APPEAL NO. 990297

This appeal is considered in accordance with the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). On January 22, 1999, a contested case hearing (CCH) was held. The issue at the CCH was the impairment rating (IR) to be assigned to the appellant, who is the claimant.

The hearing officer determined that the claimant's IR was 14% in accordance with the report of the designated doctor, which was not overcome by the great weight of contrary medical evidence.

The claimant has appealed, arguing that the designated doctor improperly used the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) to assess impairment for loss of strength. The claimant argues that the correct IR is that of his treating doctor or, based upon the designated doctor's figures and proper use of the AMA Guides, at least 15%. The respondent (carrier) did not respond, but cross-appealed certain findings of fact relating to the designated doctor's report in which the hearing officer found that an IR was calculated only for one leg and that the wrong figure from Table 47 of the AMA Guides was used. Neither party has responded to the other party's appeal.

DECISION

Affirmed.

The claimant had a lumbar back injury on _____, and resulting surgery. The claimant's operative report of January 8, 1997, indicated that various procedures were performed to alleviate severe nerve root compression at L5. Claimant reached maximum medical improvement on May 22, 1997, and this was not disputed. The testimony was very brief. Claimant, on direct examination, developed evidence only about a statement he contended was made by the designated doctor, Dr. R, prior to the beginning of his examination. The statement, that Dr. R would not give him a 15% or 25% IR even if he were in an iron lung, was purportedly made spontaneously as the two were headed toward the examination room, not in response to any comment or observation by the claimant. Although claimant contended that the examination took very little time, it was apparent on cross-examination that Dr. R conducted straight leg raising tests in the supine and sitting position, as well as range of motion (ROM).

Dr. R assigned a 14% IR. This consisted of 10% from Table 49 for specific spinal conditions and four percent for loss of ROM relating to lateral lumbar motion. Neither of these figures was disputed and, in fact, Dr. O, whose role was not explained but who appears to have been a consulting doctor for the claimant, agreed with these two elements of the IR.

The controversy stems from Dr. R's failure to assign an IR for nerve damage or loss of strength. Dr. R indicated that he used Table 47 of the AMA Guides to calculate neurological loss, and that the motor and sensory loss amounted to a total of less than one percent lower extremity impairment, which converted to zero percent whole body impairment. As part of his narrative, Dr. R stated that he observed no muscle wasting in the legs and claimant's reports of sensation loss in his feet were variable.

When this report was first questioned by the claimant's attorney, Dr. R responded that using Table 45 would assume a complete loss of L5 function and that Table 47 allowed for more specificity. He expressly stated that the affected nerve was the superficial peroneal nerve for which use of Table 47 was appropriate.

Dr. O reviewed Dr. R's IR and opined that the use of Table 47 was not appropriate, because claimant had nerve root damage emanating at the spinal level, which is measured by Table 45. Dr. O pointed out that Table 47 was the appropriate table to use only if nerve damage emanated from a distal nerve in the leg. He argued that under Table 45 the maximum loss of function, figure due to loss of strength, would be 37% rather than five percent from Table 47. He recomputed claimant's rating which resulted in an additional one percent whole body IR for motor loss. In summary, he pointed out that Dr. R's IR was based upon damage to a superficial peroneal nerve, rather than damage to the lumbar area. Dr. O further noted that although the report of Dr. R described claimant's loss as bilateral, he appeared to have only computed one unilateral loss rather than combining both extremities as required by the AMA Guides.

Dr. R's response to this conceded that Dr. O made a "nice argument" that he did not propose to dispute. Dr. R explained what he meant by certain statements in his narrative report and said they were intended to convey his belief that claimant's complaints of weakness and loss were voluntary and subjective. He concluded that because the subjective reports given by the claimant of sensation loss were variable, the claimant was not telling the truth. Dr. R stated that he no longer uses the motor/sensory loss portion of his worksheet to show that the nervous system was considered but was not impaired. Dr. R stated his current practice to directly state if the nervous system is intact. In short, this response seems to contradict his earlier clarification in which he identified the superficial peroneal nerve as the "affected" nerve.

The carrier also asked a consulting doctor, Dr. C, to perform a peer review of Dr. R's IR. Dr. C commented on both Dr. R and Dr. O's reports, and stated his opinion that in order for any impairment to be assessed for sensory deficit, there had to be a deficit manifested in a specific dermatomal pattern. This was true regardless of what table was used to compute an IR. In summary, Dr. C deemed the Table 45/Table 47 controversy somewhat academic because there was no objectively verifiable motor loss established through examination of the claimant. Dr. C agreed in principle with Dr. O's statement that Table 45 would have been the appropriate table to use.

Claimant's treating doctor, Dr. H, initially had certified a 30% IR, but then argued in a response to Dr. R's report that Dr. R's examination measurements would yield a 22% IR.

Dr. R subsequently rejected this analysis. We note that neurological testing performed by Dr. H describes the claimant's sensory deficits with reference to the superficial peroneal nerve (both sides) and the sural tibial nerve (both sides).

The report of a Texas Workers' Compensation Commission-appointed designated doctor is given presumptive weight. Sections 408.122(c) 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 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 hearing officer made clear in his discussion of the evidence that he did not accept as credible the claimant's recitation of what did, or did not, transpire in the examination.

Table 47 is entitled "Specific Unilateral Spinal Nerve Impairment Affecting the Lower Extremity." The title to Table 45 is "Unilateral Spinal Nerve Root Impairment Affecting the Lower Extremity." The instructional text for rating spinal nerve roots with Table 45 directs the examiner to combine each leg for bilateral impairment and then convert the rating to a whole body IR. However, for Table 47, the instructional text indicates that each unilateral impairment should be determined separately and each converted to whole person impairment, states that the tables should be used for unilateral involvement, and where there is bilateral involvement, the values derived from the table for each leg should be thereafter combined. Furthermore, the articulated difference in the tables in this introductory text also states that Table 45 relates to nerve roots and Table 47 relates to peripheral nerves affecting the lower extremity. An example in the text illustrating the use of Table 47 has to do with a knee, not a spinal, injury.

On Dr. R's computational schedule to his report, he indicated under the motor sensory loss portion of the table that the affected nerve is "L5," not the superficial peroneal nerve. The preprinted schedule makes reference to Table 47 and does not seem to allow for use of Table 45.

However, the figures used by Dr. R were these set out in Table 45, as the figures that should have been used for superficial peroneal nerve impairment would be five percent and 10%, not the five percent and five percent actually used. Table 45 also describes a five percent loss of function due to sensory deficit and a 37% loss of function due to loss of strength as the "maximum % loss." The instructions underneath this table indicate that Tables 10 and 11 must next be used by the examiner to determine what range of impairment should be derived from Table 45, using a percentage of the maximum percentages in Table 45. As we review Tables 10 and 11, it is apparent that Dr. R took the lowest figure in the range for the first category of loss where the range is above zero. For loss of sensation, this category is described as "decreased sensation with or without pain, which is forgotten during activity"; for loss of strength, that category is "complete [ROM] against gravity and some resistance, or reduced fine movements and motor control."

However, Dr. R went on to compute his final lower extremity impairment using the methods and figures set out in Table 47.

As we compare these categories to his findings on examination, we cannot agree that his judgment in this regard is against the great weight of other medical evidence. To the extent that the hearing officer may be saying that the designated doctor's “diagnosis" of peripheral nerve impairment was entitled to presumptive weight, we note that we have stated before that extent of injury is expressly not a matter entitled to such weight. Texas Workers' Compensation Commission Appeal No. 941739, decided February 7, 1995. However, the source of any neurological impairment was not only Dr. R's impression but that of Dr. H as well, who based part of his own IR on peripheral nerve impairment. (We do not agree with the hearing officer that it is clear that Dr. H used Table 45, as his figures appear to have been taken from Table 47.) Against this was the operative report indicating compromise of the L5 nerve root because of the accident, with the operation performed involving decompression of that area, as well as the peer review report of Dr. O.

We disagree with carrier’s assignments of error in its cross-appeal. As pointed out by Dr. O, and apparently believed by the hearing officer, Dr. R appears to have performed his actual computations for unilateral, rather than bilateral, loss. He also did not use the correct figure of 10% from Table 47 for loss of strength. But, as the hearing officer further points out, the resulting IR is not changed by an adjustment for bilateral impairment. Dr. R's response to Dr. O's report, as noted by the claimant's attorney, was not to disavow the arguments set forth by Dr. O, but to apparently decode the language he used in his original report to relate his "true" determination that there was no objective impairment after all. Dr. C then followed with his observation that an objective loss is required for any impairment.

While Dr. R's approach of first recording some small amount of impairment (albeit a zero percent whole body IR) and then completing disavowing impairment is questionable, we are persuaded that his IR should not be set aside on appeal because of the threshold requirement that an IR must be based on objective clinical or laboratory findings. Section 408.122(a). With no muscle wasting and with variable reported sensory loss, we cannot agree that the great weight of contrary medical opinion is to the contrary of the zero percent IR for sensory and strength loss.

Accordingly, we affirm the hearing officer's decision that the claimant's IR for his compensable injury was 14%, and his order that income benefits be paid in accordance with this rating.

_____
Susan M. Kelley
Appeals Judge

CONCUR:

_____
Philip F. O'Neill
Appeals Judge

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Tommy W. Lueders
Appeals Judge