

APPEAL NO. 990747

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on February 4, 1999. With respect to the single issue before him, the hearing officer determined that the appellant's (claimant) impairment rating (IR) is 12%, in accordance with a portion of the certification of the designated doctor selected by the Texas Workers' Compensation Commission (Commission). In her appeal, the claimant essentially argues that the hearing officer erred in determining that the great weight of the other medical evidence was contrary to the findings of the designated doctor related to the impairment he assigned for depression, specific cervical disorder, specific lumbar disorder, and left knee. In its response, the respondent (carrier) urges affirmance.

DECISION

Reversed and a new decision rendered that the claimant's IR is 32% as certified by the designated doctor.

It is undisputed that the claimant sustained a compensable injury on _____, in the course and scope of her employment with (employer). The parties stipulated that the claimant reached maximum medical improvement (MMI) on September 6, 1996, and that Dr. F is the Commission-selected designated doctor.

Because only the issue of the correct IR is before us on appeal, our factual recitation will be limited to the facts germane to that issue. The claimant testified that she injured her neck, low back, left leg, and left arm in her slip and fall injury. She stated that she also has been treated by Dr. S, a psychiatrist, for depression as part of the compensable injury. She testified that, with the exception of a brief period after her injury, she continued to work in a light-duty position with the employer until March 1997. She stated that she had to stop working light duty in March 1997 because she was no longer physically capable of performing her duties. On March 10, 1997, the claimant underwent left knee surgery. Her preoperative diagnosis was internal derangement of the left knee. A March 5, 1996, MRI of the left knee revealed a horizontal cleavage tear involving that posterior horn of the medial meniscus, osteochondritis of the medial femoral condole, grade IV chondromalacia of the lateral patellar facet, and synovial irritation. On October 10, 1997, the claimant underwent left ulnar nerve transposition surgery. Dr. S treated the claimant with Prozac for her depression. Her lumbar and cervical injuries were treated conservatively, with medication, physical therapy, and injections. The claimant's initial treating doctor was Dr. B and subsequently she changed treating doctors to Dr. AS.

On a Report of Medical Evaluation (TWCC-69) of January 17, 1995, Dr. B certified that the claimant reached MMI on January 6, 1995, with an IR of 15%, which was comprised of eight percent for a specific disorder of the lumbar spine and seven percent for loss of lumbar range of motion (ROM). The narrative report accompanying Dr. B's TWCC-69 does not indicate that he considered the claimant's neck, arm or leg injuries in assessing

his MMI and IR. In a TWCC-69 of April 17, 1996, Dr. FR, to whom the claimant stated she was referred by Dr. B, certified that she reached MMI on April 9, 1996, with an IR of three percent for her upper extremity injury. In the narrative report accompanying his TWCC-69, Dr. FR states that the claimant "was seen by me on 9/11/95 and was MMI'd for cervical spine pain, degenerative disc disease which was aggravated in the injury."

On September 2, 1997, Dr. AS examined the claimant for purposes of completing an MMI/IR evaluation. In a TWCC-69 dated September 5, 1997, Dr. AS certified that the claimant reached MMI on September 6, 1996, which is apparently the claimant's statutory MMI date, with an IR of 25%. Dr. AS stated in his narrative report that the claimant injured her cervical and lumbar spine, her left shoulder, left upper extremity, and both lower extremities. The 25% IR was comprised of three percent for loss of lumbar ROM, eight percent for a specific disorder of the lumbar spine, eight percent for the left upper extremity and eight percent for the left lower extremity. In his narrative report, Dr. AS noted that he would contact Dr. S to see if there was any IR from a psychiatric standpoint and that he would incorporate any such rating with his 25%.

On November 24, 1997, Dr. F performed a designated doctor examination on the claimant. In a TWCC-69 of the same date, Dr. F certified that the claimant reached MMI on September 6, 1996, with an IR of 32%. In his narrative report, Dr. F explained that the 32% was comprised of four percent for depression which had previously been assigned by Dr. S, her treating psychiatrist, noting that he was in agreement with Dr. S's evaluation; four percent for a specific disorder of the cervical spine; eight percent for lumbar specific disorder (grade 1 spondylolisthesis); four percent for loss of cervical ROM; four percent for loss of lumbar ROM; nine percent for the left knee, which was comprised of 10% lower extremity impairment for the torn meniscus/meniscectomy and 12% lower extremity impairment for arthritis under Table 36 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides); and four percent for ulnar nerve impairment.

At the request of the carrier, Dr. RP reviewed and critiqued Dr. F's IR. Dr. RP opined that the claimant did not have "significant depression directly related to this injury"; therefore, he recommended that she not be assigned any rating for depression. Dr. RP also recommended that a zero rating be assigned for cervical specific disorder, noting that he questioned whether there was "an actual significant cervical spine injury." Based upon his assessment that there was no cervical injury, Dr. RP also stated that he did not consider it appropriate to assign a rating for loss of cervical ROM. Dr. RP stated that in "all medical probability the injury did not cause a spondylolisthesis," thus, he concluded that the eight percent lumbar spine specific disorder impairment for that condition was improperly awarded. With respect to the left knee, Dr. RP noted that Dr. F's ratings for the arthritis and meniscal tear/meniscectomy were within the ranges provided in Table 36 for those conditions; however, he opined that Dr. F should have assigned a rating at the lower end of the range for each condition. Finally, Dr. RP opined that Dr. F's use of the spinal nerve root tables to rate the ulnar nerve impairment was "inappropriate."

A Commission benefit review officer (BRO) sent Dr. RP's report to Dr. F and asked if it caused Dr. F to amend his report. In his response of October 26, 1998, Dr. F addressed each of Dr. RP's criticisms. With respect to the four percent rating for depression, Dr. F stated:

This depression was assessed by a psychiatrist at 4% and as is normal practice, we are permitted as a Designated Doctor to seek an outside value such as a psychiatric evaluation in order to derive impairment from that standpoint. I believe it to be accurate.

Dr. F reaffirmed his opinion that a cervical specific disorder and ROM impairment were properly assigned and that he correctly considered the spondylolisthesis even if it was preexisting in assessing the claimant's lumbar rating. Similarly, Dr. F stated that he believed the rating he assigned for the claimant's left knee meniscal impairment and the arthritis were accurate, noting that it was a "judgment call" where the claimant's impairment fell within the range of impairments provided for those conditions in Table 36. Finally, with respect to the ulnar nerve impairment, Dr. F noted that his assessment was accurate based on the "very detailed medical records showing a definite impairment." Dr. F concluded his letter stating that the "only reason I would change anything is if I were given specific instructions indicating that the cervical spine, lumbar spine or any other body part in question were not part of the compensable injury. Since this does not seem to be the issue, I believe the actual assignment of impairment for each individual area and then the combined value is correct."

As noted above, the hearing officer determined that the great weight of the other medical evidence was contrary to Dr. F's findings related to impairment for depression, specific cervical disorder, specific lumbar disorder, and the left knee. Thus, he gave presumptive weight to the 12% that Dr. F assigned for loss of cervical ROM, loss of lumbar ROM and ulnar nerve impairment. The carrier did not appeal that determination. The Appeals Panel has long held that the 1989 Act does not provide for "picking and choosing" parts of the designated doctor's report and giving presumptive weight only to those parts. Texas Workers' Compensation Commission Appeal No. 94646, decided July 5, 1994; Texas Workers' Compensation Commission Appeal No. 94732, decided July 20, 1994; Texas Workers' Compensation Commission Appeal No. 981474, decided August 17, 1998. Under the guidance of those cases, the hearing officer erred in this case in giving presumptive weight to only a portion of the IR assigned by Dr. F. Nevertheless, we will consider each of the challenged portions of the rating to determine if, as the hearing officer determined, the great weight of the other medical evidence is contrary to the designated doctor's findings, which would necessitate a remand to determine the correct IR or whether Dr. F's rating can be given presumptive weight as a whole. In his decision, the hearing officer did not explain how the great weight of the other medical evidence was contrary to Dr. F's rating in those areas; however, he listed the carrier's assertions in that regard; thus, it appears that he accepted the position of the carrier as the "great weight of the other medical evidence."

Initially, we will consider the four percent IR Dr. F assigned for the claimant's depression. That rating was assigned by Dr. S, the claimant's treating psychiatrist. The carrier asserted that Dr. F's rating was "not based upon independent evaluation or his own independent medical judgment." We have previously recognized that as long as the designated doctor does not abdicate his evaluative role to a consulting doctor, he may consult with other experts concerning the IR to be assigned to a claimant for the compensable injury. Texas Workers' Compensation Commission Appeal No. 961215, decided August 7, 1996; Texas Workers' Compensation Commission Appeal No. 92627, decided January 7, 1993. We find no merit in the hearing officer's apparent determination that Dr. F's assessment of a four percent rating for depression was not the product of the exercise of his medical judgment. In both his narrative report and the response to the request for clarification from the BRO, Dr. F stated that he believed Dr. S's rating was accurate and that he was incorporating it into his rating based upon that determination. While Dr. F could have referred the claimant to another psychiatrist for that evaluation, the carrier cites no authority, and we are unaware of any authority, which prohibits a designated doctor from incorporating a psychiatric rating from a treating doctor where, as here, the designated doctor has independently determined the accuracy of the rating. We find no basis for the determination that Dr. F did not exercise independent medical judgment in assigning a rating for depression; thus, we likewise find no basis for determining that his inclusion of a rating for that component demonstrates that his IR is not entitled to presumptive weight.

Next, we consider the hearing officer's determination that the cervical specific disorder rating was improperly included in the claimant's IR. The carrier asserted that that rating was not "based upon a medically documented cervical injury." Initially, we note that it is incongruous to determine that there is no cervical injury in light of the determination, that was not appealed, that cervical ROM impairment was properly assigned. If there was no cervical injury in this case, then ROM impairment could likewise not be assigned. The carrier in this case did not dispute the existence of a cervical injury. In this instance, Dr. F opined that the cervical injury resulted in a four percent specific disorder impairment. Admittedly, Dr. RP opined that there was no "significant cervical injury" that would support the assignment of a specific disorder rating; however, Dr. RP's opinion is not the great weight of the other medical evidence contrary to the report of the designated doctor. We have long recognized that the difference of whether an injury caused impairment is a medical difference of opinion and that based upon Sections 408.122 and 408.125, the 1989 Act has given presumptive weight to the designated doctor's resolution of such differences.

Texas Workers' Compensation Commission Appeal No. 971063, decided July 23, 1997; Texas Workers' Compensation Commission Appeal No. 950991, decided July 28, 1995. The evidence does not support the hearing officer's determination that the great weight of the other medical evidence is contrary to the designated doctor's cervical specific disorder rating.

The hearing officer also discounted the eight percent lumbar specific disorder rating assigned for the grade I spondylolisthesis. The carrier argued that that award was improper because the eight percent was awarded for a 1992 compensable injury. The carrier stated that it was not talking about contribution, insisting that it was talking about an

award under the specific disorder table for an area that has previously been awarded. We are unable to discern a difference. The argument advanced is that the claimant has already been awarded an eight percent IR for lumbar spondylolisthesis for which she has been compensated. Contribution is the appropriate method for seeking to address this concern. It was improper for the hearing officer to discount the eight percent lumbar rating from the IR assessed by Dr. F.

Finally, we consider the rating assigned for the claimant's left knee. As noted above, Dr. F assigned a nine percent whole body rating for the left knee, which is comprised of 10% lower extremity impairment for the torn meniscus/meniscectomy and 12% lower extremity impairment for arthritis due to any etiology, including trauma/ chondromalacia. The carrier argued that the meniscectomy should not be considered because it was performed in March 1997, after the claimant reached MMI. In Texas Workers' Compensation Commission Appeal No. 990584, decided April 28, 1999, we considered and rejected a similar argument. In that case, as in this one, the claimant had had the surgery at the time of the designated doctor's examination. Appeal No. 990584 thus distinguished the cases where a designated doctor amends his report based upon a surgery after his examination. In so doing, that case noted that we had previously rejected the assertion that the IR "should be a 'snapshot' of the claimant's IR on the date of MMI" and noted that it would be "nearly an impossible task" for the designated doctor to give an opinion as to the claimant's IR on the date the claimant reached MMI some 14 months prior to his examination of the claimant. In this instance, the claimant had knee surgery prior to her examination with the designated doctor as part of her treatment for the compensable injury.

Under the guidance of Appeal No. 990584, we find no merit in the assertion that the designated doctor's report was not entitled to presumptive weight because it considered the claimant's condition on the date of the examination as opposed to attempting to determine the IR based on her condition 14 months prior to the examination. See Texas Workers' Compensation Commission Appeal No. 951273, decided September 18, 1995, and Texas Workers' Compensation Commission Appeal No. 960300, decided March 28, 1996, for examples of two other cases that gave presumptive weight to a designated doctor's IR determined at a post-statutory MMI examination. The carrier also contended that the designated doctor improperly assigned a rating for chondromalacia/arthritis. The carrier argues that arthritis is one of the disorders under Table 36 that does not provide for combining the diagnosis-related rating with impairment for loss of ROM. It maintains that if impairment for ROM was combined with the diagnosis-related rating, the rating would overstate the impairment. Although the carrier properly notes that Table 36 does not provide for the combination of the diagnosis-related impairment with ROM impairment for arthritis, it does not follow that in the absence of ROM impairment the claimant cannot be assigned a specific disorder rating. There is no dispute that the claimant has been diagnosed with arthritis/chondromalacia in this case. Based on this diagnosis, Table 36 provides for the assessment of a lower extremity rating between the range of zero to 20%. Dr. F assigned a 12% lower extremity rating. He was permitted to assign a rating within the range stated in Table 36 based upon his professional judgment as to what rating was appropriately assigned to the claimant. It is entirely possible that his decision to assign 12% rather than a larger rating may have been based upon the fact that the claimant had full ROM in her knee. In any event, we are unprepared to state that the designated doctor

did not have the discretion to assign a diagnosis-related IR in this case because the claimant had full ROM in her knee, particularly in light of the fact that the carrier did not present any medical evidence in support of that assertion.

Given our long-standing determination that the hearing officer cannot pick and choose the portions of the designated doctor's report to which he will give presumptive weight and in light of our determination that the hearing officer erred in determining that the great weight of the other medical evidence was contrary to the designated doctor's depression, cervical specific disorder, lumbar specific disorder, and left knee ratings, we reverse the hearing officer's determination that the claimant's IR is 12% and render a new decision that her IR is 32% as certified by Dr. F, the designated doctor selected by the Commission.

Elaine M. Chaney
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Thomas A. Knapp
Appeals Judge