APPEAL NO. 990187

Following a contested case hearing held on January 6, 1999, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer, resolved the disputed issues by finding that the certification of the designated doctor is not contrary to the great weight of the other medical evidence and by concluding that the appellant (claimant) reached maximum medical improvement (MMI) on June 11, 1997, with a five percent impairment rating (IR). Claimant has appealed the finding and the conclusion, asserting that the designated doctor failed to consider her residual left wrist symptoms as well as the surgical removal of her ganglion cyst after he determined her MMI date and the IR. The respondent (carrier) filed a response, urging the sufficiency of the evidence to support the appealed findings.

DECISION

Affirmed.

The parties stipulated that claimant sustained a compensable injury on _____, and that Dr. GM was the designated doctor selected by the Texas Workers' Compensation Commission (Commission).

Claimant testified that she had been employed by (employer), as a bus driver for about a year when, on _____, she experienced pain and a knot in her left wrist and numbness in her fingers and that, later that day, she sought medical attention at a hospital and was subsequently treated by Dr. R and by Dr. DM. She said she was also seen by Dr. D, that Dr. P examined her for the carrier, that in June 1997 she was examined by Dr. GM, and that in November 1997 she underwent surgery on her left wrist by Dr. O. She also stated that although she still cannot do much with her wrist, the surgery did improve it and she can do better than before. Claimant further stated that at a benefit review conference, she succeeded in getting a letter sent to Dr. GM requesting that he review the medical records made since his exam and reconsider his IR, and that Dr. GM responded that his opinion as to the MMI date and IR remained unchanged.

Dr. DM's January 9, 1997, report states that claimant's chief complaint is pain in the left wrist with tingling and numbness, that upon examination the left wrist appears to be essentially within normal limits, and that the impressions are lateral radiculopathy of C6-7 and C7-8 and a ganglion on the volar aspect of the left wrist.

Dr. P's January 15, 1997, report stated the impression as cyst over the left wrist, probably ganglion; nonphysiologic motor and sensory examinations with no evidence of any significant neurological problems based on exam and MRI studies; no evidence of carpal tunnel based on exam and EMG studies; and degenerative cervical disk disease "unrelated to the present work 'injury.'" Dr. P commented that the only objective finding he can demonstrate at the exam is the cyst and that, in view of the significant subjective symptoms, this may very well be the source of her present pain. Dr. P recommended

further workup for the wrist, noting that claimant may need a surgical procedure to remove the cyst in order to fully recover and return to bus driving. Dr. P's February 28, 1997, report states that claimant was seen by Dr. D, who did not feel that the ganglion would be reasonably causative of her symptoms and that she was not a surgical candidate; that he, Dr. P, found claimant's history of spontaneous hand pain while at work to be "highly unusual"; that he agreed with Dr. D that claimant's symptoms are well out of proportion to her objective findings; and that in his opinion she reached MMI on January 15, 1997, with an IR of "0%." Dr. P signed a Report of Medical Evaluation (TWCC-69) on March 5, 1997, certifying that claimant reached MMI on "1/15/97" with an IR of "0%."

Dr. GM's TWCC-69 dated June 16, 1997, certifies that claimant reached MMI on June 11, 1997, with an IR of five percent. His accompanying June 12, 1997, report states that he examined claimant on June 11, 1997; that on January 29, 1997, claimant underwent an MRI of the left wrist which disclosed a ganglion; that she was found to be at MMI on April 24, 1997, by her treating doctor with an IR of "0%"; and that she complains of constant pain in the left forearm and hand. Dr. GM stated the diagnosis as ganglion cyst of the flexor surface of the left wrist, and subjective pain in the distal left upper extremity. Dr. GM assigned a zero percent rating for neurologic impairment since claimant has a nonanatomic distribution of her sensory changes, a zero percent rating for neurological impairment owing to lack of effort and inconsistency in testing, and a five percent IR for loss of left wrist range of motion (ROM). Dr. GM concluded that claimant has had a prolonged course of left upper extremity discomfort, multiple examinations, multiple diagnostic investigations, and conservative therapy without resolution of her complaints, and that, on physical examination, she demonstrates only a mild loss of ROM, most likely secondary to disuse.

Dr. DM wrote the Commission on August 14, 1997, stating that on June 25, 1997, he opined that claimant had not reached MMI and that no IR could then be assigned. He further stated that, although Dr. GM noted claimant's ganglion cyst, he did not take it into account in assigning the IR; that in his opinion, the ganglion is directly related to the injury; that claimant would benefit from a surgical removal and thus has not reached MMI; and that, if claimant "opts not to have the ganglion removed, it should be addressed in assigning her [IR]."

Dr. O's operative report of November 6, 1997, reflects that on that date he performed an excision of a ganglion cyst in the left wrist. He wrote the carrier on February 16, 1998, stating that he evaluated claimant on January 30, 1998, that she has a pain pattern consistent with a post-injury chronic pain pattern that he felt requires a pain management program to help her regain functional status, and that, if pain management and work hardening are approved, he anticipates there is a reasonable likelihood that claimant could return to work in two months.

Dr. DM reported on May 4, 1998, that claimant had only two sessions of therapy following her surgery on November 6, 1997; that she has not been approved for work hardening or pain management; that she feels that her left wrist and arm are worse than before removal of the ganglion; and that she states she is unable to bend her left hand

fingers, has limited left wrist motion, and has pain radiating up the left arm to the elbow. Dr. DM wrote on June 2, 1998, that there has been no change in claimant's condition with her neck and left arm and that it was suggested that she discuss with her attorney whether he should perform an IR or reapply for work hardening.

On July 21, 1998, a Commission benefit review officer (BRO) wrote Dr. GM, enclosed medical records, and asked that Dr. GM review them and advise whether they caused him to amend his prior certification of MMI and IR.

Dr. GM responded on August 4, 1998, stating that he reviewed not only the records forwarded but also the records from claimant's examination of June 11, 1997, and that, after this review, he saw no reason to amend either the MMI date or the IR.

Dr. DM reported on September 18, 1998, that physical therapy has not been approved; that claimant still has significant left arm and wrist pain; that she "has had a carpal tunnel release and excision of a ganglion"; and that, since she has failed to make any improvement and continues to be symptomatic, it is requested that she be considered for work conditioning as a prelude to work hardening in order to allow her to return to regular work, lessen her pain, and decrease her medications.

In her closing argument, claimant did not contend that Dr. GM's report was contrary to the great weight of the other medical evidence in terms of the reports of other doctors stating differing MMI dates and/or IRs. Rather, claimant urged the hearing officer to determine that Dr. GM's report was not entitled to presumptive weight because his response to the request that he review the medical records created after his evaluation, including the record of the November 1997 left wrist surgery, was a mere "one or two liner" to the effect that his review of the records did not cause him to change his opinion. Claimant contended that Dr. GM should be required to state a rationale as to why the surgery did not result in his changing his opinion on MMI and the IR.

With regard to an injured employee's MMI date and IR, Sections 408.122(c) and 408.125(e) provide that the report of the designated doctor selected by the Commission shall have presumptive weight and that the Commission shall base the MMI date and IR on the designated doctor's report unless the great weight of the other medical evidence is to the contrary. The Appeals Panel has frequently noted the important and unique position occupied by the designated doctor under the1989 Act. *See, e.g.,* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. We have just as frequently stated that a "great weight" determination amounts to more than a mere balancing or preponderance of the medical evidence (Appeal No. 92412) and that a designated doctor's report should not be rejected "absent a substantial basis to do so." Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993. The carrier cited our decision in Texas Workers' Compensation Commission Appeal No. 94421, decided May 25, 1994, where the designated doctor certified that the injured employee had reached MMI with an IR of "0%" for a foot injury, the employee later developed neuromas which were excised, and the designated doctor did not change his

MMI date or IR. The Appeals Panel noted that "MMI does not mean that there will not be a need for some further or future medical treatment, and that the need for additional or future medical treatment does not mean that MMI was not reached at the time it was certified," citing Texas Workers' Compensation Commission Appeal No. 93489, decided July 29, 1993. Our opinion further stated that "subsequent surgery for the compensable injury does not automatically invalidate a prior finding of MMI. [Citations omitted.]"

The hearing officer is the sole judge of the weight and credibility of the evidence (Section 410.165(a)) and, as the trier of fact, resolves the conflicts and inconsistencies in the evidence, including the medical evidence (Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ)). As an appellate reviewing tribunal, the Appeals Panel will not disturb the challenged factual findings of a hearing officer unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust and we do not find them so in this case. 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 hearing officer could conclude from Dr. GM's report and his response to the BRO that the presence of the ganglion cyst did not prevent claimant from reaching MMI on June 11, 1997, and that the fact that the ganglion cyst was excised after that date did not necessarily result in impairment as that term is defined in Section 401.011(23).

The decision and order of the hearing officer are affirmed.

_____
Philip F. O'Neill
Appeals Judge

CONCUR:

_____
Elaine M. Chaney
Appeals Judge

_____
Judy L. Stephens
Appeals Judge