APPEAL NO. 92511

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 through 11.10 (Vernon Supp. 1992). On August 12, 1992, a contested case hearing was held in (city), Texas, with (hearing officer) presiding, to determine issues relating to the attainment of maximum medical improvement (MMI), the date of such attainment, and the impairment rating. The hearing officer determined that (claimant), the claimant, had attained MMI as of January 31, 1992, with an impairment rating of zero percent. It was undisputed that the claimant had sustained a compensable injury on (date of injury), in the course and scope of his employment with (employer), the self-insured employer, hereinafter called carrier.

In arriving at his decision, the hearing officer determined that the parties had agreed that one (Dr. S) would examine the claimant in the capacity of "designated doctor." The hearing officer then concluded that Dr. S's assessment of MMI and zero percent impairment rating, as a matter of law, were reached by the claimant on January 31, 1992.

The claimant has appealed this decision for two primary reasons. First, he contends on appeal, as he did throughout the hearing, that Dr. S was not a designated doctor, let alone an agreed-upon designated doctor. Included as part of this argument is the unavailability of an ombudsman to explain the contents of an agreement for a designated doctor. Second, the claimant contends that Dr. S's certification of MMI and impairment is invalid because it was not filed within seven days after the physical examination of the claimant. The carrier asks that the decision be upheld.

DECISION

After reviewing the record of the case, we reverse and remand for further development and consideration of the evidence in order to resolve the issue of whether, and when, the claimant attained MMI and what, if any, permanent impairment he may have. We take such action on the basis that the findings and conclusions that Dr. S acted as a "designated doctor" are not supported by the record, as, at the time of his examination, Dr. S was neither appointed, nor was he agreed to as a designated doctor in accordance with the rules promulgated by the Texas Workers' Compensation Commission to implement the 1989 Act, Arts. 8308-4.25 and 4.26. We would suggest that the Commission consider prompt appointment of a designated doctor in order to resolve the issues.

FACTS

In this case, the claimant, employed as a bus driver by the carrier, said he was injured (date of injury). He stated that he worked a split shift that day. After the first shift, he had trouble rising from his seat. When he did, he checked in at his headquarters, reported his pain, but said he would return for the second part of his shift. During this time, he was

involved in a minor collision at the city airport with an airport shuttle. Medical records show that the next day claimant went to a nearby "minor emergency" clinic, and was treated by (Dr. W) for back strain and degenerative lumbar (L5) spine. Dr. W's initial medical report indicates that he estimated that claimant would attain MMI in four to six weeks, and could return to full time work in two weeks. Claimant said that he treated with Dr. W for about a week and a half, and was then referred to (Dr. D) by Dr. W. The record indicates that Dr. D has a specialty in medical and surgical treatment of the lower back. Dr. D examined claimant on October 31, 1991, noting that he had not improved in two weeks. He noted in his initial medical report that x-rays showed a narrowed L5-S1 disc space. Dr. D recommended that claimant be off work for two additional weeks, after a short course of physical therapy.

Claimant said he was not satisfied with Dr. D's examination. He testified that he called the Texas Workers' Compensation Commission's local field office and spoke to (Ms. G), who informed him that he could change to another doctor. He said Ms. G told him to confirm this in writing, but the record indicates this was not mailed to the Commission until sometime in January 1992. He stated that he made an appointment with (Dr. Z), for November 18, 1991, and he called Dr. D's office to cancel a November 19th appointment. Claimant said that he saw Dr. D only once. On January 21, 1992, Dr. Z wrote a "To Whom It May Concern" letter stating that claimant had not reached MMI, but that he would "estimate" claimant's whole body impairment rating as about 12%.

The record indicates that, sometime in November, the carrier's adjuster contacted Dr. D about claimant's medical status. Dr. D, without further examination, completed a TWCC-69 Report of Medical Evaluation that stated claimant had attained MMI on October 31, 1991, with a zero percent impairment rating. An accompanying letter states that claimant missed a scheduled November 19th appointment and had not returned to see him. Based upon this report and letter, the carrier terminated the claimant's temporary income benefits effective December 18, 1991. The claimant testified that he did not receive a communication from the carrier about this, but was informed by the Commission about three weeks after the action was taken about the basis for the action. Claimant said that, as a result of his dispute with Dr. D's assessment and the carrier's action, a benefit review conference was scheduled and held on January 21, 1992.

Prior to this conference, claimant desired an examination with another orthopedic specialist, and, having been informed that the carrier would not pay, he stated that he made an appointment with a doctor in (city), Texas, where relatives lived who would pay for the examination. He was examined by (Dr. B); Dr. B's narrative report of January 9, 1992, indicates that x-rays made that date show "degenerative disc disease at the L5-S1 space with marked narrowing of the L5-S1 disc and arthritic change in the facet joints at the lower two lumbar levels primarily on each side. This type of condition is one that would be aggravated by an occupation which would require one to drive, particularly a bouncy not shock-absorbed type vehicle or riding in the type of seat that he describes." This letter itself takes no position on MMI, noting that "if it is felt by workmen's compensation insurance that

he has reached MMI . . . then it is my recommendation that he be disabled from this job . . ." and Dr. B recommended vocational rehabilitation.

The claimant stated that he has sought light duty work from the employer but has been told there is none. He understands that his job is being held open for him and consequently has not applied for unemployment benefits because he understands he would not qualify.

INVOLVEMENT OF PURPORTED "DESIGNATED DOCTOR"

The presiding officer at the January 21, 1992, benefit review conference was (Mr. S). The claimant was not represented by an attorney at this conference. Claimant stated that he understood that, because of the wide discrepancy between the opinions of Dr. D, Dr. Z and Dr. B, the carrier wanted him to be examined by another doctor. He stated that the adjuster for the carrier gave him a list of four doctors and told him that he had to be examined by one of those doctors within ten days or Mr. Solomon would appoint a doctor. A list in the record indicates that claimant rejected two of the doctors at the conference. Claimant stated that he did not agree to see either of the other two at the conference, but reserved a decision.

No report was made of this conference, nor was any written agreement or confirmation of an agreement, required by Rule 130.6(c), entered into the record by the carrier. There is no evidence that (Mr. S), or anyone at the Commission, subsequently appointed Dr. S as a designated doctor. However, the claimant stated that he had Dr. Z make an appointment with Dr. S, and that he was examined by Dr. S on January 31, 1992. Claimant said that Dr. S's assessment of his condition was different than that ultimately reflected in his TWCC-69. After this examination, he called the Commission and the carrier's adjuster to report that he had been examined by Dr. S.

On February 5, 1992, the carrier's adjuster wrote to Dr. S, forwarding claimant's medical records. The letter does not show that copies were sent to anyone else. Portions of this letter are worth highlighting:

> ". . . [A] hearing was held at the TWCC on January 21, 1992, as [claimant] disputed the medical that was submitted by [Dr. D]. The Hearing Officer gave us 10 days to decide on an independent medical examination. At that time, I made a request that you be allowed to perform this examination and [claimant] said he would not make a decision that day. I discussed this with him again on several occasions, the last being January 31, 1992. On Friday morning he advised me that he had not made a decision and that I should not call you and make an appointment until he did decide. I was notified by TWCC yesterday that he was in fact examined by you within hours after our conversation. . . . There was quite a disparity among the opinions of each doctor, and your examination was to aid us in resolving the dispute. However, [claimant] did

> not allow me to provide you with the reports as he failed to disclose his appointment with you. I have been informed by a Commission representative that you do not feel that [claimant] has reached maximum medical improvement. Please review the medical reports and express your opinion whether or not he may have reached maximum medical improvement at the time stated by [Dr. D] . . ."

The adjuster then expressed the carrier's concern "about this claim" and the claimant's intentions about ever returning to work. The letter fails to note how either consideration would be relevant to impartial determination of the claimant's medical status. The letter does not refer to Dr. S anywhere as a "designated doctor."

An initial medical report completed by Dr. S on January 31, 1992, shown as received by the carrier on February 7, 1992, states that claimant has degenerative disc disease, and shows an "indefinite" estimated date of MMI or return to work; claimant's prognosis is assessed as "good."

Thereafter, apparently sometime after the unilateral contact by the adjuster, Dr. S completed and submitted a TWCC-69 report finding that claimant had attained MMI on January 31, 1992, with zero percent impairment. Dr. S's narrative report dated the same date indicates that the claimant brought Dr. B's records and some physical therapy records; claimant discussed Dr. D's x-ray with Dr. S (although he did not have it with him), as well as the findings of other doctors. Dr. S's narrative recommended a CT scan if he failed to improve, but recommended that he try to return to work, continue exercises at home, and use over-the-counter pain relief. Dr. S said he sees no evidence of permanent physical impairment from an orthopedic standpoint. In addition to the TWCC-69, Dr. S completed another initial medical report regarding the January 31st visit (which was stamped as received by the carrier's adjuster on February 26, 1992, the same day as the TWCC-69 and narrative). This second initial medical report resembles the previously-submitted report, except that an additional diagnosis of lumbar strain is added and estimated return to work and MMI dates show "1-31-92."

WHETHER THERE WAS AN AGREEMENT FOR A DESIGNATED DOCTOR

At the outset, we would note that the use of a designated doctor is clearly intended under the Act to assign an impartial doctor to resolve disputes over MMI and impairment rating. To achieve this end, his/her report is given at least presumptive weight, and possibly conclusive weight on the issue of impairment rating, this distinction depending upon whether he/she is appointed by the Commission or selected through agreement of the parties. Art. 8308-4.26(g). The status of a doctor as "designated," as opposed to a medical examination order doctor appointed under Art. 8308-4.16, or a carrier-recommended treating doctor, should be established prior to the date the examination is conducted. The applicable statutes contain no language upon which we can detect a legislative intent that appointment of a designated doctor is retrospective, after an opinion has been rendered or after the

sentiments of the prospective doctor have been ascertained by either party in advance.

It is clear to us that there is no evidence indicating, as set forth in the hearing officer's statement of the evidence, that "on January 21, 1992, at a prior benefit review conference, the claimant and carrier agreed that [Dr. S] would be a designated doctor." The adjuster's February 5th letter specifically states the absence of any such agreement prior to the January 31st examination (and, for that matter, indicates that there was no agreement as of the date of the letter). If there was an "agreement," it came after the examination. And, contrary to the plain intent of the 1989 Act that the designated doctor be impartial, the evidence indicates that each party would have understood, at the time of the retroactive "agreement," that Dr. S's opinion would be favorable to its position. The record here is in stark contrast to that considered in Texas Workers' Compensation Commission Appeal No. 92312, decided August 19, 1992, where there was ample correspondence, consistent with Rule 130.6, to document the parties' agreement on a designated doctor prior to his examination, and to refute the contention that the doctor was to conduct only a required medical examination.

While an agreement on a designated doctor need not be a signed contract, Rule 130.6(c) plainly requires that any verbal agreement be memorialized in a written letter of confirmation. Moreover, the Commission's confirmation of the argeement is envisioned. Rule 130.6(d). While we can understand that there could be a situation where a clear agreement for a designated doctor is documented but the Commission is inadvertently left "out of the loop," we would point out that parties who did not seek confirmation could run the risk that the trier of fact will not give effect to an agreement. Such extra safeguards were apparently deemed necessary by the Commission, because an agreed designated doctor's report will, according to Art. 8308-4.26(g), conclusively bind the parties to the impairment rating, and prevent the Commission from considering medical evidence to the contrary. If a designated doctor is not agreed to, but is appointed by the Commission, this is done by order, as described in Rule 130.6(d). Then, the designated doctor's report has presumptive weight, and may be rebutted by the great weight of contrary medical evidence. Arts. 8308-4.25(b) and 4.26(g). In our opinion, Rule 130.6 sets forth the two ways in which a designated doctor indisputably is "appointed."

Putting aside whether any agreement was ever made, the claimant maintains he never understood that Dr. S was a "designated" doctor as that function is set out in the statute. His testimony indicates that he thought this doctor was to provide additional information to assist the carrier to resolve the discrepancy between claimant's treating or referral doctors who had given opinions. Frankly, the claimant's accounting is corroborated, not refuted, by the record, and by statements of the carrier's representative at the contested case hearing that demonstrate confused understanding over the role of Dr. S.

As quoted above, the adjuster's February 5th letter indicates that Dr. S was to perform an "independent medical examination." This reference would indicate that Art. 8308-4.16 (which also requires that the carrier solicit the agreement of the injured employee

to such examination) was the statute being invoked at the benefit review conference. At the hearing, the carrier's representative in his opening statement counted Dr. S as one of claimant's choices of doctor: "We take that as a designated doctor, certainly the third or fourth choice." Later in cross-examination, the carrier asked claimant the following questions, concerning the January 21, 1992 benefit review conference:

Q "So no one discussed with you that you could see another physician if it was designated by the Commission or agreed upon by the carrier? That you could see three physicians or four or five or whoever . . . ?"

Claimant"Well, I know that the carrier would not pay for my visit to [Dr. B]."

* * * *

Q "Was it your understanding that if you, at the hearing, had stated that you did not want to see any of these physicians, you did not want to treat with the four or the forty that carrier would have provided to you, was it your understanding that Tom Solomon the hearing officer was then going to designate a doctor for you to see?"

Claimant"Yes."

A mistaken premise, that Dr. S was offered to "see" or to "treat" the claimant in the context of another opinion, rather than to presumptively resolve a dispute, is indicated by the opening statement and these questions. This confusion was manifest at the relatively late date of the contested case hearing. This does not inspire confidence that the carrier's adjuster, at a January 21st benefit review conference, was able to clearly convey that the purpose for Dr. S's examination was a resolution of MMI and impairment under Arts. 8308-4.25 and 4.26.

It is also possible to infer, from the lack of evidence that the Commission reacted in the manner contemplated by Rule 130.6, that Mr. Solomon did not understand that the carrier was ultimately seeking a "designated doctor," as opposed to an independent medical examination order under Art. 8308-4.16. The filing of initial medical reports by Dr. S also implies that he did not understand his role as one of "designated doctor."

Our insistence upon compliance with the very simple procedures set out in Rule 130.6 is not elevation of form over substance; it is the very means to preserve the designated doctor's status as the impartial decision maker, and, not incidently, his/her immunity from liability, under Art. 8308-8.05. As this case illustrates, expediency and excess of informality in the short term can ultimately prolong resolution of issues that are in both parties' interest to conclude.

LATE-FILING DOES NOT INVALIDATE REPORT

As to the contention that the report of Dr. S would be invalid because it was not filed within seven days after the examination, we would note that the Appeals Panel has already determined that such delay does not negate the substantive value of the designated doctor's report as a certification of MMI. *See* Texas Workers' Compensation Commission Appeal No. 92132 [decided May 18, 1992]. The 1989 Act, under Art. 8308-10.07(c)(3) specifically sets out an administrative penalty sanction for late filing of required medical reports. Given this, the fact that Rule 130.1 does not provide for invalidation of a report based upon late filing, and the clear direction given to the Commission in Art. 8308-4.25 and 4.26 on the use to be made of the report, the time frame for filing a report that is set forth under Rule 130.1 is for the purpose of promoting proper, orderly, and prompt conduct of business. As such, the time limitation for filing the TWCC-69 report, notwithstanding the use of the word "shall" in Rule 130.1(h), appears to us to be in the nature of a directory, not mandatory, administrative rule, and the late filing does not deprive the Commission of the power to consider such report. *See* Lewis v. Jacksonville Building and Loan Association, 540 S.W.2d 307, 310 (Tex. 1976).

For the reasons expressed above, the hearing officer's decision is reversed, and remanded for further action consistent with this opinion. Pending decision on remand (or any appeal that may be made from such decision), a final decision is not rendered in this case for purposes of judicial review.

Susan M. Kelley
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Lynda H. Nesenholtz
Appeals Judge