APPEAL NO. 961699

Following a contested case hearing held on July 31, 1996, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer resolved the sole disputed issue by determining that correct impairment rating (IR) for the appellant and cross-respondent (claimant) is zero percent. Claimant has appealed, challenging the hearing officer's finding that the designated doctor's assessment of a 30% IR was not based on objective clinical or laboratory finding as well as the finding that the designated doctor's 30% IR was overcome by the great weight of contrary medical evidence. The respondent and cross-appellant (carrier) responded, urging first that claimant's appeal has not invoked the jurisdiction of the Appeals Panel and alternatively that the evidence sufficiently supports the challenged findings and zero percent IR determined by the hearing officer. The carrier's cross-appeal takes issue with a sentence in the hearing officer's discussion which states in part that the hearing officer did not believe it would necessarily constitute error to use Chapter 14 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) since paragraph 4.1 of Chapter 4 indicates that, when appropriate, Chapter 14 should be used in conjunction with Chapter 4.

DECISION

Affirmed.

The carrier contends that the jurisdiction of the Appeals Panel has not been invoked by the claimant because the claimant's appeal is not signed by her but rather by her husband who is not a party to the proceeding. Claimant's handwritten appeal states her name, date of injury and "TWCC No." at the top of the first page and at the end of the last page is written the following: "These words are mine & [claimant's] words written & assisted by the ombudsman [Ms. H] Thank you [Mr. D]." It is not clear from the quoted sentence and signatures below it whether the appeal was written by the ombudsman and signed by the ombudsman and Mr. D or written by and signed only by Mr. D (who was identified at the hearing as claimant's husband). Section 409.041(b)(4) provides, in part, that an ombudsman shall assist unrepresented claimants, employers and other parties "to enable those persons to protect their rights in the workers' compensation system." While claimant's signature is not at the bottom of the appeal, it is on the certificate of service appended to the appeal and we are thus satisfied that we have an appeal from the claimant which has invoked our jurisdiction.

Claimant did not testify. On her Employee's Notice of Injury or Occupational Disease and Claim for Compensation (TWCC-41), signed on February 24, 1995, claimant stated that on _____, she injured her head, neck and back when she walked into a Cushman sprayer and that she had a concussion and whiplash. The Employer's First Report of Injury or Illness (TWCC-1), signed on _____, stated that claimant was

walking around a vehicle and collided with a sprayer attached to a Cushman tractor, bruising her forehead and eye area. A (Hospital) record reflects that on (week after date of injury), claimant took herself to the emergency room where she was seen by (Dr. B). She gave a history of being hit in the forehead a week earlier and of thereafter having headaches and neck and low back pain. Dr. B's diagnosis was closed head injury and cervical and lumbar spasm and he noted that claimant was discharged to her home in no acute distress and took her off work for one week. Cervical spine x-rays of that date revealed satisfactory alignment with no fracture, subluxation or foraminal narrowing and a CT scan of her head revealed no intracranial abnormality or fracture.

According to her medical records, claimant saw (Dr. Da), an orthopedic surgeon, in January and again on February 1, 1995, complaining of headaches and neck and back aches. She was found by Dr. Da to be neurologically intact although he noted he would refer her for a neurological exam. (Dr. LB), a neurologist, reported on February 8, 1995, that claimant gave a history of walking in the parking lot at work with her sunglasses on and walking into a steel beam on the back of a small Cushman cart which jammed her sunglasses into her forehead resulting in a laceration of her right forehead and swelling around her eye. Dr. LB stated that claimant was "tearful and anxious in a manner which seems out of proportion to her complaints." Dr. LB further reported that claimant's cranial nerve exam was "benign" and her cerebellar exam within normal limits. Dr. LB's impression was "a 35-year old, right-handed lady, with injury after striking a beam on the forehead with no loss of consciousness and negative CT with myofascial symptoms and posttraumatic headaches." (Dr. A), a neurologist, examined claimant and reported on April 12, 1995, that his impression was posttraumatic headache, depression and myofascial pain syndrome.

In evidence was a document indicating that on May 4, 1995, claimant changed treating doctors from Dr. Da to (Dr. K) and on May 9, 1995, Dr. K diagnosed postconcussion syndrome with headache, dizziness, memory difficulties and depressive psychiatric symptoms. On May 18, 1995, Dr. K reported a normal EEG and on June 8, 1995, Dr. K reported that he had referred claimant to (Dr. S) for a psychiatric evaluation and that Dr. S in turn referred claimant to (Dr. HB) for neuropsychiatric testing.

In her May 24, 1995, report, Dr. S stated the impression as "a 35 year old married white female with no past psychiatric history referred due to chronic headaches of unclear underlying medical reason." Dr. S also stated that claimant had "some evidence of secondary gain" and mentioned claimant's husband's wanting Dr. S to "approve another 3-4 months off so she could get an advance on her Worker's Comp to get her car fixed." Dr. S further reported that claimant "may be malingering or may have somatization or conversion disorder," and that she needed neuropsychiatric testing.

Dr. HB reported on June 5, 1995, that claimant had "a moderate tendency to selfdepreciation and exaggeration of her current emotional problems" and that she "likely reported more psychological symptoms than objectively exist." Dr. HB's impressions were dysthymic disorder (provisional), pain disorder associated with both psychological factors and a general medical condition, and schizoid traits.

On June 19, 1995, Dr. K reported to the carrier that he had referred claimant to a medical school's pain control and functional restoration clinic where she was evaluated by (Dr. MB), a neurosurgeon. He also stated that claimant "has no objective findings" and that such is usually the case with the syndrome of post-traumatic headaches," usually a syndrome of multi-focal complaints." Dr. MB on July 6, 1995, reported a diagnosis of "1. Status post head and neck injury from being struck by Cushman vehicle, _____; 2. Post traumatic syndrome secondary to 1; 3. Right upper quarter myofascial pain syndrome secondary to 1."

On July 14, 1995, (Dr. De) examined claimant and reported the impression of "Headaches, Depression, Closed head injury."

Dr. K reported on August 30, 1995, that claimant was being followed by Dr. S; that claimant reported pain 24 hours a day instead of six hours a day, as well as other symptoms; that he felt claimant had reached maximum medical improvement (MMI); and that claimant was to be referred to (Dr. G) for an IR. There was no IR from Dr. G in evidence however.

Dr. MB reported on September 12, 1995, that "[p]rogram compliance was essentially non-existent as indicated by the fact that [claimant] did not achieve any of her stated goals" and that Dr. MB felt claimant had reached MMI and could do sedentary work.

Dr. K reported on October 25, 1995, that claimant had an MRI of the cervical spine which was normal, that claimant continued to complain of headaches, neck and back pain, and dizziness, and that she continued psychiatric treatment with Dr. S.

(Dr. O), the designated doctor appointed by the Texas Workers' Compensation Commission, signed a Report of Medical Evaluation (TWCC-69) on January 22, 1996, certifying that claimant reached MMI on "10-25-95" with an IR of 30%, and on January 30, 1996, Dr. K endorsed on the TWCC-69 his agreement with the MMI date and IR. In his narrative report of January 12, 1996, Dr. O stated that claimant "states that she is globally impaired due to her problems, and that any activity at all is affected by her pain"; that she frequently gets dizzy and has photophobia; that she kept her sunglasses on during the entire exam except when asked to take them off; and that she and her husband described the pain management program at the medical school as a "joke." In recounting claimant's medical history, Dr. O reported that claimant had an MRI scan of her head on August 16,

1995, which was reported as normal. He also stated that claimant was tested for impairment on December 18, 1995, at a rehabilitation center; that her cervical and lumbar tests were invalidated at the center due to her failure to give maximum effort; that she "demonstrated non-anatomical, give-way weakness and deficits about all four extremities"; and that the therapist at the center recommended "that a neuropsychiatrist or psychologist consider performing the [IR]." Dr. O also stated that an MRI scan showed no evidence of disc herniation, that a bone scan was normal, and that the head CT scan showed no evidence of intracranial pathology. According to Dr. O, claimant told him she needs help with dressing, bathing, walking and housework, that she does not drive, that light bothers her eyes, and that her husband stated that she was very withdrawn. Dr. O also stated that claimant would not attempt to subtract seven serially from 100, that when asked who was the President of the U.S., she refused to answer, and that her performance of upper extremity range of motion (ROM) displayed "ratchety type motions." Dr. O's diagnosis was "1. Musculoskeletal cervical thoracic pain, unclear etiology" and "2. Mental health impairment, unclear etiology" and he stated that the first diagnosis was "primarily limited by motivation" due to the second.

Dr. O further reported that he assigned a "0% impairment due to the cervical thoracic spine disorder." Referring to Table 49 of the AMA Guides, Dr. O noted that claimant had no demonstrable lesion and that her ROM limitations were limited by motivational factors due to the mental health impairment. Concerning the mental health impairment, Dr. O stated the following:

> Regarding the mental health impairment, provided [claimant] has an eligible mental health impairment, the following impairment was assigned based on the AMA Guides, Chapter 14. On pg. 233, Table 12, she was placed in a Class III moderate impairment. Pg. 97 of the AMA Guides was used to translate the ordinal scale from pg. 233 to an integral scale of percent impairment. In my opinion, she displayed mild to moderate impairment of the whole person. Therefore, in summary, [claimant] has a 30% impairment of the whole person based on mental health impairment as noted above. This is assuming that the mental health impairment is a compensable injury under TWCC law.

Responding to a Commission employee's inquiry, Dr. O wrote on March 7, 1996, that he had reviewed Dr. HB's June 5, 1995, report which indicated that claimant "had a pre-existing mental impairment," that apportioning the 30% IR would be difficult based on Dr. HB's report, and that he estimated that five percent or less of claimant's current impairment would be attributable to preexisting psychological disorders. Dr. O also stated that it was his opinion that claimant has 30% whole person impairment "[b]ased on psychological dysfunction." He also enclosed two pages from the AMA Guides which he said he used, namely, page 233 from Chapter 14 (Mental and Behavioral Disorders) with

the category "class 3, moderate impairment" circled and page 97 from Chapter 4 (The Nervous System) with the percentage impairment range of "20 - 45" circled and the figure "30%" written next to it.

Dr. S wrote on June 25, 1996, that she evaluated claimant on June 18, 1996, that claimant "has deteriorated psychiatrically, currently having a psychotic depression with paranoia and auditory hallucinations," that claimant does not require inpatient treatment and that claimant's husband was encouraged to get her out of the house to reduce her isolation.

The carrier introduced a videotape showing various activities of claimant taken by investigator (Mr. N) on February 7 and 20, 1996. Mr. N testified that he identified claimant (and her husband) in the hearing room as the person whom he surveilled on the above dates and on a third occasion in March. He further testified that on those dates, he observed claimant driving a pickup truck, walking and shopping, all with no apparent difficulty; sitting outside in the sunlight without wearing sunglasses; and visiting a friend on the latter's front porch. He contrasted claimant's behavior on those occasions with her appearance in the hearing room where she was represented as wearing sunglasses and appearing withdrawn.

In his deposition, (Dr. PO) stated that he had viewed the carrier's videotape and that her activities as seen in the videotape contradicted statements she gave to the healthcare providers who have examined and treated her. Dr. PO further testified that he had reviewed Dr. O's report and did not believe there was enough data to draw the conclusions Dr. O drew concerning mental health impairment, pointing out that claimant never had neuropsychological testing with organicity screens, that the available testing could suggest that claimant had the problems prior to her trauma, that claimant may well be using her trauma to manipulate her environment, and that "without adequate neuropsychologicals and complete psychological evaluation, even emeritus professors are not good at arriving at a proper opinion." Dr. PO also opined that, while there was not enough data to determine if claimant had a dysfunction of the brain, spinal cord, cranial nerves or other peripheral nerves, it was more likely that she has psychological problems as opposed to closed head injury. Dr. PO further stated that he did "not believe there is adequate information in order to make an accurate determination" of claimant's IR.

The hearing officer made the following findings and conclusion and claimant has challenged Nos. 7 and 8:

FINDINGS OF FACT

6.[Dr. O] rendered an opinion that Claimant had a thirty percent whole body impairment, all of which was attributable to Claimant's alleged head

injury, and none of which was attributable to the condition of Claimant's neck.

7.[Dr. O's] opinion that Claimant has a thirty percent whole body impairment due to her alleged head injury was not based on objective clinical or laboratory findings.

8.[Dr. O's] opinion that Claimant has a thirty percent impairment due to her alleged head injury has been overcome by the great weight of contrary medical evidence.

9.[Dr. O's] opinion that Claimant has a zero percent whole body impairment due to the condition of her neck has not been overcome by the great weight of contrary medical evidence.

CONCLUSION OF LAW

3.Claimant has a zero percent whole body impairment.

"Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. Section 401.011(23). Section 408.122(a) provides in part that a claimant may not recover impairment income benefits unless evidence of impairment based on an objective clinical or laboratory finding exists. "Objective" means "independently verifiable or confirmable results that are based on recognized laboratory or diagnostic tests, or signs confirmable by physical examination." Section 401.011(32). "Objective clinical or laboratory finding" means "a medical finding of impairment resulting from a compensable injury, based on competent objective medical evidence, that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee." Section 401.011(33). Section 408.125(e) provides in part that the Commission shall base the IR on the report of the Commission-selected designated doctor unless it is contrary to the great weight of the other medical evidence.

We first note, significantly, that there was no disputed issue concerning the extent of claimant's injury, which, from the medical evidence, could run the gamut from a laceration and contusion on the right forehead to a closed head injury with consequent psychological injuries. In essence, the hearing officer has adopted the zero percent IR assigned by Dr. O for the cervicothoracic spine injury he diagnosed, finding it not contrary to the great weight of the other medical evidence. That determination has not been appealed. Further, the hearing officer has found Dr. O's 30% IR for claimant's psychological injury resulting from her compensable head injury to be unsupported by objective clinical or laboratory findings and contrary to the great weight of the other medical evidence. In the latter regard, the

hearing officer could consider not only Dr. PO's deposition testimony regarding the insufficiency of neurological testing to support Dr. O's 30% IR determination but also the lack of evidence of objective clinical findings and the indications of symptom exaggeration in some of the other medical reports and the content of Dr. O's report itself. The hearing officer could also consider the credibility of the symptoms related by claimant to the doctors treating and examining her. The hearing officer is the sole judge of the weight and credibility of the evidence. Section 410.165(a). We cannot say that the challenged findings are so against the great weight of the evidence as to be clearly wrong or manifestly unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

The carrier's appeal asserts that the hearing officer erred in commenting on the use of Chapter 14 to arrive at an IR, as mentioned above, and that two Appeals Panel decisions approving the use of Chapter 14 (Texas Workers' Compensation Commission Appeal No. 950104, decided March 7, 1995, and Texas Workers' Compensation Commission Appeal No. 951447, decided October 9, 1995) misinterpret Sections 408.006, 408.123 and 408.124 of the 1989 Act as well as the AMA Guides and "are invalid." We decline to revisit our decisions in those cases and find no merit in the carrier's appeal.

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Alan C. Ernst
Appeals Judge