APPEAL NO. 94300

This appeal arises under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On February 15, 1994, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The disputed issues presented at the hearing for resolution were: (1) has the appellant (claimant) reached maximum medical improvement (MMI); (2) if the claimant has reached MMI, what is the date of MMI; and (3) if so, what is his impairment rating (IR). The hearing officer determined in accordance with the report of the Texas Workers' Compensation Commission (Commission) selected designated doctor that claimant had reached MMI on December 13, 1993, with an IR of zero percent. The claimant appeals the hearing officer's decision asserting disagreement with the way certain evidence was characterized and the weight given it by the hearing officer and arguing primarily that the designated doctor did not comply with the testing requirements of the "Guides to the Evaluation of Permanent Impairment," third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) in assigning an IR. For these reasons he contends the designated doctor's report should not carry presumptive weight. No response was filed by the respondent (carrier).

DECISION

Finding that the decision and order of the hearing officer are supported by sufficient evidence, we affirm.

The claimant testified, and it is not disputed that on (date of injury), he was injured in the course and scope of his employment when, while wearing a hard hat, he struck his head on a metal I-beam. The claimant recounted that he first visited an unnamed doctor after the accident who told him his injury involved a "strain" or "sprain" to his neck. He testified that he next went to (Dr. PR), who became his treating doctor. On April 5, 1993, Dr. PR diagnosed cervical, thoracic and lumber strain as well as trauma to the shoulders, chest and ribs and "post-traumatic headache" and apparently over several visits in 1993 never revised this diagnosis. There is no evidence that Dr. PR ever conducted any range of motion (ROM) testing. Dr. PR referred claimant to (Dr. S), a neurosurgeon, for a neurological evaluation. On April 27, 1993, Dr. S diagnosed closed head injury and mechanical spine injury. Nerve conduction studies on May 5, 1993, in Dr. S's opinion were "highly suggestive of a C5-C6 nerve root irritation bilaterally for which further evaluation highly recommended." Dr. S also noted that the ROM of the cervical spine was partially restricted.

Dr. PR also referred the claimant to (Dr. F), a doctor of osteopathy. Dr. F performed an examination of the claimant on October 22, 1993, and diagnosed post-concussion syndrome, C2-C3 cervical facet syndrome with occipital neuralgia, and myofacial pain syndrome prominent in the cervical musculature. In a Report of Medical Evaluation (TWCC-69), dated October 25, 1993, Dr. F certified the claimant reached MMI on October 21, 1993, and assigned a six percent IR. On February 4, 1994, he clarified this TWCC-69 by saying:

It was our opinion at that time [the date of his examination] that he would be considered at his [MMI] if, in fact, he had undergone selective cervical facet injections or . . . epidural injections for his pain related problems. We have been unable to confirm that, in fact, he did received [sic] these . . . . Therefore, to clarify the issue, the TWCC-69 form should indicate he was not at his [MMI]. [Emphasis in original.]

It was undisputed at the hearing that the Commission appointed (Dr. PO) as the designated doctor to determine MMI and IR. In a TWCC-69 dated December 21, 1993, Dr. PO found that the claimant had reached MMI with a zero percent IR. He concluded that the claimant "sustained no permanent impairment and/or loss of physical function either to his cervical or his thoracic region as a consequence of this soft tissue pattern of injury." Dr. PO, in his report attached to the TWCC-69, also remarked, "A copy of the [ROM report on the spine] is enclosed. The [ROM] assessment was felt to be invalid as is noted." There was no separate ROM report entered into the record.[1] However, Dr. PO observed in his report that no ROM testing can take into account a patient's pre-accident ROM, body "habitus (obesity, muscularity, etc.)" or "physiologic stiffness." He concluded, "the assessment of impairment relating solely to the loss of [ROM] without objective evidence of structural abnormality is not warranted." Dr. PR, in a January 26, 1994, critique of Dr. PO's conclusions, wrote that the claimant presently "remains in considerable pain and has some persistent deficits." He reviewed Dr. PO's report, and opined that Dr. PO did not take into account the claimant's "very real deficits." Dr. PR also noted that Dr. S and Dr. F have also detailed the continuing pain and functional limitations. Dr. PR noted that Dr. PO's testing gave the claimant a 13% total cervical ROM impairment, and he questions why Dr. PO did not find the cervical ROM testing valid, and why no reason was given by Dr. PO to explain why the testing was not valid.

Other medical evidence introduced at the hearing included a report of (Dr. C), a neurosurgeon, identified as a referral doctor from claimant's treating doctor, Dr. PR. In a TWCC-69 dated December 23, 1993, Dr. C found the patient to have reached MMI on December 10, 1993, with a zero percent IR. He performed a neurological examination and found "good [ROM] of the neck" with normal sensation, nerve roots "patent", no spurs, and minimal spondylosis. In a TWCC-69 dated July 2, 1993, (Dr. M), who was identified as the carrier's medical examination doctor, found the claimant to have reached MMI on June 7, 1993, with a zero percent IR. Dr. M, in his report attached to the TWCC-69, stated that the claimant tends to magnify his symptoms and that the cervical collar he presented with did not appear significantly worn even though the claimant claimed to have worn it since the date of the injury. He concluded that the claimant "possibly" sprained his neck and back, but found no clinical evidence of fracture, nerve root compression or muscle spasm.

The claimant was apparently directed by the Commission to be examined by (Dr. W) for the purpose of determining a causal connection between the claimant's original injury to

[1]The claimant in his appeal also refers to this report and states that it contains a handwritten annotation "[claimant] did not meet the consistency criterion . . . "

his head and neck and complaints of thoracic and lumbar pain. Dr. W "found nothing to suggest claimant's thoracic and lumbar spine complaints of pain are related to his original injury and I am unable to find any confirmatory evidence of any injury to these areas." The claimant did not take exception to these conclusions at the hearing. In a TWCC-69 dated July 20, 1993, (Dr. W) diagnosed "compressive strain, cervical spine (by history)," and found that the claimant reached MMI on July 20, 1993, with a zero percent IR. Dr. W noted that examination of the claimant's cervical spine showed "near normal" ROM.

The carrier also introduced both a May 6, 1993, CT scan which showed a normal appearance of the cervical spine and an October 4, 1993, MRI which revealed no significant degenerative changes, no herniation, and no stenosis of the cervical spine and a normal MRI of the cervical spine.

On appeal the claimant raised numerous objections to the way the hearing officer handled the evidence at the hearing and to comments about the weight and conclusions drawn from that evidence. The claimant argues that the hearing officer should have admitted all of Dr. PR's reports not just the one letter of Dr. PR marked Claimant's Exhibit No. 1. From the record at the hearing it appears the claimant and the assisting ombudsman submitted and meant for all the medical reports of Dr. PR to be considered for admission. Although the decision refers to Dr. PR's "report" (singular) and there was some confusion about the numbering of exhibits,[2] it is clear that the hearing officer had before him and considered all the reports of Dr. PR submitted at the hearing. The claimant also argues on appeal that other exhibits containing Dr. S's reports were not admitted when in fact they were and have been considered. We find no fault with the hearing officer in this regard.

Section 410.165(a) provides that the hearing officer is the sole judge of the weight and credibility of the evidence. The hearing officer also may draw reasonable inferences from that evidence. His account of the evidence in the decision and order, with which the claimant disagrees, represents his interpretation of the evidence made in the discharge of his duties as hearing officer. The Appeals Panel has also observed that Section 410.168(a) requires a decision of a hearing officer to contain only findings of fact, conclusions of law, a determination of whether benefits are due, and if so, an award of benefits. Any inclusions beyond this need not discuss every piece of evidence, "but should generally provide a reasonably fair summary of the material." Texas Workers' Compensation Commission Appeal No. 93955, decided December 8, 1993. We believe the decision of the hearing officer, including his analysis of the evidence, meets this requirement.

The claimant also argued at the hearing and now on appeal that Dr. PO did not comply with the AMA Guides. However, no evidence of Dr. PO's noncompliance with the AMA Guides was introduced at the hearing and we note that on Dr. PO's TWCC-69, he clearly stated that the IR was based on the correct version of the AMA Guides. The claimant also testified that Dr. PO only asked him a couple of questions and checked his

[2]For example, what the ombudsman intended to offer as Claimant's Exhibit No. 2 became part of Claimant's Exhibit No. 1, and no Claimant's Exhibit No. 2 was, according to the transcript, ever offered.

"ROM" and that Dr. PO sent the claimant upstairs to have "ROM" tests completed. As we observed in Texas Workers' Compensation Commission Appeal No. 93424, decided July 12, 1993, the designated doctor must personally examine a claimant, but he is not required to personally conduct all the testing on which he relies. We thus find no merit in these objections.

The core of claimant's appeal is his disagreement with Dr. PO's zero percent IR, specifically Dr. PO's invalidation of ROM testing, his refusal to assign a rating for nerve damage, and his premature determination of a date of MMI. The 1989 Act assigns presumptive weight to the opinion of a designated doctor which can only be overcome by the a "great weight" of other medical evidence. Sections 408.122(b) & 408.125(e); Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. A designated doctor's report should not be rejected unless there exists a substantial basis to do so. Texas Workers' Compensation Commission Appeal No. 93483, decided July 26, 1993. In the present case, all examining physicians, with the exception of Drs. PR and F, found MMI and a zero percent IR. Dr. F withdrew his TWCC-69, but did find both nerve root irritation (three percent IR) and limited ROM (presumably three percent IR). Dr. PR provided no IR, but commented that the 13% IR for loss of ROM invalidated by Dr. PO was "in line with what would reasonably have been expected on the basis of the patient's clinical status as I have seen it." We do not believe that Dr. PR's disagreement with Dr. PO and the somewhat vague representation that a 13% IR was "in line" with what he would have (but in fact had not) given, or Dr. F's statement that MMI depended on cervical injections for pain constitutes the great weight of the other medical evidence. Dr. PO in an extensively detailed report, based on his own examination, a review of the records and testing by his assistants, concluded that ROM testing was invalid because there was no evidence of limited ROM beyond the claimant's subjective symptoms, *see* Section 401.011(33) and 408.122(a), and there was no nerve damage. Drs. C, M, and W reached the same ultimate conclusions.

The correct date of MMI and IR are questions of fact. Under the 1989 Act, the hearing officer is the sole judge of the relevance and materiality of the evidence offered and of the weight and credibility to be given the evidence. Section 410.165(a). As the finder of fact, the hearing officer can believe all or part or none of any witness's testimony. Taylor v. Lewis, 553 S.W.2d 153, 161 (Tex. Civ. App.-Amarillo 1977, writ ref'd n.r.e.); Texas Workers' Compensation Commission Appeal No. 93426, decided July 5, 1993; Texas Workers' Compensation Commission Appeal No. 93155, decided April 14, 1993. The hearing officer can also resolve the conflicts in the medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). We believe the medical evidence of Dr. PO, Dr. C, Dr. M, and Dr. W, provides a sufficient basis for the hearing officer's decision and the great weight of the other medical evidence was not contrary to Dr. PO's report. Where, as here, sufficient evidence supports a hearing officer's conclusions and his findings are not so against the overwhelming weight of the evidence as to be clearly wrong and unjust, the decision should not be disturbed. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Dyson v. Olin Corp., 692 S.W.2d 456, 457 (Tex. 1985); In Re King's Estate, 150 Tex. 662, 664-665, 244 S.W.2d 660-661 (1951).

We affirm the decision and order of the hearing officer.

Alan C. Ernst
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Thomas A. Knapp
Appeals Judge