APPEAL NO. 950016
FILED FEBRUARY 9, 1995

Following a contested case hearing on November 29, 1994, the hearing officer resolved the two disputed issues by giving presumptive weight to the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission) and determining that the appellant (claimant) reached maximum medical improvement (MMI) on July 26, 1994, with an impairment rating (IR) of seven percent. Pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 410.202(a) (1989 Act), the claimant has appealed the IR determination asserting that his treating doctor's examination for his IR took more time than that of the designated doctor and that the designated doctor's IR is invalid because he was forced by that doctor's assistant "to do things over the limit" after which he had pain. Claimant seeks another evaluation "for a possible better rating disability." The respondent (carrier) urges the sufficiency of the evidence to support the hearing officer's determination of the IR and seeks an affirmance.

DECISION

Affirmed.

Claimant, the sole witness, testified through a Spanish language translator that he disagreed with the MMI date of July 26, 1994, determined by the designated doctor, (Dr. LW), because his back was not well and he still has low back pain and loss of strength in his legs. He further testified that his left hand began to hurt about two months previously. Claimant also indicated his disagreement with the seven percent IR assigned by both (Dr. PO) and by Dr. LW. He did not express disagreement with the 19% IR assigned by his treating doctor, (Dr. MP); however, his primary contention seemed to be that he had not yet reached MMI. With respect to his examination by the designated doctor, he stated that Dr. LW did examine him, had him sit, stand, and lie down, touched him where it hurt, and inquired about the ratings assigned by other doctors. He did not testify to the length of the exam nor to being forced to overexert during measurements. Our review is limited to the evidence admitted at the hearing. Section 410.203(a).

The Report of Medical Evaluation (TWCC-69) signed by Dr. LW on July 26, 1994, certified that claimant had reached MMI on that date with an IR of seven percent. According to her narrative report of that date, Dr. LW gave a history of sudden onset of low back pain on June 2, 1993, when claimant moved a barrel half-full of sand. Dr. LW further reported that claimant had been treated by several doctors including the company doctor who first treated him, (Dr. G), (Dr. MD) of the (back clinic), Dr. PO, and his most recent treating doctor, Dr. MP. She reported that an August 2, 1993, MRI revealed degenerative disc disease with mild to moderate herniation at the L4-5 level. According to her narrative report, Dr. LW assigned the seven percent rating for claimant's specific spinal disorder. Her physical examination found no acute paraspinal spasm nor any motor or sensory

deficits. With regard to range of motion (ROM) impairment, Dr. LW stated that although claimant did meet the straight leg raise validity and consistency criteria, she did not feel that ROM impairment could be included in his whole person IR because she observed him bending more than his measured maximum lumbar flexion while getting on and off the examination table and doffing and donning his clothing.

On February 24, 1994, Dr. PO reported that claimant had had appropriate treatment, was not a surgical candidate, had reached a plateau, and was not likely to improve with further treatment. He stated that claimant had reached MMI and assigned an IR of seven percent for claimant's degenerative disc disease at L4-5 with a disc bulge or herniation at that level. Through use of the straight leg raise test, Dr. PO found claimant's ROM to be invalid and also found no loss of strength or sensation. Dr. PO further reported that "[u]nfortunately, all of the evaluation of the patient shows invalidation."

Dr. MP's unsigned TWCC-69 stated that claimant reached MMI on May 6, 1994, with an IR of 19%.

Under the 1989 Act, Dr. LW's report was entitled to presumptive weight unless the great weight of the other medical evidence was to the contrary. Sections 408.122(b) and 408.125(e). The Appeals Panel has often noted the unique position occupied by the designated doctor under the 1989 Act in resolving disputes over MMI and IRs. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. No other doctor's report, including that of the treating doctor, is accorded this special presumptive status. Texas Workers' Compensation Commission Appeal No. 93932, decided November 29, 1993. A "great weight" determination amounts to more than a mere balancing or preponderance of the evidence and medical conclusions are not reached by counting the number of doctors who take a particular position. Appeal No. 92412, *supra*. In this case Dr. PO had the same opinion on claimant's IR as Dr. LW and the only contrary medical opinion was the 19% IR assigned by Dr. MP. To allow the mere existence of a contrary medical opinion on impairment to constitute the "great weight" of the medical evidence would tend to invalidate the entire designated doctor program and preclude the finality the program was designed to foster. Texas Workers' Compensation Commission Appeal No. 93825, decided October 15, 1993.

We are satisfied the evidence sufficiently supports the challenged findings and that the hearing officer's decision is not so against the great weight and preponderance of the evidence as to be manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Lynda H. Nesenholtz
Appeals Judge