APPEAL NO. 93756

On August 3, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The issue to be determined at the contested case hearing was whether the impairment rating assigned by the designated doctor was correct or overcome by the great weight of other medical evidence. Claimant (who is the appellant) sustained an injury on (date of injury), while involved in an automobile accident in the course and scope of his employment by the (employer), who is the employer and the carrier in this matter.

The hearing officer determined that the presumptive weight to be accorded to the 11% impairment rating assigned by the designated doctor was not overcome by the great weight of other medical evidence, and adopted it.

The claimant has appealed, arguing primarily that the designated doctor's report is based upon a mistaken assumption by the designated doctor that impairment can be assessed for radiculopathy only if it results in a loss of function. Essentially, the claimant argues that the American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (Guides), require that radiculopathy detected through an EMG test be assigned an impairment rating. The carrier responds that the claimant did not demonstrate, through a great weight of other medical evidence, that the designated doctor was incorrect. The carrier notes that there is differing medical opinion in the record as to even the existence of radiculopathy. The carrier argues that the designated doctor has clearly pointed out that any loss of sensation or pain must translate into a loss of function in order to be assigned an impairment.

DECISION

After reviewing the record, we affirm the hearing officer's decision.

The claimant did not testify at the hearing, and the case was tried primarily on records entered into evidence by either side. The claimant injured his back and neck when the vehicle in which he was driving was struck by another vehicle that illegally entered the intersection. The claimant's vehicle was turned around by the impact, according to the history of the accident set out in some of the medical evidence. The accident occurred on (date of injury), and the fact that claimant was injured was undisputed. His objective injuries to the spine include a herniated lumbar disc and bulging cervical disc; the cervical condition is noted to be a degenerative condition (but, as it has been included as part of the "compensable injury," was apparently aggravated by the accident). The evidence also indicated that claimant is receiving treatment for post-traumatic stress disorder relating to the accident.

There is differing medical evidence as to the existence of nerve damage or irritation (radiculopathy).

-May 11, 1992/Dr. H stated that claimant had stiffness and tenderness but no

radicular complaints or nerve problems.

- June 16, 1992/(Dr. Y), of Neurosurgical Associates of (city), noted claimant's objective conditions and stated that he was "without clinical evidence of radiculopathy or neurological deficit.

-September 10, 1992/(Dr. B), claimant's treating physician, assessed 23% impairment, including 12% for radiculopathy.

-(Dr. GB), an orthopedic surgeon, examined claimant at the carrier's request. By letter dated October 21, 1992, stated that claimant had a normal gait, full range of motion of the entire spine, and negative neurological examination. He completed a TWCC-69 that assessed 11% impairment due to objective injuries to the cervical and lumbar spine. In March 23, 1993, Dr. GB stated that he felt a new EMG was not needed and his original assessment was adequate.

-January 5, 1993/(Dr. V), the designated doctor and an orthopedic surgeon, evaluated the claimant. His report showed a diagnosis of HNP at L5-S1, and degenerative disc disease at C6-7. Dr. V stated claimant was at maximum medical improvement, without evidence of radiculopathy (based upon records and his examination), and had an 11% impairment rating. Zero percent impairment was assessed for loss of range of motion. Dr. V expressly disagreed with 12% assessed on rating for radiculopathy and noted that it did not appear that the computation was correct in that the combined values chart was not used.

-January 18, 1993/a letter signed by (Dr. S) and Dr. B, of Texas Trauma Rehabilitation Associates, directly disputed Dr. V's failure to assess for radiculopathy, citing the results of a May 20-21, 1992 Somatosensory Evoked Potential test as probative of radiculopathy. The letter supported the original 23% assessment given by Dr. B, and opined about perceived abuses in handling claimant's case. The letter did not directly address the point raised by the carrier that such radiculopathy should be accompanied by loss of function, although the table from the Guides used by Dr. S described ratings in terms of "% loss of function" due to nerve root problems. It appears from the described computations that most of the radiculopathy was assessed for loss of sensation, with none being assessed for loss of strength.

-April 27, 1993/(Dr. A), a diplomate in neurology, performed electromyographic studies on claimant. He assessed a 28% impairment rating, with over half of it being attributed to radiculopathy. A significant part of the radiculopathy impairment assessed by Dr. A related to "motor dysfunction," with no or very little impairment calculated for sensory dysfunction or pain.

-June 11, 1993/Dr. V wrote that he had reviewed the results of the EMG and it did not change his opinion. Dr. V noted that the Guides clearly specified that there must be a loss of function related to pain or loss of sensation.

On July 11, 1993, an unsigned letter from Texas Trauma Rehabilitation Associates disputed Dr. V's contention that the Guides require a loss of function, and pointed to Table 10 of the Guides as supporting his contention that there are grades for loss of sensation, with 0 being appropriate only if there is no loss. That letter stated, "I agree with both Dr. [GB] and Dr. [V] that the patient does not have a marked muscle weakness in either of the arms or the legs which is related to the cervical and lumbar radiculopathy." The author did point out, however, that claimant had radiculopathy which was "electrodiagnostically proven."

The Tables set forth in the Guides appear to support Dr. V's interpretation that some loss of function must result from any measurable nerve affects. Table 10 of the Guides, for example, affirmatively requires assessment of the impact of loss of sensation on daily activities. The medical evidence from claimant's own physicians indicated great range of motion and ability to move. In any case, the existence of any "permanent" radiculopathy, as well as the conflicting opinions on application of the Guides, were matters for the hearing officer to weigh.

The report of a Texas Workers' Compensation Commission (Commission) appointed designated doctor is given presumptive weight. TEX. LAB. CODE ANN. §§ 408.122(b), 408.125(e). The amount of evidence needed to overcome the presumption, a "great weight," is more than a preponderance, which would be only greater than 50%. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992.

The medical evidence against Dr. V's report does not appear to have complied with the Guides in some significant respects. The Guides describe the procedure to be used for assessing impairment relating to spinal nerve roots and impairment of the affected body part due to pain, discomfort, or loss of sensation. Table 10, part b, on page 40, states the procedure as follows:

1.Identify the area of involvement, using the dermatome chart.

2.Identify the nerve(s) that innervate the area(s).

3.Find the value for maximum loss of function of the nerve(s) due to pain or loss of sensation or pain, using the appropriate table (Table 12 is referenced for nerve roots).

4.Grade the degree of decreased sensation or pain according to the grading scheme above.

5.Multiply the value of the nerve (from the appropriate table) by the degree of decreased sensation or pain.

It is apparent from reading Dr. S's letter setting out Dr. B's impairment calculations for radiculopathy that the recommended procedure was not followed. For example, the text of the January 18, 1993, letter indicated that maximum percentages (5) were taken from Table 12 for each of the C8 and T1 nerve roots. But then these amounts were added and used as the upper extremity impairment, omitting the step of applying the "grading scheme" set forth in Table 10 of the Guides. By using the maximum functional loss values from Table 12 and deriving an upper extremity impairment as he did, Dr. S essentially assumed that the maximum level of impairment existed in claimant from Table 10: "Decreased sensation with pain, which may prevent all activity- 100%." There is no medical record which would support such a grade for claimant.

Dr. S's report indicated no loss of muscle strength from radiculopathy. By contrast, Dr. A's report appears to conclude that there was little (and in some case, no) sensory dysfunction, but that impairment relating to radiculopathy came from motor dysfunction. Leaving aside the point made by Dr. V that radiculopathy must result in loss of function in order to translate into an impairment rating, the medical evidence opposing Dr. V's report is inconsistent and appears to a degree to bypass the recommended procedures for rating impairment in those areas. We would agree with the hearing officer's conclusion that it is not a "great weight" of medical evidence against the designated doctor's report.

Finally, although comparatively minor, it does not appear that regional spinal impairments on Dr. B's report were combined through the Combined Values Chart on page 246 of the Guides to derive the final rating.

The hearing officer is the sole judge of the relevance, the materiality, weight, and credibility of the evidence presented at the hearing. TEX. LAB. CODE ANN. § 410.165(a). The decision of the hearing officer will be set aside only if the evidence supporting the hearing officer's determination is so weak or against the overwhelming weight of the evidence as to be clearly wrong or manifestly unjust. Atlantic Mutual Insurance Co. v. Middleman, 661 S.W.2d 182 (Tex. App.-(city) 1983, writ ref'd n.r.e.).

The decision of the hearing officer in this case is supported by the record, and we affirm.

Susan M. Kelley
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Thomas A. Knapp
Appeals Judge