APPEAL NO. 002121

Following a contested case hearing (CCH) held in (city 1), Texas, on August 16, 2000, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer, resolved the disputed issues by determining that the appellant's (claimant) impairment rating (IR) is 14% as determined by the designated doctor and that there was no good cause for removal of the designated doctor and appointment of a second designated doctor. The claimant appeals the determinations of the hearing officer, arguing that they are against the great weight and preponderance of the evidence and requesting that we reverse the decision of the hearing officer. Additionally, the claimant asserts that the hearing officer erred in failing to appoint a second designated doctor because of the designated doctor's refusal to comply with a deposition on written question, a witness subpoena, and because of "blatant actions of impropriety" by the designated doctor. There is no response in the file from the respondent (self-insured).

DECISION

Affirmed.

The claimant was employed by the self-insured as a special education teacher at a school in (city 2), Texas. On _____, while helping another teacher with his class, the claimant was attacked by an emotionally disturbed student and sustained multiple injuries. The claimant reached statutory maximum medical improvement (MMI) on December 20, 1998.

In a report dated May 6, 1997, Dr. WS certified that the claimant had reached MMI on May 6, 1997, with a 2% IR. Dr. WS's certification of MMI and IR was disputed and Dr. B was selected by the Texas Workers' Compensation Commission (Commission) as the designated doctor. Dr. B examined the claimant on August 7, 1997, and, on August 11, 1997, reported that the claimant had not reached MMI. In the narrative report accompanying his report of August 11, 1997, Dr. B noted that the claimant had been diagnosed with post concussive syndrome, cervical herniated nucleus pulposus, multiple contusions, anxiety, depression, panic attacks, and allergic rhinitis. At the time of the examination, the claimant's primary complaints were of a constant headache that was mainly in the posterior aspect and extending forward to her eyes, numbness in the left hand, dull aching pain in her neck, deep aching low back pain, and some cognitive issues with early mental fatigue.

Dr. B examined the claimant again on June 30, 1998. He again determined that she had not reached MMI. In his narrative report of that visit, Dr. B noted that the claimant had complained of headaches, stiffness of the neck, numbness and tingling down both arms, weakness in the left hand, and a constant, throbbing low back pain that extended to her upper back. The report also stated:

> [S]he also complains of emotional stress and anxiety that has been caused by lack of medical treatment and having her treatment denied. She has had unnecessary appeal [sic] for medical requests that have been denied, creating frustration. Because of this, she states it has created a financial burden, more time is lost, and at no time has her helplessness and fear from the event that has happened been addressed through psychological testing and counseling. She feels that not enough time has been devoted to working through her emotional trauma from the assault. She states that it is hard to concentrate, comprehend or process and remember things that were said to her even five minutes earlier. She complains again of the numbness in her fingers and is worried about being able to do her job again at the level required. She states that she has both physical and mental fatigue and she states she is depressed.

Dr. B also noted that the claimant had been evaluated by Dr. O, a clinical psychologist, who felt that the claimant had symptoms of a major depressive disorder rather than an adjustment disorder, which was consistent with post-traumatic stress disorder (PTSD). Dr. B stated that he believed that the claimant was suffering from PTSD with major depressive disorder and recommended neuropsychology and pain psychology.

Dr. Bl, the claimant's treating doctor, referred her to Dr. FG, a pain management specialist, who examined the claimant on March 23, 1999. Dr. FG obtained a history, evaluated the claimant, and then expressed his opinion that she could have a closed-head injury, but he was concerned that many of her cognitive deficits were the result of polypharmacy. Dr. FG noted that the claimant would need inpatient care with detoxification.

Dr. FG referred the claimant to Dr. RS for a neuropsychological evaluation. On April 2, 1999, Dr. RS evaluated the claimant and concluded that:

> [The claimant] does appear to have some genuine neuropsychological dysfunction; however, as mentioned, the depression is contributory to this and the fact that she is taking a number of psychiatric medications, most prominently 8 mg of Xanax daily in addition to two to three alcohol drinks a day, could certainly be the cause of some, if not all, of her cognitive problems.

Dr. RS then stated that the claimant did not appear to be a suitable candidate for a pain management program without some form of detoxification.

On April 19, 1999, the claimant was admitted to (the hospital) in city 1. Dr. FG was the admitting and attending physician. At the time of the claimant's admission into the hospital, Dr. FG diagnosed a mild closed-head injury and chronic pain syndrome. According to the claimant's testimony, Dr. B is associated with the hospital and maintains an office there. She testified that during her hospitalization she saw him several times

while she was exercising and once in her room. According to the discharge summary of May 14, 1999, by Dr. FG, Dr. B was neither consulted about nor participated in the claimant's treatment at the hospital. In his discharge summary, Dr. FG stated:

> From a physical medicine standpoint, she is all independent in all activities, no longer requiring a wheelchair for mobility, and is ambulating independently with good gait pattern. Other disciplines involved included psychology and psychotherapy. She completed a course of biofeedback. Her breathing and anxiety levels have significantly decreased.

On March 12, 1999, the claimant had been examined by Dr. B, but Dr. B declined to rate the claimant's impairment at that time, preferring to obtain a comprehensive neuropsychologic evaluation and testing before doing so. Before completing his IR report, Dr. B obtained Dr. RS's report and medical records regarding the claimant's hospitalization. Dr. B then rated the claimant's cervical and lumbar spine, awarding 4% for specific disorders of the cervical spine and 5% for specific disorders of the lumbar spine. He then rated emotional distress and disturbance for brain impairment. In doing so, Dr. B used Table 1 on page 101 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). In his report regarding that section of the IR, Dr. B stated:

> Utilizing Table 1 on page 101, it is noted that the maximum percent impairment for the brain that can be given has to be the maximum % impairment in any one category of language disturbance, complex integrated cerebral function disturbance, emotional disturbance, consciousness disturbance, episodic neurologic disorders, and sleep and arousal disturbances. As the patient does not have language disturbance, no impairment can be given in this rating. As the patient can carry out all activities of daily living, I do not feel an impairment is warranted for a brain impairment in this area. As the patient may have some emotional disturbances under stress, although these are significantly improved with chronic pain treatment, I feel the maximum percent impairment we can give in this category is a 5% impairment. I do not feel the patient has any consciousness disturbances, hence, no impairment can be given in this area. I do not feel the patient has episodic neurologic disorders; hence, no impairment can be given in this area. I am unsure whether the patient has any sleep or arousal disorders and it does not appear that this would interfere with activities of daily living; hence, no impairment will be given in this level. Hence, I feel the patient can be given a 5% impairment of the whole person for emotional disturbances that are only present under unusual stress. Hence, the patient will be given a 5% impairment for brain impairment.

At the hearing and on appeal the claimant argues that Dr. B failed to properly rate her brain injury. She points to various ratings from Dr. Bl, the first a 50% IR for the brain injury and then a later 70% IR in January 1999. While there is a marked disparity in the ratings given by Dr. Bl and Dr. B, the primary difference in the two consist of the ratings allowed for emotional disturbances. Dr. B's rating was given after the claimant had undergone treatment by Dr. FG, including an inpatient brain injury course. The differences between the two amount to no more than a difference in medical opinion. The claimant also offered evidence of another psychological evaluation by Dr. SG, a clinical psychologist. Dr. SG became involved in the claimant's care after the claimant had attempted to return to work for the self-insured, but found it very stressful, and the claimant's hospitalization after an attempted suicide over the Christmas holidays. It is the claimant's position that the great weight of the other medical evidence, notably Dr. Bl's assessments and the information and assessment by Dr. SG, are contrary to Dr. B's report.

The hearing officer is the trier of fact and is the sole judge of the relevance and materiality of the evidence and of the weight and credibility to be given to the evidence. Section 410.165(a). The trier of fact may believe all, part, or none of the evidence presented. Taylor v. Lewis, 553 S.W.2d 153 (Tex. Civ. App.-Amarillo 1977, writ ref'd n.r.e.); Texas Workers' Compensation Commission Appeal No. 93426, decided July 5, 1993. This is equally true regarding medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). The hearing officer looks at all of the relevant evidence to make factual determinations and the Appeals Panel must consider all of the relevant evidence to determine whether the factual determinations of the hearing officer are so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. Texas Workers' Compensation Commission Appeal No. 941291, decided November 8, 1994. An appeals level body is not a fact finder, and it does not normally pass upon the credibility of witnesses or substitute its own judgement for that of the trier of fact even if the evidence could support a different result. National Union Fire Insurance Company of Pittsburgh, Pennsylvania v. Soto, 819 S.W.2d 619, 620 (Tex. App.-El Paso 1991, writ denied).

The hearing officer found that the great weight of the other medical evidence was not contrary to Dr. B's determination of the claimant's impairment and that his report is entitled to presumptive weight. Only were we to conclude, which we do not in this case, that the hearing officer's determinations were so against the great weight and preponderance of the evidence as to be manifestly unjust would there be a sound basis to disturb those determinations. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Company, 715 S.W.2d 629, 635 (Tex. 1986). Since we find the evidence sufficient to support the determinations of the hearing officer, we will not substitute our judgement for his. Texas Workers' Compensation Commission Appeal No. 94044, decided February 17, 1994.

The claimant also contends that Dr. B's association with the hospital, and his maintaining an office in the hospital, somehow taint his performance of his duties as a designated doctor. We do not agree. The claimant's argument that the designated

doctor's "blatant actions of impropriety" mandate his disqualification is without substance or merit. The hearing officer did not err in refusing to appoint another designated doctor.

One other matter requires comment. The claimant noted at the CCH that the designated doctor did not respond to her deposition on written questions nor did the designated doctor appear to testify, although a subpoena had been issued. The claimant, nonetheless, affirmatively decided to proceed with the CCH and not request a continuance. She did not allege, either at the hearing or on appeal, that she had attempted to secure the designated doctor's responses to the deposition on written questions by requesting a motion to compel from a district court. The hearing officer correctly noted that a deposition on written questions by a party does not constitute a request for clarification by the Commission. We find no error in the hearing officer's finding that the designated doctor did not fail or refuse to cooperate with requests from the Commission for clarification.

There being no reversible error shown and there being sufficient evidence to support the determinations of the hearing officer, the hearing officer's Decision and Order are affirmed.

Kenneth A. Huchton
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Judy L. Stephens
Appeals Judge