact, the self-insured employer's position in the present case would appear to estop it from denying such benefits.

The decision and order of the hearing officer are affirmed.

Gary L. Kilgore
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Alan C. Ernst
Appeals Judge