APPEAL NO. 950387

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held in (city), Texas, on February 10, 1995, with (hearing officer) presiding as hearing officer. With respect to the only issue before him, the hearing officer determined that the respondent's (claimant) impairment rating (IR) is 16% as certified by the claimant's treating doctor. The appellant (carrier) requested review arguing that the report of (Dr. Z), the Texas Workers' Compensation Commission (Commission)-selected designated doctor, is entitled to presumptive weight, that the great weight of the other medical evidence is not contrary to the report of the designated doctor, and that the claimant's IR is 14% as certified by the designated doctor. A response has not been received.

DECISION

We reverse and remand.

The claimant injured her back on (date of injury). The claimant testified that she hurt her lower back. She said that later that evening her left hip and left leg started bothering her. She said that she did not have a loss of sensation in her left leg prior to hurting her back and that the loss of sensation in her left leg occurred about a week and one-half or two weeks after the accident. She said that before the surgery on February 15, 1993, she was tripping over her foot, and that after the surgery she got some of the sensation back but that she still has loss of sensation in her left leg. She testified that Dr. Z forced her legs several times on straight leg raises during the examination and caused pain that brought tears to her eyes. She said that Dr. Z touched her with something sharp and asked her if she had loss of sensation and that she responded that she did. She testified that she had no loss of strength prior to the injury. She said that she preferred not to return to Dr. Z because of the pain he caused her and because of the examination that he conducted. On cross-examination she said that she was offered the opportunity to return to Dr. Z for further testing, but that she declined.

The claimant introduced medical reports from health care providers who treated her. In a letter dated January 11, 1995, (Dr. C), the claimant's treating doctor, wrote that he was the claimant's physician prior to her injury on (date of injury), and that at no time prior to her injury did she have any problem with the L5 nerve root and that foot drop was not evident. He also wrote that (Dr. B) examined the claimant on October 6, 1992, and reported some weakness of the great toe on the left foot, diminished ankle reflex on the left, and diminished sensation to pin prick and light touch over the distribution of the L5 nerve root on the left side. Dr. C also wrote that on February 4, 1993, (Dr. H) noted that the left knee reflex was consistently diminished compared with the right knee. Dr. C includes the following from a January 6, 1993, report from (Dr. Y): "[s]he has significant weakness of the left tibialis anticus, exterior halluces longus and peroneal muscles. Sensory exam is normal. The left knee is equivocally depressed" and the following from a January 14, 1993, report of Dr. Y: "[s]he has severe weakness of the left extensor halluces longus and tibialis anticus. There

is essentially no power in the EHL, the tib anticus is profoundly weak. She has partial foot drop." Dr. Y performed surgery on the spine at L4 and L5 on February 15, 1993. Dr. C wrote in his January 11, 1995, letter that on December 21, 1993, (Dr. R) reported "[s]he has good strength except in the extensor halluces longus on the left side. The sensory examination is normal with the exception of decreased sensation in the L5 dermatome on the left side." In a Report of Medical Evaluation (TWCC-69) dated May 24, 1994, Dr. C reported that the claimant reached MMI on May 16, 1994, with an IR of 16% comprised of 10% for a specific disorder, four percent for loss of ROM, and two percent neurological deficit. In a narrative attached to the TWCC-69, Dr. C noted that the claimant's greatest concern was "not getting any feeling back in my left leg" and that the claimant has had several surgeries including surgery on her foot. On April 13, 1993, Dr. Y reported that the claimant had some residual incisional pain and intermittent paresthesia in the left lower extremity and on July 7, 1993, Dr. Y reported that the claimant's sciatica has resolved and that her paresthesia has largely resolved. In a letter dated July 28, 1993, Dr. R wrote:

> The neurological examination shows decreased sensation and paresthesia in the L4 dermatome on the left side. Otherwise, her sensory function is good. On strength testing, she has good strength bilaterally, and the extensor halluces may be slightly weaker on the left compared to the right. Reflexes are bilaterally symmetrical.

On September 7, 1993, Dr. R noted that the claimant was able to ambulate better than the first time she saw her, that on testing there was no leg strength discrepancy, and that the neurological examination shows diminished sensation to light touch and pin prick at the L4 dermatome pattern. In a letter dated February 11, 1994, (Ms. P), a physical therapist, reported that the claimant complains of lower extremity pain on the left which radiates posteriorly along the buttock and into the thigh and gastric and that "[h]er reflexes are within normal limits. Her sensation is diminished over the lateral aspect of the thigh, gastric, and foot, however, it is present." Ms. P also noted that the claimant is deconditioned and stiff, is not an athletic person, and has not done well on a home exercise program to regain her flexibility.

The carrier introduced the TWCC-69 of Dr. Z dated August 17, 1994. After noting that the claimant had multiple foot problems, Dr. Z wrote:

> The patient could not heel to toe walk, but I suspect this was probably secondary to the previous congenital foot abnormalities that she had in the past. Motor examination showed minimal residual weakness of dorsiflexion of the left great toe. Sensory examination was unremarkable.

Dr. Z noted that the claimant had pain on straight leg raising and did not assign IR for loss of ROM for flexion and extension because the results were invalidated by the straight leg raising. He assigned 10% for a specific disorder to the spine and four percent for loss of lateral flexion. In a letter dated August 23, 1994, Dr. C stated that he agreed with Dr. Z on the rating for the specific disorder and the ROM, but that he did not agree with Dr. Z's finding no neurological impairment. He said that he saw the claimant prior to the injury and she

was not having any problems with her feet and that on his own examinations he found weakness in the L5 dermatome with sensory loss present. In a letter dated November 28, 1994, Dr. Z wrote that he believed that his original interpretation was probably correct, that to the best of his recollection the claimant's examination was consistent with congenital abnormality, that the findings stated by Dr. C were at least ten months prior to his examination and that it would be extremely difficult at this time to comment on Dr. C's findings and criticism, and that he would have no objection to reevaluating the claimant.

The treating doctor and the designated doctor agree on the IR for the claimant's specific disorder and her loss of ROM. The treating doctor assigned a two percent IR for neurological deficit and the designated doctor did not assign any IR for neurological deficit. Disputes involving IR are not uncommon. The 1989 Act sets forth a mechanism to help resolve conflicts concerning IR by according presumptive weight to the report of a doctor referred to as the designated doctor. Texas Workers' Compensation Commission Appeal No. 92495, decided October 28, 1992. If the Commission selects the designated doctor and the validity of the report of the designated doctor is challenged as was done in this case, the Commission must determine whether the report of the designated doctor is valid and is entitled to presumptive weight. Texas Workers' Compensation Commission Appeal No. 93735, decided October 4, 1993. The hearing officer found that the claimant's injury included her loss of sensation to the L5 nerve root and her foot drop and that Dr. Z failed to follow the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) in not rating the claimant's loss of function and sensory loss on his suspicion which is not supported in the prior medical evidence. The report of the designated doctor is accorded presumptive weight regarding MMI and IR; however, the 1989 Act does not provide presumptive weight to the report of the designated doctor in regard to the extent of the injury. Appeal No. 93735, *supra*. The hearing officer weighed the evidence and determined the extent of the injury. But the hearing officer still had additional determinations to make to determine the claimant's IR. The fact that the claimant's injury included loss of sensation to the L5 nerve root and foot drop does not indicate that an IR for neurological deficit must be included in the IR assigned at the time of MMI. Some of the evidence concerning the extent of the injury and loss of sensation and foot drop is in medical records dated prior to the spinal surgery on February 15, 1993. Dr. R's report references L4 nerve root and other doctors refer to the L5 nerve root. Some of the medical records after the surgery are consistent with the report of the designated doctor concerning neurological deficit in which he reported that motor examination showed minimal residual weakness of dorsiflexion of the left great toe and that sensory examination was unremarkable. From the fact that the designated doctor did not rate the claimant's loss of function or sensory loss, it does not necessarily follow that the designed doctor did not consider the full extent of the claimant's injury. Both Dr. C and Dr. Z refer to foot surgery that appears to have been performed prior to the injury on (date of injury); however, the record does not contain other information about foot surgery. If records concerning the claimant's foot condition prior to the injury on (date of injury), are available, they should be provided to Dr. Z and made part of the record. The hearing officer should advise Dr. Z that the Commission has determined that the claimant's injury included loss of sensation to the L5 nerve root and her foot drop. The designated doctor should be asked to determine if the claimant has a permanent impairment from that

part of her (date of injury), injury, and if so, to include the IR for it in the whole body IR. Since it appears that the prior foot condition is congenital rather than resulting from a prior compensable injury, the designated doctor need not provide information on which the Commission could make a determination on contribution concerning the foot condition. We reverse and remand for the hearing officer to provide information to Dr. Z, ask him questions concerning neurological deficit, and seek clarification as to why he did not include an IR for neurological deficit in the IR.

Also, the Commission shall base its determination of the claimant's IR on the report of the designated doctor that is made in compliance with the AMA Guides unless the great weight of the other medical evidence is to the contrary. Section 408.125(e). We have held that it is not just equally balancing the evidence or a preponderance of the evidence that can overcome the presumptive weight given to the report of the designated doctor. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. No other doctor's report is accorded the special presumptive status given to the report of the designated doctor. Texas Workers' Compensation Commission Appeal No. 92366 decided September 10, 1992. The hearing officer resolves conflicts in expert evidence and assesses the weight to be given to expert evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). The hearing officer determined that the great weight of the other medical evidence is contrary to the report of the designated doctor because he did not rate the loss of function or sensory loss. In Texas Workers' Compensation Commission Appeal No. 92522, decided November 9, 1992, we stated that a hearing officer who rejects a designated doctor's report because the great weight of the other medical evidence is to the contrary must clearly detail the evidence relevant to his or her consideration, clearly state why the great weight of the other medical evidence is to the contrary, and further state how the contrary evidence outweighs the designated doctor's report. In the case before us, the hearing officer states the same basis that he used for determining that the report of the designated doctor is not entitled to presumptive weight rather than detailing and discussing the medical evidence sufficiently for us to clearly discern how the hearing officer arrived at his decision that the great weight of the other medical evidence is contrary to the report of Dr. Z, that is, how the great weight of the other medical evidence establishes that the IR of the claimant should include impairment for loss of function or sensory loss. If the hearing officer determines that the report of the designated doctor is entitled to presumptive weight and that the great weight of the other medical evidence is contrary to the report of the designated doctor, he should follow the guidance in Appeal No. 92522, *supra*, in setting forth the great weight of the other medical evidence that is contrary to the report of the designated doctor..

We note that the claimant declined to return to Dr. Z for further examination. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6(d) provides that if the parties do not agree on a designated doctor, "the commission shall issue an order directing the employee to be examined by a designated doctor chosen by the commission." The rule does not address reexamination, but since the claimant has challenged the report of the designated doctor and a reexamination of the claimant would not again involve the straight leg raises that she complained about, she should return for further examination concerning neurological deficit.

The claimant should be instructed to return to Dr. Z for an additional examination. A claimant who challenges the report of the designated doctor and who without good reason declines to be reexamined by a designated doctor does not have as strong an argument as a claimant who fully cooperates.

We reverse the decision and order of the hearing officer and remand the case for the hearing officer to fully develop the facts required to determine the claimant's IR, to make findings of fact and conclusions of law, and to award an IR not inconsistent 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.

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Tommy W. Lueders
Appeals Judge

CONCUR:

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Lynda H. Nesenholtz
Appeals Judge

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Thomas A. Knapp
Appeals Judge