

APPEAL NO. 991366

This appeal arises pursuant to the 1989 Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). On June 1, 1999, a hearing was held. He determined that appellant (claimant) reached maximum medical improvement (MMI) on September 19, 1998, with an impairment rating (IR) of zero percent, as set forth by the designated doctor, Dr. S. Claimant disagreed with several comments made in the Statement of Evidence and Discussion; she also disagreed with the conclusion that her IR is zero percent as found by the designated doctor. Finally, she questions why certain reports and documents were omitted. Respondent (carrier) replied that the decision should be affirmed.

DECISION

We affirm.

Claimant worked for (employer) on _____, when, she testified, she worked in a warehouse; a box containing a stereo, or stereo component, fell; she said she turned to catch it, and "it fell and I grasped it." She added that this occurrence "pushed me over to the table." She kept working but took aspirin and laid down during her lunch period.

The medical records do not provide a lot of detail. However, it should be noted, especially in view of claimant's comment that various reports were omitted, that all of the documents claimant offered into evidence were admitted. (While claimant withdrew two documents, neither was a medical document.) Claimant's treating doctor is Dr. M. At the time claimant was examined by the designated doctor, Dr. S, on September 19, 1998, the only documents from Dr. M in evidence were reports dated July 7, 1998, and May 5, 1998, along with an off-work slip dated March 24, 1998. Dr. M's impression in May 1998 was "acute intervertebral traumatic disc syndrome (rule out herniated disc syndrome and narrowed disc foramina), myofascitis, and radiculities." He spoke primarily of claimant's recent (noncompensable) fall and fractured hip. He did note an increased range of motion (ROM) and decreased spasms in July 1998.

Dr. Sh also saw claimant on July 8, 1998; his assessment was a lumbar strain, chronic with left lower extremity radiculitis. He referred to claimant having broken her hip in May 1998.

Dr. O had seen claimant on behalf of the carrier on June 10, 1998. He noted that there had not been an MRI. He also noted that ROM measurements were invalid, but that claimant earned a four percent IR for lateral deficits. No sensory or strength deficits were shown. No spasm or rigidity was present, so no specific disorder was rated. He said that claimant had four positive Waddell signs, but noted that claimant came for the examination using a walker (the records show she fractured her hip in May 1998).

Dr. S examined claimant on September 19, 1998. She referred to both an EMG and a CT, the latter dated August 11, 1998, which either were read as normal or showed no significant disc bulging. Dr. S noted that claimant was not cooperative, would not wear an examination gown, and said, "palpation examination was not performed due to patient non-compliance." Claimant's lumbar ROM was invalidated regarding flexion and extension and other measurements were normal. She said that the medical records do not warrant a diagnosis-related impairment and there were no neurological deficits. MMI was said to have been reached by September 19, 1998, with a zero percent IR. Thereafter, the Texas Workers' Compensation Commission (Commission) wrote to Dr. S in January 1999, asking whether Dr. S performed the examination or whether it was done by Mr. R, a health care provider. Dr. S was asked to explain her procedure. Dr. S replied later in January 1999, saying that the accusation that Mr. R performed the examination is "false." She added that she "performed a thorough examination on [claimant]"; she said that she "re-certif[ies] every two years as required" for designated doctors. She said that Mr. R is certified to do ROM testing and did so on claimant "in my presence." Dr. S said she made the "observations" during the ROM testing. Dr. S also said that when claimant's ROM testing was invalid, claimant was given an opportunity to repeat it but "she would not allow myself or the technician to touch her." Dr. S repeated her comment from the original report, that claimant would "not allow me to perform palpation examination." Just before commenting that she stood by her original rating of zero percent, Dr. S said that she observed claimant's ROM to "far exceed" her testing measurements.

Dr. M in February 1999, commented that Dr. S was an "out-of-town evaluator." He also questioned why Dr. O performed an examination of claimant who had hip surgery "just one month prior to the time" of the evaluation. He added that claimant was not completely healed from the hip surgery in September when Dr. S evaluated her. He pointed out some questions raised by the EMG (it does state its overall impression as "most likely within the normal range of variation"), and he said there was no mention of the CT scan (Dr. S did mention the CT in both her narrative and her response letter). Dr. M also mentioned that Dr. S spent three to five minutes with the claimant (as testified to by claimant).

All the points set forth about the quality of the evaluation presented factual questions for the hearing officer to address. He is the sole judge of the weight and credibility of the evidence. See Section 410.165. In considering questions of MMI and IR, the designated doctor's opinion is given presumptive weight (see Sections 408.122 and 408.125) and his opinions are used unless the great weight of the medical evidence is to the contrary.

Claimant addressed the Statement of Evidence by pointing out that she saw Dr. O on June 10, 1998, not July 22, 1998. We agree with claimant on this; while Dr. O dated his report July 22, 1998, he indicates that the examination took place on June 10, 1998. Claimant disagreed with the comment that she saw Dr. O about a month after the surgery, saying it was 15 to 20 days later; claimant did not testify to the date of that surgery, did not provide a copy of the operation report, and her own doctor, Dr. M, in his February 1999 letter referred to the surgery as being "one month prior" to the time Dr. O saw her. We do not agree that the hearing officer reported an inaccurate time period based on the records provided him. Claimant takes exception to a comment that the designated doctor

"reviewed" the CT scan and EMG, stating what she thought these reports showed and why she had not had an MRI. Claimant also disagreed with a comment that Dr. O and Dr. S "noted patient non-compliance" by addressing other matters and saying she did not refuse to have an MRI. Claimant also disagreed with a comment that claimant's medical records showed a lumbar strain, by adding that she has an entrapped nerve. Claimant disagreed with the comment that the hearing officer found Dr. S's reply to the Commission "persuasive." Finally, claimant stated that she did not believe that all of the evidence presented was considered, referring to exhibits withdrawn. (As stated, no medical records were withdrawn.)

Claimant's disagreement with the conclusion of law, stating that her IR is zero percent, is based on assertions that the designated doctor did not do the medical examination, that Dr. S gave an invalid report, and that Mr. R is uncertified. She adds that the carrier violated the "privacy act." The Commission does not administer the Privacy Act in regard to how a carrier obtains medical records. The hearing officer, as fact finder, could give more weight to Dr. S's statement (which said that she was present, observed measurements taken, and examined claimant) than he did to the testimony of claimant in regard to the way the examination was conducted. While claimant cited Tex. W.C. Comm'n, 28 Tex. Admin. Code § 126.10(b)(2) (Rule 126.10(b)(2)), that rule applies to designated doctors. Claimant did not allege that Dr. S was not certified or that her certification had run out.

Other medical personnel may perform certain functions under the direction of a doctor. See Rule 130.6(l) which does require a health care provider to have successfully completed Commission-approved training; that rule also provides for the health care provider to have completed testing within seven days of the designated doctor's examination, which indicates that the provider may test a claimant outside the presence of the designated doctor. In this case, the designated doctor's reply to the Commission, which the hearing officer found to be "persuasive," says that the testing was done in her presence and she made the observations. In addition, we note that the designated doctor stated that lumbar ROM was invalidated by the straight leg raise. Under these circumstances, for the designated doctor to have used a health care provider, who was one month past his time to recertify, does not invalidate the designated doctor's report.

Claimant's reference to documents omitted from consideration identifies several documents that were not offered into evidence. Other points mentioned as omitted included that Mr. R pulled her head back, that all comments on the CT scan were not referred to, and that the carrier obtained her medical records without her permission.

The evidence sufficiently supports the determination that the great weight of medical evidence was not contrary to the designated doctor's report. The hearing officer heard claimant's arguments about Dr. S's examination and made a factual determination that is not against the great weight and preponderance of the evidence. In addition, the other points raised by claimant do not warrant a reversal of the determination that the great weight of the medical evidence was not contrary to the designated doctor's report. See Sections 408.122 and 408.125.

Finding that the decision and order are sufficiently supported by the evidence, we affirm. See In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

Joe Sebesta
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Dorian E. Ramirez
Appeals Judge