

APPEAL NO. 000907

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 April 3, 2000. The hearing officer determined that the date of maximum medical improvement (MMI) is December 7, 1998, and that the appellant (claimant) did not have disability as a result of the compensable injury of _____, from December 7, 1998, to April 14, 1999. The claimant appealed and argued that the designated doctor did not independently confirm the certification of MMI and impairment rating (IR) that was certified by the treating doctor for a noncompensable injury. She argued that testimony supported an inability to work due to the injury. The respondent (self-insured) recited evidence from the record that supports the decision.

DECISION

We affirm the hearing officer's decision.

At the outset of the CCH, the claimant stated that she was not seeking to have disability after February 1, 1999. The claimant was a teaching assistant at a facility operated by the (employer and self-insured). She said that on _____, she hit her right leg against a protruding screw in a chair, on the shin close to her knee. She was wearing pants and there was no abrasion or puncture. She sustained an injury to her right saphenous nerve (although a peer review doctor for the self-insured disputed the nerve injury). The claimant said that her first treating doctor was Dr. D and she was then referred to Dr. H. Before Dr. D, she was treated by Dr. P, although he was not a treating doctor. She disagreed that Dr. P told her on August 25, 1998, that she had totally recovered from her leg injury; his notes on his Specific and Subsequent Medical Report (TWCC-64) of that day state that he believed her problem had essentially resolved. Dr. D released the claimant to work on October 14, 1998, with restrictions against prolonged standing or walking. Dr. D wrote in his notes on June 23, 1999, that the claimant had received a one percent IR and that although the claimant wished him to disagree, he did not. The claimant denied she asked Dr. D to disagree. Dr. H administered pain injections to the claimant. At some point, the self-insured denied continued payment for this.

The claimant had an earlier injury to her right foot and ankle in 1996; her treating doctor was Dr. R and he was to treat only her foot. She said that she was diagnosed with stress fractures of the foot and plantar faciitis. She went to see Dr. R on August 31, 1998, for pain in her ankle and mentioned her leg to him as well. The claimant said she was not aware at a December 1998 examination that he was also looking at her leg in response to a request from the self-insured to do so. This was referred to at the CCH as an "informal" required medical examination. Dr. R certified that the claimant reached MMI on December 7, 1998, with a zero percent IR for the 1998 leg injury. His notes on his TWCC-64 on that date note that the claimant was depressed. He noted also that she had chronic reflex sympathetic dystrophy due to her 1996 injury.

The claimant disputed this MMI and IR and Dr. T was appointed as designated doctor. He examined her on May 5, 1999, and agreed that she had reached MMI on December 7, 1998. He assessed a one percent IR for functional loss due to the nerve injury. Dr. H gave her the same IR, with an MMI date of April 15, 1999.

The claimant testified that she was unable to work due to her leg until February 1, 1999, after which time she returned to work. She said that Dr. R took her off work on October 26, 1998, because of her ankle, foot, and leg. She disagreed that he took her off work only for her 1996 injury. In fact, the claimant maintained that her foot problem did not prevent her from working.

"Impairment" is defined in the 1989 Act 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(23). Further, impairment must be based upon the "objective clinical or laboratory finding." Section 408.122(a). "Maximum medical improvement" is defined, as pertinent to this case, as "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. . . ." Section 401.011(30)(A). We have stated many times that the presence of pain is not, in and of itself, an indication that an employee has not reached MMI; a person who is assessed to have lasting impairment may indeed continue to experience pain as a result of an injury. See Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1993.

The report of a Texas Workers' Compensation Commission-designated doctor is given presumptive weight. Sections 408.122(c) and 408.125(e). The amount of evidence needed to overcome the presumption, a "great weight," is more than a preponderance, which would be only greater than 50%. See Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992. We have reviewed the record and cannot agree that the medical evidence against the date of MMI, essentially Dr. H's opinion, amounts to a "great weight" against Dr. T's assessment. We also cannot agree that he did not base his report on clinical observation.

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 cannot agree that this is the case here and affirm the decision and order.

Susan M. Kelley
Appeals Judge

CONCUR:

Gary L. Kilgore
Appeals Judge

Dorian E. Ramirez
Appeals Judge