APPEAL NO. 000795

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 February 3, 2000. The hearing officer determined that the appellant (claimant) reached maximum medical improvement on July 20, 1997, with a five percent impairment rating (IR), as certified by Dr. W, the Texas Workers= Compensation Commission (Commission)-selected designated doctor. The hearing officer found that this report was not overcome by the great weight of the contrary medical evidence. The claimant appealed and argues various facts that he believes refute the hearing officer's findings. The respondent (carrier) responded, that the decision was correct and should be confirmed.

DECISION

Affirmed.

The claimant, in his early 50s at the time of the CCH, said he was injured when he fell in his garage while preparing for a business trip on _____. The compensability of the accident was not in issue in this hearing and was stipulated. He worked subsequent to the injury after about two months off; medical records refer to the fact that he had an emotional outburst on a business trip to Las Vegas. Both claimant and his wife testified as to considerable change of personality after the accident.

No MRIs or CT scan results were presented which showed any injury to the brain. However, a deposition from Dr. S, who reviewed claimant's records for the carrier, noted that a CT scan administered at the hospital emergency room (ER) where claimant was taken the day of his injury was normal. There was no evidence on Emergency Medical Services records that day of any bruising, swelling, or trauma to the claimant's head. These records indicated that claimant responded to questions by blinking.

Our summary of the evidence will be extremely brief. Dr. F was claimant's treating doctor. He said that claimant had improved considerably, but that he still considered him greatly emotionally impaired. He had given claimant an 80% IR. He said he "tried" to follow the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association in coming up with this IR.

Against this was the five percent IR of the designated doctor, Dr. W, who claimant's wife said confessed that he had not done an IR for the Commission before and didn't know what was expected of him in considering a stack of medical records. However, she agreed he had "everything" by way of claimant's medical records. Also against this was the evaluation of the carrier's doctor, Dr. C, who saw claimant on August 14, 1997, and concluded he had a zero percent IR and was malingering. He based this on high scores on objective psychological testing that was consistent with trying to simulate psychiatric disturbance, noted that he did not seem to have objective memory dysfunction to match his subjectively reported

lapses, and noted that ER records did not show any significant injury to the head. Dr. C stated that claimant's ability to blink responses to answers was indicative not of a comatose state but cognitive ability to process information. Dr. C's answers to written questions are unequivocal in his belief that claimant is faking his symptoms for secondary gain.

On September 29, 1995, Dr. Ck, conducted an evaluation and found that claimant was performing in the average range of intellectual functioning. She noted no average attention span, below average memory retrieval, and a "cry for help" level of distress on personality evaluation. However, Dr. Ck noted that claimant's pattern of neuropsychological performance was not that usually seen following a concussion or his reported amnesia characteristic of mild head injury. She said that her observations raised the question of a possible lesion.

Dr. Ck also found below average visual memory, in contrast to the report of Dr. T, who examined claimant earlier in that same month and noted that visual memory was a "relative strength," even if lower than what one might expect in a person at claimant's educational level. Dr. T found impaired mental control as reflected by forward adding of numbers by threes. He also found that claimant had significant difficulties when asked to retain information from verbal narrative read aloud to him. He recommended that claimant return to part-time work where interpersonal relationships would not be of primary importance.

According to the 1989 Act, the report of a designated doctor can be overcome, not by a preponderance, but only a "great weight" of the contrary medical evidence. Section 408.122(c). An IR assessed by the claimant's doctor must be confirmable by objective clinical or laboratory findings from a carrier's doctor or a designated doctor. Section 408.122(a). As we review the record, it does not appear that the hearing officer's determination that Dr. W's report was entitled to presumptive weight is in error, or that her assessment that the great weight of other medical evidence is not contrary to this report has no support. The lack of medical evidence showing a physical injury to the brain, coupled with the report of Dr. C stating how objective testing failed to support impairment linked to the asserted injury and in fact indicated malingering, support the hearing officer. She could consider that both Dr. F and Dr. C were arguably "aligned" with their respective clients in evaluating those reports.

While the claimant complains on appeal of the conduct and demeanor of the hearing officer, and says that a request for a break was denied, we cannot agree with these observations as presented. The claimant presents himself articulately on the tape of the CCH and does not sound as agitated as he states in his appeal, at least on the record, nor did the hearing officer state that she would rule against the claimant. While the hearing officer cautioned the ombudsman that claimant's wife's testimony would be considered lay testimony on the matter of IR, we cannot agree that she did so in an irritated manner. The claimant appeared to be present throughout his wife's testimony because he can be heard audibly sighing and there were no breaks evidently taken on the tape except for turning the tape over. At this point, the hearing officer noted on the record only that claimant had briefly left the room.

Both parties agreed that no additional evidence was taken during this time. No objection was made on the record to the conduct of the hearing officer.

In considering all the evidence in the record, we cannot agree that the findings of the hearing officer are so against the great weight and preponderance of the evidence as to be manifestly wrong and unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

We affirm the decision and order of the hearing officer.

Susan M. Kelley
Appeals Judge

CONCUR:

Gary L. Kilgore
Appeals Judge

Judy L. Stephens
Appeals Judge