APPEAL NO. 002802

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 October 26, 2000. The hearing officer rejected the report of the Texas Workers' Compensation Commission (Commission)-selected designated doctor and determined that the appellant (claimant) reached maximum medical improvement (MMI) on May 10, 2000, with an impairment rating (IR) of 5%. The hearing officer also determined that claimant had disability from March 2, 2000, through March 8, 2000. Claimant appealed, contending that the hearing officer erred in rejecting the designated doctor's report. Claimant also asserts that she had disability continuing after March 9, 2000, to June 26, 2000. Respondent self-insured ("carrier" herein) responded that the Appeals Panel should affirm the hearing officer's decision and order.

DECISION

We affirm in part and reverse and render in part.

Claimant contends the hearing officer erred in determining that she did not have disability continuing after March 8, 2000. Claimant asserts that her treating doctor had her in an off-work status until the MMI date found by the designated doctor, June 26, 2000.

Claimant testified that she sustained a compensable injury in _____ when her chair began to lose its wheels and she fell back, staying seated, and struck her shoulder on the floor. She indicated that she injured her hips, her back and her knees. Claimant agreed that before her compensable injury, she had already attempted to obtain a doctor's statement regarding her "disability" and that she had represented to the Social Security Commission that she was unable to work. Claimant said she is unable to work even a sedentary job, that she became a lot worse after her compensable injury, and that she believes all of her problems are related to the compensable injury.

Absence authorizations from Dr. C and Dr. S, claimant's treating doctors, dated in October 1999, April 2000, and June 2000 state that claimant is off work. In a March 17, 2000, report, Dr. C stated that claimant's work category was "sedentary" with regard to lifting tests, but that she was unable to complete testing regarding prolonged sitting, standing and walking. Dr. C recommended an aggressive rehabilitation program.

The applicable law and our standard of review are discussed in Texas Workers' Compensation Commission Appeal No. 002668, decided December 21, 2000. As the fact finder, it was for the hearing officer to consider all the evidence relevant to the duration of claimant's disability and assign whatever weight he felt appropriate to the March 2000 functional capacity evaluation, records and reports of Dr. C, and Dr. S. There was evidence that claimant's work ability before the compensable injury was at a sedentary level only. The hearing officer reviewed the evidence and determined what facts were established. The hearing officer indicated that he did not find the evidence regarding

disability to be credible. We will not substitute our judgment for the hearing officer's because his disability determination is not so against the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986).

Claimant contends the hearing officer erred in rejecting the report of Dr. G, the designated doctor. The hearing officer stated that he rejected the designated doctor's report because: (1) the great weight of the other medical evidence is contrary to the designated doctor's report; (2) the designated doctor did not follow the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), in that he rated conditions not included in the compensable injury; (3) the designated doctor relied on an inaccurate history; and (4) the range of motion (ROM) testing performed by the designated doctor was "questionable" and was not "conducted properly."

Section 401.011(23) defines "impairment" as an abnormality or loss "existing after [MMI] that results from a compensable injury and is reasonably presumed to be permanent." *See* Texas Workers' Compensation Commission Appeal No. 94149, decided March 16, 1994. An "[IR]" is the "percentage of permanent impairment of the whole body resulting from a compensable injury." Section 401.011(24). The existence and degree of an impairment must be determined using the AMA Guides. Section 408.124. Sections 408.122(c) and 408.125(e) further provide that the report of a designated doctor selected by the Commission has presumptive weight and the determination of MMI and IR shall be based on that report unless the great weight of the other medical evidence is to the contrary. Only medical evidence can rebut the presumptive weight afforded the report of the designated doctor. Whether the great weight of the other medical evidence is contrary to the report of the designated doctor is a question of fact for the hearing officer to decide. Texas Workers' Compensation Commission Appeal No. 93459, decided July 15, 1993.

The great weight of the medical evidence is more than a preponderance of the evidence. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. A hearing officer should not reject the report of a designated doctor absent a substantial reason to do so. Texas Workers' Compensation Commission Appeal No. 93483, decided July 26, 1993. A hearing officer who finds that the great weight of the other medical evidence is contrary to the report of the designated doctor must identify the specific evidence on which this conclusion is based and clearly state why this evidence is contrary to the report of the designated doctor. *See* Texas Workers' Compensation Commission Appeal No. 961429, decided September 6, 1996; Texas Workers' Compensation Commission Appeal No. 941457, decided December 13, 1994.

Claimant agreed that she was already taking all of the same medications, such as Ultram and Naprosyn, before her compensable injury, but that she had been taking them for her fibromyalgia. Claimant said her doctors thought her fibromyalgia may have started after a car accident she had "five years ago." Claimant did not disagree with the September 1998 record of Dr. CO that stated that claimant complained of persistent lower

back and bilateral knee discomfort. Claimant testified that when she told doctors that she had been "symptom free" before her compensable injury and that she had had no prior back problems, she meant that she had experienced no significant problems, she was free of "the usual everyday pain," and that her pain was "normal pain."

In his July 2000 report, the designated doctor stated that claimant "indicated that she had not experienced prior symptoms similar to her current complaints, with the exception of a bilateral knee complaint, and was symptom free at the time of the" _____ compensable injury. The designated doctor stated that he was unable to tell whether claimant's spondylolisthesis was preexisting and said that he found nothing in her medical records to clarify this. In September 1999, Dr. GO stated that claimant returned for follow up and that her spondylolisthesis is a preexisting condition. In an April 12, 1999, report, written about three months before the compensable injury, Dr. CO stated that claimant's fibromyalgia condition is stable, that her condition has improved, but that she continues to complain of chronic pain. He stated that claimant had excellent ROM in all joints. Dr. CO also reported that claimant had excellent ROM in all joints in December 1999, approximately six months after the compensable injury. In a December 1999 report, Ms. S, a physical therapist, noted that claimant's ROM was diminished and that her trunk flexion was 25% of normal, and her extension was 0%. However, in a March 2000 report, Dr. C indicated that claimant's ROM needed improvement and in an August 2000 record from Dr. S's office, it states that claimant's "back extension" was "fair."

In a May 2000 report addressed to carrier, Dr. E stated that: (1) claimant claimed that she had no previous history of back problems, but that her medical records showed preexisting spondylolisthesis and lumbar problems since 1994; (2) claimant has undergone extensive physical therapy for the compensable injury, but has not had surgery; (3) claimant said she stopped working in August 1999 because she could no longer walk, but now walks with the aid of a cane; (4) claimant exhibited dramatic symptom magnification and complained of severe pain when Dr. E applied his hands to her skin; (5) claimant's lumbar ROM tests were invalid[1]; and (6) claimant said her treating doctors told her she is totally disabled. Dr. E's 5% IR, which was adopted by the hearing officer, consisted of 5% impairment under Table 49.

The designated doctor's 20% IR included 13% impairment for loss of lumbar ROM and the designated doctor's worksheets indicate that his test results were valid. There is no indication in the record that the designated doctor did not conduct ROM testing properly, as stated by the hearing officer.

Regarding whether the designated doctor failed to follow the AMA Guides by rating conditions not included in the compensable injury, the hearing officer is clearly referring to the spondylolisthesis rated by the designated doctor under Table 49. However, the designated doctor stated that he did not know if this condition was preexisting. He

[1]Right and left lateral flexion was normal or very close to normal.

indicated that he did not have all of claimant's medical records. The designated doctor said he would be happy to make adjustments to the IR if he were presented with the "facts." It does not appear that the designated doctor failed or refused to follow the AMA Guides in this regard.

Regarding whether the designated doctor relied on an inaccurate history, it does appear that claimant was not the most accurate historian regarding her condition. Claimant's diagnosis for her compensable lumbar injury involved a back strain or sprain. The fact is that she has a preexisting spondylolisthesis that could contribute to her loss of ROM. The designated doctor is to rate a claimant as the designated doctor finds them and is not to "back out" impairment from prior injuries. It appears that the hearing officer believed that the loss of ROM was not caused by the compensable injury, so he sought to reject the designated doctor's report for that reason. However, it was the role of the designated doctor to rate claimant's compensable injury and to decide what impairment resulted from that injury. It was error in this case for the hearing officer to reject the designated doctor's report, as the great weight of the other medical evidence was not contrary to the designated doctor's report. The designated doctor's ROM measurements should not be rejected just because claimant has a preexisting condition that could contribute to her loss of ROM. Further, a designated doctor's report should not be rejected because the designated doctor rated a condition that he was not sure was included in the compensable injury. Instead, the better practice is to inform the designated doctor of the extent of the injury, if necessary, so that he or she can rate only the compensable injury. Additionally, a hearing officer may decline to include in the IR impairment for a body part that is not part of the compensable injury.

Regarding ROM and whether the great weight of the other medical evidence is contrary to the designated doctor's report, the other medical evidence regarding claimant's ROM test results are not all contrary to the designated doctor's report. It appears that various doctors reported varying degrees of lumbar ROM loss. Some found that claimant had excellent ROM. The fact that doctors did not all agree on the ROM test results does not mean that the great weight of the other medical evidence is contrary to the designated doctor's report. The designated doctor observed claimant's ability to walk and move, and he did not invalidate ROM testing based on the straight leg raise test or clinical observation. We conclude that the hearing officer erred in determining that the great weight of the other medical evidence is contrary to the designated doctor's report regarding ROM measurements.[2]

In this case, it appears that the hearing officer may have relied on reports from Dr. E and concluded that a 20% IR is very high for a back strain. This was not a proper reason to reject the designated doctor's report in this case and we conclude that there was error in that regard. The designated doctor's IR included 8% impairment under Table 49, but

[2]A great number of designated doctor's reports would necessarily be rejected if the Appeals Panel failed to acknowledge that doctors' ROM test results often vary a great deal.

that impairment cannot be included in the designated doctor's report because the hearing officer determined that the compensable injury does not include spondylolisthesis. The remaining impairment from the designated doctor's IR is for loss of lumbar ROM. We render a determination that claimant's IR is 13%, which is for loss of lumbar ROM.

Claimant contended that the hearing officer erred in determining that the spondylolisthesis is not included in the compensable injury. However, this involved a fact issue for the hearing officer. Claimant complained that preexisting spondylolisthesis cannot be "factored out" of any IR, citing Texas Workers' Compensation Commission Appeal No. 981773, decided September 17, 1998. However, in that case, the hearing officer considered aggravation and extent of injury and "split the difference" and added 4% of the 8% impairment found by the designated doctor for spondylolisthesis, stating that he did so because of claimant's preexisting condition. That case is not applicable here. The hearing officer did not err in considering whether the compensable injury included spondylolisthesis.

Claimant contends the hearing officer erred in determining that the IR of Dr. E is a valid certification of MMI and IR. However, we are rendering that the hearing officer should not have rejected the designated doctor's report in this case. In any case, our review of Dr. E's report does not indicate that it is invalid.

We affirm that part of the hearing officer's decision and order that determines that claimant did not have disability continuing after March 8, 2000. We reverse the hearing officer's determinations regarding MMI and IR and render a decision that claimant reached MMI on June 26, 2000, with a 13% IR.

Judy L. Stephens
Appeals Judge

CONCUR:

Elaine M. Chaney
Appeals Judge

Susan M. Kelley
Appeals Judge