APPEAL NO. 991426

Following a contested case hearing held on April 19, 1999, with the record closing on May 27, 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 determining that based on the final report of the designated doctor, which she found not to be against the great weight of the other medical evidence, the appellant (claimant) reached maximum medical improvement (MMI) on December 22, 1997, with an impairment rating (IR) of eight percent. Claimant's request for review seems to focus on the IR issue and asserts that for a variety of reasons the designated doctor's report is against the great weight of the evidence. The respondent (carrier) asserts in response that claimant's request for review is untimely and, in the alternative, that the evidence is sufficient to support the challenged determination.

DECISION

Affirmed.

The hearing officer's decision was distributed to the parties by the Texas Workers' Compensation Commission (Commission) on June 15, 1999, and claimant is deemed to have received it on Monday, June 21, 1999. *See* Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE §§ 102.5(h) and 102.7 (Rule 102.5(h) and Rule 102.7). Claimant had 15 days to file a request for review after the date she is deemed to have received the decision and order, that is, until July 5, 1999. Since claimant's request for review was mailed to the Commission's central office on July 2nd and was received on July 7, 1999, it was timely filed.

The parties stipulated that on _____, claimant was the employee of (employer); that on that date the employer had a policy of workers' compensation insurance with the carrier; that on that date claimant sustained a compensable injury; and that the designated doctor selected by the Commission is Dr. P. Dr. P's reports indicate that his specialty board certifications include neurology and psychiatry.

No testimony was taken at the hearing and the parties submitted their respective cases to the hearing officer on their exhibits and closing statements. The Employer's First Report of Injury or Illness (TWCC-1) dated September 5, 1997, reflects that the nature of the injury and the body part injured as "back of neck" and that the injury occurred when "student hit her with a chair (thrown) while teacher was sitting on carpet." According to the history claimant provided Dr. P on July 14, 1998, when he first examined her, claimant was in a kneeling position showing a six-year-old child with Down's syndrome a book when he suddenly picked up a chair and threw it at the back of her head, and that she got up and went outside for some air, went to the school nurse's office, and later that day went to a clinic where she was diagnosed with a neck strain.

Dr. S, a neurologist, signed a Report of Medical Evaluation (TWCC-69) reflecting an examination date of "2-25-98" and certifying that claimant reached MMI on that date with an IR of "0%." In his narrative report of February 25, 1998, Dr. S related the numerous symptoms of which claimant complained and stated that she relates them all to the injury she sustained on _____; that the cervical x-ray taken when she was seen at a clinic on the date of her injury showed a narrowing of the C5-6 interspace with some posterior spur formation; that both an MRI of the brain and EEG were normal; and that he was unable to find any evidence of abnormalities on her clinical examination that would explain her multitude of symptoms. Dr. S further stated that he felt claimant had a Conversion Disorder (psychosomatic reaction) to her trauma; that she should continue to work and put the unfortunate experience behind her; and that "[d]ue to the lack of objective abnormality, it is [his] opinion that she has a zero percent whole person [IR]" and has reached MMI.

In his TWCC-69 dated July 22, 1998, Dr. P certified that claimant reached MMI on "12-22-97" with an IR of 15%. In his very detailed narrative report of July 15, 1998, Dr. P stated that prior to his examination of claimant's nervous system, cervical spine and upper and lower extremities, and mental and behavioral status, he reviewed claimant's extensive medical records and his report contains a summary of numerous medical reports reviewed including that of the first doctor to see claimant on _____, who diagnosed a neck strain, prescribed a medication, recommended the application of ice, and returned claimant to work as of September 8, 1997. His medical records summary further stated that the next day claimant saw Dr. R who diagnosed a closed head injury without loss of consciousness and cervical strain, who later obtained an EEG which was normal, and who followed her periodically and advised her on December 22, 1997, to return to work part time. Dr. P stated that he felt claimant had reached MMI on that date. Dr. P further reported that claimant's impairment from abnormal cervical spine range of motion (ROM) was five percent but that this loss of ROM "is not related to" her injury but to a preexisting cervical spine osteoarthritis. He also stated that after being released for work by Dr. R, a Conversion Disorder developed, as diagnosed by Dr. S, which has been compounded by multi-disciplinary physical treatments and which is unlikely to respond to psychotherapy. Dr. P described Conversion Disorder as essentially the unconscious translation of suggestibility into physical symptoms. Dr. P's diagnosis included Conversion Disorder with pseudo-hemi-hypoesthesia, pseudo-sensory ataxia, pseudo-dysmetria, psychogenic vomiting, perceptions of inability to process information, and "possible occiput or neck contusion at time of injury (now healed)." Dr. P further stated that individuals with claimant's psychological makeup are "inclined to idealize those clinicians whom they trust and value," and that such idealization "makes them prone to suggestibility emanating out of given diagnoses and medical opinions." He further stated that claimant's Conversion Disorder will likely worsen with the ongoing medical treatment she is receiving but that if it is stopped, her prognosis would be a spontaneous remission within 18 months to three years. Dr. P stated that "in accordance with the Mental and Behavioral Disorders section of the Guides [Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides)]," he estimated "a 15% whole person impairment based upon moderate

impairment affecting Adaptation" and that "there is a 0% injury-related medical impairment attributable to the nervous system, the spine, and the upper and lower extremities."

Dr. P signed another TWCC-69 on "10-15-98" certifying that claimant reached MMI on "12-22-97" with an IR of "0%." In his accompanying narrative report, Dr. P stated that he viewed a surveillance videotape taken on July 27, 1998, showing claimant ambulating without any evidence of ataxia, climbing in and out of an automobile, and carrying various objects; that the discrepancy between the pseudo-neurological signs claimant demonstrated during his clinical exam, such as having to hold onto side walls when asked to ambulate, emphatically alters his previous opinion since an essential feature of Conversion Disorder is that the patient's behavior is unconscious; that in his opinion claimant is consciously and deliberately producing pseudo-neurological symptoms for secondary gain; that (Dr. F), apparently a former treating doctor, had noted the discrepancy in claimant's gait when asked to ambulate and when not aware she was being observed; and that in his opinion the diagnosis is malingering. Incidentally, Dr. F's June 9, 1998, follow-up report states the impression as "status post mild traumatic brain injury with various neuromedical complications, resolving." Dr. P further reported that the description of witnesses to claimant's injury that she was struck on the left side of her head and claimant's revealing during his interview that she was struck on the back of her head "impels an opinion that a minor head **but not a neck injury**, was sustained [emphasis in the original]."

The October 23, 1998, report of Dr. H, claimant's current treating doctor, states her impression as post-concussion syndrome secondary to a closed head injury; post-traumatic stress syndrome; TMJ dysfunction secondary to a closed head injury; stretch injury of the right ulnar nerve; right SI joint pathology; and visual pathology. In her November 30, 1998, report, Dr. H states that a conversion reaction "never entered my mind as a diagnosis for this patient," that she has dealt with many patients with mild head injuries and claimant falls into that category, and that claimant "has no secondary gain." Dr. H reported on December 14, 1998, that claimant has pain in her neck going down both shoulder blades and this "would go along with a C7 radiculopathy."

Dr. P signed another TWCC-69 on "12-10-98" certifying that claimant reached MMI on "12-22-97" with an IR of "8%." In his accompanying narrative report, Dr. P stated that at the request of the Commission, he reviewed a July 27, 1998, surveillance videotape of claimant, which was admitted into evidence without objection by claimant, and certain other medical records including reports of Dr. F and Dr. H, and that he reexamined claimant. The July 27, 1998, investigative report in evidence states that claimant was surveilled on July 12, July 18, and July 20, 1998; that the videotape documents claimant's walking, ascending and descending steps, standing, walking a dog, moving in a free and agile manner with no outward signs of disability or use of orthopedic support, and at one point even running a few steps. Dr. P stated that based on the videotape taken of claimant just two weeks after his prior examination, he felt that a diagnosis of malingering had to be added to the diagnosis of Conversion Disorder with pseudo-neurological findings (iatrogenically induced) and possible occipital contusion (healed). He further stated that the AMA Guides required

him to modify the previously assigned 15% IR to account for elements of malingering; that the elements of malingering required him to halve the 15% IR and that he estimated claimant's whole person IR to be eight percent due to iatrogenic-induced Conversion Disorder. He noted that Dr. O had reviewed his earlier report and agreed with it except for taking exception to the assignment of a 15% IR for the Conversion Disorder for the reason that Dr. P had prognosticated that the condition would remit in 18 months to three years following cessation of the ongoing medical treatment. Dr. P stated that, based on his present examination and the fact that claimant is still receiving treatments, he is of the opinion that "the Conversion Disorder does represent permanent impairment." As for the cervical spine, Dr. P stated that he did not reexamine the ROM because the five percent limitation is preexisting.

Dr. H wrote on January 9, 1999, that she was responding to Dr. P's evaluation; that she does not think claimant exhibits the symptoms of Conversion Disorder and that she did not earlier address that diagnosis because she thought it was "ridiculous"; that she has had several other "confrontations" with Dr. P and is "an advocate for my patients"; that Dr. P's statement that claimant's five percent cervical ROM limitation was preexisting is another indication of his bias against claimant since he did not see her until after the injury and thus could not know if the cervical spine condition was preexisting; and that she could go through the videotape and point out subtle indications of claimant's balance problem. She indicated that claimant's mechanism of injury, being struck in the back of the head with a chair, would cause the head to go forward and then backward with the frontal lobes of the brain impacting the skull base and receiving microscopic damage resulting in post-concussive syndrome. Dr. H further reported that Dr. P is a very biased doctor and that she finds it "interesting that he depends so much on [Dr. O's] evaluation about conversion disorder being a permanent impairment." As noted above, Dr. O stated just the opposite in his report.

Responding to the hearing officer's request for clarification concerning cervical spine injury and impairment, Dr. P wrote on May 3, 1999, that it is clinically unrealistic to speculate that a small chair thrown by a six-year-old child and striking claimant on the back of her head aggravated preexisting cervical spine degenerative disease, and that it remains his opinion that the preexisting cervical spine degenerative disease was not aggravated by the _____, injury. As for the assignment of eight percent for the Conversion Disorder, Dr. P indicated that he did so because although he also diagnosed malingering, the over-diagnosis and over-treatment to which claimant was subjected did, in all likelihood, produce some degree of Conversion Disorder.

Section 408.125(e) provides that the report of a Commission-selected designated doctor shall have presumptive weight and that the Commission shall base the IR on that report unless the great weight of the other medical evidence is to the contrary. Claimant appears to assert that she was entitled to a higher IR for her closed head injury and she assails Dr. P's insistence that she did not have impairment from a cervical injury, noting that he is not an orthopedist and referring to his opinions as "junk science." However, to successfully overcome Dr. P's report limiting the IR to eight percent for the Conversion

Disorder, claimant had the burden to establish that the great weight of the other medical evidence established that she should have received a higher rating for that condition and any rating at all for a cervical injury. We note that the only other IR in evidence, aside from those assigned in Dr. P's reports, was the zero percent assigned by Dr. S. 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)). 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 decision and order of the hearing officer are affirmed.

_____
Philip F. O'Neill
Appeals Judge

CONCUR:

_____
Joe Sebesta
Appeals Judge

_____
Tommy W. Lueders
Appeals Judge