APPEAL NO. 031892
FILED SEPTEMBER 5, 2003

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 June 18, 2003. The hearing officer rejected the report of the Texas Workers' Compensation Commission (Commission)-selected designated doctor and then determined that respondent (claimant herein) reached maximum medical improvement (MMI) on May 20, 1999, with an impairment rating (IR) of 24% as certified by the treating doctor. Appellant self-insured (carrier herein) appealed these determinations, contending that: (1) there was a mere difference of medical opinion regarding claimant's condition and whether claimant improved after elbow surgeries; (2) the hearing officer did not explain how the IR changed after surgery; and (3) the designated doctor rated all of the injury. The file does not contain a response from claimant.

DECISION

We affirm.

Carrier contends that the hearing officer erred in rejecting the report of the designated doctor and in determining that claimant's IR is 24%. Carrier asserts that there is a mere difference of medical opinion regarding claimant's condition; that the disagreement between the treating doctors and designated doctor regarding whether claimant improved after surgery is not a basis to reject the designated doctor's report; and that the designated doctor considered all of the "compensable body parts" in rating the injury.

Claimant testified that he was injured on _____, when he hit his head and fell injuring his back, neck, and elbows. There was evidence that claimant began missing time from work immediately. In his first report, dated _____, the designated doctor said claimant complained of headaches, back pain, elbow pain, and left leg pain; that claimant was in no acute distress; that claimant had a normal gait, no atrophy, and above-normal muscle strength; that ROM studies were inconsistent; that claimant's diagnosis is cervical strain, LS lumbar strain, contusion to his elbows, and a closed head injury with mild concussion. The designated doctor noted that claimant jogs and lifts weights. The designated doctor said that "due to no other testing" after his work hardening program ended on January 20, 1998, he did not feel that claimant demonstrated any "new problems." The designated doctor certified an MMI date of February 3, 1998, with an IR of 9% for specific disorders of the lumbar spine pursuant to Table 49 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). Claimant testified and denied that he lifted weights after his injury. He said he told the designated doctor that he used to lift weights.

A June 1998 letter from (Company A) indicates that a request for repeat EMG and CT scan was denied by carrier.[1] In a March 30, 1999, peer review report, Dr. L said that claimant complains of pain without justification; that there are no objective findings or diagnostic tests indicating any type of significant injury to "any part" of claimant's body; that there is symptom magnification and functional overlay; that loss of range of motion (ROM) in claimant's neck appears to be caused by a lack of cooperation; and that claimant's IR should be 2% for loss of lumbar ROM.

One of claimant's treating doctors, Dr. W,[2] noted that the other treating doctor, Dr. M, performed a December 21, 1998, EMG and nerve conduction (NCV) study and found compression of the bilateral ulnar nerves. In April 1999, Dr. W noted that claimant had bilateral ulnar nerve entrapment. Both Dr. W and Dr. M noted that claimant complained of upper extremity pain. In a July 28, 1999, report, Dr. W stated that claimant reached MMI statutorily; that claimant has left and right elbow neuritis; that a positive electromyography and NCV study done on December 21, 1998, is consistent with bilateral compression of the ulnar nerve; that claimant is a candidate for ulnar release though precertification has been rejected; that claimant's arms go to sleep and get numb; and that claimant has an extension lag in both elbows.

On July 20, 2000, a benefit review officer (BRO) of the Commission wrote to the designated doctor and asked for a copy of his calculations and a list of records reviewed. The letter also asked the designated doctor to review the July 28, 1999, report of Dr. W "and all subsequent medical attached to this letter," and determine if the IR and MMI date stay the same. In closing argument, carrier represented that the designated doctor had all of the relevant medical and operative reports. On August 21, 2000, the designated doctor responded that:

> I monitored [claimant's] activities in the exam room and discussed his activities of daily living and what he is accomplishing at home. I felt that these findings were not consistent due to the effort made by [claimant]. *[Claimant] did not relate any problems to his upper extremities.* When examined, he had adequate strength in his upper extremities . . . .

The designated doctor said he reviewed all of the medical records sent to him, including Dr. L's report; records from Texas Orthopedic and Trauma Associates (Dr. W's office); records from Dr. V; and records from Dr. D. The designated doctor said the 9% IR and MMI date of February 3, 1998, are "valid."

In a November 29, 2001, report, Dr. M said that a cervical MRI done "two years ago" showed osteophytes and spurs and that a lumbar MRI showed an annular bulge at L5/S1, 2mm." Dr. M said claimant needed a lumbar CT myelogram because claimant was experiencing severe pain and sciatica. By February 2002, Dr. M said claimant had had "multiple workups," that a cervical MRI showed a torn annulus at C2-3, and that a lumbar MRI showed an annuar bulge at L5/S1 with facet arthropathy. The medical

[1] The relation of Company A to carrier was not explained.
[2] Dr. M became the treating doctor after Dr. W retired.

records also show that claimant eventually underwent three elbow ulnar release surgeries in September 2001, November 2001, and March 2002. The medical evidence indicates that two surgeries were to the right elbow and one to the left although there was conflicting evidence in this regard.

In a December 18, 2002, letter, a BRO wrote to the designated doctor and said claimant has undergone two surgeries to the left upper extremity on September 6, 2001, and March 25, 2002, and noted that records for the period after the last designated doctor examination were enclosed. The letter asked if the records changed the designated doctor's opinion regarding MMI and IR and also asked the designated doctor to consider the following questions from carrier:

1. Since you last examined [claimant] on May 18, 1999, has his condition materially changed?

2. If so, what objective medical evidence, if any, establishes this?

3. If his condition has materially changed, does this [affect] the date of [MMI] earlier certified?
4. Based on your review of the records being forwarded to you, what objective medical evidence if any, is there that established that [claimant's] condition has improved since your examination of 5/18/99."

5. Have the surgeries performed materially improved [claimant's] condition?

6. Were the surgeries indicated at the time of your examination on 5/18/99?

7. As of 02/03/98 (MMI date) was [claimant's] condition of such a nature that, based on reasonable medical probability, further material recovery from or [lasting] improvement to the injury has occurred? If so, please outline specifically what objective medical evidence supports a material recovery or lasting improvement from the injury.

8. If your position remains that he reached [MMI] on 02/03/98 with a zero percent [IR], what medical evidene supports your opinion that no change is necessary or warranted?

In a February 3, 2003,[3] response, the designated doctor responded and indicated that he reexamined claimant on January 9, 2003, and reviewed documents that were sent to him. The designated doctor said that claimant's condition has "materialistically worsened" since his May 18, 1999, examination due to the surgical procedures that were performed; that claimant's condition has not improved; that the surgeries were not indicated; that "claimant's condition with MMI would not be expected to increase more than 3% in the next twelve months;" and that "his condition was attempted to be made

[3] The date of the letter is stated as 2002 but this is clearly a typographical error.

better with surgical procedures" but they failed. The designated doctor stated that the IR would not change.

In February 2002, Dr. M certified that claimant reached MMI "statutorily" with a 24% IR. The IR included 11% for ulnar neuropathy of the upper extremities; 5% for specific disorders of the cervical spine; 7% for specific disorders of the lumbar spine; and 3% for loss of lumbar ROM.

The hearing officer determined that claimant's surgeries improved his condition; that his impairment is not limited to his lumbar spine; that the great weight of the other medical evidence is contrary to the designated doctor's report; and that claimant reached MMI on May 20, 1999, with an IR of 24%.

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.

The 1989 Act does not provide for presumptive weight to be attached to the opinion of a designated doctor concerning the extent of an injury. *See, e.g.,* Texas Workers' Compensation Commission Appeal No. 951135, decided August 28, 1995. In this case, clarification had already been sought from the designated doctor and he was aware of the diagnostic test results and the opinions of Dr. W and Dr. M regarding claimant's bilateral ulnar nerve condition. The hearing officer relied on the reports of Dr. M and Dr. W in making her determinations, determined that claimant had more than a mere contusion to his elbows, and that the designated doctor did not rate the entire injury despite being provided with test results and medical records regarding claimant's elbows. Because clarification had already been sought from the designated doctor, and because the designated doctor responded indicating that claimant had no upper extremity complaints, we conclude that the hearing officer need not have gone back to the designated doctor yet another time in this case. *See* Appeal No. 951135. This is not a case where the designated doctor just did not believe there was any permanent impairment to claimant's elbows. Instead, the designated doctor indicated in his August 21, 2002, letter that claimant actually did not relate any upper extremity complaints. The hearing officer compared this statement with multiple medical reports over the years from claimant's treating doctors in which they noted repeated complaints of pain and problems with claimant's upper extremities. The hearing officer could also compare this statement to the designated doctor's earlier statement that claimant complained of elbow pain. The hearing officer could consider the designated doctor's statement and compare it to a report of July 28, 1999, that stated that preauthorization had been sought for elbow surgery. We conclude that the hearing officer did not err in determining that the great weight of the other medical evidence is contrary to the report of the designated doctor under the particular facts of this case. *Compare* Texas Workers' Compensation Commission Appeal No. 941576, decided January 9, 1995; Appeal No. 951135.

We note that carrier does not specifically complain about Dr. M's application of the AMA Guides to arrive at the 24% IR. Carrier does contend that the report of Dr. M does not address the issue of how the IR changed after surgery. However, Dr. M rated claimant for ulnar neuropathy, which had been diagnosed both before and after claimant had surgery. Claimant had been diagnosed with ulnar neuropathy before the date of statutory MMI. The hearing officer could find from the evidence that May 20, 1999, was the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury could no longer reasonably be anticipated. We would also note that although Dr. M did not include a specific analysis of how he applied the AMA Guides, the figures he used are not so devoid of medical judgment in assigning impairment that they are clearly wrong. We perceive no error in the adoption of Dr. M's MMI date and IR.

Carrier's focus in its appeal concerns whether the hearing officer could find that claimant improved after his elbow surgeries. There was evidence from which the hearing officer could find that the surgery improved claimant's left elbow condition and also that improvement was anticipated due to the surgeries. However, whether there was any such actual improvement is not the sole concern here. As discussed above, the hearing officer also had other valid concerns. We have reviewed the complained-of determinations and conclude that the hearing officer's determinations are supported by the record and are not so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986).

We affirm the hearing officer's decision and order.

According to information provided by carrier, the true corporate name of the insurance carrier is **WILLAMETTE INDUSTRIES, INC. (a certified self-insured)** and the name and address of its registered agent for service of process is

CT CORPORATION SYSTEMS
350 NORTH ST. PAUL STREET
DALLAS, TEXAS 75201.

_____
Judy L. S. Barnes
Appeals Judge

CONCUR:

_____
Elaine M. Chaney
Appeals Judge

_____
Gary L. Kilgore
Appeals Judge