APPEAL NO. 94336

On February 10, 1994, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). The issues at the hearing were maximum medical improvement (MMI) and impairment rating. Based on the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission), the hearing officer concluded that the appellant (claimant) reached MMI on October 11, 1993, with a zero percent impairment rating. The claimant disagrees with the decision and requests that we reverse the hearing officer's decision and render a decision that the claimant has not reached MMI. The respondent (carrier) requests that we affirm the hearing officer's decision.

DECISION

Affirmed.

The parties stipulated that the claimant was injured in the course and scope of employment on (date of injury). The claimant testified that he is a maintenance welder and that on (date of injury) he fell about 10 feet off a ladder. The claimant said that he has continued to have back pain which radiates into his legs, and that because of his injury he has been unable to work since the date of his injury.

On March 2, 1993, (Dr. W), the claimant's treating doctor, diagnosed the claimant as having a cervical sprain, lumbar sprain, bilateral knee internal derangement, and right shoulder impingement. Dr. W recommended physical therapy which the claimant undertook. A functional capacity evaluation performed on March 3, 1993, indicated that the claimant could function at a light-medium to medium physical demand level.

On March 13, 1993, (Dr. L) performed an MRI scan of the claimant's lumbar spine and reported the following results: 1. mild disc desiccation and degeneration at the L1-2 and L2-3 levels with no disc bulge or herniation; 2. a disc bulge or protrusion at the L3-4 level with disc degeneration and desiccation; 3. a very small disc herniation at the L4-5 level with disc degeneration; 4. disc desiccation and degeneration with disc bulging at the L5-S1 level with no evidence of disc herniation.

Also on March 13, 1993, Dr. L performed a "computerized axial tomography" (CAT scan) of the claimant's lumbar spine and reported that the test revealed disc bulging at the L3-4, L4-5, and L5-S1 levels. Disc herniations were not noted.

(Dr. J) reported that EMG and nerve conduction studies of the claimant's upper and lower extremities performed on March 22, 1993, were essentially within normal limits.

At the request of the carrier, the claimant was examined by (Dr. T) on April 14, 1993. Dr. T performed a physical examination and reviewed x-rays of the claimant's right shoulder, cervical spine, and lumbar spine, which he reported showed degenerative changes, but

were otherwise negative. Dr. T does not indicate that he reviewed the MRI scan and the CAT Scan of the claimant's lumbar spine done on March 13th. Dr. T diagnosed a resolving cervical strain, a resolving lumbar strain, and a probable resolving contusion of the right shoulder. Dr. T stated that the claimant did not appear to have sustained a significant permanent orthopedic injury, that in a month to six weeks the claimant would probably reach MMI and would be able to return to full duty work, and that the claimant had a "zero percent partial permanent disability rating." In a Report of Medical Evaluation (TWCC-69) dated April 16, 1993, Dr. T reported that the claimant would reach MMI on May 28, 1993, with a zero percent impairment rating.

(Dr. B) performed an MRI scan of the claimant's cervical spine on April 21, 1993, and diagnosed: 1. multi-level moderate to severe spondylitic changes in the cervical spine, worse at the C4-5, C5-6, and C6-7 levels; and 2. severe cervical spinal canal stenosis from C3-4 through C7-T1.

In a letter to the carrier dated June 2, 1993, Dr. W reported that the claimant's knees and shoulders were still symptomatic but were responding to physical therapy. Dr. W stated that the claimant's major problem was his back, that straight leg raising and flip tests were bilaterally positive, and that the claimant was scheduled for a discogram of the lumbar spine to determine whether he was a surgical candidate, because his back symptoms were not remitting with nonoperative care. In a letter to the carrier dated June 8, 1993, Dr. W said he disagreed with Dr. T's report. Dr. W stated that the claimant had a cervicothoracic sprain and was still symptomatic in his back, and that he had four discs which were noted to be suspicious on a CAT scan and MRI. He further stated that the discogram that had been ordered would clarify whether any disc levels were ruptured, and that "in all probability he will need surgery in relation to the stated injury." Dr. W then stated that he did not feel that the claimant had reached MMI and that the claimant is a surgical candidate "in both knees, both shoulders and the back." Dr. W also noted that the claimant has cervical spondylosis. In a TWCC-69 dated June 15, 1993, Dr. W reported that it was "undetermined" as to when the claimant would reach MMI.

In a "History and Physical Examination" report dated June 22, 1993, Dr. W reviewed the history of the claimant's work-related injury of (date of injury), and stated that the claimant had positive findings in his back and that a discogram was to be done that day. Dr. W further stated that "[h]e has L5-S1 designated disk with 2 millimeter posterior bulge. L4-5 shows paraspinal - - disk herniation. L3-4 shows posterior central disk protrusion and rupture 3 millimeters in size in all probability related to industrial accident." Dr. W further noted that the claimant had full range of motion of the cervical spine. In this pre-discogram report, Dr. W gave the following impression "disk rupture and sciatica bilaterally, in all probability related to stated industrial accident."

Then, in an "Operative Report" also dated June 22, 1993, Dr. W noted that he had performed a "discography" and reported that the L2-3 level was normal, the L3-4 level was normal, the L4-5 level was normal, and the L5-S1 level was normal. In discussing the L3-4 level, Dr. W stated that the discogram showed normal findings and that there was no

posterior leakage. However, on the report, the word "no" preceding the words "posterior leakage" is crossed through and Dr. W's initials are next to the crossed-out word, which indicates that there was posterior leakage. However, no change was made to the stated conclusion that the L3-4 level was normal. Dr. W stated in this report that "[a]t the present time, the patient is not a candidate for surgery. He has a positive CAT scan and positive MRI revealing bulging degenerative disk [sic] at L3-4, L4-5, L5-S1. [Claimant] will be continued to be treated nonoperatively."

In another report dated June 22, 1993, which is a radiology report for a "lumbosacral spine post-discogram," Dr. W stated that "[i]ntradiscal disruption and posterior leakage are noted at L5-S1 and L3-4." And, (Dr. G) stated in a report dated June 22, 1993, that the results of the lumbar discogram would be consistent with a bulging disc with an intact annulus at the L3-4 level. Dr. G further noted that no disc herniation was seen on the lumbar discogram.

Dr. L reported that a post-discography CAT scan of the lumbar spine done on June 22, 1993, revealed generalized disc bulging at the L3-4 level, a left posterolateral annular rent with a left foraminal disc protrusion at the L4-5 level, and a left posterolateral disc herniation at the L5-S1 level.

In a letter to the carrier dated June 24, 1993, Dr. W stated that the discogram showed a complete rupture at the L3-4 level and that the L4-5 level was problematic with a rupture anteriorly and "laterally bilaterally," but not posteriorly. Dr. W stated that the claimant is a candidate for chemonucleolysis and/or back surgery at the L3-4 level. He further stated that Dr. G (in a subsequent letter Dr. W refers to Dr. G as a radiologist) had not properly read the discogram and that he disagreed with Dr. G's opinion (that no disc herniation was seen on the lumbar discogram).

On July 8, 1993, Dr. W reported to the carrier that the claimant had not reached MMI, that the claimant's knees and neck were responding to nonoperative care, that he did not feel neck surgery was needed, and that the claimant's major problem was the back. On July 15, 1993, Dr. W reported to the carrier that the claimant would be continued on nonoperative care and treatment with epidural steroid injections, and that the claimant "may become a candidate for surgery in the future." However, Dr. W also stated that the claimant needed a L5-S1 decompression. In a report to the carrier dated August 19, 1993, Dr. W again noted that the claimant had a positive discogram on his lumbar spine and stated that "[i]n the future, he may be a candidate for surgery, we will reevaluate him at that time." In this report, Dr. W diagnosed a ruptured disc at L3-4, bilateral knee impingement syndrome and internal derangement, right shoulder impingement syndrome, cervical spondylosis, and a cervical sprain.

The parties stipulated that (Dr. D) was the designated doctor in this case. The parties represented that the Commission had selected Dr. D as the designated doctor to determine MMI and impairment rating. In a TWCC-69 dated October 11, 1993, Dr. D certified that the claimant reached MMI on October 11, 1993, with a zero percent impairment

rating. In a 14 page narrative report also dated October 11, 1993, Dr. D reviewed the history of the claimant's injury, treatment, and prior medical history, and set forth his findings on physical examination of the claimant. Dr. D observed that Dr. W had found that the claimant had not reached MMI. Dr. D noted that the claimant had normal range of motion of the neck and shoulders, normal muscle strength of the neck and shoulders, and normal grip strength. Dr. D also noted no demonstrable atrophy of the upper extremities and that neurological examination of the upper extremities was normal. In addition, shoulder tests for impingement tendinitis were negative. Dr. D further noted that an MRI scan of the right knee revealed no tears in the medial or lateral menisci, and that an MRI scan of the left knee was normal (the reports of the results of the MRI scans of the knees were not in evidence).

In regard to the claimant's back, Dr. D found no evidence of scoliosis, muscle spasm, or swelling. In addition, range of motion of the back was normal and straight leg raise (seated and supine) was negative bilaterally. Vibratory sensation and sensation to pinprick were also reported to be normal.

Dr. D also found that range of motion of the lower extremities was normal, that there was not atrophy of the lower extremities, and that knee examination tests were all negative.

In regard to review of medical records, Dr. D noted that he had numerous records from Dr. W and that they were read in their entirety. He stated that on March 2, 1993, Dr. W had diagnosed cervical strain, lumbar strain, and bilateral knee internal derangement. He also noted the negative EMG of March 22, 1993, the MRI scans of the knees, Dr. T's report of April 14, 1993, and reports of physical therapists. In addition Dr. D stated that the MRI scan of the neck showed moderate to severe spondylitic changes and severe spinal canal stenosis, but that in his view, those conditions were pre-existing. Dr. D also noted that Dr. L had read a June 22, 1993, CAT scan of the lumbar spine to show some leakage at the L5-S1 level. Dr. D then noted that in a further report Dr. W "contradicts the reading, namely, stating that there was intradiscal disruption and posterior leakage at L5 and S1 and L3-4." Dr. D also noted that on August 19, 1993, Dr. W had stated that the claimant may be a candidate for surgery.

Dr. D diagnosed: 1. cervicolumbar strain, resolved; and 2. contusion of left and right knee, resolved. Dr. D stated that most of the claimant's tests were essentially normal with the exception of arthritic changes which pre-dated the injury. He further stated that the claimant had a "CT scan, discogram, MRI's of the neck and knees which were normal." Dr. D opined that the claimant had reached MMI, that the claimant has a zero percent impairment rating, that no further testing or treatment is necessary, and that the claimant is not a surgical candidate. In addition, Dr. D stated that the claimant is able to return to work without restrictions.

In a letter to the carrier dated October 19, 1993, Dr. W stated that he disagreed with Dr. D's assessment that the claimant's diagnostic studies were normal. Dr. W stated that the studies showed positive findings; however, he said he agreed that "some of the findings are, in fact, prior to the injury." Dr. W reiterated that the claimant had not reached MMI.

He also stated that "[a]ny pre-existing conditions were aggravated, accelerated and accentuated by the stated injury, which made necessary the treatment program provided by myself. In the future, he will need surgery for the neck and back." He also disagreed with Dr. D's finding that the claimant could return to full duty, and noted that the cervical spine, lumbar spine, knees, and right shoulder are all "problematic." Dr. W said he would continue to treat the claimant nonoperatively. In a letter to the carrier dated December 14, 1993, Dr. W diagnosed cervical sprain, bilateral shoulder impingement, lumbar sprain, L3-4 bulging disc, and bilateral knee contusion. In this letter, Dr. W said that the claimant would probably need surgery on his right shoulder and that the claimant had reduced range of motion of the neck. He also said he was planning to do surgery on the neck and shoulder. Finally, in a letter to the carrier dated December 28, 1993, (Dr. BL), who is associated with Dr. W, stated that the claimant had not reached MMI, that the claimant had three bad discs, that "there had been small ruptures with marked bulges being present," and that "[m]ore probably, he [claimant] will need a major operation which will probably include fusion at three levels."

The hearing officer found that the great weight of the medical evidence was not contrary to the report of Dr. D, the designated doctor, and concluded that the claimant reached MMI on October 11, 1993, with a zero percent impairment rating.

In his appeal, the claimant contends that the designated doctor's report is invalid because it is based upon on incorrect diagnosis. The claimant states that the "uncontroverted diagnostic tests in this case reveal that the claimant has at least one, if not more herniated disk(s)." The claimant argues that the following medical evidence proves that the claimant has at least one herniated disc: 1. MRI of March 13, 1993, read by Dr. L as showing a very small disc herniation at the L4-5 level; 2. CAT scan of March 13, 1993, read by Dr. L as showing disc bulging at three levels; 3. Dr. W's lumbosacral spine post-discogram radiology report of June 22, 1993, which states "intradiscal disruption and posterior leakage are noted at L5-S1 and L3-4;" and 4. CAT scan of June 22, 1993, which was read by Dr. L as showing disc bulging at the L3-4 level, a left posterolateral annular rent with a disc protrusion at the L4-5 level, and a disc herniation at the L5-S1 level. The claimant also faults the designated doctor for not discussing each of the aforementioned tests. The claimant's appeal centers solely on the condition of the claimant's lumbar spine, and does not take issue with the designated doctor's findings regarding the neck, knees, or shoulders.

We first point out that of the four reports of diagnostic tests the claimant refers us to on appeal for evidence of lumbar disc herniation, two of them, Dr. L's report of the CAT scan of March 13, 1993, and Dr. W's June 22, 1993, report of the lumbosacral spine post-discogram, do not specifically state that the claimant has a herniated disc in his lumbar spine. However, we agree that Dr. L's report of the MRI scan of March 13, 1993, diagnoses a disc herniation at L4-5 (but no evidence of disc herniation at L5-S1), and that Dr. L's report of the CAT scan of June 22, 1993, diagnoses a disc herniation at L5-S1 (which was contrary to the MRI of March 13, 1993).

We next point out that it was Dr. W's opinion that a discogram was needed in order to clarify whether any discs were ruptured and that in his June 22, 1993, report of the results of the discogram, Dr. W indicated that all lumbar disc levels showed normal findings, except for posterior leakage at the L3-4 level, and that the claimant was not a candidate for surgery. Subsequently, Dr. W reported that the discogram showed a rupture at the L3-4 level and at the L4-5 level, and that the claimant was a candidate for surgery. But, contrary to the claimant's assertion on appeal, such findings were not uncontroverted. Dr. G stated in his report dated June 22, 1993, that no disc herniation was seen on the lumbar discogram.

As to the 14-page report of Dr. D, the designated doctor, although he did not set forth the results of each and every diagnostic test that had been performed on the claimant's lumbar spine, he did note that Dr. L had found in June 1993 that "there was some leakage at L5-S1, 2-3 mm in size," and that Dr. W had determined that there was "intradiscal disruption and posterior leakage at L5 and S1 and L3-L4." He also noted that Dr. W had opined that the claimant had not reached MMI and that the claimant was a surgical candidate. In the Statement of the Evidence portion of the hearing officer's decision, the hearing officer stated that Dr. D had provided a thorough report. Dr. D did not feel that the claimant was a surgical candidate.

The 1989 Act provides that where a designated doctor is chosen by the Commission to determine MMI and impairment rating, the report of the designated doctor shall have presumptive weight and the Commission shall base the determinations of MMI and impairment rating on that report unless the great weight of the other medical evidence is to the contrary. Sections 408.122(b) and 408.125.(e). No other doctor's report, including that of the treating doctor, is entitled to presumptive weight. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992; Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992. It requires more than a preponderance of the evidence to overcome the presumptive weight accorded to the report of the designated doctor. The great weight of the medical evidence must be contrary to the report. Appeal No. 92412, *supra*. The hearing officer is the sole judge of the weight and credibility to be given to the evidence. Section 410.165(a). As the finder of fact, the hearing officer resolves conflicts in the medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). Having reviewed the record, we cannot conclude that the hearing officer erred in determining that the great weight of the other medical evidence is not contrary to the report of the designated doctor, nor can we conclude that the hearing officer erred in determining that the claimant reached MMI on October 11, 1993, with a zero percent impairment rating as reported by the designated doctor. The hearing officer's decision and order are affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Gary L. Kilgore
Appeals Judge