APPEAL NO. 93637

On June 11, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. Sec. 401.001 *et seq.* (1989 Act). The issue at the hearing was the respondent's (claimant's) impairment rating. The hearing officer determined that the report of the designated doctor that the claimant's impairment rating is 14% is contrary to the great weight of the other medical evidence and further determined that the claimant's correct whole body impairment rating is 31% as assigned by another doctor. The appellant (carrier) contends that certain findings of fact are not supported by the evidence and that certain conclusions of law are erroneous because they are based on the challenged findings. The carrier requests that the hearing officer's decision be reversed and a decision rendered that the designated doctor's opinion is not contrary to the great weight of the other medical evidence, that it is entitled to presumptive weight, and that the claimant's correct whole body impairment rating is 14%.

DECISION

The decision of the hearing officer is affirmed.

The claimant, who worked as a truck driver for the employer, (employer)., Mr A., sustained injuries to his neck, back, ribs, and left knee when his 18-wheel truck loaded with blowsand rolled over on the driver's side when rounding a curve on (date of injury). The claimant was taken to a hospital emergency room and was then referred to (Dr. W), who is his treating doctor. On April 16, 1992, Dr. W performed surgery on the claimant's left knee. The preoperative diagnosis was internal derangement of the left knee. The surgical procedure performed was a partial meniscectomy, chondroplasty of the femoral condyles, and diagnostic arthroscopy. The postoperative diagnoses were torn meniscus and severe degenerative change throughout the joint. A radiology report dated June 4, 1992, revealed posterior vertebral body spurring on the inferior margin of C4 and an asymmetric disc bulge/protrusion at the C4-5 level. This exam also showed a normal lumbar computed tomography. A lumbar myelogram performed on August 18, 1992, revealed a congenitally stenotic spinal canal at the L2-3 and L3-4 levels. A cervical myelogram of the same date revealed a mild annular bulge and hypertrophic lipping at the C3-4 level without disc herniation. A thoracic myelogram was reported as normal.

In an undated Report of Medical Evaluation (TWCC-69), Dr. W certified that the claimant reached maximum medical improvement (MMI) on November 9, 1992, with a five percent impairment rating. However, Dr. W stated in the report that "for a detailed impairment rating, an appointment with [Dr. P] must be scheduled."

The claimant testified that he was examined by Dr. P on October 27, 1992. In an undated TWCC-69, Dr. P certified that the claimant reached MMI on October 13, 1992, with a 30% whole body impairment rating. In a narrative report dated October 27, 1992, which was attached to the TWCC-69, Dr. P diagnosed 1) status post arthroscopic surgery to the

left knee for a torn medial meniscus with residual restricted range of motion and strength deficits in the quadriceps; 2) lumbosacral strain without evidence of radiculopathy; and 3) left cervical muscular spasm with decreased range of motion (ROM) consistent with left cervical facet syndrome. In the narrative report Dr. P gave the claimant 12% impairment for the cervical spine, 12% impairment for the lumbar spine, and 12% impairment for the left lower extremity (left knee consisting of 10% for a torn meniscus, 18% for ROM, and five percent for chondromalacia of the femoral condyle) all of which Dr. P stated resulted in a 32% whole person impairment (note that in the TWCC-69 Dr. P assigned a 30% whole body impairment). The carrier disputed the impairment rating assigned by Dr. P and requested that the claimant be examined by (Dr. WR), a chiropractor.

Dr. WR examined the claimant on November 19, 1992, and in an undated TWCC-69 certified that the claimant reached MMI on November 19, 1992, with a 26% whole body impairment rating. In a narrative report dated November 19, 1992, Dr. WR diagnosed 1) post traumatic cervical sprain with facet syndrome; 2) post traumatic lumbar sprain with evidence of thoracic and lumbar stenosis apparently congenital in nature; and 3) status post orthoscopic surgery on the left knee with repair of the medical meniscus with residual loss of range of motion. Dr. WR gave the claimant an eight percent impairment rating for his cervical region, an 11% impairment rating for his lumbar region, and a 10% impairment rating for his left lower extremity (left knee which consisted of 10% for a torn meniscus and 18% for ROM, the same as found by Dr. P except Dr. P added five percent for chondromalacia of the femoral condyle) all of which Dr. WR said resulted in a 26% whole body impairment rating. Dr. WR specifically pointed out that comparing his findings with "previous impairment rating" revealed very similar findings.

On January 8, 1993, the Texas Workers' Compensation Commission (Commission) selected (Dr. G), as the designated doctor. In a TWCC-69 dated January 15, 1993, Dr. G certified that the claimant reached MMI on January 15, 1993, with a 19% impairment rating. In an attached narrative report also dated January 15, 1993, Dr. G reported that he examined the claimant's cervical spine, lumbar spine, and left knee. Dr. G found no evidence of a cartilage or meniscus problem in the knee. Dr. G also reported that objective findings included spondylosis in the cervical spine of a minimal nature and decreased ROM. Dr. G said that the claimant's complaints were out of proportion to the objective findings. Dr. G diagnosed 1) low back pain; 2) cervical spondylosis; and 3) osteoarthrosis of the knee. Dr. G stated in his narrative report that the claimant has an impairment rating of 14% "of the body" (note that Dr. G assigned a 19% whole body impairment rating in his TWCC-69). In an attachment to his narrative report Dr. G noted that the claimant had a total whole person impairment of 14% which consisted of 10% (using combined value chart) for impairment of the spine (four percent due to specific "spondylosis" disorder of the cervical spine, four percent due to loss of ROM of the cervical spine, and two percent for loss of ROM of the lumbar spine), and four percent impairment of the knee (five percent for "meniscectomy" and five percent for "arthritis"). No impairment from loss of ROM was given for the left knee.

Dr. G stated in his narrative report with regard to ROM testing that "part of these ranges of motion were found to be invalid."

In a report dated February 10, 1993, Dr. P stated that he had found an error in his rating of the claimant's cervical impairment and lowered his rating by one percent giving a 31% whole body impairment rating. Dr. P also compared his evaluation with those of Dr. WR and Dr. G and noted that while he and Dr. WR gave the claimant loss of ROM for the knee, Dr. G did not, and that while he and Dr. WR found the claimant had a lumbar strain, Dr. G found no specific disorder of the lumbar spine yet Dr. G gave a two percent ROM loss for the lumbar spine. In an undated TWCC-69 with the notation "amended report," Dr. P assigned the claimant a 31% whole body impairment rating.

In another TWCC-69 dated March 11, 1993, which has written on it "corrected report," Dr. G certified that the claimant reached MMI on January 15, 1993, with a 14% whole body impairment rating (which is the rating shown in his narrative report of January 15, 1993). In an attached report dated March 10, 1993, Dr. G said that he had failed to report the ROM of the knee and that the ROM of the knee was within normal limits. Dr. G further stated that arthritis was the claimant's main knee problem and that the "A.M.A. Guide" does not allow impairment for ROM loss in the case of arthritis, but does allow "for a combination with impairment for loss of motion in the case of a torn meniscus."

In a letter dated April 5, 1993, Dr. W, the claimant's treating doctor who had referred the claimant to Dr. P for an impairment rating, stated that he agreed with the 32% impairment rating assigned by Dr. P.

In reaching his conclusion that the great weight of the medical evidence was contrary to the report of the designated doctor, the hearing officer found that Drs. P and WR based impairment on a torn meniscus whereas the designated doctor selected "arthritis" as the disorder. While we agree with the carrier that Dr. G also found impairment due to a torn meniscus in addition to arthritis, his rating for the meniscus was 50% lower than that given by Drs. P and WR. The hearing officer further found that Drs. P and WR were able to obtain consistent ROM tests, but the designated doctor was not able to do so and he failed to retest. The hearing officer also found that the designated doctor found symptom magnification which none of the other doctors had found. In addition, the hearing officer found that Drs. P and WR found that the claimant had a specific disorder of the lumbar spine whereas the designated doctor found that the claimant had spondylosis. While we believe that the evidence showed that the designated doctor attributed spondylosis to the cervical spine and not the lumbar spine, we believe that the gist of this finding to be that the designated doctor did not give an impairment rating for a specific disorder of the lumbar spine whereas the claimant's doctor and the carrier's doctor found a specific disorder of the lumbar spine and attached an impairment

rating to it. The hearing officer concluded that the report of the designated doctor was not entitled to presumptive weight because it was contrary to the great weight of the other medical evidence, and further concluded that the claimant's correct whole body impairment rating is 31% (which is the rating given by Dr. P in his amended TWCC-69).

Section 408.125(e) provides as follows:

> If the designated doctor is chosen by the commission, the report of the designated doctor shall have presumptive weight, and the commission shall base the impairment rating on that report unless the great weight of the other medical evidence is to the contrary. If the great weight of the medical evidence contradicts the impairment rating contained in the report of the designated doctor chosen by the commission, the commission shall adopt the impairment rating of one of the other doctors.

In Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992, we pointed out that it is not just equally balancing evidence or a preponderance of the evidence that can overcome the presumptive weight given the designated doctor's report; rather, such other medical evidence must be determined to be the "great weight" of the medical evidence contrary to the report. We have also pointed out that no other doctor's report is accorded the special presumptive weight given to the designated doctor's report. *See* Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992. We have also required the hearing officer to articulate his or her reasoning when determining that the great weight of the medical evidence is contrary to the report of the designated doctor. *See* Texas Workers' Compensation Commission Appeal No. 93124, decided April 1, 1993.

Having reviewed the record in this case, we conclude that the hearing officer's evaluation of the medical evidence goes beyond a mere balancing of the evidence, as we have held is required in order to overcome the presumptive weight accorded to the designated doctor's opinion, and we further conclude that the medical evidence sufficiently supports the hearing officer's determinations that the great weight of the medical evidence is contrary to the report of the designated doctor and that the claimant's whole body impairment rating is 31%.

The decision of the hearing officer is affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Philip F. O'Neill
Appeals Judge