APPEAL NO. 92335

This appeal arises under the Texas Workers' Compensation Act of 1989, TEX. REV. CIV. STAT. ANN. arts. 8301-1.01 *et seq*. (Vernon Supp. 1992) (1989 Act). A contested case hearing was convened on May 27, 1992 in (city), Texas, (hearing officer) presiding. The hearing was continued to permit additional discovery, and the record was closed on June 10, 1992 after additional testimony and evidence was taken. The issue was whether the claimant's (respondent herein) correct impairment rating is 0%, 17%, or 27% based on her work-related injury. The hearing officer held that the respondent was entitled to impairment income benefits based upon a 17% impairment rating, as determined by a doctor designated by the Texas Workers' Compensation Commission (Commission). The hearing officer also held that the respondent has been properly awarded advancements against her income benefits in accordance with Article 8308-4.32, and that she has established eligibility for acceleration of impairment income benefits pursuant to Article 8308-4.321 provided she files written request for same.

The workers' compensation insurance carrier for the employer (appellant herein) contends that the hearing officer erred in adopting an impairment rating which included an assessment based upon range of motion and which was not based on the correct version of the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides), and in finding there is no significant difference in the AMA Guides and the guides used by the designated doctor. Appellant asks that the Appeals Panel either reverse the decision and render a decision that respondent proved no impairment, or reverse and remand for further consideration and development of the evidence. In either event, appellant requests reimbursement from the subsequent injury fund for all advancements previously made. No response to the request for review was filed.

DECISION

Because we find error in the hearing officer's decision as it relates to use of other than the statutorily prescribed version of the AMA Guides, we reverse the decision and order on that point. We remand to allow the designated doctor an opportunity to properly determine impairment.

Respondent injured her lumbar and cervical spine and her ankle on or about (date of injury), while in the course and scope of her duties with the (employer). Medical benefits and temporary income benefits were initiated by the appellant.

Three different doctors assigned impairment ratings to respondent, including her treating doctor, (Dr. C); the carrier's doctor, (Dr. B); and the doctor designated by the Commission, (Dr. W). Their findings and impairment ratings were as follows:

I.Dr. C:

1.A December 10, 1991, report from the Care Clinic reported the results of lumbar

range of motion (ROM) testing and assigned a whole person impairment rating of 13.42%. A letter from the Care Clinic also dated December 10 stated respondent was tested using the standard lumbar spine protocol for inclinometer as described by the AMA Guides, 3rd edition 1988. The letter also stated that, using two measures of validity as outlined in the AMA Guides, the evaluation was considered to be invalid.

2.A January 3, 1992, specific and subsequent medical report (TWCC-64) and attached letter filed by Dr. C said the December 10 report from the Care Clinic was invalid on technical grounds, but that nevertheless he felt that respondent's impairment, based on clinical evaluations and the AMA Guides, was in the range of 13%. Dr. C also found respondent had reached maximum medical improvement and released her to return to work.

3.A January 13 TWCC-64 noted that the impairment rating from the Care Clinic was for the lumbar spine only, and that he was sending respondent back for reevaluation of the lumbar and cervical spine.

4.A January 24 report from the Care Clinic assigned respondent a whole person impairment of 27%. Lower extremity impairments were 4% cervical intervertebral disc, 5% lumbar intervertebral disc, 0% cervical ROM, and 20% lumbar ROM. The report said the determination of impairment was based on the AMA Guides, third edition.

5.A February 14 TWCC-64 from Dr. C stated that respondent had reached maximum medical improvement (MMI), and released her to work. It also stated, "The patient's whole body combined values of neck and back are 27%. I have no independent thoughts that her impairment would be any different than that done by the Care Clinic and feel that that must be what her impairment is since it follows the AMA guidelines and is indeed the workers compensation rules. It is my considered opinion that her impairment must be at least 9% due to the fact that these are the structural numbers and not range of motion numbers. The range of motion numbers reveal an abnormality of 20%."

6.An undated report of medical evaluation (TWCC-69) by Dr. C basically restated the opinion he gave in the February 14 TWCC-64.

II.Dr. B:

A letter dated January 22 reported the results of Dr. B's examination and review of X-ray and CT scan, and concluded that respondent "should have zero percent (0%) permanent or partial disability related to her injury." Dr. B's letter did not mention the AMA Guides.

III.Dr. W:

A March 18 report indicates Dr. W performed an examination (including ROM) and reviewed respondent's records including the impairment ratings of Drs. C and B. The recommendation was as follows: "We have been asked to give a disability rating. MMI on 3-18-92 and the disability rating is 17% permanent partial disability on the basis of the following: Cervical disc C5-6 4%, lumbar degenerative disc 5% with greater than six months disability, range of motion of the lumbosacral spine - flexion is 4%, extension is 2%, right and left lateral bending 1% each for a total of 17% permanent partial disability to the body."

Admitted into evidence was the deposition on written questions of Dr. W. Dr. W said, in part, that the 17% impairment rating he had assessed was based on the AMA Guides, third edition, second printing, December 1990. Dr. W also said that assessment of ROM depends in part on the subjective evaluation of the examiner and the subjective complaints of the patient, and that it is common for ROM in a patient to vary considerably from day to day.

Also admitted was a deposition on written questions of (Dr. T), the president of the Texas Spine Society who has made a videotape on the use of the AMA Guides. He stated that ROM was based in part on subjective complaints and evaluation. He also said that while ROM complies with the AMA Guides, he felt it was unreliable, and that the consensus of the Texas Spine Society was that ROM should not be used in determining impairment ratings in the lumbar spine.

Based on the foregoing, appellant argued at the hearing and argues on appeal that any impairment rating based on ROM assessments should be disregarded because of their subjective nature. He points to Article 8308-4.25(a), which provides, "Notwithstanding any other provision of this Act, a claimant is not entitled to recover impairment income benefits unless there is evidence of impairment based on an objective clinical or laboratory finding. If the finding of impairment is made by a doctor chosen by the claimant and the finding is contested, the objective clinical or laboratory finding on which the finding of impairment is based must be confirmable by a designated doctor or a doctor selected by the carrier." Appellant cites the statutory definition of "objective clinical or laboratory finding:"

[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. Article 8308-1.03(35).

Appellant also cites the statutory definitions of "objective" (Article 8308-1.03(34)) and "subjective" (Article 8308-1.03(45)) as follows:

(34)**"Objective"** means independently verifiable or confirmable results that are based on recognized laboratory or diagnostic tests or signs confirmable by physical examination.

(45)**"Subjective"** means perceivable only by an employee and not independently verifiable or confirmable by recognized laboratory or diagnostic tests or signs observable by physical examination.

Appellant claims this language limits use of the AMA Guides to objective clinical or laboratory findings that, upon contest of impairment, must be confirmable by another doctor. Appellant further claims the differences in the doctors' impairment ratings came from vastly different ROM assessments.

The hearing officer found that Dr. W's 17% impairment rating was based upon the AMA Guides, third edition, second printing, December 1990, and that there was no significant difference between the edition of the AMA Guides used by Dr. W and the AMA Guides referenced in the 1989 Act, Article 8308-4.24, as they relate to the issues disputed in this case. Appellant contends these findings were in error. The hearing officer also upheld the three advances against income benefits respondent had received, and said respondent had established eligibility for acceleration of impairment income benefits. (At the first phase of the hearing, the hearing officer added the issue of advances as an additional issue to the one identified at the benefit review conference. Appellant was not present at the May 27th hearing, but did not contest the addition of this issue.)

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." The hearing officer took official notice of the version of the AMA Guides referenced in the 1989 Act.

We have previously held that only the February 1989 second printing of the third edition of the AMA Guides may be used in assessing an impairment rating. Texas Workers' Compensation Appeal No. 92074 (Docket No. redacted), decided April 8, 1992. This is consistent with an apparent Legislative intent to achieve uniformity in permanent income benefits determinations. *See* Montford, A Guide to Texas Workers' Comp Reform, Volume 1 § 4B.24, Butterworth Legal Publications, Austin (1991). Thus, Finding of Fact No. 9 and

Conclusion of Law No. 3 approving Dr. W's assessment of impairment were in error. Where, as here, the 1990 edition of the AMA Guides was not made a part of the record, and there was no expert or other testimony comparing it to the version referenced in the 1989 Act, it is not necessary for us to decide whether under another set of circumstances another version of the Guides could be found to be identical to or not significantly different from the 1989 Act's version.

Appellant argues that use of even the correct version of the AMA Guides is qualified and limited by the 1989 Act's requirement in Article 8308-4.25(a), *supra*, that evidence of impairment be based on objective clinical or laboratory findings, the term "objective" meaning independently verifiable or confirmable results. Appellant points to the variation between ROM assessments in this case as indicative of the nonobjective nature of these tests.

We cannot agree with appellant's analysis. The requirement in Article 8308-4.25(a) that evidence of impairment must be based on an objective clinical or laboratory finding was intended to preclude recovery of impairment benefits where the only evidence of impairment is the employee's subjective complaint of pain. Montford, A Guide to Texas Workers' Comp Reform, *supra*, § 4B.25. "Impairment" is defined in the 1989 Act as "an anatomical or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." Article 8308-1.03(24). Thus, a doctor must determine whether an objective clinical or laboratory finding of impairment exists and document same, before assigning an impairment rating. The existence and degree of impairment are determined in accordance with the appropriate version of the AMA Guides.

That impairment cannot be based solely on a subjective complaint does not mean that subjectivity can play no part in the determination or measurement of impairment. The AMA Guides addresses both the protocols for measurement and the evaluative processes. Specifically with regard to ROM of the spine, the Guides set forth the recommended tests and procedures and provide for calculating variability between tests to see whether the measurements fall within reproducibility guidelines; if they do not, the test is determined to be invalid. AMA Guides, second printing, Third Edition, February 1989, Chapter 3.3. Thus the AMA Guides contain safeguards to validate the tests and make them more reliable.

For these reasons we are not persuaded by Dr. T's opinion that ROM is neither reliable nor reproducible, and thus not an objective medical finding. We likewise disagree that Dr. T provided the only medical evidence on the issue. As Dr. T testified, the American Medical Association has adopted ROM assessments, and the doctors' reports which were part of the record in this case relied upon ROM. Therefore, the hearing officer was not obliged to accept Dr. T's consensus.

Whether the impairment ratings assessed by the other two doctors can be considered depends on the circumstances under which Dr. W was designated. Article

8308-4.26(g) provides that in the event of an impairment rating dispute the Commission shall direct the employee to be examined by a designated doctor selected by the mutual agreement of the parties; if the parties are unable to agree on a designated doctor, the Commission shall direct the employee to be examined by a designated doctor selected by the Commission. The Commission is required to adopt the impairment rating of a designated doctor agreed to by the parties. However, if the Commission selects the designated doctor, the report of that doctor shall have presumptive weight and the Commission shall base the impairment rating on that report unless the greater weight of the other medical evidence is to the contrary, in which case the Commission shall adopt the impairment rating of one of the other doctors.

The Commission's order designating Dr. W pursuant to Article 8308-4.26(g) was not made a part of the record. The benefit review conference report, which was included as a hearing officer's exhibit, recites that Dr. W "is the designated doctor selected by the Commission in accordance with Section 4.26(g)." The respondent also testified at the hearing that the Commission appointed Dr. W. Ordinarily, then, Dr. W's findings would be entitled to presumptive weight, which could be rebutted if the great weight of other medical testimony is to the contrary. However, we find that a designated doctor's findings cannot rise to the level of presumptive weight unless they comply with the appropriate statutory requirements. This obviously includes use of the correct AMA Guides as discussed herein. However, it also includes compliance with Commission rules concerning certification of MMI and assignment of impairment ratings, Texas W. C. Comm'n 28 TEX. ADMIN. CODE § § 130.1 and 130.5. We note that Dr. W's March 18, 1992 report omits several items contained in these rules. While a designated doctor's failure to include one or more of these may not be fatal, we have previously held that MMI and impairment are not properly certified in the absence of the doctor's signature. Texas Workers' Compensation Commission Appeal No. 92027 (Docket No. redacted) decided March 27, 1992. Thus, we remand to allow the designated doctor an opportunity to properly certify MMI and assess impairment.

The decision and order is reversed and remanded consistent with this panel's discussion herein. Pending resolution of the remand, a final decision has not been made in this case, including on the issue of advances.

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Lynda H. Nesenholtz
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.
Chief Appeals Judge

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Joe Sebesta
Appeals Judge