APPEAL NO. 000759

This appeal arises pursuant to the Texas Workers= Compensation Act, TEX. LAB. CODE ANN. ' 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on March 17, 2000. With regard to the issues before him, the hearing officer determined that appellant (claimant) reached maximum medical improvement (MMI) on June 16, 1998, with a zero percent impairment rating (IR), as assessed by the designated doctor whose report was not against the great weight of other medical evidence to the contrary. In addition, the hearing officer made findings that the designated doctor was not biased or prejudiced and that additional requests for "further clarification from the designated doctor . . . are denied."

Claimant appealed and takes issue with some of the hearing officer=s wording, requests that the designated doctor be sent further questions interpreting certain Appeals Panel decisions, asserts that the designated doctor was biased, takes issue with the designated doctor=s report on virtually a line-by-line basis, and asserts that she did not reach MMI until October 15, 1999, when she returned to work for a different employer. Claimant requests that we reverse the hearing officer=s decision and render a decision in her favor. Respondent (carrier) responds to claimant=s appeal regarding the alleged bias of the designated doctor and the disputed issues and urges affirmance.

DECISION

Affirmed.

Claimant had been employed by (employer) and assigned to a client company "to code check copies" and other tasks. Claimant testified that at about 10:00 a.m. on _____, she was under a desk plugging in a computer and as she came out, she hit her "head on something and it went in an awkward position, and that=s how it happened." Claimant said that she "felt an immediate sharp pain, cramping-type sensation . . . ." It is undisputed that claimant finished her normal shift that day, came to work the next day, _____, and went to a hospital emergency room (ER) that afternoon because of shortness of breath, apparently brought on by stress. The ER record notes complaints of "hard to breathe, left shoulder pain" but makes no mention of claimant hitting her head and/or neck pain. Claimant testified that the pain in her neck continued to get progressively worse. Claimant testified that she saw her family doctor who treated her with medication and physical therapy until March 1999 when she changed treating doctors to Dr. Cl. No medical reports from claimant=s family doctor or Dr. Cl are in evidence. Claimant argues that she had "similar problems" with her neck in 1992. In evidence is an MRI of the cervical spine performed in October 1992 and another cervical MRI of April 16, 1998.

Dr. L, carrier=s independent medical examination doctor, in a Report of Medical Evaluation (TWCC-69) and narrative both dated April 30, 1998, certified MMI on that date with

a zero percent IR. Dr. L noted the head bump incident, claimant=s visit to the ER for breathing difficulty, and noted:

> Though there are reported disc herniations noted on the MRI of the cervical spine, the symptoms of the examinee are on the contralateral extremity from the reported findings of the MRI involving the left upper extremity, therefore, no [IR] is noted. Furthermore, there is no evidence to support that there is a minimum of six months of medically documented pain, recurrent muscle spasm or rigidity associated.

Range of motion (ROM) was invalidated and no neurological deficits were noted. Claimant was found to be able to return to full duty with no restrictions. Claimant apparently disputed Dr. L=s certification of MMI and IR. Claimant testified that the Texas Workers= Compensation Commission (Commission) sent her a list of designated doctors and that she "chose [Dr. Ch] because he was closest to my house." The Commission subsequently appointed Dr. Ch as its designated doctor. Dr. Ch, on a TWCC-69 dated June 17, 1998, certified MMI on June 16, 1998, with a zero percent IR. Dr. Ch recites the computer-plugging incident and notes diagnostic testing; claimant=s complaints; a March 19, 1998, report from Dr. H which is not in evidence; other medical reports; Dr. L=s IR; and the 1998 MRI. Dr. Ch also notes symptom magnification, diagnoses a cervical sprain/strain, mentions a 1977 back injury and assesses a zero percent IR. No rating was given from Table 49 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides); ROM was "invalid"; exaggeration was noted; and Dr. Ch concluded that the "anatomical abnormalities of the spine are assessed to be pre-existing and therefore 0 for table 49." Claimant called Dr. Ch directly, made some inquiries and apparently sent Dr. Ch some additional handwritten medical notes on July 14, 1998. Dr. Ch, in a letter dated July 27, 1998, replied that "[w]hether the disc degeneration pre-existed or not is irrelevant as it does not affect the rating in this case" and gave the AMA Guides definition of MMI noting that MMI "never means that the treatment will never be needed in the future." Dr. Ch confirmed his zero percent IR. Subsequently, the Commission wrote Dr. Ch, by letter dated September 1, 1998, asking whether the information claimant had submitted changed Dr. Ch=s opinion. Dr. Ch replied by letter dated September 3, 1998, stating he had "re-reviewed" his original report and previous letter and that:

> The condition at the time of my examination had been static for several months. In my mind there was no doubt of the "exaggeration of symptoms" as noted in my original report. [Dr. H=s] letter attached to your correspondence states "although [claimant] is somewhat histronic [sic]."
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> As stated in my original report, later correspondence, MMI in this case only means that there is no further progress in her condition with or without treatment. Her own statements were that with or without medication and treatment her condition did not change. When the condition is static, as outlined in my last letter, MMI is reached. This however does not mean that further treatment may not be needed. Given the nature of this disease, variation in symptoms from

day to day is common, and recurrences and acute exacerbations are also common.

Dr. H, in a report dated August 6, 1998 (which may have been the report submitted to Dr. Ch in September 1998), diagnoses degenerative disc disease and herniated nucleus pulposus at C4-5, C5-6 and C7-T1. In this report, he does state that claimant is "somewhat histronic [sic] in nature" but that in his opinion MMI has not been reached. Dr. H estimates that when MMI is reached, the "MMI [sic] rating would be expected to be in the range of 18% . . . ." Also in evidence is a report dated December 28, 1999, from Dr. M, who comments that he found no symptom magnification; that both Dr. Ch and Dr. L "have missed some key issues" in that there "was no way to know how much, if any, of the degenerative disc disease is attributable to this injury"; that on ROM, claimant has good days and bad days; and that all of claimant=s complaints should be rated.

Claimant, at the CCH and on appeal, contends that Dr. Ch was biased and racially prejudiced against her and that the hearing officer erred in refusing to submit further questions to Dr. Ch seeking "clarification." Claimant testified about the incident which caused her to believe Dr. Ch was biased and prejudiced, testifying:

> A. Well, I went in and introduced myself to [Dr. Ch] and went to shake his hand, and he says, oh, yes. Well, he did shake my hand but kind of reluctantly. But I didn=t think anything of that at the time. I just assumed that he wanted to maintain his impartial role as a designated doctor and not, you know, get too friendly.
>
> So, he says, I need you to read this form and sign this form. And I said, oh, I forgot my glasses. I left them in the car. He says, oh, you can=t read. I said, I never told you that. I said that B I said, I left my glasses in the car. I=ll just have to go get them. That=s all. Well, from that point on I was furious from that remark. I did not appreciate the remark at all.

The hearing officer specifically found that Dr. Ch "is not biased or prejudiced." We agree. Neither the complained-of incident nor anything else in the record indicates bias or prejudice by Dr. Ch. At worst, the incident was a misunderstanding.

Claimant wanted the hearing officer to submit 11 pages of single-spaced questions to Dr. Ch for "clarification." As an example, one such question was:

> 4) WHAT WAS [DR. CH] LOOKING FOR WHEN HE REVIEWED THE EMG?
>
> A. WHAT DID HE FIND IN REVIEWING THE EMG, AND WHAT DOES HIS FINDINGS MEAN AS FAR AS THE AMA GUIDES USED IN THIS CASE?

B. DOES WHAT [DR. CH] FOUND ON THE EMG CLINICALLY CORRELATE WITH THE AMA GUIDES USED IN THIS CASE, IF SO HOW DOES HIS FINDINGS CLINICALLY CORRELATE WITH THE GUIDES, AND WHY DO THEY CLINICALLY CORRELATE WITH THE GUIDES?

C. IF [DR. CH=S] FINDINGS ON THE EMG DO NOT CLINICALLY CORRELATE WITH THE GUIDES PLEASE EXPLAIN THE CLINICALLY BASIS FOR HIS FINDINGS?

D. WHAT DOES RIGHT C7 RADICULOPATHY MEAN CLINICALLY?

E. WHAT DOES MOTOR ABNORMALITIES OF SUBACUTE NATURE MEAN CLINICALLY?

F. IF AN EMG SHOWS A RIGHT C7 RADICULOPATHY, AND LEFT **BILATERAL FORAMINAL STENOSIS** WORSE ON THE LEFT, CAN A RIGHT C7 RADICULOPATHY, AND LEFT FORAMINAL STENOSIS BE CLINICALLY LINKED, IF S O HOW, AND WHY?

G. HOW DOES AN ABNORMAL EMG FINDING CLINICALLY CORRELATE WITH [DR. CH=S] DIAGNOSES?

The hearing officer refused to send these questions to Dr. Ch. We review the hearing officer=s action regarding the refusal to submit those questions to Dr. Ch on an abuse of discretion standard. We find no error in the hearing officer=s refusal to send the questions to Dr. Ch and the hearing officer did not abuse his discretion in refusing to do so.

On the merits of the case, Section 401.011(30)(A) and (B) defines MMI as the earlier of "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated," or "the expiration of 104 weeks from the date on which income benefits begin to accrue." Further, Sections 408.122(c) and 408.125(e) provide that the report of the designated doctor selected by the Commission shall have presumptive weight and that the Commission shall base the MMI date and IR on the designated doctor=s report unless the great weight of the other medical evidence is to the contrary. The Appeals Panel has also noted the important and unique position occupied by the designated doctor under the 1989 Act. *See, e.g.,* Texas Workers= Compensation Commission Appeal No. 92412, decided September 28, 1992. We have just as frequently stated that a "great weight" determination amounts to more than a mere balancing or preponderance of the medical evidence (Appeal No. 92412) and that a designated doctor=s report should not be rejected "absent a substantial basis to do so."

Texas Workers= Compensation Commission Appeal No. 93039, decided March 1, 1993. In this case, both Dr. Ch, the designated doctor, and Dr. L have certified MMI with a zero percent IR. Medical evidence to the contrary is Dr. H=s August 6, 1998, report where he states claimant is not at MMI and speculates that the IR may be "in the range of 18%" and the December 1999 report from Dr. M who disagrees with Drs. Ch and L, but gives no IR. Under the circumstances of this case where Dr. Ch found no ratable impairment and explained why he did not find the herniations ratable, and generally invalidated ROM based on symptom magnification, which was accepted by the hearing officer, we hold that the hearing officer=s decision is supported by the evidence.

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:

Philip F. O=Neill
Appeals Judge

Dorian E. Ramirez
Appeals Judge