APPEAL NO. 980285
FILED MARCH 23, 1998

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on December 2, 1997, with the record closing on December 30, 1997, in (City), Texas, with (hearing officer) presiding as hearing officer. On the single issue before him, the hearing officer determined that the appellant's (claimant) impairment rating (IR) was zero percent as certified by her treating doctor and rejected the 18% IR assigned by a designated doctor. The claimant appeals urging that the evidence overwhelmingly supports the designated doctor's IR and that the great weight of other medical evidence is not against the designated doctor's report. The respondent (carrier) urges that there is sufficient evidence to support the decision of the hearing officer and that the decision goes into great detail to support the rejection of the designated doctor's report.

DECISION

Affirmed.

The report of a designated doctor is accorded presumptive weight and the IR is based on that report "unless the great weight of the other medical evidence is to the contrary." Section 408.125(e); Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. When a hearing officer rejects a designated doctor's report because the great weight of the other medical evidence is to the contrary, he must clearly detail the evidence relevant to his consideration and state the reasons why the great weight of the other medical evidence is to the contrary and how it outweighs the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 93123, decided April 5, 1993. The hearing officer has done that in his decision in this case, and we cannot conclude that his determination is so against the great weight and preponderance of the evidence as to be clearly wrong or unjust, our standard of review. Pool v. Ford Motor Company , 715 S.W.2d 629, 635 (Tex. 1986); Texas Workers' Compensation Commission Appeal No. 92083, decided April 16, 1992.

The claimant testified that she fell at work on _____, hurting her neck and lower back. She treated initially with Dr. L and was diagnosed with cervical/lumbar strain/sprain and was treated conservatively. Dr. L examined her on March 19, 1997, and rendered a Report of Medical Evaluation (TWCC-69) on March 27, 1997, certifying maximum medical improvement (MMI) on March 19, 1997, with a zero percent IR, and released her from further care. Dr. L notes that the claimant reported that her neck and back were feeling better and only bothered her with weather changes. The claimant stated at the hearing that the only time she had problems with her neck and back was when the weather changed. She also stated that she is not working but for other personal reasons.

Earlier, the claimant was seen by a carrier doctor on March 6, 1997, for an MMI and IR determination. Dr. A examined the claimant, certified that she reached MMI with a two percent IR for lumbar range of motion (ROM). His report also indicates the claimant could return to her former work, that she has "no diagnostic codes which would warrant an impairment," and that she has full lumbar flexion and extension greater than 60 degrees and 25 degrees respectively and that a slight decrease in lateral flexion may be secondary to her girth. He found no evidence of radiculopathy or discogenic pain or posterior element pain or sacroiliac joint dysfunction. He states the claimant's condition is not likely to change, with no further intervention although she will slowly improve.

The claimant changed treating doctors and saw a Dr. C, who in a medical report dated March 11, 1997 indicated that the claimant had no spinous process pain, and good ROM on flexion and extension, and normal lordosis in the cervical spine. Regarding the lumbosacral spine, Dr. C also stated there was no spinous process tenderness, no trigger point pain, and that the claimant would anteriorly flex to nine inches from her shoes. The claimant was involved in a rear-end collision on or about March 7, 1997, and continued treating with Dr. C for both the incidents.

The claimant was examined by a designated doctor on April 21, 1997, who certified MMI as of February 20, 1997, with an 18% IR consisting of specific disorders under Table 49 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), for both the cervical and lumbar areas and for loss of ROM.

The hearing officer discusses at some length his reasoning for rejecting the report of the designated doctor as being against the great weight of the contrary medical evidence and for selecting the report of the treating doctor. Section 408.125(e). From his discussion, it is apparent he found credible the medical evidence from Dr. L, Dr. A and Dr. C regarding any permanent impairment sustained by the claimant and their observations of the claimant's cervical and lumbar condition. He also states that he found the claimant's treating doctor's report important in determining the IR, that he did not find the medical reports to support any rating for specific disorders ratable under Table 49, that the medical reports show the injury to be strain/sprain, and the March 1997 medical reports indicated the claimant's ROM was essentially normal. Considering all the medical evidence before him, the hearing officer concluded that the designated doctor's report was contrary to the great weight of the other medical evidence and determined to base the IR on the report of the treating doctor. We do not conclude, after reviewing the evidence of record, that the hearing officer's determination was so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. In re King's Estate , 150 Tex. 662, 244 S.W.2d 660 (1951).

Accordingly, the decision and order are affirmed.

Stark O. Sanders, Jr.
Chief Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Tommy W. Lueders
Appeals Judge