APPEAL NO. 990161

Following our remand of this case to the hearing officer in Texas Workers' Compensation Commission Appeal No. 982097, decided October 12, 1998 (Unpublished), a contested case hearing (CCH) on remand was held on December 14, 1998. The CCH was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). The appellant (claimant) requests reversal of the hearing officer's decision on remand that she reached maximum medical improvement (MMI) on April 26, 1996, with a zero percent impairment rating (IR) as certified by the designated doctor chosen by the Texas Workers' Compensation Commission (Commission). The respondent (carrier) requests affirmance.

DECISION

Affirmed.

While working on _____, claimant received an electrical shock which threw her back onto the floor. She reported that the electrical shock entered her left hand and exited her right hand, that she landed on her back and head, and that she lost consciousness. The parties stipulated that claimant sustained a compensable injury on _____. Following her accident, claimant has been seen by doctors for pain in her back, legs, and arms, and for depression. An MRI of her lumbar spine done in June 1995 was reported to be normal. An electromyography (EMG) of her lower extremities done in July 1995 was reported to be normal. Dr. R wrote in July 1995 that claimant sustained an "electrocution" type of injury with a lumbosacral contusion. On November 10, 1995, Dr. F, who was then her treating doctor, reported in a Report of Medical Evaluation (TWCC-69) that she reached MMI on November 10, 1995, with a nine percent IR. The nine percent IR was for impairment of the lumbar spine. Dr. S wrote in January 1996 that he suspected that an injury to unmyelinated fibers is responsible for claimant's "sensory disturbance." The Commission chose Dr. C as the designated doctor and he examined claimant and reviewed medical reports on April 26, 1996, and reported in a TWCC-69 that claimant reached MMI on April 26, 1996, with a zero percent IR. Dr. C noted that the IR was based on the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (the AMA Guides). He opined that claimant has meralgia paresthetica from constriction of an inguinal ligament that did not arise from her injury.

Dr. D began treating claimant in September 1996 and he reported on several occasions that claimant had not reached MMI. Dr. D wrote that an EMG of claimant's lower extremities done in May 1997 showed evidence of a neuromuscular injury. He diagnosed claimant as having cervical and lumbar disc injuries with radiculopathy, bilateral shoulder injuries, post-concussion syndrome, and peripheral neuropathy. Dr. KR, diagnosed claimant as having major depression in November 1996. Dr. D referred claimant to Dr. B, who wrote in December 1996 that claimant has possible neuropathic pain of the upper and lower extremities due to the electrical shock and possible discogenic pain. Dr. B referred

claimant to Dr. K, who wrote in April 1997 that claimant's back pain is probably related to hypertrophied facets and degenerative mild disc disease.

Dr. H, examined claimant in July 1997 and reported that claimant suffered an extreme change in the electrical potential of her nervous system, that claimant has cervical and lumbar radiculopathy, and that the radiculopathy alone is greater than a zero percent IR. Dr. W reported that nerve conduction velocity studies he performed on claimant's upper and lower extremities on August 29, 1997, were abnormal and that an EMG done the same day had findings suggestive of a bilateral C5 radiculopathy. On November 13, 1997, Dr. J performed cervical and lumbar myelograms and CT scans on claimant and he reported that the lumbar myelogram did not show disc protrusions or herniations, that the cervical myelogram showed a minimal defect which may reflect a minimal disc bulge or protrusion at C3-4, that the lumbar CT scan showed a disc bulge at L4-5 less than 2 millimeters, without evidence of a more focal disc herniation, and that he did not see evidence of a disc protrusion or herniation at C3-4 on the cervical CT scan.

Claimant began treating with Dr. VW, in October 1997 and in a TWCC-69 dated November 28, 1997, Dr. VW reported that claimant had not reached MMI and that she has a 63% IR. The 63% IR assigned by Dr. VW was for impairment of claimant's bilateral upper and lower extremities, cervical spine, thoracic spine, lumbar spine, spinal cord disorder affecting station and gait, and emotional disturbances. He noted that he used the AMA Guides in evaluating claimant's IR. In an amended report dated January 20, 1998, Dr. VW reported that claimant reached MMI on November 28, 1997, with a 63% IR. Dr. VW testified that claimant has improved with his treatments, that he disagrees with Dr. C's MMI date and zero percent IR, that the 63% IR he assigned is a conservative figure, that claimant has nerve damage and disc herniations from her injury, and that claimant does not have meralgia paresthetica.

After Dr. C reported that claimant reached MMI on April 26, 1996, with a zero percent IR, the Commission sent Dr. C various medical records and reports concerning claimant's treatment, diagnoses, and additional testing on numerous occasions and Dr. C replied in September 1996, February and June 1997, and April 1998, that his opinion on claimant's date of MMI and IR remained unchanged.

The hearing officer found that Dr. C's findings are a valid certification that claimant reached MMI on April 26, 1996, with a zero percent IR; that Dr. C examined claimant in accordance with the AMA Guides; and that the great weight of the other medical evidence is not contrary to the findings of Dr. C. The hearing officer concluded that claimant reached MMI on April 26, 1996, with a zero percent IR. Claimant contends that the hearing officer's findings and conclusions are in error and urges adoption of Dr. VW's report.

Section 408.122(c) provides that the report of the designated doctor has presumptive weight, and the Commission shall base its determination of whether the employee has reached MMI on the report unless the great weight of the other medical evidence is to the contrary. Section 408.125(e) provides that if the designated doctor is

chosen by the Commission, the report of the designated doctor shall have presumptive weight, and the Commission shall base the IR on that report unless the great weight of the other medical evidence is to the contrary, and that, if the great weight of the medical evidence contradicts the IR contained in the report of the designated doctor chosen by the Commission, the Commission shall adopt the IR of one of the other doctors. There is much conflicting medical evidence in this case. As the finder of fact, the hearing officer resolves conflicts in the evidence. The hearing officer is the judge of the weight and credibility of the evidence. Section 410.165(a). We conclude that the hearing officer's decision is supported by sufficient evidence and is not contrary to the great weight and preponderance of the evidence.

The hearing officer's decision and order are affirmed.

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Robert W. Potts
Appeals Judge

CONCUR:

_____
Stark O. Sanders, Jr.
Chief Appeals Judge

_____
Alan C. Ernst
Appeals Judge