APPEAL NO. 991135

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On April 27, 1999, a contested case hearing was held. With regard to the only issue before her, the hearing officer, after according the designated doctor's report presumptive weight, determined that the great weight of other medical evidence was contrary to the designated doctor's opinion regarding the impairment rating (IR) and, therefore, adopted the 24% IR of the treating doctor.

Appellant (carrier) appeals, contending that the designated doctor's report was supported by another doctor and since the designated doctor's opinion has presumptive weight, that doctor's 14% IR should have been adopted. Carrier argues that if the Texas Workers' Compensation Act's presumptive weight provision is to have any meaning, we should reverse the hearing officer's decision and render a new decision that respondent's (claimant) correct IR is 14% as found by the designated doctor.

DECISION

Affirmed.

Claimant did not testify but it is undisputed that claimant sustained compensable head, shoulder and back injuries on _____. Both the hearing officer's decision and various medical reports recite the extent of claimant's injuries when claimant, a welder, was struck in the left side of his head and shoulder by a "large piece of steel." Claimant was unconscious for a period of time and has been diagnosed as having post-traumatic stress disorder, and various neurological problems, including cognitive defects. Claimant has not had spinal surgery. The maximum medical improvement date is not at issue so only the IR will be discussed.

Chronologically, the first IR was by Dr. G, D.O., apparently a Texas Workers' Compensation Commission (Commission) required medical examination (RME) doctor, who in a Report of Medical Evaluation (TWCC-69) and narrative dated July 17, 1997, assessed a 12% IR. Dr. G arrived at the rating using the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). He assessed a five percent impairment from Table 6 for a surgically repaired epigastric hernia and seven percent impairment from Table 49, Section II C (six months documented pain with moderate to severe degenerative changes). Range of motion (ROM) was invalidated and there was no comment on neurological deficits. This report was disputed by claimant.

Contrary to the hearing officer's recitation, the next certification, chronologically, was the first report of Dr. F, the Commission-selected designated doctor. In a report dated October 17, 1997, Dr. F assessed a 14% IR. (The hearing officer quotes from the report at some length.) Basically, Dr. F assessed one percent impairment for the left shoulder; two percent for the hernia; four percent from Table 49, Section II B for the cervical spine; five

percent from Table 49, Section II B for the lumbar spine; and two percent for cervical ROM. Lumbar ROM was invalidated. Dr. F goes on to say:

> On the other hand, one could refer to the mental and behavioral disorder section and in particular Table 1 on Page 233 which would put him in Class 3 with impairment levels compatible with some but not all useful function and utilizing the same [AMA] Guides, this too could have a range of 10-15% which would be in keeping with the 14% calculated per the above. I would like to point out that in my opinion, it would be incorrect to add the psychological findings to the specifics since it would appear that most of his symptomotology is on a myofascial pain behavior basis with normal diagnostic studies and that would be the equivalent of assigning twice for the same presentation. Therefore, today's examination calculated either way would give him a 14% Whole Person Impairment.

Dr. F was asked to clarify his report by the Commission and in a letter dated May 13, 1998, Dr. F commented that his October 1997 IR "clearly indicated [his] thought process" and:

> It was my opinion then, as it is today, that impairment could be rated <u>either</u> on the basis of the total body areas involved in which he continued to exhibit pain, or it could be based on the psychological factors resulting in his incapacitation and ongoing pain complaints. In fact I indicated in my report that I made the two distinctions and clarified the rating based on that. (Emphasis in the original.)

The treating doctor, Dr. HS, in a report dated August 12, 1998 (the TWCC-69 is dated August 19, 1998), assessed a 24% IR based on four percent from Table 49, Section II B for cervical impairment, plus one percent for cervical loss of ROM, five percent from Table 49, Section II B for lumbar impairment plus one percent ROM for left lateral flexion (11% impairment for the spine), two percent for the right knee, two percent for the right shoulder, zero percent for the hernia and 10 percent impairment for "emotional disturbance" using the table on page 97 under Section 4.1(a) The Brain. Dr. HS contends the head and brain injury "is a separate entity in and of itself and a separate area that needs to be rated independent of the patient's other impairments." Dr. HS takes issue with Dr. F on some of Dr. F's orthopedic ratings and then comments that Dr. F believes that:

> one had to choose between the psychological factors as the source of the patient's ongoing problems versus the areas reported to be suffering from pain. He in fact once again is erroneous in making such a statement. This is his opinion which is incorrect and is not supported by the AMA [G]uides or the [Commission] guidelines. The emotional component is due to the patient's head injury and the chronic pain syndrome and should have been rated in addition to the impairments of the rest of the body that was examined.

Claimant was also examined by Dr. JS, a carrier RME doctor. In a report dated September 4, 1998, Dr. JS assessed a 31% IR based on 17% impairment for the spine (combining specific disorders and ROM, Dr. JS assessed eight percent impairment for the cervical, two percent for the thoracic and seven percent for lumbar), five percent for ROM loss in the left shoulder and zero percent for the knee. Regarding cognitive deficits, Dr. JS remarked:

> This examinee describes to me cognitive deficits which are interfering with his ability to perform daily tasks. This includes black-out spells, and problems with memory. Other doctors have noticed similar impairments. Impairments due to brain injury are handled in Section 4.1 A of the [AMA] Guides where there are seven categories under which a brain injury can be rated. We are instructed in the AMA Guides to use the maximum impairment from the most impaired category to characterize the examinee's deficit. I will rate him under disturbances of complex integrated cerebral function on page 97. I believe he is in the first category where 'there is a degree of impairment of complex integrated cerebral functions, but there is ability to carry out most activities of daily living as well as before onset'. I believe the examinee is on the borderline of Category I and Category II in those descriptions, and as such, I have rated him at the highest level of Category I, which is 15%. Therefore, due to cognitive dysfunction that this examinee is demonstrating on a consistent basis, secondary to his injury, he receives a 15% whole person IR.

Dr. JS used the combined values tables to arrive at the 31% IR.

Dr. F was again asked for clarification and was sent Dr. HS's August 1998 report. Dr. F replied by letter dated November 2, 1998. Dr. F restated and reiterated his prior position (quoted at some length by the hearing officer) confirming his 14% IR. Carrier, in its appeal, complains that the hearing officer does not mention the report of Dr. B "a well respected physician" who agrees with Dr. F. In fact, Dr. B did a record review, dated November 27, 1998, where he states that "any impairment given for depression would be influenced by the past medical history" and that the designated doctor's 14% IR "would be difficult to overcome by other referring physicians in determining an impairment for cognitive deficits related to the injury."

The hearing officer, in her Statement of the Evidence, commented (detailed the evidence) on why she found the great weight of other medical evidence to be contrary to the designated doctor's report, stating:

> After careful consideration of the evidence in this case, it is determined that [Dr. F] failed to properly rate the Claimant according to the AMA Guides and the [Commission] Act and Rules. The great weight of the other medical evidence in the record is sufficient to overcome the presumptive weight to which [Dr. F's] opinion is entitled. His certification cannot be corrected by

> combining the two components because it is clear that [Dr. F's] medical opinion is that they should not, and that Claimant's IR should be 14%. Although Claimant asserts that [Dr. JS's] certification of 31% should be adopted, [Dr. HS's] certification will be adopted. [Dr. HS] has been Claimant's treating doctor and is most familiar with his condition. [Dr. HS] provided a well-reasoned and detailed explanation of his certification and the problems with the certification of the designated doctor. Claimant is entitled to have the entirety of his injury rated, and that consists both of the physical as well as the psychological component of his impairment.

Section 408.125(e) gives presumptive weight to the designated doctor's report unless the great weight of the other medical evidence is to the contrary. If the great weight of the medical evidence contradicts the IR in the designated doctor's report (or, as in this case, the hearing officer determines that the designated doctor's report is wrong as not being in compliance with the AMA Guides as mandated by Section 408.124(b)), "the commission shall adopt the [IR] of one of the other doctors." The hearing officer explained why she did not use Dr. F's IR. We find no error in the hearing officer's analysis. She gave presumptive weight to Dr. F's report and opinion and then found that the great weight of other medical evidence, being the opinions of Dr. HS and Dr. JS (a carrier RME doctor) to be that great weight. Basically, this case comes down to the issue of where a claimant suffers both orthopedic and psychological injuries, are both to be rated and included in the total IR or as Dr. F states, the impairment could be rated on either but not both. Dr. F refers us to page 233 of the AMA Guides as authority for his position; however, our review of that section, A Method of Evaluating Psychiatric Impairment, nowhere suggests, much less mandates, that a psychiatric rating due to a head or brain injury somehow precludes or prohibits rating a spinal injury under Table 49 with loss of ROM. At least two other sources document that claimant sustained a closed head injury which resulted in cognitive deficits.

We find no error in the hearing officer's determination that the great weight of the medical evidence contradicts the IR contained in the designated doctor's report, that the hearing officer detailed the other medical evidence that she relied on and that the hearing officer adopted the IR of one of the other doctors. Dr. F was given ample opportunity to clarify his report and we find no basis in the AMA Guides or the 1989 Act which requires that orthopedic and psychological injuries are to be rated separately and only one or the other included in the total IR. All of the doctors (except perhaps Dr. G), including Dr. F, noticed cognitive defects but Dr. F stood alone in saying that only either/or orthopedic or cognitive defects can be rated under the AMA Guides.

Accordingly, the hearing officer's decision and order are affirmed.

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Thomas A. Knapp
Appeals Judge

CONCUR:

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Susan M. Kelley
Appeals Judge

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Gary L. Kilgore
Appeals Judge