APPEAL NO. 000225

On January 25, 2000, a contested case hearing (CCH) was held. The CCH was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). The hearing officer resolved the disputed issue by deciding that appellant's (claimant) impairment rating (IR) is nine percent as reported by the designated doctor chosen by the Texas Workers' Compensation Commission (Commission). Claimant requests that the hearing officer's decision be reversed and that a decision be rendered that he has a 23% IR. Respondent (carrier) requests that the hearing officer's decision be affirmed.

DECISION

Affirmed.

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.

It is undisputed that claimant sustained work-related injuries to his neck, back, and right shoulder on _____, while working for employer. In a Report of Medical Evaluation (TWCC-69) dated August 7, 1997, Dr. M, D.C., claimant's treating doctor, certified that claimant reached maximum medical improvement (MMI) on August 7, 1997, with a 23% IR. Dr. M assigned claimant impairment of four percent for a specific disorder of the cervical spine, five percent for a specific disorder of the lumbar spine, ten percent for loss of cervical range of motion (ROM), four percent for loss of lumbar ROM, and one percent for loss of right shoulder ROM. Claimant has undergone conservative treatment for his injuries, including injections, therapy, and medications.

The Commission chose Dr. C, D.C., as the designated doctor. Claimant said that he took his medical reports to Dr. C on the date of the examination, December 1, 1997; that carrier had not sent the medical reports to Dr. C; that Dr. C was rude to him; that Dr. C did not examine him right; and that Dr. C spent 20 minutes reviewing the medical reports and 15 minutes examining him. In a TWCC-69 dated January 5, 1998, Dr. C certified that claimant reached MMI on December 1, 1997, with a nine percent IR. Dr. C states in his narrative report that he was to examine claimant to determine if MMI was reached, and if so, to determine claimant's IR. The parties stipulated that neither party disputed Dr. C's certification that claimant reached MMI on December 1, 1997. The only issue before the hearing officer was claimant's IR. Dr. C noted that Dr. D, who apparently was a carrier-selected independent medical examination doctor, examined claimant on March 25, 1997, and was of the opinion that MMI had been reached and that claimant has a zero percent

IR, and that Dr. M had certified that claimant reached MMI on August 7, 1997, and assigned claimant a 23% IR. Dr. C's narrative report reflects that he reviewed claimant's medical records, that claimant had previously had MRIs of the lumbar spine and right shoulder done, that he obtained a history from claimant, and that he performed a physical examination of claimant, including ROM testing. Dr. C assigned claimant impairment of four percent for a specific disorder of the cervical spine and five percent for a specific disorder of the lumbar spine. Dr. C noted that claimant has no neurological deficits and that claimant exhibited symptom magnification throughout the examination. Dr. C wrote that right shoulder ROM was normal. With regard to cervical and lumbar ROM, Dr. C wrote that, although recorded measurements warranted an assigned impairment, in Dr. C's opinion the ROM limitations were solely due to voluntary restriction and thus he assigned claimant no impairment for loss of cervical or lumbar ROM. Dr. C wrote that claimant exhibited considerably more motion outside the testing situation than he did during the actual test.

Claimant said that Dr. C sent him a copy of Dr. C's report and that he, claimant, sent Dr. M a copy of that report. Claimant indicated that prior to his examination by Dr. C, he had told Dr. M that he did not want to have surgery, but that sometime after Dr. C's examination he had had an MRI done and that an orthopedic doctor told him he has a damaged disc and needs surgery.

In January 1999, Dr. M wrote a rebuttal letter to Dr. C's report, opining that Dr. C's opinions that claimant exhibited symptom magnification and that claimant had voluntary restriction of cervical and lumbar ROM were purely subjective opinions. In September 1999, Dr. C responded to Dr. M's letter, stating that the comments he made in his report about claimant's behavior were not only justified but were actually understated, that claimant exaggerated every aspect of the evaluation, and that there was no question that his opinions regarding symptom magnification and voluntary restriction were accurate. Dr. C wrote that he had no intention of amending the nine percent IR he assigned to claimant and that in his opinion that IR was more than fair.

The hearing officer found that Dr. C's determination that claimant has a nine percent IR is not against the great weight of the other medical evidence and he concluded that claimant has a nine percent IR from the July 25, 1996, injury. The 1989 Act makes the hearing officer the sole 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 that it is not so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

With regard to claimant's assertion that Dr. C failed to send a copy of his TWCC-69 to Dr. M, Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6 (Rule 130.6) regarding the designated doctor general provisions, provides in subsection (n) that the designated doctor shall complete and file the medical evaluation report in accordance with Rule 130.1, and Rule 130.1 regarding reports of medical evaluation provides in subsection (h) that a report required under that rule shall be filed with the Commission, employee, and insurance

carrier no later than seven days after examination. Neither Rule 130.6 nor Rule 130.1 requires the designated doctor to file the report of medical evaluation with the treating doctor. We note that Rule 130.6(h) provides in part that the treating doctor and the carrier are both responsible for sending to the designated doctor all the employee's medical records relating to the medical condition to be evaluated by the designated doctor that are in their possession without a signed release from the employee, that the medical records must be received by the designated doctor at least three days prior to the date of the appointment, and that if the designated doctor has not received the medical records at least three days prior to the examination, the designated doctor's office shall notify the Commission and the Commission staff will send an order to the treating doctor and/or insurance carrier for the delivery of the medical records. In the instant case, claimant testified that he took his medical records to Dr. C and Dr. C's report reflects that he did review claimant's medical records.

The hearing officer's decision and order are affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Judy L. Stephens
Appeals Judge