APPEAL NO. 991112

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On May 5, 1999, a contested case hearing (CCH) was held. With respect to the issues before her, the hearing officer determined that appellant's (claimant) impairment rating (IR) was 11% as assessed by the designated doctor in an amended report, and that the respondent (carrier) is entitled to contribution from an earlier compensable injury in the amount of 73%.

Claimant appeals, contending that the lumbar range of motion (ROM) should not have been invalidated and that he should be retested by the designated doctor. Claimant contends that the designated doctor did "not properly follow the guides [Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides)]." Claimant also appeals the contribution findings, contending that the carrier had not sustained its burden and that contribution "is discretionary not automatic." Claimant requests that we reverse the hearing officer's decision and render a decision in his favor. Carrier responds to the claimant's appeal, cites Appeals Panel decisions and urges affirmance.

DECISION

Affirmed.

There was no live testimony. The parties stipulated that claimant had sustained a compensable injury on (date of earlier compensable injury) (not the injury at issue), and received an eight percent IR; that claimant sustained the instant injury on _____; that the Texas Workers' Compensation Commission-selected designated doctor is (Dr. R); that (Dr. S), claimant's prior treating doctor, had certified that claimant reached maximum medical improvement (MMI) on May 13, 1998, with a zero percent IR; that Dr. R initially certified that claimant reached MMI on September 3, 1998, and assessed a 15% IR; and that Dr. R amended his report and assigned claimant an 11% IR on February 23, 1999.

As the stipulations establish, claimant sustained a low back injury in 1992, which resulted in an eight percent IR due to a rating from Table 49, AMA Guides, Section III A (a Grade 1 L5-S1 spondylolisthesis). The medical records indicate that on _____, claimant injured or reinjured his lower back while trying to lift or move a motor at work. Although not in evidence, Dr. S apparently assessed claimant at MMI on May 13, 1998, with a zero percent IR. Claimant apparently disputed that rating and Dr. R was appointed the designated doctor. Dr. R, in a Report of Medical Evaluation (TWCC-69) dated November 17, 1998 (as opposed to the stipulated date), certified MMI on September 3, 1998, with a 15% IR. That report does not specify a specific disorder impairment, although it does note:

> The Straight Leg Raising [SLR] angle on the tightest side (50 degrees) is not within 10 degrees of the total hip motion (S1 Flexion plus S1 Extension), which is 39 degrees, thus invalidating the Lumbosacral flexion and extension test results.

The report goes on to assess a five percent IR for lumbar flexion, seven percent IR for lumbar extension and three percent IR for right lateral flexion. That report was reviewed by (Dr. D), carrier's peer review doctor, who, in a report dated February 7, 1999, recited the history of claimant's 1992 injury, Dr. S's zero percent IR, and commented on the cumulative impact of the two injuries. Dr. D comments that although the lumbar flexion and extension figures "did not meet the SLR validity criteria," Dr. R still assigned an impairment for those functions, but "did not assign a value from Table 49 so this would appear to have been attributed to the (date of earlier compensable injury) injury . . . ."

Dr. D's report and a request for clarification, together with a suggestion that the "parties would not be opposed to a complete re-examination," were sent to Dr. R by letter dated February 18, 1999. In an amended TWCC-69 and brief letter, both dated February 23, 1999, Dr. R responded by assessing an 11% IR, explaining:

> This letter is in response to your inquiry dated 2-18-99, in which it is being asked of me to reconsider the [IR] assigned to the above patient. Upon further review of my original report, it is correct that the spinal flexion and extension were invalid, yet included in the [IR]. This correction would leave a 3% [IR] for [ROM]. Also, an 8% should be assigned as a result of the MRI due to Table 49 IIIA. These factors together contribute for a total [IR] of 11%. (See attached worksheet).

The worksheet attached showed no ROM figures and simply repeated the information contained in the quoted letter in another form. Apparently, another request was made for the completed worksheet which is in evidence as Claimant's Exhibit No. 4. That worksheet contains several numbers that have been written over, or changed, and some are capable of being interpreted as different numbers. Claimant, at the CCH, characterizes the worksheet figures as "scribble scramble." (Dr. M), claimant's current treating doctor, in a report dated April 30, 1999, interprets Dr. R's worksheet figures as showing ROM validity and states even if the testing was invalid by one degree, then the test should be repeated.

The hearing officer, in her Statement of the Evidence, comments that claimant disputes the IR based on the illegible notations of the ROM measurements on Dr. R's worksheet. The hearing officer then notes that the designated doctor's report has presumptive weight and no other doctor's report "is given such special, presumptive status." The hearing officer pointed out that Dr. R was given an opportunity to reexamine

or retest (claimant, in his appeal, tries to distinguish a reexamination from retesting) claimant and declined to do so, instead, he amended his prior IR.

Regarding contribution, in evidence is a 1993 report from (Dr. A) which details exactly how the eight percent IR for the 1992 injury was calculated and states that "Table 49, Category 3A" was used for a specific spinal disorder with zero percent impairment for the ROM. Also in evidence is Dr. D's report where he compares the 1993 report of Dr. A with claimant's current injury and IR. Dr. D was asked to consider the cumulative impact of the 1992 injury to the 1998 injury and commented:

> [Claimant] has a longstanding L5-S1 spondylolisthesis, with degenerative discs at L4-5 and L5-S1. He had previously been assigned an 8% [IR] due to this grade I L5-S1 spondylolisthesis by [Dr. A] on 6/2/93 for his (date of earlier compensable injury) injury. The _____ injury appears to have been an aggravation of the previous condition (the degenerative disc changes and the spondylolisthesis), as documented by [Dr. S] in his medical records.
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> * * * *
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> The 8% due to specific disorders was previously rated by [Dr. A], and this should be attributed to the (date of earlier compensable injury) injury. The remaining 3% due to restricted right lateral bending would be attributed to the _____ injury.

The hearing officer specifically referenced these ratings and reports in finding that based on the medical records and cumulative impact of the 1992 injury on the 1998 injury, the carrier is entitled to contribution in the amount of 73% (8/11).

Claimant, in his appeal, cites Dr. M's April 30, 1999, report, which states claimant should be retested, attempts to distinguish between a reexamination (which Dr. R apparently declined) and a retest for lumbar ROM. Claimant contends that Dr. R did not follow "the guides" and urges a lumbar ROM retest. Claimant also contends that carrier "failed to produce" sufficient medical evidence to support a finding of contribution. All of the points claimant raises on appeal were raised at the CCH and are factual matters for the hearing officer to resolve. Our standard of review is to determine whether the hearing officer's decision is so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986). The hearing officer explained her rationale, that the designated doctor's report has presumptive weight (Section 408.122 and Section 408.125), that the designated doctor adequately explained his rating and that the designated doctor chose not to reexamine (or retest) claimant. Similarly, on contribution, there was the medical report of Dr. A and the cumulative impact opinion by Dr. D. We agree with claimant's contention that contribution

is discretionary and not automatic. *See* Section 408.084(a). The hearing officer exercised her discretion in awarding contribution and that decision is supported by the evidence.

Upon review of the record submitted, we find no reversible error and we will not disturb the hearing officer's determinations unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). We do not so find and, consequently, the decision and order of the hearing officer are affirmed.

Thomas A. Knapp
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Elaine M. Chaney
Appeals Judge