APPEAL NO. 950447

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). On September 12, 1994, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as hearing officer to consider the issues of when appellant (claimant) reached maximum medical improvement (MMI) and his impairment rating (IR). The hearing officer determined that the great weight of other medical evidence was not contrary to the report of the Texas Workers' Compensation Commission (Commission)-selected designated doctor; therefore, she accorded the report presumptive weight and adopted his August 15, 1992, MMI date and zero percent IR. Claimant appeals asking that the 11% IR of (Dr. KF), to whom he was referred by his treating doctor, be adopted. Respondent (carrier) requests affirmance, arguing that the claimant has failed to satisfy his burden of proving that the great weight of other medical evidence is contrary to the designated doctor's findings.

DECISION

We affirm.

It is undisputed that claimant sustained a compensable back injury on (date of injury), while he was pushing a pallet jack loaded with boxes. On the day following the injury, the claimant went to the emergency room. Thereafter, he was referred to (Dr. W), the company doctor. Claimant stated that he treated with Dr. W for approximately three weeks but Dr. W did not do any diagnostic testing. Therefore, claimant changed to (Dr. M), who treated him with therapy and medications. Dr. M referred claimant to (Dr. A), who ordered an MRI and continued treating claimant conservatively. Claimant stated that he next went to his family doctor, (Dr. I), who referred claimant to (Dr. BW) and (Dr. GF). Dr. GF certified that claimant reached MMI on July 10, 1992, with an IR of zero. Dr. BW certified that claimant reached MMI on August 28, 1992, and likewise determined that claimant had a zero percent IR. Thereafter, claimant changed to (Dr. D), who certified that claimant reached MMI on November 23, 1992, with an IR of zero.

The Commission selected (Dr. X) as the designated doctor in this case. On March 19, 1993, Dr. X examined claimant for the purposes of determining his date of MMI and his correct whole body IR. Dr. X certified that claimant reached MMI on August 15, 1992, and assessed an IR of zero, as had Drs. GF, BW and D. In the narrative report accompanying his Report of Medical Evaluation (TWCC-69), Dr. X stated that "[t]here is really no evidence of disc dysfunction and he has normal spinal function at this time. I detect no disability and I cannot verify his subjective complaints with my objective examination."

After claimant had seen Dr. X, he again changed treating doctors to (Dr. JW), who was the first doctor to order an EMG test. The EMG test revealed L5-S1 radiculopathy, which Dr. JW treated with epidural steroid injections. Dr. JW referred claimant to Dr. KF, who examined claimant on May 12, 1994, and certified that claimant reached MMI on that date with an IR of 11%.

In a letter dated March 30, 1993, Dr. X stated that he reviewed a CT scan of claimant's spine, an April 1992 MRI, and lumbar x-rays, and that he would stand by his original MMI date and IR. Similarly, in a report of June 14, 1994, Dr. X stated that he reviewed the April 1992 MRI, 1994 x-rays of the spine, the lumbar myelogram of May 18, 1994, the Bone Scan of May 4, 1994, the MRI of January 10, 1994, and Dr. F's report assessing an 11% IR. Dr. X stated that "I find no reason to change my original report and I would still give him a zero percent impairment." Finally, Dr. X responded to a letter of June 2, 1994, from a benefit review officer (BRO), stating that he did use the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), he did perform range of motion testing, he did use an inclinometer, and that it remained his opinion that claimant's IR was zero.

Under the 1989 Act, a report of a designated doctor is to be is to be accorded presumptive weight, unless the great weight of other medical evidence is contrary thereto. Sections 408.122(b) and 408.125(e). We have consistently noted the unique position that a designated doctor's report occupies under the 1989 Act. *See* Texas Workers' Compensation Commission Appeal No. 92495, decided October 28, 1992 and Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Further, we have stated that "it is not just equally balancing evidence or a preponderance of the evidence that can outweigh [a designated doctor's] report but only the `great weight' of the other medical evidence that can overcome it." Appeal No. 92412, *supra*.

The correct IR is a question of fact. Under the 1989 Act, the hearing officer is the sole judge of the relevance and materiality of the evidence offered and the weight and credibility to be given thereto. Section 410.165(a). As the finder of fact, the hearing officer is required to resolve the conflicts in the evidence, including the medical evidence and to enter findings of fact and conclusions of law accordingly. Texas Employers Ins. Co. v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). Where a hearing officer's determinations are supported by sufficient evidence and are not so against the great weight of the evidence as to be clearly wrong or manifestly unjust, there is no basis for disturbing the decision on appeal. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986). The basis of the difference in the ratings of Dr. KF and Dr. X is that Dr. X determined that claimant did not have any permanent impairment as a result of the compensable injury, whereas Dr. KF found that he did have such impairment. After reviewing the medical evidence in this case, we are satisfied that the hearing officer correctly determined that Dr. KF's report does not rise to the level of the great weight of other medical evidence contrary to Dr. X's report, particularly in light of the fact that Drs. GF, BW and D also assessed IRs of zero. Rather, it appears that the difference in the ratings of Dr. KF and Dr. X represents nothing more than a medical difference of opinion as to whether or not claimant had permanent impairment as a result of his compensable injury. Accordingly, we find no error in the hearing officer's having accorded the designated doctor's report presumptive weight and adopting his zero percent IR and August 15, 1992, MMI date.

In his appeal, claimant refers to the hearing officer's "total lack of concern over Dr. [X's] lying on at least two of the questions submitted to him on 6-2-94 by the BRO . . . ." Specifically, claimant insists that Dr. X did not perform ROM testing and did not use an inclinometer. As we previously noted, however, in response to the request for clarification from the BRO, Dr. X answered yes to the questions of whether he performed ROM testing and whether he used an inclinometer. Thus, the hearing officer was presented with conflicting evidence as to whether Dr. X had evaluated claimant's ROM using an inclinometer. It was within the hearing officer's province as the finder of fact to so resolve the conflict in the evidence, electing to credit the evidence from Dr. X that he had tested claimant's ROM using an inclinometer over the testimony of claimant to the contrary. *See* Texas Workers' Compensation Commission Appeal No. 94149, decided March 16, 1994 (noting that credibility determinations were hearing officer's to make where there is conflicting evidence as to whether or not designated doctor used an inclinometer). The fact that the evidence in this case would have supported a different inference does not provide a sufficient basis for disturbing the hearing officer's decision on appeal. Texas Workers' Compensation Commission Appeal No. 92308, decided August 20, 1992.

Likewise, claimant asserts that the AMA Guides were "totally ignored." However, in response to the BRO's questions, Dr. X stated that he used the correct version of the AMA Guides in determining claimant's IR. Again, this was a factual question for the hearing officer to resolve. Her resolution of that dispute is not so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust and there is, therefore, no basis for disturbing it on appeal. Cain, *supra*.

Finally, claimant alleges that Dr. X's report was biased, inaccurate and "totally fabricated." Claimant has not provided any evidence to support these allegations. Our review of the record indicates that on three separate occasions Dr. X was asked to review additional information and to provide his opinion as to whether it changed his opinion as to claimant's date of MMI or IR. In each instance, Dr. X promptly responded and said it did not. We cannot agree that the fact that Dr. X initially assessed a zero IR and did not change it after reviewing additional information is indicative of bias, prejudice or inaccuracy, particularly in light of the fact that three other doctors who treated claimant also assessed zero IRs. Therefore, we find no merit in the assertion that Dr. X's report was premised on bias or prejudice.

The decision and order of the hearing officer are affirmed.

Stark O. Sanders, Jr.
Chief Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Alan C. Ernst
Appeals Judge