APPEAL NO. 94289

At a contested case hearing held in (city), Texas, on February 2, 1994, the hearing officer, (hearing officer), having accorded presumptive weight to the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission) pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. §§ 408.122(b) and 408.125(e) (1989 Act), determined that the appellant (claimant) reached maximum medical improvement (MMI) on June 9, 1993, with a zero percent whole body impairment rating (IR). Claimant's request for review contends that the designated doctor's MMI and IR findings were against the great weight of the other medical evidence because the designated doctor examined claimant only once and then not thoroughly, because he offered no rationale for the zero percent IR other than reliance on an unsupported statement by claimant's former treating doctor that she was free of pain, and because he recommended certain non-surgical treatment modalities for claimant which were inconsistent with her having reached MMI. Claimant seeks reversal and a finding that she had not reached MMI or, alternatively, an IR of 15%. The response filed by the respondent (carrier) asserts the sufficiency of the evidence to support the challenged findings and the absence of evidence to support the requested 15% IR.

DECISION

Affirmed.

There was no disputed issue at the hearing regarding claimant's having sustained a compensable injury on (date of injury), while employed by (employer), nor was there any disputed issue concerning the hearing venue and employer's workers' compensation insurance coverage. Although there were no stipulations of record nor evidence offered thereupon, the hearing officer nonetheless made factual findings on these matters. Since neither party has appealed any of these findings, however, we need not further address their support in the evidence.

Claimant, the sole witness, testified that when she grasped a ladder to carry to a location in the employer's store where she was going to stock some shelves, the ladder tilted and she twisted her back and neck in an effort to keep the ladder from striking an object. She reported the injury about 15 minutes later and was taken to the doctor used by the employer, (Dr. Q), who gave her medications and took her off work for a few days. When she first returned to work she was only able to work for a few hours because of the pain. She said she returned to Dr. Q who took x-rays and referred her to the (Clinic No. 1). However, she said she did not keep the appointment at Clinic No. 1 because she was afraid the doctors there would want to perform surgery. When she next returned to work, she said she worked a full shift but "hurt real bad" afterwards and did not return to work the next day. At some later date, claimant began treating, variously, with (Dr. D), (Dr. F), and (Dr. G) of the Clinic No. 2) in (city, state). She was taken off work, prescribed medication and rest, and given an MRI. Claimant said she still has not been released to return to work, still cannot work, and still has pain.

According to the claimant, Drs. D, F, and G have not yet said she has reached MMI "because I'm still in pain." She also stated that her examination by Dr. F was "a lot more thorough" than the examination by the designated doctor, (Dr. T). Claimant's position at the hearing was that the designated doctor's report was against the great weight of the other medical evidence because he did not examine her until November 1993 yet somehow determined that she had reached MMI in June 1993, and because she was still in pain and could not work.

The medical evidence showed that Dr. Q returned claimant to her regular work on June 9, 1993, and that in a Report of Medical Evaluation (TWCC-69) he certified that claimant reached MMI on June 9, 1993, with a zero percent IR. The designated doctor's TWCC-69 also certified that claimant reached MMI on June 9, 1993, with a zero percent IR. According to his attached narrative report, Dr. T examined claimant on November 19, 1993. This report related that claimant had been scheduled to see (Dr. M), an orthopedic surgeon in Clinic No. 1, "but returned to [Dr. Q's] office stating she was pain free and had no more complaint on June 9, 1993." Dr. T noted that radiographic studies of claimant's thoracic and lumbar spine were normal and that her "range of motion of neck, thoracic, and lumbar areas are regarded as full in accordance with the Guides." Dr. T's diagnosis was stated as: "1. History of work related injury most probably due to thoracic area sprain/strain. 2. No evidence of neurologic impingement or bone or joint injury." Dr. T's report went on to state that he felt claimant reached MMI as previously stated by Dr. Q, and that she has an IR of zero percent based upon the "Guides to the Evaluation of Permanent Impairment, third edition, second printing." *See* Section 408.124 which requires the Commission to use this publication to determine the existence and degree of an employee's impairment.

Dr. G's report of June 28, 1993, indicated claimant's examination included range of motion (ROM) measurement and neurological testing. Dr. G diagnosed cervical and thoracic spine strain. He prescribed mild analgesic and anti-inflammatory medications, took claimant off work for four weeks, and scheduled a follow-up visit for a month later. Dr. D's August 3, 1993, report stated that claimant was "getting better" but still reported middle back pain and was not working because of her pain. X-rays revealed a small bone spur at C5, no intervertebral disc narrowing or arthritic degeneration, and a normal thoracic spine. Dr. D's provisional diagnosis was "cervical, midthoracic syndrome" and he planned to start some physical therapy (PT) and order MRI and EMG tests. Dr. G's December 6, 1993, report related that claimant had visible paracervical muscle spasm on the right but that her MRI showed a normal cervical spine. Dr. G's impression was "cervical and thoracic syndrome" and he planned to order an EMG and see her again in a month. Dr. F's January 4, 1994, report noted that claimant had not had any PT but had some Darvocet and Naprosyn, that her ROM was "good," that the neurological exam of her upper extremities was "intact," and that he read her MRI to show a bulge with a possible herniation at C3-4 but was going to get a reading by a neuroradiologist.

At the hearing, claimant indicated she had yet to receive answers to a deposition of Dr. D upon written questions and his records requested in the deposition, but that such had been requested and would be sent to the carrier for comment. The hearing officer stated

she would leave the record open for the receipt of those documents and for the carrier's comments, if any. The hearing officer's decision stated that no comment was received from the carrier and that the hearing record was closed on February 15, 1994. Though not specified in the hearing officer's decision, these documents were, apparently, admitted into evidence and considered by the hearing officer. The records which accompanied Dr. D's deposition contained some additional records including a December 3, 1993, report from the Diagnostic Center (center) stating the impression: "Normal MRI study of the cervical spine." In his answers to deposition questions, Dr. D responded "see attached records" when asked whether claimant had reached MMI, and "no" when asked if he could state when claimant would reach MMI. When asked what rating he would give claimant under the AMA Guides, Dr. D answered "2%."

We are satisfied the evidence sufficiently supports the hearing officer's determinations and that the designated doctor's report was not contrary to the great weight of the other medical evidence. *See* Sections 408.122(b) and 408.125(e), 1989 Act. We have frequently noted the important and unique position occupied by the designated doctor in resolving disputes over MMI and IR, and we have stated that a "great weight" determination amounts to more than a mere balancing or preponderance of the medical evidence. *See e.g.* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Both Dr. Q and Dr. T reached the same conclusions respecting claimant's MMI date and IR. The records of Clinic No. 2 indicate claimant was simply continued on certain medications, that PT was considered, and that Dr. D was going to get the MRI read by another doctor. There was no evidence that Dr. T failed to personally examine claimant and only her bare assertion that his examination was somehow not "thorough." The ultimate determination of the extent of impairment must be made upon medical and not lay evidence. Texas Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992. Dr. T's narrative report stated not only the history of the injury but also the results of Dr. T's physical examination including ROM as well as his diagnosis. The Appeals Panel has observed that a doctor may determine that MMI was reached in the past. Texas Workers' Compensation Commission Appeal No. 92336, decided August 31, 1992. In Texas Workers' Compensation Commission Appeal No. 93424, decided July 12, 1993, the Appeals Panel stated: "Texas Workers' Compensation Commission Appeal No. 93300, decided June 3, 1993, indicated that MMI and an impairment rating may be given even when the claimant is still in pain. (Medical care can continue after these points are reached.)" The Appeals Panel has also stated that the report of the designated doctor should not be rejected "absent a substantial basis to do so" (Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993), and we find no such substantial basis in this case.

The hearing officer is the sole judge of the weight and credibility to be given the evidence. Section 410.165(a). The hearing officer resolves 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). We will not disturb the hearing officer's findings unless they are so against the great weight and preponderance of the evidence as to be

manifestly unjust. Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986); In re King's Estate, 244 S.W.2d 660 (Tex. 1951).

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Thomas A. Knapp
Appeals Judge