APPEAL NO. 990678

This appeal arises pursuant to the Texas Workers' Compensation Act of 1989, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). On February 9, 1999, a hearing was held. She (hearing officer) determined that respondent (claimant) has an impairment rating (IR) of 36%. Appellant (self-insured) asserts that a finding of fact that claimant was sincere was not applicable to impairment provided to the cervical spine which is in issue, that the designated doctor, Dr. M, based a neurological deficit for the cervical spine on a lumbar EMG, that cervical range of motion (ROM) testing was just done once resulting in no showing of "validity", and concluding therefrom that the designated doctor should not be given presumptive weight. Claimant replied that Dr. M did provide three tests of ROM showing consistency but did not address the school's assertion as to the neurological IR.

DECISION

We affirm.

Claimant worked for (employer) when she slipped and fell at work on _____. Claimant has had no surgery relative to the compensable injury. There is no appeal to the finding of fact that claimant sustained a compensable back and neck injury; there was no disagreement as to the date of maximum medical improvement. The only issue at hearing concerned the amount of claimant's IR.

In October 1997, claimant saw Dr. G for evaluation upon the request of the carrier. He provided an IR of 9%, based on 4% for a specific disorder of the cervical spine and 5% for a specific disorder of the lumbar spine. Dr. G measured claimant's cervical ROM at 20%, but allowed 0% IR based on his comment that the limitation is "attributable to voluntary restriction." While he stated that claimant's flexion and extension in the lumbar area were invalidated by the straight leg raise, he also said that 4% IR measured laterally was "voluntarily restricted," as he also stated for the cervical measurements, and gave no ROM IR. However, Dr. G pointed out that claimant's Waddell tests, including light touch, simulation, regional disturbances, and overreaction were "appropriate," while distraction straight leg raising was not.

Dr. M was appointed as the designated doctor. At the hearing there was some argument concerning the fact that claimant had seen Dr. M in the past for medical care, but the testimony was that claimant had received no treatment in more than one year; there was no allegation in regard to this point on appeal.

Dr. M measured claimant's cervical ROM at 20% also. He did not disregard cervical ROM because of "voluntary restriction" as Dr. G did. As noted by claimant at the hearing, it could be questioned how a claimant who gave less than maximum effort could be measured at the same IR on two occasions by different doctors. Dr. M's initial report provided only one set of figures and self-insured attacks Dr. M's figures as not showing repetitions so as to measure consistency. However, the record shows that Dr. M later

provided his measurements showing the repetitions in question; those figures add up to 20% even though Dr. M, on that page, stated their sum to be 21%. Those figures were referred to by carrier's peer review doctor, Dr. C, in his second report dated September 4, 1998. While Dr. C took issue with one series of those cervical measurements as not showing consistency, Texas Workers' Compensation Commission Appeal No. 980985, decided June 26, 1998, stated that the deviation in measurements could be measured from the median number, not just from the maximum number. As such, the figures of 8, 12, and 16 (degrees) when measured from the median number, 12, do not exceed the allowed variation and may be considered in determining the total ROM. The assertion that cervical ROM was only done once and not shown to be "valid" does not have merit.

Dr. M, also like Dr. G, invalidated lumbar flexion and extension based on the straight leg test, and he measured no IR for lateral ROM. He allowed 6% and 7% for cervical and lumbar specific disorders respectively, and then added 5% for neurological, which is addressed on appeal by self-insured. Dr. M's narrative concerning his physical examination is virtually nonexistent, containing three lines of type. In that comment he states that claimant has "no loss of sensation." In a deposition he gave in January 1999, Dr. M also said that claimant did not have any motor weakness. However, Dr. M's summary of the IR in which he provided 5% for neurological is not inconsistent with the above comments; beside "neurological" he entered the words, "pain, etc." and 5%; he also indicated on that summary that there was no loss of strength.

The Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), at section 3.1i, provides two tables that may be relevant. Table 12 on page 41 provides for IR based on "loss of function due to sensory deficit, pain or discomfort", and table 14 on page 42 provides for IR based on "loss of function due to sensory deficit, pain, or discomfort." Therefore, while it would have been very appropriate to have queried Dr. M concerning what he found of a neurological nature that was worthy of an IR, what table applied, the amount of IR selected from that table, and whether table 3 was then used to determine IR of the whole body, we cannot say that a neurological IR cannot be based on pain in a particular area.

The issue of neurological deficit was complicated somewhat by Dr. M's response to Dr. C's March 1998 written opinion. In the March opinion Dr. C states that there was no apparent neurological deficit present. He also stated that there were not three measurements so that consistency could not be determined. In providing a 4% IR, Dr. C also commented that the Report of Medical Evaluation (TWCC-69) "places additional requirements . . . over and above those of Table 49", in referring to the AMA Guides Table 49, which "only require 6 months of symptoms". (The appeals panel notes that it does not agree that TWCC-69 requires a higher standard for IR than that required by the AMA Guides, which are specifically stated to be the basis for IR at Section 408.124.)

The record contains an undated letter from Dr. M in which he responded to Dr. C's review, apparently with no specific questions from the Texas Workers' Compensation Commission about his IR. He stated that he enclosed the added charts showing the three

measurements of ROM. Dr. M did not change his diagnosis related IR for cervical and lumbar, both of which were based on MRI results showing a herniated disc. Dr. M then made a comment that is not consistent with his original summary in which he entered "pain" by neurological, and provided a 5% IR. In the undated letter Dr. M said:

> [r]egarding the neurologic deficits, the EMG of 5-28-97 . . . shows a L5-S1 nerve root irritation bilaterally . . . . Therefore, I disagree that no "neurologic deficit was . . . present".

That statement does respond to the assertion by Dr. C that there was "no apparent neurological deficit." However, it may not be relevant to a cervical IR and Dr. C stated in his testimony that the EMG was for the lumbar area and would have "no validity" for the cervical area -- the 5% neurological IR was shown by Dr. M to be for the cervical area in his IR report.

We believe that the hearing officer as sole judge of the evidence (*see* Section 410.165) must have chosen to believe Dr. M's original statement relative to the 5% neurological IR, i.e., that it was for pain, as may be considered by tables 12 and 14, rather than Dr. M's response to Dr. C's criticism. The neurological IR in this case is much less than clear; however, we cannot say that there is no basis for affirming, based on tables 12 and 14.

The other finding of fact appealed, which has not been discussed within the prior comments, concerned a reference to an examination by Dr. B, in which "Dr. B concluded that the claimant was sincere and had significant myofascial pain." The appeal pointed out that this exam related to the lumbar area. We point out that the hearing officer did not express any finding of fact in regard to what she thought of Dr. B's opinion or what she thought of the total medical evidence regarding claimant's honesty- - *see* past comments of Dr. G's in reference to claimant having passed all but one Waddell sign. We observe that the prior finding of fact indicated that Dr. G assigned a 9% IR, which also did not indicate what the hearing officer thought the IR should be. Findings of fact that merely reflect what a physician said or did mean nothing unless what was said or did was itself litigated at the hearing. (Compare to a finding of fact in which the hearing officer finds that, "the evidence shows this claimant did not magnify symptoms but did exhibit satisfactory effort in tests conducted". The finding of fact concerning Dr. B could be disregarded as not necessary to the determination of the issue in this case, but since it only reflects what one doctor stated, with nothing more, it does not need to be disregarded.

The determination that the great weight of the medical evidence was not contrary to Dr. M's IR is not against the great weight and preponderance of the evidence.

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

_____
Tommy W. Lueders
Appeals Judge