APPEAL NO. 950285

Following a contested case hearing held in (city), Texas, on December 15, 1994, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et. seq* (1989 Act), the hearing officer, (hearing officer), resolved the two disputed issues by determining that the respondent (claimant) reached maximum medical improvement (MMI) on May 31, 1994, with an impairment rating (IR) of 23% as found by the designated doctor selected by the Texas Workers' Compensation Commission (Commission). The appellant (carrier) asserts on appeal that the IR of the designated doctor was contrary to the great weight of the other medical evidence because claimant did not have a herniated disc and thus his IR should be "0%." The carrier also asserts error in the hearing officer's exclusion from evidence of two carrier exhibits. No response was filed by the claimant.

DECISION

Affirmed.

Claimant, the sole witness, testified that (Dr. CC) was his first treating doctor and once told him he was giving him a 14% IR as "a temporary rating for future reference" but that he was never given a writing to that effect; that (Dr. S) was his current treating doctor and has not advised him that he has reached MMI; that he saw (Dr. PC) at the request of the carrier and that Dr. PC did not perform a range of motion (ROM) examination but just "used a dirty toothpick to stick in various parts of [his] body;" that (Dr. K), the designated doctor, did a thorough examination and used instruments in measuring his ROM. Claimant's position was that he agreed with Dr. K's MMI date and IR and he urged it be given presumptive weight.

Dr. PC's TWCC-69 dated March 28th stated that claimant reached MMI on that date and assigned an IR of "0%." In his attached narrative report Dr. PC stated that he had reviewed various diagnostic studies which showed claimant to have degenerative cervical discs with bony spurs impinging the dural sac but not the spinal cord and he characterized the lumbar spine studies as negative. Dr. PC stated that he explained to claimant that "we do not operate on bulging discs and this is the reason why his doctor deferred his surgery and recommended blocks for his neck and low back and that he had no surgical lesions in his neck nor in his low back."

The hearing officer sustained claimant's objection to the carrier's introduction of the May 19, 1994, TWCC-69 report of Dr. S stating an MMI dated of "5.5.94" and an IR of "12% whole body." (The TWCC-69 referred to an attached narrative report which was not with the exhibit.) The hearing officer also sustained claimant's objection to the introduction of the May 5, 1994, TWCC-69 and narrative report of Dr. CC stating that claimant reached MMI on "5/5/94" with an IR of "12%." The carrier represented to the hearing officer that it would be willing to accept a determination that claimant's IR was 12%.

A July 7, 1993, CT scan report showed "probable left L5-S1 disc herniation" and recommended a myelography with CT scanning or magnetic scanning for more definitive evaluation. The September 17, 1993, report of spine films stated that there were mild changes of degenerative disc disease at multiple levels of the mid and lower cervical spine and that the lumbar spine was normal. The September 17, 1993, report of the cervical and lumbar myelograms showed small extradural defects secondary to spurring at the C4-5, C5-6, and C6-7 levels which did not appear to significantly encroach on the dural sac or spinal cord, while the lumbar myelogram was normal. The September 17, 1993, report of CT scans showed a minimally bulging disc at C5-6, moderate spurring at C6-7, and very mild bulging discs at the L4-5 and L5-S1 levels which "do not encroach on the nerve roots or dural sac and are felt not to be clinically significant."

Also in evidence was Dr. CC's October 20, 1994, report which stated his diagnostic impression to include chronic cervical myofascial syndrome, chronic musculoskeletal lower back pain, herniated nucleus pulposus at L5-S1, degenerative changes at C5-6 and C6-7, and history of mild left carpal tunnel syndrome.

The hearing officer admitted the June 23, 1994, report of (Dr. N) which stated he had reviewed claimant's records. Dr. N reported that on January 7, 1994, Dr. S gave claimant a 12% IR and indicated he would reach MMI by May 5, 1994, and that on May 5, 1994, Dr. CC "indicated the claimant had reached [MMI] with a 12% permanent physical impairment" consisting of 10% for loss of cervical ROM and two percent for loss of lumbar ROM and that he "did not assess any impairment due to structural findings." Dr. N stated that he felt that the IRs of Dr. CC and Dr. K were "significantly higher than the medical records indicate they should be" and that he agreed with Dr. PC that the IR is "0%." Dr. N went on to state that the recitation of the history of claimant's injury in Dr. CC's records indicated it was less serious than stated by Dr. K; that he felt that the cervical spine condition was preexisting, degenerative, had no traumatic relationship, and should be apportioned; that the cervical ROM should be reaccomplished by an independent observer using the double inclinometer method; and that the straight leg raise tests were negative and thus made the lumbar spine ROM evaluations "unreliable." Dr. N also noted that in reviewing Dr. K's method of deriving the IR, he noted that the actual rating assessed by Dr. K's percentages was 27%.

Dr. K reported on a Report of Medical Evaluation (TWCC-69) dated June 24, 1994, that claimant reached MMI on "05/31/94" with an IR of "17%" consisting of 12% for the cervical spine and 12% for the lumbar spine. In his accompanying narrative report of May 31st Dr. K recited a history of claimant's having fallen down some stairs "tumbling to the bottom" on (date of injury), injuring his neck and back, and that he complained of neck pain and numbness and tingling down both arms and legs. Dr. K assigned four percent for an unoperated cervical disc, 10% for loss of cervical ROM, and five percent for the unoperated spinal injury and nine percent for loss of lumbar ROM. Dr. K also reported that an MRI of claimant's cervical spine showed a minimally bulging disc at C5-6 and moderate posterior spurring and encroachment on C6-7 central; that x-rays of the lumbar spine were normal;

and that a CT scan of the lumbar spine "was read as a left L5-S1 disc herniation of significance."

A Commission benefit review officer (BRO) wrote Dr. K on June 24, 1994, stating that the Combined Values Chart of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), showed that 12% and 12% combined to 23%. The BRO also inquired as to whether Dr. K had used the AMA Guides and asked him to provide his cervical and lumbar ROM measurements on enclosed charts (Figures 83a and c from the AMA Guides). Dr. K responded on August 9th enclosing his ROM measurements and stating that he had used the AMA Guides, had erred in combining 12% with 12%, and that claimant's IR was 23% The BRO entered an interlocutory order on October 20th requiring the carrier to commence payment of impairment income benefits based on the 23% IR.

The report of the Commission-selected designated doctor is entitled to presumptive weight regarding an injured employee's MMI date and IR unless such report is contrary to the great weight of the other medical evidence. Sections 408.122(b) and 408.125(e). The Appeals Panel has often noted the unique position occupied by the designated doctor. *See, e.g.,* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. While appealing both the MMI date and IR determined by the hearing officer based on Dr. K's report, the appeal focuses on the controversy over whether claimant actually had a herniated disc at L5-S1. The hearing officer noted the evidence indicating that claimant did not have a herniated disc at L5-S1 but also noted that both Dr. CC and Dr. K included such condition in their respective diagnoses. It was for the hearing officer as the finder of fact to resolve the inconsistencies and conflicts in the medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). The hearing officer felt that the other medical evidence including the reports of Dr. PC and Dr. N could not be said to constitute the great weight of the medical evidence sufficient to overcome the presumptive weight accorded to Dr. K's report. While recognizing that different inferences could be drawn from the evidence by another fact finder, we cannot say that the challenged findings and conclusions are so against the great weight and preponderance of the evidence as to be manifestly wrong and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

We find no abuse of discretion in the hearing officer's determinations that the carrier failed to show good cause for not having disclosed the excluded exhibits within the time required by Section 410.160 and Tex. W.C. Comm'n 28 TEX. ADMIN. CODE § 142.13(c).

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Gary L. Kilgore
Appeals Judge