APPEAL NO. 980185
FILED MARCH 12, 1998

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On January 9, 1998, a contested case hearing was held. She (hearing officer) determined that appellant (claimant) had an impairment rating (IR) of 13%, as determined by the designated doctor, (Dr. M). Claimant asserts that Dr. M should have used the range of motion (ROM) measurements obtained in a subsequent examination rather than earlier measurements and asks that an IR be constructed based on the subsequent ROM figures or that another designated doctor be appointed. The respondent (carrier) replied that the decision should be affirmed.

DECISION

We affirm.

Claimant testified that he worked for (employer) on _____, when he fell, with a bread rack he was moving falling on his left leg. He had surgery to his left knee. Dr. M indicates that claimant's surgery addressed a partial medial meniscal tear. Although there was no testimony about another injury, Dr. M states that in April 1994 claimant was back at work after surgery when another incident occurred, which, according to Dr. M's records, was "thought to be a new injury," and thereafter an MRI showed "a fracture, a tear in the . . . medical meniscus and fraying of the ACL." Dr. M refers to opinions by various doctors whose records were not provided. Dr. M refers to IRs provided by (Dr. S) of five percent, (Dr. Ma) of 21% and (Dr. Si) of nine percent, all of which occurred after the April 1994 incident. Dr. M refers to Dr. Si as a "designated doctor," and claimant identified Dr. Ma as his treating doctor.

There is no indication, other than Dr. M's reference and claimant's testimony that Dr. Si gave him an IR of nine percent, as to what Dr. Si's role was. Claimant then saw Dr. M in December 1996; Dr. M initially said that claimant was not at maximum medical improvement (MMI), but indicated that an IR was prepared. In March Dr. M provided another report indicating that he had been told by the Texas Workers' Compensation Commission (Commission) that claimant had reached statutory MMI, and he then provided a Report of Medical Evaluation (TWCC-69) indicating a 13% IR. Dr. M referred to his December 1996 examination in which he said that a goniometer had been used to record a ROM deficit of 11% for the knee which resulted in a four percent whole body IR; with that he added nine percent for specific disorders, which totaled 13%.

While claimant did not testify that ROM measurements were not made at the December 1996 examination, on appeal he asserts that no measurements were taken in December 1996. With there being no evidence in the record that no measurements were taken, this allegation will not be considered for the first time on appeal. We note that the record provides a worksheet for claimant's left knee of 11% as alluded to by Dr. M in his

report provided in March 1997. While an IR cannot be provided until a claimant is at MMI, the record reflects that claimant reached MMI statutorily in December 1995, prior to the time that ROM measurements were provided by Dr. M.

Claimant also states that Dr. M should have used the ROM measurements he obtained when claimant saw him again in August 1997. Dr. M at that time referred to "no new medical information." The record provides no information as to why claimant was returned for another examination by Dr. M, since no letter of inquiry (presumably one was written) from the Commission to Dr. M was included in the record. Whether or not the second evaluation by Dr. M was based on a proper reason is not evident. *See* Texas Workers' Compensation Commission Appeal No. 971531, decided September 17, 1997. At any rate, Dr. M recorded that there was an accumulation of fluid on claimant's left knee, which affected ROM, so he elected to use the ROM recorded in December 1996, pointing out that it was more than that given by Dr. Si. The manner in which Dr. M refers to Dr. Si's IR, after having provided his own reasoning as to why he was maintaining his original ROM, could be reasonably interpreted by the hearing officer as not showing that Dr. M based the IR on Dr. Si's IR. In addition, even claimant's treating doctor, Dr. Ma, states in a letter in evidence that the ROM "should not be changed every time he is seen even though the measurements may change with time."

Claimant states in his appeal also that Dr. Si was seen for the 1994 injury, not the 1993 injury. However, without added evidence, we are at a loss to conclude that Dr. Si could perform ROM measurements on the left knee, relative to the 1994 injury, without having his measurements affected by the 1993 injury; in effect, an examination after both injuries for ROM had to consider the total ROM limitation; this could only have assisted claimant in recording a larger ROM deficit, which was still less than Dr. M's.

The hearing officer is the sole judge of the weight and credibility of the evidence. *See* Section 410.165. Without any evidence indicating that Dr. M did not obtain ROM measurements at the time of his December 1996 examination, the hearing officer could certainly consider Dr. M's report, indicating that such measurements were then taken. She could also give presumptive weight to Dr. M's March 1997, or even the August 1997, report (the two stated the same IR), although there was no showing that claimant was reevaluated for a proper reason. She could not give presumptive weight to any report of Dr. M that included his August 1997 ROM measurements that were taken of claimant's effused knee, because Dr. M rejected those figures. No report of IR includes them. While claimant did not ask that his treating doctor's IR be accepted by the hearing officer, with no medical evidence indicating that what Dr. M did was contrary to the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association, there would be no basis to conclude that the great weight of the other medical evidence was contrary to Dr. M's reports. *See* Section 408.125. Similarly, there has not been a showing that another designated doctor should be appointed.

Finding that the decision and order are sufficiently supported by the evidence, we affirm. *See* In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

Joe Sebesta
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Judy L. Stephens
Appeals Judge