

APPEAL NO. 92074
FILED APRIL 8, 1992

On January 15, 1992, a contested case hearing was held in _____, Texas, with (hearing officer) presiding as hearing officer, to consider three disputed issues, to wit: (1) whether the treating doctor and the designated doctor arrived at claimant's impairment ratings based upon the correct version of the medical guidelines; (2) whether claimant's spinal range of motion impairment was based on objective clinical or laboratory findings; and (3) whether claimant's impairment rating correctly included a seven percent impairment rating for "moderate to severe" degenerative changes to the lumbar spine or should only have included a five percent impairment for "none-to-minimal" degenerative changes. The hearing officer determined that the edition of the medical guidelines used in the calculation of claimant's impairment ratings was not the edition required by the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN art. 8308-1.01 *et seq.* (1989 Act), and invalidated the ratings. He directed that carrier pay impairment income benefits (IIBS) based upon carrier's "reasonable assessment" of claimant's correct impairment rating pending the prompt assignment of an impairment rating by the designated doctor based upon the correct edition of the medical guidelines; and, that carrier later make any necessary adjustments to claimant's income benefits once claimant's impairment rating is redetermined. Carrier's sole issue on appeal is whether the hearing officer erred in ordering carrier to pay IIBS based upon a yet to be determined impairment rating by the designated doctor in view of the fact that the hearing officer closed the evidence after determining that the impairment ratings in evidence were invalid.

DECISION

Having considered the request for review and the record developed at the contested case hearing, we reverse the decision of the hearing officer and remand this case to the hearing officer for further consideration and development of the evidence as discussed below.

Respondent (claimant below) was employed by (employer), a self-insured entity, as its Chief of Police. The parties stipulated that claimant sustained an injury to his back within the course and scope of his employment on January 25, 1991. Apparently, claimant's injury occurred as he and two other persons attempted to lift a woman who weighed approximately 500 pounds. The parties further stipulated that Dr. M, claimant's treating doctor, certified claimant as having reached maximum medical improvement (MMI) on September 16, 1991, and assigned claimant an impairment rating of 19%, and, that Dr. P later assigned claimant an impairment rating of 17%. Claimant, who represented himself at the hearing and who has not filed a response to the appeal, testified but offered no exhibits.

Carrier introduced a "Report of Medical Evaluation" form (TWCC-69), ostensibly prepared by Dr. M, which purported to certify that on September 16, 1991, claimant reached MMI and that his whole body impairment rating was 19%. This report went on to state that the "body part/system" impaired was the "lumbar spine" and that "[T]he objective clinical findings on which this impairment rating is based includes length of disability, area of injury, findings on objective neurologic evaluation, specific diagnosis based on history, physical

examination and imaging tests, as well as range of motion where applicable." In a letter on Dr. M's letterhead dated September 10, 1991, pertaining to claimant and attached to the TWCC-69 ostensibly prepared by Dr. M, there is a statement that the impairment evaluation "was performed using the AMA Guides for the Evaluation of Permanent Impairment (Revised Third Edition)." Though the signature page of this letter was not adduced, the parties treated this correspondence as having been authored by Dr. M.

We note that the TWCC-69 from Dr. M, as admitted into evidence, was not signed by the doctor. In Texas Workers' Compensation Commission Appeal No. 92027, decided on March 27, 1992, we stated that Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 130.1(a) (TWCC Rules) requires the doctor's signature on the medical evaluation report and found that absent the doctor's signature, the evidence in that case failed to support the hearing officer's findings and conclusions that the claimant's having reached MMI had been "certified." In the case *sub judice*, the parties stipulated that Dr. M had "certified" that claimant had reached MMI. TWCC Rule 140.1 defines "stipulation" as a voluntary accord between the parties to a contested case hearing regarding any matter that doesn't constitute an "agreement" or a "settlement." "Agreement" is defined by Article 8308-1.03(3) as the resolution by the parties to a dispute of one or more issues regarding an injury, death, coverage, compensability, or compensation. However, it is not necessary for us to decide whether the parties can stipulate to a claimant's having reached MMI in the absence of a "certification" meeting the requirements of TWCC Rule 130.1 since we are remanding the case for the development and consideration of additional evidence. While only the impairment rating of the treating doctor was disputed as far as we know, and a designated doctor was selected by the parties to evaluate claimant's condition and to assign an impairment rating, the designated doctor can consider and certify to claimant's having reached MMI. Further, the treating doctor could sign the TWCC-69 ostensibly prepared by him.

After introducing the evidence of Dr. M's "certification" of MMI and assignment of an impairment rating using the Third Edition Revised of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association (AMA Guides), carrier introduced a report dated October 3, 1991, from Dr. P. Claimant testified that Dr. M's impairment rating had been disputed and that he had agreed to be evaluated by and to abide by the impairment rating assigned by Dr. P. According to his report, Dr. P was asked by (insurance company), possibly carrier's insurance adjuster or insurance administrator, "to evaluate whether or not [claimant's] previous impairment evaluation was based on valid criteria and whether his range of motion measurements were valid." Dr. P was also asked to give his opinion as to the amount of claimant's medical impairment. Dr. P's report does not mention whether he was also asked to opine on whether claimant had reached "[MMI]" and those words are not found in the report. Dr. P's review of Dr. M's records (which were not introduced at the hearing) led him to state that Dr. M, using the Third Edition Revised of the AMA Guides, gave claimant a seven percent impairment rating for specific disorders of the spine and a 13% range of motion rating for a combined impairment rating (using the combined values chart) of 19%. Referencing

Dr. M's records, Dr. P, however, felt that claimant had not met the validity criteria required for his lumbar spine flexion and extension readings. Accordingly, Dr. P assigned claimant a "total lumbar range of motion impairment" of 11% in contrast to the 13% assigned by Dr. M. Both Dr. M and Dr. P assigned claimant a seven percent impairment rating for a specific disorder of the spine. The combined values chart resulted in Dr. P's assigning claimant a 17% whole person impairment in contrast to Dr. M's 19%. Dr. P's diagnosis included "degenerative disc disease and facet syndrome L5/S1" which he didn't characterize as to degree. Dr. P's report also stated that he, too, used the Third Edition Revised of the AMA Guides.

Dr. P's report was not accomplished on a form prescribed by the Texas Workers' Compensation Commission (Commission) and did not contain claimant workers' compensation claim number nor Dr. P's professional license and federal tax identification numbers, all as required by TWCC Rule 130.1. The report stated that claimant had been released to full-time work with certain lifting restrictions, was to continue to be followed by Dr. M for two months, was fully capable of returning to work, "has been fully treated at this point," and that claimant's "clinical condition is stabilized and not likely to improve with surgical intervention or active medical treatment." However, Dr. P's report does not certify that claimant has reached MMI which is defined in Article 8308-1.03(32) as the earlier of:

- (A) the point after which further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated, based on reasonable medical probability; or
- (B) the expiration of 104 weeks from the date income benefits begin to accrue.

Claimant also introduced various imaging reports pertaining to claimant's spine. The apparent purpose for this evidence was to support carrier's disputed issue concerning the correctness of the impairment rating of seven percent for a specific disorder of the spine. According to the extracts in evidence from the AMA Guides, 3rd Edition, Second Printing, Table 49, entitled "Impairments Due to Specific Disorders of the Spine," contains in Part II impairment ratings for several categories of "intervertebral disc or other soft tissue lesions." Category "II.B" pertains to lesions with "none-to-minimal degenerative changes" while Category "II.C" pertains to lesions with "moderate to severe degenerative changes." The latter category when related to the lumbar spine carries a seven percent impairment rating while the former category carries a five percent rating. However, apparently both Dr. M and Dr. P assigned the seven percent rating.

As mentioned above, carrier contended at the hearing that one of the issues was whether or not the range of motion impairment tests met the "objective clinical or laboratory finding" requirements of Article 8308-4.25 (1989 Act) since they depend, at least in part, upon the subjective complaints or symptoms of claimant. Notwithstanding that the reports of both Dr. M and Dr. P assigned impairment ratings for claimant's range of motion impairment of the lumbar spine, carrier argued that since claimant had to advise the doctors

as to how far he could bend his spine during the range of motion measurements, his advice, in effect, disqualified the range of motion testing as being "objective." Article 8308-4.25(a) provides that "a claimant is not entitled to recover [IIBS] unless there is evidence of impairment based on the objective clinical or laboratory finding . . ." Article 8308-1.03(35) defines "objective clinical laboratory findings as "a medical finding of impairment resulting from a compensable injury, based on competent objective medical evidence, that is independently confirmable by a doctor, including a designated doctor, without reliance on the employee's subjective symptoms." The hearing officer made the following findings of fact and conclusions of law pertinent to this issue:

FINDINGS OF FACT

13. That the range of motion tests given CLAIMANT by [Dr. M] and [Dr. P] and those tests specified by the second printing of the American Medical Association's Guides to the Evaluation of Permanent Impairment, third edition, require an examinee, on command of an examiner, to bend or move as far as possible in a certain way or direction and then the movement of that examinee is measured by the examiner using various mechanical devices.
14. That the AMA text cited in Finding of Fact No. 17 (sic) requires that all "range of motion" tests reflect whether or not each particular test's measurements fall within a range of $\pm 10\%$ or 5 degrees of each other, and for the results of each particular test to be considered valid, at least three of no more than six consecutive measurements of reproduction of abnormal motion are included in the range of motion tests to validate optimum effort on the part of the person being examined.
15. The "range of motion" tests given CLAIMANT all reflect whether or not each particular test's measurements given each time were within a range of $\pm 10\%$ or 5 degrees.
16. That the range of motion tests given CLAIMANT by [Dr. P] all were within the $\pm 10\%$ or 5 degrees consistency described in Finding of Fact 13 above.

CONCLUSIONS OF LAW

4. That even though Conclusion of Law No. 3 above may seem to render further conclusions moot, since the impairment guidelines in the correct version of the American Medical Association text contain tests for the calculation of degree of impairment that require an examinee to bend as far as possible on command by the examiner while the range of motion is measured by a mechanical device, and since further testing of CLAIMANT pursuant to the correct guidelines will be necessary,

then further conclusions of law are necessary to resolve the range of motion issue posed by CARRIER.

5. That the range of motion tests used in the second printing of the Guides to the Evaluation of Permanent Impairment, third edition, published by the American Medical Association, do provide sufficient basis for an "objective clinical or laboratory finding" on which a doctor can base an impairment rating of CLAIMANT because those tests require that a finding that at least three of no more than six consecutive measurements each fall within a range of $\pm 10\%$ or 5 degrees of each other to be consistent and a valid indication of the examinee's optimum effort on the test. This requirement, and the specific instructions in the foregoing text on how to administer the tests, which equipment to use, and how the tests are scored provide sufficient objectivity required by Section 4.25 of the Texas Workers' Compensation Act.

Since carrier has not challenged these findings and conclusions on appeal, we are not required to address them. Article 8308-6.42(c).

With regard to the issue concerning whether category II.B or category II.C pertaining to the extent of claimant's specific spinal disorder should have been used in the determination of claimant's impairment rating, the hearing officer made the following finding and conclusions:

FINDING OF FACT

12. That both [Dr. M] and [Dr. P] used II.C of the Table relating to "Impairments Due to Specific Disorders of the Spine" and assigned CLAIMANT a 7% impairment for the specific disorder of the spine of CLAIMANT.

CONCLUSIONS OF LAW

6. That the record in this case contains insufficient evidence to decide the issue of whether II.B or II.C of the Table on Impairments due to Specific Disorders of the Spine should have been used by the two doctors that assigned CLAIMANT an impairment rating.

7. That a remand or reopening of CLAIMANT'S case to develop sufficient evidence to decide the third issue in this case mentioned in Conclusion No. 6 above is unnecessary at this point because CLAIMANT (and/or the information and data in [Dr. P's] tests) should be referred to the designated doctor, [Dr. P], for the assignment of a correct impairment rating for CLAIMANT using the proper text required by law cited in Conclusion of Law No. 3 above herein.

Again, we have not been called upon by carrier to address this finding and conclusion on appeal.

The remaining issue at the hearing was whether or not claimant's impairment ratings were determined by Dr. M and/or Dr. P by reference to the impairment guidelines required by the 1989 Act. Article 8308-4.24 provides as follows:

The commission shall use the second printing, dated February, 1989, of the Guides to the Evaluation of Permanent Impairment, third edition, published by the American Medical Association for the determination of the existence and degree of an employee's impairment. All determinations of impairment under this Act, whether before the commission or in court, must be made in accordance with the above-named guide.

Article 8308-4.26(a) provides that:

All awards of [IIBS] shall be based on an impairment rating using the impairment guidelines referred to in Section 4.24 of this Act.

And see TWCC Rule 130.1(e). The hearing officer found that both Dr. M and Dr. P used the Third Edition (Revised) of the AMA Guides; that the Third Edition (Revised) is "not the same text" as the second printing of the third edition; and, that "significant differences" exist between the versions. He then reached the following conclusion of law:

3. That the impairment ratings assigned CLAIMANT by both [Dr. M] and [Dr. P] are invalid because those ratings were calculated by using the American Medical Association's Guides to the Evaluation of Permanent Impairment, Third Edition (Revised) and not the second printing, dated February, 1989, of the Guides to the Evaluation of Permanent Impairment, third edition, published by the American Medical Association, as required by Section 4.24 of the Texas Workers' Compensation Act.

At the hearing the carrier declined to enter into a proposed stipulation that Dr. M's impairment rating was disputed by carrier and that carrier and claimant had agreed to Dr. P as the "designated doctor" as that term is defined in the 1989 Act. The claimant, however, testified that carrier had disagreed with Dr. M's impairment rating of 19% and that the parties agreed that claimant would be evaluated by Dr. P and that they would abide by the impairment rating he assigned. The hearing officer found that Dr. P was agreed upon by the parties as the "designated doctor" to examine and assign to claimant an impairment rating. Carrier has not challenged that finding on appeal. We note that Article 8308-4.26(g) provides that if the impairment rating is disputed, and "[I]f the parties agree on a designated doctor, the Commission shall adopt the impairment rating made by the

designated doctor." Also, Article 8308-4.26(d) provides in part that "[T]he certifying doctor shall issue a written report certifying that [MMI] has been reached, stating the impairment rating, and providing any other information required by the Commission" We also note that TWCC Rule 130.6(g) provides that "[T]he designated doctor shall complete and file the medical evaluation report in accordance with [Rule] 130.1. . . ."

Turning to the sole issue raised on appeal, we focus on the decision of the hearing officer which follows:

DECISION

CARRIER shall promptly pay CLAIMANT [IIBS] based on its reasonable assessment of the correct impairment rating of CLAIMANT. Further, CLAIMANT shall be assigned a new impairment rating by the designated doctor, [Dr. P], based on a certification of impairment made in compliance with the rating criteria contained in the second printing dated February, 1989, of the American Medical Association's Guides to the Evaluation of Permanent Impairment, third edition. This referral to [Dr. P] for the assignment of a proper impairment rating for CLAIMANT should be made without delay, and it is so ordered by the Texas Workers' Compensation Commission. When CLAIMANT is assigned a correct impairment rating, CARRIER shall make any necessary adjustments so that CLAIMANT is promptly paid [IIBS] for a period based on the correct impairment rating.

In its Request for Review, carrier contends this decision is in error "because the evidence was closed and the hearing officer correctly concluded the only impairment ratings in evidence were invalid." Carrier argues that this decision permits claimant to develop further evidence to support his claim for IIBS and deprives carrier of "the same opportunity to develop and present further evidence on the issues involved . . . deprives [carrier] of the right to further contest the amount and validity of the proposed ratings . . . [W]ithout benefit of a hearing, the order binds [carrier] to an impairment rating that has not even been certified yet . . . [and] exceeds the authority extended to the hearing officer pursuant to Article 8308, Section 6.34(g). . . ."

At the conclusion of the hearing, the hearing officer and counsel for carrier engaged in a colloquy regarding the option of returning the reports on claimant to Drs. M and P for their assignment of new impairment ratings based upon the mandated version of the AMA guides. Since a designated doctor had been selected to evaluate claimant's impairment, however, a return of Dr. M's report for that purpose would not have been necessary. Nonetheless, carrier appeared to agree to such a post-hearing procedure when its counsel stated, "I'm satisfied with that, your Honor. I'd like to see this move forward . . . I'm satisfied with that solution." The hearing officer then stated that, "I could go ahead and, if you agree, will try it. I'll go ahead and issue an order . . . that they go ahead or tell the DDO to send those back to the doctors," to which carrier's counsel responded, "Yeah,

that's fine." The hearing officer said, "[W]hat it would do, it might save you some time, you know, if they, in effect, say to do it and you are already doing it," to which carrier's counsel responded, "Yeah, if they do kick it back, we've already got things in the works." The hearing officer then concluded that he would return claimant's case to the doctors so that if the Commission's Appeals Panel were to remand the case for a determination of impairment rating under "the right guidelines," the effort to obtain same would already be underway. Carrier's counsel then stated, "All right." Carrier appeared to acquiesce in the procedure suggested by the hearing officer in an effort to save some time and anticipating that the claimant's impairment rating would have to be redetermined using the required edition of the AMA Guides. However, carrier cannot be said to have agreed to pay impairment benefits on an interlocutory basis pending such redetermination. TWCC Rule 130.5 pertaining to "Impairment Rating Disputes" provides a procedure for the resolution of impairment rating disputes which requires an insurance carrier disputing an impairment rating to file with the Commission "a statement of disputed impairment benefits that gives the insurance carrier's reasonable assessment of the correct rating;" and if the carrier chooses not to perform its reasonable assessment, the carrier may request the selection of a designated doctor to assess impairment. The latter procedure appears to have been employed in this case. Regrettably, the designated doctor's impairment rating assessment was not accomplished with reference to the second printing of the third edition of the AMA guides and the hearing officer correctly concluded it was invalid for that reason. It further appears that Dr. P's report did not meet all the requirements of Rule 130.1 for the certification of MMI and permanent impairment and that Dr. M's TWCC-69 purporting to certify to MMI, which was not disputed, and to assign an impairment rating, which was disputed, was not signed.

We agree with carrier that the parties should have the opportunity to consider and address whatever additional evidence of claimant's impairment rating as may be adduced and we remand for that purpose. However, we do not agree with carrier that the hearing officer exceeded his authority in ordering carrier to commence payment of IIBS to claimant pending resolution of the impairment rating issue. Article 8308-6.34(g) requires that the hearing officer's written decision include, *inter alia*, a determination of whether benefits are due, and, an award of benefits. Having decided to conclude the hearing and issue a written decision, rather than simply recessing the hearing pending the redetermination of the impairment rating by Dr. P, the hearing officer determined that impairment benefits should be paid by claimant based upon its "reasonable assessment" of the correct rating. Both the treating and designated doctors had already determined the existence of impairment and assigned impairment ratings of 17% and 19%, respectively. Claimant's issues disputed the percentage of the spine disease impairment (five percent or seven percent) and the validity of the loss of range of motion measurements but not the existence of some impairment. Having decided that some impairment income payments were due, the hearing officer simply ordered carrier to commence payment based on its reasonable assessment of the impairment rating subject to a later adjustment. Article 8308-4.21(b) provides that "[E]xcept as otherwise provided by this Act, income benefits shall be paid without order from the Commission on a weekly basis as and when they accrue. . . ." Article 8308-4.26(e) provides that "[T]he insurance carrier shall begin to pay the [IIBS] not later than

the fifth day after the date on which the insurance carrier receives the doctor's report certifying [MMI]," and Article 8308-4.26(f) provides that "if the insurance carrier disputes the impairment rating it shall pay the employee [IIBS] based on its reasonable assessment of the correct rating."

The decision of the hearing officer is reversed and the case is remanded for development of appropriate evidence, if any, and reconsideration not inconsistent with this opinion.

Philip F. O'Neill
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Robert W. Potts
Appeals Judge