APPEAL NO. 951447
FILED OCTOBER 9, 1995

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on July 31, 1995. He (hearing officer) determined that the respondent's (claimant herein) correct impairment rating (IR) for her compensable mental trauma injury was 40% as determined by (Dr. P), a designated doctor selected by the Texas Workers' Compensation Commission (Commission). The appellant (carrier herein) appeals arguing that an IR cannot be given under the circumstances of this case or, alternatively, that the designated doctor incorrectly applied the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) and that the great weight of the other medical evidence is contrary to his assigned IR. The claimant replies that the decision and order of the hearing officer should be affirmed.

DECISION

We affirm.

It was not disputed that the claimant sustained a mental trauma injury in the nature of post-traumatic stress disorder (PTSD) on _____, when she was the victim of an armed robbery. On November 14, 1994, Dr. P, a psychiatrist selected by the Commission as designated doctor to determine an IR, completed a Report of Medical Evaluation (TWCC-69) in which he assigned a 40% IR. Dr. P explained that he based his entire rating on Chapter 14, Mental and Behavioral Disorders, of the AMA Guides. In doing so, he said he utilized Table 1, Impairment Due to Mental and Behavioral Disorders, and concluded that claimant had a class 3, or moderate impairment. He considered this "roughly analogous" to a class 2 or class 3 impairment under Chapter 4, p. 97, of the AMA Guides for an emotional disturbance secondary to organic brain damage which would support an IR in the 20% to 45% range for class 2 and 50% to 90% for class 3. Since Dr. P would have classified the claimant at a lesser severity than class 3 had her condition been the result of organic brain damage, Dr. P assigned a 40% IR under Chapter 14. Dr. P not only interviewed the claimant, but also reviewed the results of Minnesota Multiphasic Personality Inventory testing and a Structured Clinical Interview for DSM-III-R (SCID), both of which he found consistent with PTSD. Dr. P stated that:

> . . . to determine a Class II or Class III impairment one needs to have a sense of a clinical diagnosis which affect [sic] the patient but most specifically one needs to be aware of their ability to function within the areas of activities of daily living, social functioning, concentration and adaption. There are no single objective tests for this but rather a clinical evaluation is required.

At the CCH, (Dr. G), a psychiatrist, testified by telephone on behalf of the carrier. He examined the claimant on March 21, 1995, and concluded that she did not suffer from PTSD. The relevance of this conclusion is limited because the carrier does not contest the existence of this injury or its compensability, at least with regard to medical benefits. Dr. G further expressed the belief that no IR can be given under Chapter 14 because "no percentages or numbers" are given in this chapter, but only broad classes according to which a percentage IR is given. He finds no objectivity in this process and, hence, no way to challenge the IR as against the great weight and preponderance of the evidence. He also believes it impermissibly to do as Dr. P did and refer to Chapter 4 of the AMA Guides for guidance.

Relying on Dr. G's opinion, the carrier took the position both at the CCH and now on appeal that the correct IR for the claimant's condition is zero percent because no rating can be given under Chapter 14, and, alternatively, if one could be given, Dr. P's rating impermissibly considered Chapter 4 in arriving at his 40% IR.

First, we address the carrier's Chapter 14 argument. It points out that Section 408.122 provides that impairment income benefits (IIBS) may not be awarded unless "evidence of an impairment based on an objective clinical or laboratory finding exists." Section 401.011(33) defines objective findings as those that are "independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee." The carrier then directs our attention to various parts of Chapter 14 which describe the chapter as an "approach to quantifying mental impairment" and as a "guide." The carrier also quotes the AMA Guides that "there is no available empirical evidence to support any method for assigning percentage of impairment of the whole person" for a mental trauma injury. It asserts that neither the MMPI or SCID administered to the claimant produced objective results, but only subjective symptoms.

As the carrier correctly points out, the Appeals Panel in Texas Workers' Compensation Commission Appeal No. 950104, decided March 7, 1995, rejected this argument because it would require us to "virtually read . . . out of the 1989 Act" Section 408.006 which deals with mental trauma injuries. We also observed that the carrier's argument "too narrowly defines 'objective clinical or laboratory findings'." The key to Chapter 14 lies in the exercise of clinical judgement. We further stated:

> These clinical observations together with the acceptance of the testing procedures by the medical community as valid indicia of mental and behavioral disorders constitute, in our opinion, the required objective clinical and laboratory findings on which this IR was based.

We decline to retreat from this position as the carrier invites us to do, but affirm our holding that Chapter 14 of the AMA Guides can be a valid basis for assigning an IR.

The carrier next contends that Dr. P somehow contaminated his rating under Chapter 14 by improperly looking to Chapter 4 for guidance and in the process converted a Chapter 14 rating into a Chapter 4 rating. We are unwilling to place such constraints on the professional, clinical judgment of a physician. To the contrary, we believe that an experienced practitioner may seek help and guidance from sources deemed relevant and appropriate in his or her professional opinion. In looking to Chapter 4 for guidance, Dr. P did not thereby turn the claimant's injury into an organic instead of a psychiatric injury. Rather, by his own explanation, he looked to how Chapter 4 rated the effects of an organic condition as reflected in the conduct of a claimant and that claimant's ability to function in the ordinary circumstances of life. Chapter 14 takes a not dissimilar approach and addresses impairment in terms of a claimant's ability to function in daily living and with its associated stresses. We thus cannot conclude that Dr. P did not follow the AMA Guides when he referred to Chapter 4 for whatever information he deemed useful, nor that in doing so he transformed a Chapter 14 rating into a Chapter 4 rating.

Finally, the carrier argues that Dr. P's 40% IR is contrary to the great weight and preponderance of the evidence and for this reason is not entitled to presumptive weight under Section 408.125(e). The only other IR in evidence is that of Dr. G who gave a zero percent IR. As noted above, Dr. G concluded that the claimant was not suffering from PTSD, depression or anxiety. The carrier, however, conceded the existence of PTSD as resulting from the armed robbery. Since Dr. G declined to rate the compensable injury, his IR can hardly be said to constitute the great weight of the other medical evidence.

For the above reasons, we affirm the decision and order of the hearing officer.

Alan C. Ernst
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Thomas A. Knapp
Appeals Judge