APPEAL NO. 991779

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On July 21, 1999, a contested case hearing (CCH) was held. With respect to the only issue before her, the hearing officer determined that appellant's (claimant) impairment rating (IR) was 11% as assessed by the designated doctor, whose July 21, 1998, report was not contrary to the great weight of other medical evidence.

Claimant appeals, contending that the designated doctor "assisted" him in doing the range of motion (ROM) testing, that he disagrees with the designated doctor's invalidation of ROM (no specifics are given), that he is not at maximum medical improvement (MMI) (although stipulated to at the CCH) and that two other doctors have assessed him as having a 25% and 17% IR. Claimant requests that we reverse the hearing officer's decision and render a decision in her favor. Respondent (carrier) responds, urging affirmance.

DECISION

Affirmed.

The parties stipulated that claimant sustained a compensable (low back) injury on _____ (lifting a heavy pipe), that claimant reached MMI on February 18, 1998, by operation of law (*see* Section 401.011(30)(B)) and that Dr. G was the Texas Workers' Compensation Commission (Commission)-selected designated doctor. Dr. EG initially was claimant's treating doctor but, at sometime during the process, he retired and Dr. N became the treating doctor. Claimant had spinal surgery in the form of "a lumbar laminectomy with discoidectomy at L4-L5 and L5-S1 on the left" on March 19, 1997.

It is not apparent how or why Dr. G was appointed as the designated doctor in 1996 (before claimant's spinal surgery) but, nonetheless, in a report dated July 19, 1996, Dr. G opined that claimant was not at MMI. Subsequently, in a report dated November 18, 1996, Dr. T, a carrier-required medical examination doctor, certified MMI on that date and assessed a seven percent IR based on a history of a herniated disc. This report was also prior to spinal surgery of March 19, 1997.

Dr. EG, claimant's then-treating doctor, in a report dated February 4, 1998, certified MMI and assessed a 25% IR based on an 11% impairment from Table 49, Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), Section II F, and 16% impairment for loss of ROM and, using the combined values table, arrived at the 25% IR. No rating was given for neurological or sensory deficit. Dr. G saw claimant again and, in a Report of Medical Evaluation (TWCC-69) dated March 25, 1998, and narrative dated March 31, 1998, certified MMI with an 11% IR based on 11% impairment from Table 49, Section II F with no impairment based on "nerve damage" or ROM. The Commission apparently asked Dr. G to review a report by Dr. EG regarding ROM. Dr. G replied by letter dated May

28, 1998, stating that he agreed with Dr. EG that he had not repeated ROM studies. Dr. G asked that claimant return for a reevaluation. Dr. G saw claimant again and, in a TWCC-69 and narrative dated July 22, 1998, again assessed an 11% IR based on Table 49, Section II F (which included an extra one percent for an additional level of involvement) of the AMA Guides and again assigned no impairment for ROM or neurological involvement. Dr. G remarked:

> The results of the [ROM] evaluation and the neurological evaluation is such that the patient was not assigned any impairment due to abnormality of [ROM] or due to any nerve damage or impairment. This is because there was no validity to the flexion and extension [ROM] and no consistency to the lateral flexion [ROM] of the lumbar spine. This is shown on the worksheet which I have enclosed.

In the meantime, Dr. EG had retired and Dr. N, a chiropractor, became the treating doctor. Dr. N referred claimant to Dr. H for evaluation. Dr. H, in a TWCC-69 and narrative dated July 31, 1998 (incorrectly identified as July 13, 1998, in the hearing officer's decision), certified MMI and assessed a 17% IR based on 11% impairment from Table 49, Section II E, six percent impairment for loss of ROM and two percent impairment for "sensory deficits in both the L4 and L5," using the combined values table to arrive at the 17% IR. Dr. N basically agreed with Dr. H's rating in a letter dated September 9, 1998, and, in another letter dated September 24, 1998, to the Commission, suggested that Dr. G should have used Table 50 (Impairment Due to Ankylosis) and Tables 56 and 57. The Commission benefit review officer, in a letter dated October 2, 1998, sent Dr. N's letter to Dr. G and asked Dr. G why he had not rated for neurological/sensory loss when claimant's treating doctor had done so. Dr. G replied by letter dated October 9, 1998, stating that use of the ankylosis tables was inappropriate because the diagnostic testing does "not show any evidence of any anatomical ankylosis," which Dr. G defined as "anatomical fusion in the bones," and claimant's "[ROM] abnormality is not due to ankylosis." Dr. G states that he would "welcome any imaging study which demonstrated the presence of ankylosis." Dr. G goes on in some specific and lengthy detail to describe why he reached the conclusion that claimant did not have any neurological/sensory loss.

The hearing officer summarizes the medical evidence in some detail and concludes that claimant has an 11% IR as assessed by Dr. G, the designated doctor, and that opinion was not contrary to the great weight of other medical evidence. Claimant appeals, arguing that Dr. G invalidated the ROM measurements by "assisting" him and "telling me to do better every time." Claimant "disagrees with everything [Dr. G] did to [him] to make those tests invalidated." Dr. G did ROM testing on claimant on two occasions, submitting figures showing the ROM was invalid. We do not know what Dr. G may have said to claimant and claimant's assertions could be interpreted as Dr. G merely asking claimant to give optimal effort. Section 408.125(e) provides that the report of the 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. The Appeals Panel has said with respect to "presumptive weight" that it is not just equally balancing evidence or a preponderance of the evidence that can outweigh the designated

doctor's report but only the "great weight" of other medical evidence, that the designated doctor occupies a unique position under the Texas workers' compensation system, and that no other doctor's report, including the report of a treating doctor, is accorded this special, presumptive status. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. From our review of the evidence, we do not find a sufficient basis to conclude that the great weight of the medical evidence was contrary to Dr. G's July 21, 1998, report, which was entitled to presumptive weight, including the determination on ROM and neurological/sensory loss.

Regarding the portion of claimant's appeal which alleges that he is not at MMI, we note that claimant, together with the ombudsman, on no less than two occasions, stipulated that he had reached MMI by operation of law on February 18, 1998. We reject claimant's appeal on this ground as being without merit.

Upon review of the record submitted, we find no reversible error and we will not disturb the hearing officer's determinations unless they are 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). We do not so find and, consequently, the decision and order of the hearing officer are affirmed.

Thomas A. Knapp
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Dorian E. Ramirez
Appeals Judge