APPEAL NO. 001120

Following a contested case hearing held on April 24, 2000, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer, resolved the disputed issue by determining that the respondent's (claimant) impairment rating (IR) is 26% based on the report of the designated doctor, Dr. D. The appellant (carrier) requests our review, asserting that the correct IR is the 12% assigned by Dr. PO because there are no clinical findings of an underlying spinal cord disease or injury to support Dr. D's methodology in rating claimant's reflex sympathetic dystrophy (RSD). The file does not contain a response from claimant.

DECISION

Affirmed as reformed.

No testimony was adduced and the parties presented their respective cases on documentary evidence and argument. There was no dispute concerning the date claimant reached maximum medical improvement (MMI), apparently the date of statutory MMI.

Dr. PO's Report of Medical Evaluation (TWCC-69), signed on "10/5/98," states that claimant's IR is 12%. Dr. TO signed the bottom of this form indicating his agreement as treating doctor. In his narrative report of September 15, 1998, Dr. PO stated that claimant's diagnosis is confusing; that he does not really believe claimant has RSD given the normal bone scan, the normal venogram, the normal EMG/nerve conduction study, and the ineffectiveness of the treatment; and that claimant does have to be diagnosed with a complex regional pain syndrome (CRPS) or chronic tenosynovitis. Dr. PO further stated that claimant has a marked strength loss; that under the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), "there are several ways you can attempt to rate this patient because she has hypersensitivity"; that claimant's strength loss could be rated from Table 11 but that if she is rated from Table 11 or 12, she cannot be rated by range of motion (ROM); and that he feels the most reasonable way to approach the rating problem is by looking at the vascular effects and rating claimant from the vascular system using Table 15 (Impairment of the Upper Extremity Due to Peripheral Vascular Disease) which would give her a higher rating than rating her median and ulnar nerve deficits. Dr. PO then stated that he felt claimant's rating should be at the lower end of Class 2 in Table 15, which has a range of 10% to 35%, and he assigned an IR of 20% for the right upper extremity for a 12% whole person IR.

In evidence is the February 2, 1999, TWCC-69 of Dr. S which assigned an IR of 42%. The carrier represented that this IR was determined using the fourth edition of the AMA Guides and neither party contended it was correct. Dr. S's accompanying narrative report states that claimant, then 70 years of age, apparently injured her right hand at work on January 31, 1997; that she has seen numerous doctors, several of whom felt that she had flexor tenosynovitis; and that she has had an extensive workup. Dr. S further reported

that claimant has decreased sensation throughout the right upper extremity, more so in the fingertips, and that she also has decreased grip strength. Dr. S also stated that claimant's RSD "cannot be rated by traditional tests" and that he felt that rating her for a peripheral vascular disease would be most appropriate.

Dr. D's TWCC-69, dated April 14, 1999, assigned claimant an IR of 25%. In his accompanying narrative report, Dr. D stated that on her injury date claimant was vacuuming the floor when she developed severe wrist pain; that she has intractable right upper extremity pain, neck pain, and shoulder girdle pain; and that there has been great disagreement about the way her impairment should be rated, noting Dr. PO's 12% and Dr. S's 42%. Dr. D, who is board certified in physical medicine and rehabilitation, further reported that he is rating claimant for an obvious RSD; that RSD can be rated as a sensory nerve pain syndrome if there is a sensory nerve injury; and that since claimant did not have a sensory nerve injury, she is therefore "rated under the autonomic nervous system as a sympathetic dysfunction as an autonomic dysfunction"; and that he has awarded a 20% impairment as this is comparable to a medium nerve impairment for causalgia and an additional six percent for abnormal wrist ROM for a total combined whole person IR of 25%. Dr. D's narrative report has attached some worksheets, one of which reflects that Dr. D assigned 20% for central nervous system (CNS) impairment for autonomic dysfunction of the right arm due to RSD from Chapter 4 (The Nervous System) of the AMA Guides.

The carrier introduced the April 27, 1999, report of Dr. N who apparently reviewed the reports of Dr. PO and Dr. D. Dr. N concluded that while he was more accepting of the rating approach and 12% IR assigned by Dr. PO, he would only assign six percent for loss of wrist ROM.

Dr. PO's August 25, 1999, letter to the carrier reviewing Dr. D's report states that "the 3rd edition of the Guides does not clearly address RSD/CRPS"; that he, Dr. PO, rated claimant's impairment based on a vascular component while Dr. D rated claimant based on loss of strength and sensation, in addition to the loss of ROM at the wrist; and that, unlike himself, Dr. D does not clearly state which table or section of the AMA Guides he used. Dr. PO goes on to state that the carrier's letter to him stated that Dr. D used Chapter 4, page 99 of the AMA Guides; that this section relates to the spinal cord; that CRPS does "not necessarily indicate a spinal cord disorder which is what is rated under Section 4.1b"; and that he, Dr. PO, chose to use the vascular rating approach because it is difficult to use Table 10 (impairment from pain, discomfort, or loss of sensation) and Table 11 (impairment from loss of strength) because of claimant's hypersensitivity. Dr. PO went on to state that it appears from Dr. D's report that he used the rating chart for impairment of an extremity on page 99 of the AMA Guides with the range of 15 to 25%, that this category requires that the patient have no digital dexterity, and that claimant does have digital dexterity.

Dr. D wrote on October 21, 1999, that he reviewed Dr. PO's critique; that the AMA Guides are somewhat deficient for rating RSD (formerly known as causalgia and now known as CRPS); that the examiner can use Tables 10 and 11, as Dr. PO recognizes, or

CNS as the diagnosis of autonomic dysfunction as a CNS dysfunction; and that he chose to use the CNS dysfunction because claimant does not have a direct median nerve injury. Dr. D said the percentage amount he used "roughly equates to the amount someone with this serious or a more serious nature [sic] injury that would be accounted for using tables 10 and 11 and I use that as a guide to come up with a severity level." Dr. D concluded that he disagrees with Dr. PO's conclusions; that he and numerous other doctors who have been perplexed with the problems of rating RSD have come up with several mechanisms to make up for the deficiencies in the AMA Guides; that he felt that the 16% to 20% range was a reasonable number; and that he sees no reason to change his report based on Dr. PO's observations.

Dr. PO wrote to the carrier on November 29, 1999, stating that his own use of the vascular system to rate RSD/CRPS is just one and certainly not the exclusive approach; that the use of Tables 10 and 11 is another approach; and that he does not fault Dr. D's methodology or approach to rating RSD/CRPS, but that he does find Dr. D's report flawed for failing to communicate the AMA Guides section and table or tables used as well as the clinical findings that made the use of such section and tables appropriate.

The carrier does not dispute a finding that IR schemes for RSD/CRPS are not specifically provided for in the AMA Guides. The carrier does dispute findings that the disagreement between Dr. D and Dr. PO amounts only to a difference of professional medical opinion and that the great weight of the other medical evidence is not contrary to the report of the designated doctor.

With regard to the determination of an injured employee's IR, Section 408.125(e) provides that the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission) shall have presumptive weight and the Commission shall base the IR on that report unless the great weight of the other medical evidence is to the contrary. The Appeals Panel has frequently noted the important and unique position occupied by the designated doctor under the 1989 Act. *See, e.g.*, Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. We have just as frequently stated that a "great weight" determination amounts to more than a mere balancing or preponderance of the evidence (Appeal No. 92412) and that a designated doctor's report should not be rejected "absent a substantial basis to do so." Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993.

The hearing officer is the sole judge of the weight and credibility of the evidence (Section 410.165(a)) and, as the trier of fact, resolves the conflicts and inconsistencies in the evidence including the medical evidence (Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ)). The Appeals Panel, an appellate reviewing tribunal, will not disturb the challenged factual findings of a hearing officer unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust and we do not find them so in this case. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); In re King's Estate, 150 Tex. 662,

244 S.W.2d 660 (1951). To correct an apparent typographical error, however, we reform the hearing officer's decision and order to reflect that Dr. D's IR is 25% not 26%.

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Gary L. Kilgore
Appeals Judge

Dorian E. Ramirez
Appeals Judge