APPEAL NO. 991196

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 May 4, 1999. She (hearing officer) determined that the appellant (claimant) reached maximum medical improvement (MMI) on March 11, 1996, with an impairment rating (IR) of zero percent. Claimant appealed these determinations, contending that the great weight of the other medical evidence is contrary to the designated doctor's report and also that the medical records should be sent to the designated doctor for his evaluation. Respondent self insured ("carrier" herein) responds that the Appeals Panel should affirm the hearing officer's decision and order.

DECISION

We reverse and remand.

The parties stipulated that claimant sustained a compensable injury to both knees. Claimant testified that she sustained her compensable injury when she was kicked by a resident patient in _____. It was unclear how much time claimant missed from work, but she indicated that she continued working even though she was experiencing continuing knee problems with pain and swelling. She testified that she treated with Dr. D, who told her to ice her knee. Dr. D's medical records before 1997 mention treatment of the left knee only. Dr. D's medical records do not mention that claimant was also kicked in the right knee. Claimant said both knees were hurting after her injury and that she complained to Dr. D about both knees, but that she was primarily concerned with her left knee. Dr. D performed arthroscopic surgery on claimant's left knee in August 1995. The operative report states that there were no significant lesions or loose bodies and that the patella, femoral condyles, and menisci were all intact and without evidence of significant pathology. Dr. D said that claimant had some prominent tissue in her knee, noted that claimant had been aware of a mass, and said that the tissue was removed. In March 1996, Dr. D noted that claimant was still having discomfort in her left knee, but said she had reached a "steady state."

On June 20, 1996, Dr. D certified that claimant reached MMI on March 7, 1996, with an IR of zero percent. On July 31, 1996, the designated doctor, Dr. C, certified that claimant reached MMI on March 11, 1996, with an IR of zero percent, with a diagnosis code of 718.8 for "other joint derangement." The designated doctor stated that claimant denied difficulty with activities of daily living, that there was no left knee diagnosis or neurologic impairment, and that even though there was very slight loss of range of motion (ROM) with lower extremity impairment of one percent, the total impairment under the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) actually amounted to zero percent.

The hearing officer found that the parties stipulated that claimant reached statutory MMI on July 5, 1997, and this determination was not appealed. The next medical record from Dr. D after March 1996 was in October 1997. It said that Dr. D aspirated fluid from claimant's knee for testing purposes, noted that claimant complained of left knee swelling and popping, said

Dr. D found no significant crepitation, and said that he injected claimant's knee with Marcaine. Under "impression," Dr. D wrote, "present symptoms suggest patellofemoral malalignment and chondromalacia." Dr. D also mentioned the right knee here for the first time, stating that "actually the right knee has a worse appearance than the left." In November 1997, Dr. D noted that claimant's symptoms were "much less," continued her on anti-inflammatory medication, and released her to care through her primary care physician.

Claimant began treating with Dr. B in _____ and complained of both knees. Dr. B referred claimant to Dr. G in _____ and Dr. G performed MRI testing of claimant's left knee, which showed mild osteoarthritis and "possible tendinitis or partial thickness tear in the distal biceps femoral insertion of the fibular head." Dr. G operated on claimant's left knee in September 1998 to rule out a torn medical meniscus. The post- operative diagnosis was "degenerative arthritis, grade 3, patellofemoral groove, with a large, symptomatic plica." Dr. B testified that the operative report did not say that claimant had a partial thickness tear and that it was possible then that she did not. He said claimant developed left knee chondromalasia, arthritic changes, and a subluxated patella because of her compensable injury.

On October 14, 1998, Dr. B certified that claimant reached MMI on July 5, 1997, with an IR of 13%. His accompanying report states that the IR includes impairment for both knees. Dr. B testified that while claimant was in rehabilitation for her left knee, she developed right knee pain. MRI testing of the right knee was performed on October 29, 1998, and the impression was "mild patellofemoral osteoarthritic changes with a small to moderate joint effusion." On December 4, 1998, Dr. G certified that claimant had not reached MMI and that her IR was 13%. The diagnosis codes listed were 719.46 and 836.1 for "pain in joint" and a tear of the meniscus or cartilage of the knee. There was no accompanying report in the record. Dr. G performed surgery on claimant's right knee in March 1999, and the operative report lists the postoperative diagnosis of "chondromalasia, grade 3, of the patella."[1]

In September 1998, the Texas Workers' Compensation Commission (Commission) wrote to the designated doctor and asked him to review a letter from claimant's treating doctor. In October 1998, the designated doctor replied that claimant had injured her left knee and that an MRI and arthroscopy "did not reveal any specific pathology." The designated doctor stated that claimant received appropriate treatment and that "any subsequent pathology or surgery was not due to the compensable injury."

Sections 408.122(c) and 408.125(e) provided that the report of a designated doctor selected by the Commission is to be given "presumptive weight" and the Commission shall base its determination of MMI and IR on this report unless the "great weight of the other medical evidence is to the contrary." Great weight means more than an equal balancing or even a preponderance of the evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Whether the great weight of the other medical evidence is contrary to the report of a designated doctor is generally a question of fact for the

[1]DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 321 and 1311 (28th ed. 1994), defines chondromalacia as a degeneration of the cartilage and plica as a ridge or fold.

hearing officer to decide, Texas Workers' Compensation Commission Appeal No. 93459, decided July 15, 1993. We have also noted that the attainment of MMI does not mean a pain-free status or that further medical care will not be necessary. Texas Workers' Compensation Commission Appeal No. 961244, decided August 12, 1996. In addition, the fact that surgery may be later done does not automatically render a prior certification of MMI or IR invalid. *See* Texas Workers' Compensation Commission Appeal No. 961794, decided October 23, 1996.

The 1989 Act provides that the hearing officer is the sole judge of the weight and credibility of the evidence. Section 410.165(a). Where there are conflicts in the evidence, the hearing officer resolves the conflicts and determines what facts the evidence has established. As an appeals body, we will not substitute our judgment for that of the hearing officer when the determination is not so against the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Texas Workers' Compensation Commission Appeal No. 950456, decided May 9, 1995.

Claimant contends that the designated doctor's zero percent IR certification is overcome by the great weight of the other medical evidence because the testimony of Dr. B and the medical evidence show "different diagnoses [and] significant changes in condition" and not just a difference in medical opinion. Claimant also states that claimant's medical records and operative reports should be sent to the designated doctor for his evaluation.

It is not clear what documents were sent to the designated doctor for reconsideration of his certification. We do not have Dr. B's letter that was sent to the designated doctor. We know that the designated doctor did not receive the operative report from March 1999. Under these circumstances, we believe the decision of the hearing officer to afford presumptive weight to the designated doctor's report was premature. The hearing officer should have sent all of claimant's medical records, including all the operative reports, to the designated doctor and sought clarification from the designated doctor regarding whether there has been a substantial change of condition in this case and whether the IR should be amended. We further note that the designated doctor rated only the left knee and that the injury was to both knees. Therefore, the hearing officer should inform the designated doctor that the entire injury was not rated. We therefore reverse that determination and remand this case to the hearing officer to make further inquiry of the designated doctor concerning whether the medical condition of both knees treated by Dr. D, was significant or involved a substantial change of condition, and would cause Dr. M to amend either the date of MMI or the IR. *See, generally,* Texas Workers' Compensation Commission Appeal No. 980287, decided March 30, 1998. Should the designated doctor amend the IR in this case, the hearing officer should also determine whether such amendment was done within a reasonable time and for a proper purpose, considering the date of statutory MMI, and whether any surgery was contemplated as of that date, and whether there was a substantial change of condition. Texas Workers' Compensation Commission Appeal No. 990833, decided June 7, 1999.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Commission's Division of Hearings pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

_____
Judy Stephens
Appeals Judge

CONCUR

_____
Tommy W. Lueders
Appeals Judge

_____
Dorian E. Ramirez
Appeals Judge