APPEAL NO. 950343

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held in (city), Texas, on December 20, 1994, to determine the claimant's impairment rating (IR). The carrier appeals the decision of the hearing officer, (hearing officer), that the great weight of the other medical evidence is contrary to the IR of the designated doctor; it contends, as it did at the hearing, that the designated doctor's report was thorough and accurate and that the opposing opinion of claimant's treating doctor merely represents a difference of opinions between doctors.

DECISION

We affirm.

The claimant, who was employed by (employer), suffered a compensable back injury on (date of injury), when he slipped and fell into a ditch, landing in a semi-seated position. He was 36 years old at the time of the injury. His treating doctor, (Dr. C), referred him to an orthopedic surgeon, (Dr. K), who ordered diagnostic tests. An August 4, 1993, thoracic spine MRI showed a "prominent" disk herniation at T6-7 and smaller protrusions at T7-8 and T10-11. A lumbar MRI, which was referred to in other medical reports, apparently showed a small protrusion or herniation at L5-S1 along with some degeneration at that level, but no nerve root impingement. A bone scan was normal. On August 9, 1993, claimant was seen by (Dr. D), orthopedic surgeon, for an independent medical examination. Dr. D wrote that claimant's imaging studies "show nothing which would be of significance." He found claimant negative for any objective findings, with a normal neurological examination. Dr. D gave a diagnosis of lumbar and thoracic sprains, resolved, and found claimant to have reached maximum medical improvement (MMI) as of the date of his examination, with a zero percent IR. Dr. K thereafter wrote to state his disagreement with Dr. D's assessment, stating there was "ample objective evidence . . . to reveal multilevel degeneration" along with a large central herniation. He said he did not believe surgery was an option and that he did not believe further conservative therapy would provide any significant long term benefit. His recommendation was "complete disability from the [claimant's] prior line of work with retraining through the Texas Rehabilitation Commission," and he said the claimant would be returned to Dr. C for assessment of MMI and impairment.

In September of 1993, Dr. C wrote that he also disagreed with Dr. D's diagnosis, although he agreed with Dr. K's assessment; he said that when he next saw the claimant he would "assign him [MMI]." He also wrote that Dr. D's zero percent IR was "totally incorrect" in that the claimant merited at least a 10% IR for the specific disorder of the lumbar and thoracic spine, in addition to any impairment from range of motion (ROM). Attached to the exhibit containing Dr. C's letter is a worksheet containing ROM measurements for claimant's lumbar and thoracic spine, along with an impairment summary sheet assessing claimant's total impairment at 25% (comprised of three percent and seven percent, respectively, for the specific disorder of claimant's thoracic and lumbar spine, and ten

percent and 17%, respectively, due to claimant's loss of ROM in the thoracic and lumbar areas). The final sheet contains the following notation: "Patient has had 2 injuries. The first was (date) to his thoracic spine. Impairment for this is 10% WP. The second was (date of injury). The [IR] for this was 17% WP." At the hearing, the claimant stated that he had a thoracic spine injury in (year) for which he had lost no time from work; he did not specify whether it was a compensable injury. He said he had never had a previous injury to the lumbar spine.

The record reflects that the Texas Workers' Compensation Commission (Commission) selected as designated doctor (Dr. P), who examined the claimant on October 26, 1993. Dr. P summarized claimant's studies, including the thoracic MRI and an MRI of the lumbar spine which showed minimal subligamentous herniation at L5-S1, with no evidence of nerve root impingement. He also referred to a lifting incident approximately one year prior to this injury which, the claimant said, caused pain which resolved through conservative treatment. Dr. P certified MMI as of the date of the examination with a 10% IR. Dr. P explained his assessment in pertinent part as follows:

> He has sustained a three (3%) percent permanent physical impairment and loss of physical function of the whole body as a consequence of the degenerative process present about his thoracic spine and a seven (7%) percent permanent physical impairment . . . in the L5-S1 disk with the superimposed traumatic event as a precipitating episode. This assessment of impairment is based on the Guides to the Evaluation of Permanent Impairment, Third Edition, Second Printing, published by the American Medical Association using primarily Tables 49, 50, and the [ROM] assessment . . . The Guides . . . nor the computerized testing apparatus can taken [sic] into account the ROM that the patient had prior to the accident, the body habitus (obesity, muscularity, etc.) or the patient's individual physiologic stiffness. "Reproducibility of abnormal motion is currently the only known way to validate optimum effort." The impairment attributable to the [ROM] has been weighted accordingly. The assessment of impairment relating to the loss of [ROM] has been apportioned in both the thoracic and the lumbar regions in order to make the assessment compatible with the . . . Guides . . .

Attached to Dr. P's report were ROM calculations indicating the claimant had been assigned one percent impairment (apportioned from 10%) for thoracic and two percent (apportioned from 24%) for lumbar.

On April 4, 1994, Dr. C wrote that he disagreed with Dr. P's assessment for a number of reasons. First, pointing out that claimant's lesions were described on test results as "prominent" and "moderate," he contended that claimant's specific disorder of the spine should have been rated under Table 49, Section II.C. (which relates to "moderate to severe" changes) instead of Section II.B. ("none to minimal" changes).

Second, Dr. C maintained that Dr. P improperly apportioned claimant's lumbar and thoracic ROM impairment, citing to the provision in the AMA Guides stating that "[t]o establish that a factor could have contributed to the impairment the analysis must include a discussion of the pathophysiology of the particular condition and of pertinent host characteristics. A conclusion that a factor did contribute to an impairment must rely on documentation of circumstances under which the factor was present, and verification that the type and magnitude of the factor were sufficient and had the necessary temporal relationship to the medical condition." To the contrary, he said, Dr. P "arbitrarily eliminated 29% of the patient's calculated impairment without any documentation whatsoever." Dr. C further pointed out that a doctor should only "suggest that impairment could be apportioned to a pre-existing condition or some other factor but that such decision would still be made by [the Commission]."

Finally, Dr. C stated that Table 50 was not appropriate to be used to rate claimant's condition, as the claimant did not have ankylosis.

A Commission benefit review officer sent Dr. C's letter to Dr. P, requesting his review and response. In a letter dated July 26, 1994, Dr. P replied that the claimant had no fracture, no neurologic deficit, and no surgically treatable disease, but rather demonstrated "loss of anatomic integrity to several joints in the lumbar and in the thoracic spine . . . The medical literature documents that perhaps as high as 30 to 40 percent of randomly selected asymptomatic individuals undergoing MRI assessment . . . will demonstrate the same changes [claimant] was ultimately demonstrated to have present . . . More than likely, [claimant] had the same changes prior to (date of injury) that he was demonstrated to have subsequent to that date. Nonetheless, based on his historical information that he experienced the onset of symptoms following an injury in the course of his employment, the assessment of the patient by MRI was undertaken and an impairment was assessed based on the structural changes that were demonstrated." Dr. P pointed out that no impairment was found by Drs. D and K (the claimant contended at the hearing that the latter claim was erroneous, based upon Dr. K's reports in evidence).

As to which part of Table 49 should have been used, Dr. P stated that "the underlying pathology or abnormality or pathophysiology needs to be considered and not the adjective the radiologist used on the MRI," and said that he believed the claimant's changes in the lumbar and thoracic spine were best described by Section II.B. Regarding ROM, Dr. P wrote that:

> Tables 54 and 55 [ankylosis of the thoracic spine] address maximum values that might be assessed by virtue of the loss of motion in the thoracic spine. Table 56 [abnormal motion of the lumbosacral region] further addresses a maximum value that might be assessed by virtue of immobility in the lumbar spine. Table 50 provides further guidance as regards the maximum values that might be assessed if the spine were determined radiographically to be ankylosed. If the ROM assessment is accomplished without consideration as regards these

> maximum values, the results are not supported by simple applications of the rule of common sense. The ROM must be commensurate with the underlying pathology, pathophysiology and abnormality unless that is accomplished in a reasoned fashion. The result will be perhaps in the range that [Dr. C] proposes of twenty-nine percent. That figure, however, is not reasonable based on the maximum values available to the examiner in the appropriate tables . . . . [The AMA Guides] provides [sic] guidelines for the assessment of impairment. That assessment of impairment, however, must reflect the underlying objective evidence of structural abnormality. Attempting to use the tables without consideration for the objective evidence of structural abnormality would seem to me to be missing the forest for the trees. The underlying abnormality and the impairment associated as a consequence of that should be reasonably compatible. I think that is the figure that we have determined in [claimant] to be present.

At the hearing the claimant contended that the great weight of the other medical evidence was contrary to the report of Dr. P due to the deficiencies outlined in Dr. C's letter. The carrier maintained that all that existed was a professional difference of opinion. The hearing officer, setting forth in findings of fact the opinions of Drs. C and P, determined that Dr. P's 10% IR "is against the great weight of other medical evidence in that [Dr. P] improperly calculated impairment for loss of ROM;" that Dr. D's IR is incorrect and that no impairment award can be based on that assessment; and that because no other doctor's TWCC-69 [Report of Medical Evaluation] certifying an IR is in evidence at the CCH, no IR for the claimant can be adopted by the Commission at this time.

The 1989 Act provides that the report of a designated doctor selected by the Commission is entitled to presumptive weight and must be accepted by the Commission "unless the great weight of the other medical evidence is to the contrary." Sections 408.122(b), 408.125(e). The Appeals Panel has held that a hearing officer who rejects a designated doctor's report as against the great weight of the other medical evidence 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. 93039, decided March 1, 1993. The hearing officer's determination in this case was based upon the designated doctor's findings as to ROM, which both "apportioned" claimant's impairment and appeared to rely on portions of the AMA Guides related to ankylosis or fusion of the spine. We note with approval the fact that the designated doctor was given an opportunity to respond to Dr. C's critique. However, we also agree that Dr. P incorrectly apportioned the impairment (the Appeals Panel has held that, even in cases where contribution from prior compensable injuries was an issue--which it was not in this case--the actual reduction is to be performed by the Commission and not by the doctor, *see* Texas Workers' Compensation Commission Appeal No. 93695, decided September 22, 1993); we also agree with the hearing officer that the designated doctor's reliance on Tables 50, 54, 55, and 56 was outweighed by the medical evidence including the opinions of Drs. C and K, and claimant's diagnostic studies which showed this not to be appropriate as claimant did

not have ankylosis. As we have previously held, medical evidence should be weighed according to its thoroughness, accuracy, and credibility with consideration given to the basis it provides for the opinions asserted. Texas Workers' Compensation Commission Appeal No. 93493, decided July 30, 1993. And, we have repeatedly held that the designated doctor occupies a unique position and his certification and opinion is not to be lightly discarded. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. However, based upon our review of the medical evidence, we cannot say that it is so weak or lacking as to make the hearing officer's decision against the great weight and preponderance of the evidence. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986).

The decision and order of the hearing officer are accordingly affirmed.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Thomas A. Knapp
Appeals Judge