APPEAL NO. 93991

This appeal is considered in accordance with the Texas Workers' Compensation Act (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq*. (formerly V.A.C.S., Article 8308-1.01 *et seq*.). On March 22, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The issues to be determined at the contested case hearing were the date on which claimant, (claimant), who is the appellant, reached maximum medical improvement (MMI), the correct impairment rating to be assigned to the claimant, and whether the claimant had continuing disability. The hearing officer determined that a previous designated doctor had been appointed only to resolve whether claimant reached MMI, and since that examination, a new dispute arose over the impairment rating. Because of this, the hearing was reopened in order to allow the appointment of a designated doctor by the Texas Workers' Compensation Commission (Commission) and an examination of the claimant by the designated doctor, to provide an opinion as to the impairment rating.

Hearing Officer left the employment of the Commission prior to the reconvened hearing. Therefore, Hearing Officer (hearing officer) presided at the reconvened hearing held October 13, 1993. The record was very briefly reopened to add a letter to the record from a doctor, and closed October 25, 1993. Testimony was not given at the reconvened hearing. The sole issue determined at the reconvened hearing was the correct impairment rating, because resolution of the other two issues was agreed to by the parties.

The parties agreed that claimant had reached MMI on December 2, 1992, in accordance with the report of his treating doctor, and that he had disability, as that term is defined by Section 401.011(16), through that same date.

The hearing officer determined, based upon the report of the designated doctor, that claimant had a four percent whole body impairment rating, and that the greater weight of other medical evidence did not overcome this.

The claimant has appealed, generally charging in strong terms that he disagrees with the hearing officer's decision, attributing it in part to racism, and arguing that the rating of a referral doctor, which was 38%, should have been adopted instead. He argues that there has been a violation by the designated doctor of Rule 1130.5(e) (sic). The carrier responds that the hearing officer gave presumptive weight to the report of the designated doctor, and that the great weight of other medical evidence did not overcome this report.

DECISION

We affirm the hearing officer's decision.

The claimant stated that his left foot and ankle were injured on (date of injury), when a dolly on which he was carrying paper bundles overturned onto his foot. Medical records characterize the injury as a "crush" injury. He was employed by (employer) at the time (employer). Claimant said that his primary treating doctor was a podiatrist, (Dr. L). He stated that Dr. L has recommended surgery.

The claimant vigorously argued, during the first hearing, that he had reached MMI, and he testified that he felt he was fully able to work. He said that Dr. L had released him to work effective November 23, 1992. By the time of the reconvened hearing, the parties had stipulated that the correct MMI date was December 2, 1992.

The brief summary of some of the medical records in evidence is as follows:

-Claimant was examined March 24, 1992, by (Dr. CH) who diagnosed contusion with elevated mass in anterolateral aspect of left foot.

-An MRI of the foot, report dated June 12, 1992, noted that the bones appeared intact, as did tendons and ligaments, that there was no joint effusion, and no evidence of a mass on the lateral aspect of the foot. No significant abnormalities are noted.

-Dr. CH examined claimant July 20, 1992, and found no neurological or neurocirculatory deficit. He stated that he found a mass that was "easily palpable with a minimal amount of pain pattern." He recommended that claimant continue with full work activity.

-(Dr. C), a doctor who conducted an examination pursuant to request by the carrier, opined that claimant reached MMI on August 4, 1992 with a zero percent impairment.

-(Dr. Y), a designated doctor appointed on September 23, 1992, apparently to resolve the dispute that arose out of the carrier doctor's opinion, examined claimant September 29, 1992, and concluded he had not reached MMI at that point. Therefore, no impairment rating was assigned.

-(Dr. T), identified as a referral doctor from Dr. L, assigned a 38% impairment rating to claimant's foot, with MMI on December 4, 1992. Dr. T indicated that he used the Revised Third Edition of the AMA Guides to the Evaluation of Permanent Impairment (Guides). The various whole body values he assigned were combined arithmetically. Dr. T stated that "we can assume that the crush injury caused ankylosis of the great toe. . . ." Dr. T also assessed some impairment for peripheral nerve damage.

-December 1, 1992, letter from Dr. L opined that claimant has a 95-97% "disability." The diagnosis was contusion of the left foot and ankle complicated by tendinitis and a ganglion. Complaints of pain of four months duration were noted.

-(Dr. K), appointed by the Commission on June 29, 1993, to resolve a dispute over impairment rating only, evaluated claimant on July 13, 1993, and opined that he had a four percent whole body impairment. Dr. K, who conducted a neurological examination, stated he found no objective

evidence of ankylosis and nerve problems. Dr. K took measurements of range of motion using an inclinometer.

Appointment of a second designated doctor was appropriate in this case because the first doctor, Dr. Y, had been appointed to resolve an earlier dispute over MMI and impairment. A later dispute arose because of Dr. T's 38% rating, and had not been put through the designated doctor process at the time of the first session of the hearing on March 22, 1993. The claimant had indicated during the first session of the hearing that he would not return to Dr. Y. The report of a Commission-appointed designated doctor is given presumptive weight. Sections 408.122(b) and 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 non-medical testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992.

"Impairment" is defined in the 1989 Act as "any anatomical or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." Section 401.011(23). Further, impairment must be based upon "objective clinical or laboratory finding" and, where assigned by a doctor chosen by the claimant, must be confirmable by a designated doctor. Section 408.122(a). Doctors who assess an impairment rating are required to use a certain version of the AMA Guides to the Evaluation of Permanent Impairment (Guides), specifically the third edition, second printing, dated February 1989. Section 408.124. Dr. T did not use this version.

We cannot agree that the hearing officer was wrong in not finding that the great weight of other medical evidence (specifically Dr. T's report) was against Dr. K's report. Dr. T did not appear to use a portion of the Guides called the Combined Values Chart (page 246), which is a way to combine two or more ratings assessed for different components of impairment (*See* Section 3.2e). It appears that he used simple arithmetic to total up his values.

Further, some of Dr. T's values do not seem to correspond to those listed in the Guides. For example, Dr. T's report indicated that a 10% impairment of the great toe is equivalent to seven percent impairment of the lower extremity. However, according to Table 23 of the Guides (page 52), 10% impairment of the great toe would represent two percent impairment of the foot. This rating then is carried to Table 32 (page 58) to translate it into a percentage of impairment of the lower extremity, which, according to this table, would be one percent of the lower extremity, not seven percent as listed in Dr. T's report. (According to Table 42, the next conversion table, one percent impairment of the lower extremity translates into zero percent of the whole person.) This is a single example, we realize, but illustrates how the 38% may be an inflated rating if all the conversion tables were not used.

Finally, Dr. K opines that he found no objective evidence of ankylosis or peripheral

nerve damage that were used as some basis for Dr. T's rating. As noted above, impairment must be based upon objective criteria.

We assume that the reference to Rule 1130.5(e), which the claimant copied from a similar typographical error in the letter of an attorney who represented him at one point, refers to Rule 130.5(e). Rule 130.5(e) requires that a dispute to the first impairment rating assigned to an injured worker must be made in 90 days. The very first rating assigned was zero percent, by Dr. C, the carrier's doctor. This was disputed by the claimant within 90 days. The 90 day deadline does not apply to any other impairment rating except the first one, so it does not apply to Dr. K's rating, or to Dr. T's 38% rating.

Finally, we find nothing in this record that indicates at all that either hearing officer acted with bias or prejudice.

The determination of the hearing officer is not against the great weight and preponderance of the evidence, and we affirm his decision.

Susan M. Kelley
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Philip F. O'Neill
Appeals Judge