APPEAL NO. 991242

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On April 13, 1999, a contested case hearing (CCH) was held. In response to the issues at the CCH, the hearing officer determined that: (1) the _____, compensable injury of the respondent (claimant) did not extend to and include reflex sympathetic dystrophy (RSD) of the left hand; (2) the correct impairment rating (IR) is 15%, as certified by Dr. GH; and (3) appellant (carrier) did not timely file a controversion of the RSD. The hearing officer further found that "carrier's failure to contest compensability cannot create an injury as a matter of law."[1] The hearing officer found that the 29% IR of the designated doctor, Dr. W, is contrary to the great weight of the other medical evidence because it included impairment for RSD. The hearing officer rejected the designated doctor's IR and adopted the IR of Dr. GH. Carrier appealed, contending that the hearing officer erred in adopting Dr. GH's IR because Dr. GH included impairment for the left shoulder and left elbow, which it asserts are not part of the compensable injury. Carrier also complains that Dr. GH included impairment for motor and sensory disorders, but did not explain what the deficits were or how they related to the hearing officer's determination regarding the RSD. In her response, claimant agreed that she did not have RSD. Claimant also agreed that "the great weight of the other medical evidence was sufficient to overcome the findings of the [designated doctor]." Claimant responded that the Appeals Panel should affirm the hearing officer's determination that the IR is 15%.

DECISION

We reverse and remand.

Carrier contends the hearing officer erred in adopting Dr. GH's 15% IR because Dr. GH included impairment for the left shoulder and left elbow, which it asserts are not part of the compensable injury. Carrier also complains that Dr. G included impairment for motor and sensory disorders, but did not explain what the deficits were or how they related to the hearing officer's determination regarding the RSD.

It was undisputed that claimant sustained a compensable left upper extremity injury on _____. The hearing officer concluded that claimant reached statutory maximum medical improvement (MMI) on November 19, 1997. Claimant did not testify. In a November 19, 1997, report, the designated doctor stated that: (1) claimant said she had been employed for three and one half years as a packer; (2) claimant sought medical treatment for pain in _____ and was diagnosed with carpal tunnel syndrome (CTS); (3) claimant underwent left CTS surgery in May 1996; (4) claimant continued to be symptomatic after the surgery. Claimant treated with Dr. GH and with Dr. CO.

[1]We would note that the hearing officer's determinations in this regard were not appealed by claimant.

In a November 1995 report, Dr. CO stated that claimant's range of motion (ROM) in her shoulders and elbows was essentially normal and noted pain and tenderness only in the left forearm and wrist. In a December 14, 1995, report, Dr. CO noted that claimant complained of pain radiating into her left forearm and shoulder. In a March 1996 report, Dr. A, stated that he performed a neurological consultation, that claimant complains of pain extending from her hand to her shoulder and neck, that she had some pain in her leg, and that neurological examination is significant for mild to moderate giveway weakness of the left arm. In a May 22, 1996, report, Dr. CO noted that claimant had been diagnosed with CTS and extensor tendinitis of the left wrist, and said that an examination did not reveal other edema. In a July 26, 1996, physical therapy report received by carrier on August 6, 1996, it was noted that claimant had swelling in the left elbow and that she was receiving neuromuscular stimulation in the left wrist and elbow, and electrical stimulation to the left shoulder to decrease pain. In an August 19, 1996, report, Dr. CO stated that claimant is undergoing physical therapy; that she complains of pain in her forearm and upper arm, and that she complained of intermittent paresthesia. In a December 13, 1996, report, Dr. CO noted that claimant is status post CTS release and that she complains of swelling, pain, and numbness from the hand to the shoulder. In a November 29, 1996, report, Dr. CO stated that claimant's diagnosis is RSD. Progress notes, apparently from physical therapy, state that claimant's elbow and shoulder ROM was measured and that claimant complained of severe pain in the shoulder and elbow. A date stamp indicates that carrier received this in September 1996. In a March 1997 report, apparently from Dr. B, regarding pain management, it was noted that claimant's elbow was swollen. In a July 3, 1997, Report of Medical Evaluation (TWCC-69), Dr. GH certified that claimant's IR is 15%. In an accompanying report, Dr. GH noted that claimant has symptoms in her entire left upper extremity, that she has pain with movement of the left upper extremity joints, and that she has visible loss of mobility of the joints of the left upper extremity. The 15% IR includes impairment for loss of ROM in the left wrist, elbow and shoulder, four percent impairment for sensory deficit, and two percent impairment for motor deficit. Dr. GH stated that muscle testing, reflex testing, and sensory testing were performed "on the appropriate areas" to determine whether there were neurologic changes. In a November 18, 1997, report, Dr. GH noted that claimant continues to have left arm complaints, that she has difficulty lifting her left arm, and states that an MRI is needed to rule out derangement of the left shoulder.[2] In a January 1999 report, Dr. GH noted that claimant's pain is "so severe now that she has radiation of the pain into [her] hands and also proximal to her shoulders."

In a February 1996 report, Dr. K noted that claimant's EMG testing showed significant changes "compatible with CTS." In a January 1997 report, Dr. K stated that claimant was status post CTS release, that she did not have any swelling, that her ROM in her digits was normal, and that her two point sensibility was normal. In a February 1997 report, Dr. K indicated that claimant's CTS was not related to her work activities. In a September 12, 1997, TWCC-69, Dr. K stated that claimant reached MMI on September 9, 1997, with an IR of zero percent. In an accompanying report, Dr. K noted that there is no significant alteration in the motor or sensory function of claimant's digits, that he cannot identify any objective explanation for claimant's symptoms, and that he believes there is

[2]The date of injury is in 1997 in this report.

significant emotional overlay. In a January 20, 1998, report, Dr. G stated that he reviewed the designated doctor's 29% IR, that the designated doctor did not explain the sensory impairment, and notes that the hand surgical consultant who saw claimant failed to find any objective explanation for her symptoms. In an October 29, 1998, TWCC-69, Dr. C certified that claimant's IR is 12%. In an accompanying report, Dr. C stated that claimant had CTS surgery in 1996, that her bone scan was negative, that her EMG was negative for any significant pathology, that clinical findings were not reflective of a causalgia of the hand, that claimant has not responded to stellate ganglion blocks, and that a diagnosis of RSD is not appropriate. He stated that he did not find "any causal relationship between her elbow and shoulder and the _____ injury, and would not comment on that." Dr. C stated that claimant has a "significant problem with her hand, whatever the underlying cause." He noted that claimant had passive motion in her joint and stated that the 12% IR was for impairment due to sensory loss.

In a November 19, 1997, report, the designated doctor stated that: (1) he measured the ROM in claimant's left hand, wrist, elbow, and shoulder; (2) claimant has diminished use of the "entire left upper extremity"; (3) there were no bruises, discolorations, or signs of acute injury on the hand or upper extremity; (4) the color of the forearm was normal; (5) passive ROM was normal at the wrist, elbow, shoulder, "and all M/P, PIP, and DIP joints in the fingers and hand"; (6) no swelling was noted in any of the joints; and (7) claimant had a grip strength of zero on the left. The designated doctor's final diagnosis was left CTS and severe RSD. The designated doctor signed a TWCC-69 on November 19, 1997, that stated that claimant was not at MMI. On November 19, 1997, the designated doctor signed a second TWCC-69 certifying that claimant reached MMI on November 19, 1997, and that her IR is 29%. An attached worksheet indicates that the designated doctor measured claimant's ROM in her left hand and found her total hand impairment to be 20%, which he converted to an 18% upper extremity impairment for "motion loss," which converted to an 11% whole person impairment. The worksheets also state that the designated doctor found 20% upper extremity impairment for sensory loss and major causalgia under "Table 10" and "Table 14." The designated doctor combined these impairments and concluded that claimant had a 29% whole person IR.

In a May 1998 letter, the designated doctor stated that he reviewed the opinions of Dr. K and Dr. G, and that, despite their opinions, he believed a diagnosis of RSD was appropriate. In December 1998, a Texas Workers' Compensation Commission (Commission) benefit review officer (BRO) wrote to the designated doctor and said there is an issue whether claimant has RSD. The BRO stated that she was forwarding a letter from Dr. C, who was appointed as the medical examination order doctor regarding extent of injury and the RSD. On January 27, 1999, the designated doctor replied that "RSD best describes" claimant's symptoms. He further said, "assuming that the diagnosis of RSD. . . is correct, then the whole person impairment level is also correct." The designated doctor stated that he saw no reason to alter the IR.

Carrier's Payment of Compensation or Notice of Refused/Disputed Claim (TWCC-21) stating that it was "disputing left elbow and left shoulder as unrelated to compensable injury of L CTS." Although it was not file stamped, a stamp states that a copy was sent to

"TWCC, attorney, claimant" on July 14, 1997. At the CCH, carrier noted that it filed TWCC-21s in this case asserting that the injury is limited to CTS. Carrier asserted that the hearing officer should reject the designated doctor's IR and adopt Dr. C's 12% IR.

The hearing officer determined that: (1) Dr. W, the designated doctor, determined that claimant's IR is 29%; (2) the designated doctor included RSD in his assessment of claimant's IR; (3) the designated doctor's 29% IR is contrary to the great weight of the other medical evidence; and (4) the correct IR is 15%, as certified by Dr. GH.

The report of a Commission-selected designated doctor is generally given presumptive weight with regard to MMI status and IR. Sections 408.122(b) and 408.125(e). The amount of evidence needed to overcome the presumption is the "great weight" of the other medical evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92166, decided June 8, 1992. A designated doctor's report is not given presumptive weight regarding the extent of the injury or whether there is an aggravation of a preexisting condition that needs to be rated. Texas Workers' Compensation Commission Appeal No. 950789, decided June 30, 1995. The hearing officer may determine the extent of the injury and then return the designated doctor's report with instructions to rate the entire injury, as found by the hearing officer. Appeal No. 950789.

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 great weight and preponderance of the evidence as to be clearly or manifestly unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Texas Workers' Compensation Commission Appeal No. 950456, decided May 9, 1995.

In deciding this case, we first note that the hearing officer did not fully explain why she determined that the designated doctor's report is contrary to the other medical evidence. One reason stated was due to the fact that the designated doctor's IR included impairment for RSD. The designated doctor did not refuse to comply with the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) in this case. The hearing officer did not explain why she did not inform the designated doctor of the extent of the injury and then instruct the designated doctor to rate the injury. *See* Appeal No. 950789. The hearing officer is not required to go back to the designated doctor in this case, should the hearing officer determine that the designated doctor's IR is otherwise invalid or contrary to the great weight of the other medical evidence. The hearing officer may also adopt the rating of another doctor or a second designated doctor may be selected. We remand this case to the hearing officer for consideration of the IR issue consistent with this decision.

Carrier complained that the hearing officer should not have adopted Dr. GH's 15% IR because it included impairment for the elbow and shoulder. Carrier asserted that it accepted liability for the left wrist, only. Dr. GH's 15% IR does include impairment for the left elbow and shoulder. In the decision and order, the hearing officer does not discuss whether the left elbow and shoulder are part of the compensable injury. The hearing officer did not make a finding regarding extent of injury and the elbow and shoulder. On remand, should the hearing officer reconsider whether to adopt the IR of Dr. GH, the hearing officer should consider and make a finding regarding extent of injury, which must be decided before the IR issue is decided. The hearing officer may decide this issue after a hearing on remand on extent of injury. Should the hearing officer consider Dr. GH's IR on remand, the hearing officer should also seek clarification from Dr. GH regarding the motor and sensory loss and clarify that RSD is not part of the compensable injury in this case. Should the hearing officer adopt the rating of another doctor, the hearing officer should ensure that the IR includes impairment for the compensable injury only. We would note that it would not be proper for any IR for this injury to include impairment for RSD.

We reverse the hearing officer's decision and order and remand this case to the hearing officer for further proceedings consistent with this decision. 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 Texas Workers' Compensation Commission's Division of Hearings, pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

_____
Judy L. Stephens
Appeals Judge

CONCUR:

_____
Robert W. Potts
Appeals Judge

_____
Philip F. O'Neill
Appeals Judge