APPEAL NO. 000249

On January 19, 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 (claimant) has a 10% impairment rating (IR) 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 she be sent to another designated doctor. Respondent (carrier) requests that the hearing officer's decision be affirmed.

DECISION

Affirmed.

Claimant testified that she injured her neck, left shoulder, and low back at work on _____, when a bathroom door fell on her and knocked her against a wall. Medical reports reflect that claimant was recommended to have cervical surgery but that she decided not to have that surgery. She has been treated conservatively for her neck, back, and left shoulder injuries. Dr. H, who examined claimant at carrier's request on August 10, 1998, certified in a Report of Medical Evaluation (TWCC-69) that claimant reached maximum medical improvement (MMI) on August 10, 1998, with an 18% IR. Dr. H assigned claimant impairment of six percent for a specific disorder of the cervical spine, 10% for loss of cervical range of motion (ROM), and three percent for loss of left shoulder ROM. In a TWCC-69 dated December 2, 1998, Dr. L, claimant's treating doctor, certified that claimant reached MMI on November 16, 1998, with a 23% IR. The parties stipulated that claimant reached MMI on November 16, 1998. Dr. L assigned claimant impairment of six percent for a specific disorder of the cervical spine and 18% for loss of cervical ROM.

The Commission appointed Dr. T as the designated doctor for the purpose of determining MMI and IR. In a TWCC-69 dated January 19, 1999, Dr. T certified that claimant reached MMI on November 16, 1998, with a 10% IR. Dr. T's report reflects that he examined claimant on January 13, 1999; took a history of the injury from claimant; and reviewed claimant's medical reports. Dr. T assigned claimant impairment of six percent for a specific disorder of the cervical spine and four percent for loss of left shoulder ROM. Dr. T reported that cervical ROM findings did not meet validity criteria and that there was no evidence of neurological impairment of the cervical spine. Dr. T also reported that no impairment of the lumbar spine was indicated and that evaluation of the lumbar spine showed inconsistency in presentation.

Dr. M reported that a lumbar MRI claimant underwent on July 12, 1999, showed a minimal bulge to the left of L4-5 creating no spinal stenosis or foraminal compromise, a mild to moderate disc bulge to the left at L5-S1 creating no significant spinal stenosis or foraminal compromise, and minimal degenerative disc disease at L5-S1. Dr. L reported that an electromyographic and nerve conduction study claimant underwent on August 6,

1999, showed a moderate degree of lumbar radiculopathies involving the S1 nerve roots bilaterally with some chronic denervation changes noted. Dr. L wrote that claimant has chronic lumbar radiculopathy involving the S1 nerve roots bilaterally and chronic cervical radiculopathy involving the left C7 nerve root, that claimant wants to continue with conservative care, and that claimant has a work-related low back injury secondary to a moderate degree of chronic lumbar radiculopathies involving the S1 nerve roots bilaterally.

The Commission wrote to Dr. T in November 1999, asking him to comment on additional documentation from Dr. L and the lumbar MRI and asking him to advise the Commission if he needs to revisit his assessment of impairment of claimant's lumbar spine. In a letter to the Commission dated November 18, 1999, Dr. L wrote that he had reviewed the records that had been provided to him, that he found no basis to adjust or amend his previous determination of MMI and IR and that "[s]pecifically, there were no specific injury-related abnormalities noted on the MRI scan. In addition, as noted in my narrative of 1/19/99, there was no basis to support [ROM] calculations."

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. Section 401.011(23) defines "impairment" as "any anatomic or functional abnormality or loss existing after [MMI] that results from a compensable injury and is reasonably presumed to be permanent." Section 401.011(24) defines "[IR]" as "the percentage of permanent impairment of the whole body resulting from a compensable injury."

The hearing officer found that "[Dr. T] properly used the Guides [Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association] in assessing Claimant's [IR]", that "[Dr. T] properly rated all of Claimant's injury," and that "[t]he presumptive weight afforded the opinions of the Commission selected Designated Doctor are not overcome by the great weight of other medical evidence." The hearing officer concluded that claimant's IR is 10%.

Claimant contends that Dr. T should have included impairment for her lumbar spine and that a second designated doctor should be appointment who will rate her entire compensable injury. While it appears undisputed that claimant sustained a work-related injury to her lumbar region on _____, that does not necessarily mean that the injury resulted in permanent impairment. Neither Dr. L nor Dr. H assigned claimant any impairment for her lumbar spine. Under these circumstances, we cannot conclude that the hearing officer erred in determining that the IR assigned by Dr. T was not overcome by the great weight of other medical evidence. Dr. T promptly responded to the Commission's request for comments regarding impairment of the lumbar spine, noting that there were no specific injury related abnormalities noted on the MRI scan and that there was no basis to

support ROM calculations. The hearing officer found no basis for the appointment of a second designated doctor and neither do we. The 1989 Act makes the hearing officer the sole judge of the weight and credibility of the evidence. Section 410.165(a). As the trier of fact, the hearing officer resolves conflicts in the medical evidence. When reviewing a hearing officer's decision to determine the factual sufficiency of the evidence, we should set aside the decision only if it is so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Texas Workers' Compensation Commission Appeal No. 950084, decided February 28, 1995. We conclude that the hearing officer's findings, conclusion, and decision are supported by sufficient evidence and are 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).

The hearing officer's decision and order are affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Thomas A. Knapp
Appeals Judge