APPEAL NO. 950132

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was convened in (city), Texas, on November 7, 1994, at which the claimant failed to appear. The hearing officer, (hearing officer), allowed the carrier to present its evidence; thereafter, the hearing was recessed and the hearing officer sent a letter to the claimant directing him to appear at a hearing and show good cause for his earlier failure to appear. On December 12, 1994, the claimant appeared and offered testimony and evidence as to the issues, which were stated as follows: has the claimant reached maximum medical improvement (MMI) and if so, when; if the claimant reached MMI, what is his impairment rating (IR); and did the claimant have good cause for his failure to appear at the CCH on November 7, 1994. The hearing officer determined that the claimant had good cause for his failure to appear and that the claimant reached MMI on February 9, 1994, with a seven percent IR as found by the designated doctor selected by the Texas Workers' Compensation Commission (Commission). The claimant appeals, stating basically that he does not agree with the hearing officer's decision. The carrier responds that the claimant's appeal appears untimely but also that the hearing officer's decision is correct.

DECISION

We affirm.

The claimant's appeal is timely. Records of the Commission show that the hearing officer's decision and order were distributed to the parties on January 4, 1995. Rule 102.5(h) (Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 102.5(h)) provides that for purposes of determining the date of receipt for written communications which require action by a date specific after receipt, the Commission shall deem the received date to be five days after the date mailed, which in this case would be January 9, 1995. The claimant's appeal is date stamped as received by the Commission on January 24, 1995, the 15th day thereafter, and is thus timely. Section 410.202(a).

The 1989 Act provides that the report of a designated doctor as to MMI and IR shall have presumptive weight, and the Commission shall base its determination as to MMI and the claimant's IR on that report "unless the great weight of the other medical evidence is to the contrary." Section 408.122(b); Section 408.125(e).

According to the evidence, the claimant was injured on (date of injury), when a cement bucket struck him above the right knee. He apparently first treated with (Dr. H), who wrote that the claimant had a right quadriceps contusion and patella femoral syndrome; he said an MRI of July 1993 showed claimant's knee was normal except for a mild effusion. Dr. H found the claimant to have reached MMI on November 30, 1993, with a four percent IR. Claimant also was seen by (Dr. M), who performed an arthroscopic procedure in September of 1993 which disclosed scarring of the suprapatellar pouch. In October Dr. M wrote that the claimant's knee had returned to nearly normal motion with

the swelling almost completely gone; however, the claimant, who had been referred to physical therapy, continued to complain of weakness and pain. On November 30, 1993, Dr. M wrote that, despite claimant's complaints of pain, "Clinically there just is not anything to support a significant or serious impairment of the knee." He found claimant to have reached MMI on that date, with four percent impairment due to his range of motion (ROM) in the knee.

Other doctors seen by claimant included (Dr. G), who apparently became his treating doctor, and (Dr. S), to whom he was referred by Dr. G. Dr. G's initial medical report shows he treated claimant's knee and lumbar spine. As of July 19, 1994, Dr. G believed the claimant had not yet reached MMI. Dr. S also examined claimant based upon complaints of pain in his knee, lower back, shoulder, and neck, which he said with reasonable probability were due to the work-related accident. On July 8, 1994, Dr. S found claimant to have reached MMI as of that date, with an IR of 14% due to claimant's lower extremity, lumbar spine, and L4 neurological impairment. Also in the record was a letter from (Dr. R) stating that in May of 1994 he had performed a series of lumbar blocks for claimant's chronic low back pain.

(Dr. SI) was selected as designated doctor by the Commission; he examined the claimant on April 7, 1994, and found the claimant had reached MMI on February 9, 1994, with a seven percent IR based upon impairment of the right knee. Thereafter, a Commission benefit review officer (BRO) sent to him for his evaluation subsequent reports of Dr. G and (Dr. B). The latter wrote on July 7, 1994 that the claimant's knee remained tender and painful and swollen after standing, which prevented claimant from continuing to work; he also stated he believed claimant had internal derangement, probably a medial meniscus tear, which could warrant another arthroscopic exam. An August 30, 1994, MRI disclosed a linear oblique tear involving the posterior horn of the right medial meniscus that extends to the inferior articular margin, as well as a small joint effusion.

On October 3, 1994, Dr. SI replied to the BRO in part as follows:

> After careful consideration of [claimant] and extensive review of medical records, I feel very confident that our report . . . was entirely accurate and fair. Of particular interest in this case the onset of right sided pain several months after original accident dated (date of injury). Careful review of medical records indicates that examinee was not experiencing pain in these areas at any time after the original accident of (date of injury). Also during our interview today, [claimant] revealed that his discomfort of the right shoulder, cervical, and lumbar area occurred secondary to a fall after he was put to full duty status and after he was returned to work following his arthroscopic surgery of the right knee.

I have reviewed [Dr. G's and Dr. B's] medical records . . . these reports do not in any way influence my evaluation of [MMI or IR] . . . In evaluating the right knee for arthroscopic surgery including a meniscal tear and chondromalacia, [ROM] was also included which in fact is a very generous and fair evaluation for his permanent right knee injury . . . I feel that the length of time following surgery and following the initial injury was adequate for rehabilitation and adequate rehabilitation was performed and once again, examinee did indicate on my interview that the body aches and pains which are plaguing him at this time occurred after the arthroscopic surgery of the knee and a subsequent fall . . . .

In addition, Dr. SI in September of 1994 wrote the BRO with regard to Dr. B's report, "There seems to be some structural problems which might require surgery, but many conditions can arise after MMI which may require surgery. I do not believe in holding every MMI date on every case due to a possibility of surgery. Some of these reports indicate improvement in some areas, yet a worsening of other." And on October 24, 1994, Dr. SI wrote the BRO that he had re-examined the claimant on October 3rd and that the IR remained the same.

At the hearing the claimant argued that Dr. S's report shows claimant has not reached MMI, that his injury extends to his low back, neck, and shoulder, and that Dr. B has raised the possibility of another surgery. In the alternative, he argued that if the hearing officer found he had reached MMI, Dr. G's 14% IR should be adopted. The hearing officer found, however, that the report of Dr. SI was not against the great weight of the other medical evidence.

In interpreting the language of the 1989 Act, the Appeals Panel has held that to overcome the report of a designated doctor requires more than a mere balancing or a preponderance of the evidence. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. In addition, we have noted that no other doctor's report, including that of the treating doctor, is entitled under the law to such special, presumptive status. Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992.

In this case, three other doctors besides the designated doctor determined that the claimant had reached MMI; these included at least one treating doctor and the doctor who performed claimant's arthroscopic surgery. Moreover, two of the IRs (four percent) were very close to that of the designated doctor (seven percent). (We also note that the portion of Dr. S's rating relating to claimant's knee was also four percent.) Dr. S also added impairment due to claimant's lumbar spine; while extent of injury was not an issue in this case we note that the designated doctor considered this question and assigned his rating based upon his determination that the original injury was confined to claimant's knee, a determination which finds support in the earlier medical records. Finally, Dr. SI made clear

that he examined all medical reports, including Dr. B's which raised the possibility of further surgery, but stated that his opinion remained unchanged. While this panel has reversed and remanded to allow a designated doctor to review and comment on an outstanding surgery recommendation while a claimant has evidenced an intent to have the surgery, *see* Texas Workers' Compensation Commission Appeal No. 93293, decided June 1, 1993, we have not held that a designated doctor cannot find a claimant to be at MMI where future surgery was a possibility. Texas Workers' Compensation Commission Appeal No. 91125, decided February 18, 1992.

Based upon our review of the evidence, we find it sufficient to support the hearing officer's decision and order, which are accordingly affirmed.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Philip F. O'Neill
Appeals Judge