APPEAL NO. 991502

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On May 17, 1999, a contested case hearing (CCH) was held. The hearing officer reopened the record on May 25, 1999, in order to obtain additional clarification from the designated doctor and the record was closed again on June 18, 1999. With regard to the issue before her, the hearing officer determined that the great weight of other medical evidence was contrary to the designated doctor's report of a 15% impairment rating (IR) and she adopted the treating doctor's 30% IR.

Appellant (carrier) appealed, contending that the hearing officer's findings of fact were "simply a recitation of the evidence presented," that the hearing officer mistakenly believes that some authority "requires a worksheet to prove that a neurological exam was performed," and that this case involves a mere difference of medical opinion insufficient to overcome the presumptive weight of the designated doctor's report. Carrier requests that we reverse the hearing officer's decision and render a decision that respondent's (claimant) IR is 15% as assessed by the designated doctor. The file does not contain a response from claimant.

DECISION

Reversed and remanded.

It is undisputed that claimant, a highway worker, sustained a compensable injury on _____, when claimant was standing between two motor vehicles, when one of the vehicles rolled into the other, catching both of claimant's legs between the bumpers. Claimant sustained multiple injuries of the legs, primarily around the knees. Claimant was treated for a left "proximal fibular fracture, with a tibial plateau fracture" and a right knee "fracture of the proximal portion of the fibula, with a tibial plateau fracture." Claimant was treated locally and then transferred to the care of Dr. H, who is the treating doctor. Additional surgery was performed on October 25, 1997, to remove some hardware and on April 1, 1998, claimant had an arthroscopic procedure on his right knee by Dr. H. The parties stipulated that claimant reached maximum medical improvement (MMI) on September 14, 1998, pursuant to the report of Dr. P, the designated doctor (and we might add, Dr. H's certification of that same date).

Dr. H, in a Report of Medical Evaluation (TWCC-69) and narrative dated September 14, 1998, certified MMI and assessed a 30% IR. Dr. H based the IR using Table 36 (Impairment Ratings of the Lower Extremity For Other Disorders of the Knee) of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) assessing 17% impairment for the left leg (including a 15% impairment for the left lower extremity for sensory loss) and a 16% impairment for the right leg (including 15% impairment for "posterior tibial sensory loss"). Dr. H combined the two ratings for a total whole body 30%

IR. In evidence are motor and sensory nerve conduction studies performed by Dr. KP on August 10, 1998. Dr. KP's conclusions were:

> Conclusions: 1) Posterior tibial compression neuropathy at the knees is possible per hx. There could have been Wallerian degeneration affecting more proximal mm. 2) Lumbar radiculopathy cannot be ruled out.

Carrier disputed Dr. H's IR and Dr. P was appointed as the Texas Workers' Compensation Commission (Commission)-selected designated doctor to assess an IR only. In a TWCC-69 and narrative dated November 11 and 9, 1998, respectively, Dr. P assessed a 15% IR. Dr. P recites a detailed history and assessed a 20% impairment for each lower extremity and stated a "detailed delineation as to how the assessment was derived is enclosed." No such delineation was attached to the report in evidence. Dr. P did not address motor or sensory nerve deficit one way or another. Dr. P said that he considered "the patient's subjective history, physical findings, available medical records, x-ray examinations and reports of any diagnostic studies the patient may have had. *See* the requirements of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6(h) (Rule 130.6(h)). In a letter dated December 31, 1998, the Commission sent some additional (unspecified) information for Dr. P to consider. That additional information may have been a note dated November 18, 1998, from Dr. H criticizing Dr. P because he had not recited a "crush injury of the nerves," did not mention neurologic deficit and does not specifically recite the meniscal tear and partial lateral meniscectomies. Dr. P replied by letter dated January 9, 1999, stating that his report clearly indicates the injury and treatment to both knees and goes on to say:

> The patient was assessed for the injury about the knee joint and was given the maximum rating for arthritic involvement about both of his knees, which is the sequelae of the injury that he sustained.
>
> The patient has no gross motor deficit into the distal aspect of either extremity. The crushing injury that he sustained has fortunately not left him with gross motor and/or sensory deficits below the level of the injury. The assessment previously rendered is appropriate, based on the information available and on the primary sequelae of the injury that the patient sustained.

At the CCH, there was discussion regarding the "detailed delineations/ charts/worksheets" which Dr. P had indicated were attached to his report. After the CCH, the hearing officer apparently looked in the claims file and determined that the "file did not contain these details/charts/worksheets." The hearing officer also commented that a letter dated March 16, 1999, from Dr. H to the carrier indicated that Dr. H had not received a copy of Dr. P's worksheets "in order to assess whether a neurological evaluation had been performed." Consequently, the hearing officer reopened the record, wrote Dr. P (with copies to the ombudsman and carrier) by letter dated May 25, 1999, asking Dr. P about his November 1998 report where he stated that a "detailed delineation as to how the assessment was derived is enclosed," but that delineation was not available and to please provide "the referenced details/worksheets and or charts." Dr. P replied by letter dated May

27, 1999, enclosing a form entitled "Lower Extremity Impairment Evaluation Record" apparently dealing with flexion and extension showing a "right 28% impairment and a left 21% impairment." On another handwritten sheet, Dr. P indicates that he used Table 36 Specific Disorder "#5" of the AMA Guides to arrive at a 20% lower extremity rating on each leg and combining that with the 28% right and 21% left loss of range of motion and using Table 42 (Relationship of Impairment of the Lower Extremity to Impairment of the Whole Person) to arrive at an eight percent impairment of each lower extremity combined to give a "15% WBI - combined values." The hearing officer afforded the parties additional opportunity to comment on Dr. P's response, setting certain time limits. The hearing officer, in her Discussion, commented:

> A response, submitted as Hearing Officer exhibit 4, included additional information from [Dr. P], but no worksheets showing that a neurologic exam had been performed on Claimant.

The hearing officer made the following disputed findings of fact:

FINDINGS OF FACT

10. [Dr. P's] designated doctor's report is contrary to the great weight of the other medical evidence regarding Claimant's [IR] and therefore is not valid and not entitled to presumptive weight regarding Claimant's [IR]. The other medical evidence established a crush injury bilaterally to Claimant's legs resulting in, among other things, neurologic/ sensory loss bilaterally.

11. The great weight of the other medical evidence included [Dr. H's] credible reports and opinions regarding Claimant's very severe bilateral leg injuries resulting in neurologic/sensory loss. [Dr. KP's] credible report with Nerve Conduction Velocity studies and findings of neurologic/sensory loss bilaterally. Claimant's credible history of the mechanism of injury. [Dr. P's] report of November 11, 1998 excluding mention and/or findings from a neurologic examination of Claimant. And finally, [Dr. P's] two missed opportunities to include findings from a neurologic exam to support his December 31, 1998 conclusion that Claimant did not sustain neurologic/sensory loss in either leg.

Carrier points out that the hearing officer's findings of fact "are simply a recitation of the evidence presented." We agree in large part that the hearing officer just restates her Statement of the Evidence which consists of a summarization of the various medical reports. These are not findings of fact. The hearing officer does, in Findings of Fact Nos. 10 and 11, quoted above, make some determinations. The issue seems to be whether or not Dr. P should have awarded some sort of impairment for neurologic/sensory loss which Dr. H felt was present and whether the failure of Dr. P to submit "delineations/ charts/worksheets" as requested by the hearing officer constitutes the great weight of other

medical evidence contrary to the designated doctor's report which allowed the hearing officer to adopt the treating doctor's IR.

We have frequently noted that Section 408.125(e) provides that the report of the designated doctor has presumptive weight, and the Commission shall base its determination as to an employee's IR on that report "unless the great weight of the other medical evidence is to the contrary." The presumption afforded the designated doctor's report and certification of IR is not rebutted "absent a substantial basis to do so." Texas Workers' Compensation Commission Appeal No. 950561, decided May 22 1995, citing Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993. A mere difference of medical opinion is not enough to overcome the presumption afforded the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 960034, decided February 5, 1996. Whether the party challenging a designated doctor's report has produced the great weight of other medical evidence contrary to the report and whether the presumption afforded to the report is rebutted is a question of fact for the hearing officer. Appeal No. 950561, *supra*. When finding that a designated doctor's certification of IR is contrary to the great weight of the medical evidence, the hearing officer must "clearly detail the evidence relevant to his or her consideration and clearly state why the other evidence is to the contrary." Texas Workers' Compensation Commission Appeal No. 950317, decided April 13, 1995.

Finding of Fact No. 11, quoted above, appears to be the hearing officer's detailing of the evidence contrary to the designated doctor's report. Both Dr. H and Dr. P agree that claimant sustained very severe bilateral leg injuries and both assigned impairments from Table 36 for those injuries. Dr. KP did motor and sensory nerve conduction studies with the conclusions quoted above. Dr. H, in a report dated March 30, 1999, said that he found numbness, loss of sensation and "loss of function due to sensory pain or discomfort" and that finding was "confirmed on electromyographic evaluation by [Dr. KP]." Dr. H goes on to state that "the EMG finding by itself does not produce impairment" but that his "clinical exam finding confirming it certainly does [constitute an impairment]." Basically, Dr. H is stating that in his clinical judgment, supported by the EMG, claimant has some neurological sensory loss. Impairment is defined in section 401.011(24) as "any anatomic or functional abnormality or loss . . . reasonably presumed to be permanent." Further, to overcome the presumptive weight of the designated doctor's opinion requires other medical evidence to the contrary. Consequently, claimant's testimony and history, no matter how credible, does not constitute other medical evidence.

The hearing officer cites Dr. P's "two missed opportunities to include findings from a neurological exam" and his failure to include charts and worksheets as other medical evidence contrary to his report. It is not clear whether Dr. P had Dr. KP's EMG, sensory and motor nerve tests available. We find nothing in the 1989 Act, Commission rules or the AMA Guides that require the doctor to provide neurological worksheets. We are, however, bothered by the fact that there are EMG/NCV studies in evidence which seem to demonstrate sensory deficits that, in turn, could be interpreted as establishing some kind of impairment and we cannot be sure that Dr. P has seen those studies (he does not list the specific reports that he reviewed) or what Dr. P relies on to make his comments that

claimant has "no gross motor deficit" of the lower extremities. Consequently, we are remanding for the following specific actions. Dr. KP's EMG/NCV studies of August 10, 1998, are to be sent to Dr. P and Dr. P is to be specifically asked to comment on those studies and their effect, if any, on the claimant's IR. Dr. P is also to be specifically asked if he did, or had done, any neurological testing and to please comment on the basis for his opinion that claimant has no motor and/or sensory deficits. Dr. P's response is to be made available to the parties for comment and the hearing officer is then to prepare a Decision and Order not inconsistent with this opinion.

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.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Robert W. Potts
Appeals Judge

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Elaine M. Chaney
Appeals Judge