APPEAL NO. 000852

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on March 24, 2000. The hearing officer determined that the appellant's (claimant) impairment rating (IR) is two percent as assigned by Dr. T, the designated doctor. The claimant appeals, contending that his IR should be the 20% assigned by his treating doctor, Dr. O, because his lumbar spine injury worsened and he underwent lumbar spine surgery after the designated doctor's evaluation. The respondent (carrier) urges in response the sufficiency of the evidence to support the challenged findings and conclusions.

DECISION

Affirmed.

The parties stipulated that on _____ claimant sustained a compensable injury to his neck and low back and that he reached maximum medical improvement (MMI) on May 23, 1997. The parties submitted their respective cases to the hearing officer on exhibits and argument.

The hearing officer's recitation of the evidence states that Dr. O certified on May 23, 1997, that claimant had reached MMI with an IR of 11% and that Dr. O's Report of Medical Evaluation (TWCC-69) and narrative report are not in evidence. Dr. O's MMI and IR determinations are mentioned in the November 10, 1997, narrative report of Dr. T and claimant does not take issue with this assertion in his request for review.

Dr. T's TWCC-69 dated "11/10/97" certifies that claimant reached MMI on May 23, 1997, with an IR of "2%." Dr. T's narrative report of the same date states that claimant was injured on _____, when he opened a wing valve to release pressure from the lubricator on a well site and the lubricator exploded, causing him to be thrown away and fall on his back; that he was evaluated by Dr. T on November 10, 1997; and that his IR was determined in accordance with the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). Dr. T further reports that a January 14, 1997, lumbar spine MRI indicated normal findings; that Dr. O had assigned the 11% IR for cervical and lumbar range of motion (ROM) loss; that claimant is assigned a "0%" for his lumbar spine based on tests results; that his flexion and extension measurements were invalid based on the straight leg raise test; that based on test results for the cervical spine, "he is assigned a 2% whole person impairment for [ROM] loss"; that claimant's bilateral grip strength tests results were considered normal; that neuromuscular examination revealed no motor or sensory deficits of the lumbar or cervical spine that would be ratable; and that based upon the review of the medical records and the physical examination, claimant showed no specific disorders of the lumbar or cervical spine that would be ratable. Dr. T concluded that claimant is assigned a whole person IR based on the AMA Guides. Dr. T's summary

of records review does not indicate that claimant had a minimum of six months of documented pain, recurrent muscle spasm or rigidity.

Claimant introduced Dr. O's letter of April 8, 1998, to the Texas Workers' Compensation Commission (Commission) recommending that claimant be reevaluated by Dr. T and stating his understanding of the AMA Guides to the effect that claimant "may be at 7% whole person impairment level due to lumbar spine disc injury or protrusion with symptoms over six months plus any additional percentage due to the surgery and [ROM] restrictions."

Dr. T wrote a Commission employee on December 23, 1998, responding to her letter of December 4, 1998, forwarding Dr. O's letter of August 23, 1998, which expressed his feeling that claimant is entitled to a rating under Table 49, of the AMA Guides, for his lumbar spine. Dr. T stated that during his examination on November 10, 1997, he did not find any objective sensory or motor loss in the lumbar spine or lower extremities and did not feel that a Table 49 rating was appropriate for claimant because a January 14, 1997, lumbar spine MRI indicated normal findings.

A January 20, 1999, MRI report states the impression as a moderate to fairly large posterior disc herniation at L5-S1. The January 28, 1999, operative report of Dr. Humberto Tijerina (Dr. HT) reflects that on that date claimant underwent a bilateral decompressive lumbar laminectomy at L5-S1, right discectomy, foraminotomy, and fat graft.

The May 25, 1999, letter of a Commission benefit review officer (BRO) to Dr. T, which, incidentally, describes him as the Commission-appointed designated doctor, states that Dr. T responded on December 23, 1998, to a letter from another Commission employee stating that he "did not feel that Table 49 was appropriate in this examinee's case due to the fact that an MRI of the lumbar spine done on January 14, 1997 indicates normal findings." The BRO's letter further states that it appears that Dr. T did not have a copy of the November 7, 1997, MRI at the time of his evaluation and encloses a copy, asking whether it changes his opinion on the IR. The "11-7-97" radiology report enclosed with the BRO's letter states that when compared with the January 13, 1997, MRI, "there is now a subtle change at the level of L5-S1 which demonstrates a posterior bulging disc with slight lateralization to the right from the midline and caused flattening and slight anterior indentation of the thecal sac, more so toward the right."

Dr. T responded on June 21, 1999, stating that he found it interesting that the MRI report of January 14, 1997, indicated normal findings and the November 7, 1997, report indicates a subtle change at L5-S1. Dr. T concluded that in his medical opinion, he does "not feel that this subtle change a year after the compensable injury warrants awarding Table 49" and that his "whole person [IR] will not change."

A letter dated July 23, 1999, from Dr. B, apparently a psychiatrist, which was also signed by Dr. O, states that after an MRI showed evidence of the herniated disc, claimant had corrective surgery; that he subsequently developed anxiety and depression; that he

has asked them to help him obtain a retroactive correction of his IR; and that in their opinion, claimant has not been properly evaluated for these latter developments and conditions.

The November 11, 1999, TWCC-69 of Dr. O certifies that claimant reached MMI on that date with an IR of 20%. In his narrative report, Dr. O states that claimant has six percent rating due to ROM restrictions and a 10% rating due to a surgically treated disc lesion which combine to a 16% whole person IR and that claimant has been assessed by Dr. B with a five percent IR due to a mental disorder which combines for a total whole person IR of 20%. Attached to Dr. O's narrative report is the November 2, 1999, narrative report of Dr. B which states the diagnosis of a pain disorder and depression and which assesses a five percent IR based on Chapter 14, Table 1 of the AMA Guides.

The hearing officer found that Dr. T determined that no rating from Table 49 of the AMA Guides was supported or warranted as he was unable to confirm objective clinical or laboratory findings upon which to base an IR; that Dr. T also determined that there were no neurological deficits, sensory or motor loss, or loss of hand strength that warranted an impairment; that Dr. T determined that claimant invalidated his lumbar ROM and that the valid lumbar and cervical ROM was sufficient to not support an impairment percentage; that Dr. T was justified in not amending his original determinations in rendering his original IR; and that the great weight of the other medical evidence is not contrary to Dr. T's determinations.

Claimant contends that he was not properly evaluated by the designated doctor and that his treating doctor, Dr. O, is more familiar with his condition. Claimant urges that the Commission adopt the 20% IR assigned by Dr. O. With respect to the determination of an injured employee's IR, Section 408.125(e) provides that the report of the designated doctor selected by the Commission 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. The Appeals Panel has frequently noted the important and unique position occupied by the designated doctor under the 1989 Act. *See, e.g.,* Texas Workers' Compensation Commission Appeal No. 92555, decided December 2, 1992; 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 evidence (Appeal No. 92412, *supra*) 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. Also, as the hearing officer notes, while a designated doctor may amend his report within a reasonable period of time and for a proper reason, he or she is not required to do so.

The hearing officer is the sole judge of the weight and credibility of the evidence (Section 410.165(a)) and resolves the conflicts and inconsistencies in the evidence (Garza v. Commercial Insurance Company of Newark, New Jersey, 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ)). The Appeals Panel will not disturb the challenged findings of a hearing officer unless they are so against the great weight and preponderance of the

evidence as to be clearly wrong or manifestly unjust and we do not find them so in this case. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Elaine M. Chaney
Appeals Judge

Susan M. Kelley
Appeals Judge