APPEAL NO. 92570

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 September 10, 1992, a contested case hearing was held to determine issues relating to the correct impairment rating resulting from a cervical spine injury sustained by the claimant, _____, who is the respondent in this appeal. The hearing officer determined that the report of the designated doctor was invalid because it was not rendered by proper use of the American Medical Association's *Guides to Evaluation of Permanent Impairment* (hereinafter Impairment Guides). She likewise determined that the first impairment rating rendered by the treating doctor was invalid, but that his second impairment rating was done in accordance with the Impairment Guides and found that the claimant had a 23% permanent impairment.

The carrier has appealed this decision, noting that there is no evidence that the designated doctor's report was not correctly rendered, and arguing that it should therefore be accorded presumptive weight because the great weight of other medical evidence is not to the contrary. No response has been filed by the claimant.

DECISION

After reviewing the record of the case, we reverse the determination of the hearing officer which invalidates the designated doctor's impairment rating and adopts the impairment rating of the treating doctor. We remand to allow further development and consideration of the evidence consistent with Article 8308-4.26(g) and this decision, including affording the designated doctor an opportunity to consider the results of an EMG test conducted after he had done his examination, and, if he determines it necessary, the opportunity to amend his impairment rating.

In this case, the claimant, who was employed by (employer) in City 1, sustained an injury to his cervical spine while lifting equipment in the course and scope of his employment on _____. According to the record, the claimant was absent for approximately six weeks of work but returned to employment under certain restrictions from his treating doctor, (Dr. S).

Prior to consulting with Dr. S, the claimant was seen by other physicians. His first treatment was rendered on October 9, 1991, by (Dr. M), who prescribed a cervical collar and pain killers. After further treatment, Dr. M scheduled a magnetic resonance imaging (MRI) examination. The October 16, 1991, MRI conclusion was: "1. Small central and left paramedian disc bulge is at the C4-5 and at the C6-7 disc space levels. 2. The most impressive abnormality is that of a moderate central and right paramedian subligamentous C5-6 disc herniation."

Dr. M referred the claimant to (Dr. E), a neurologist, who in his notes of an October 29, 1991 examination described claimant's complaints of pain and some intermittent

numbness in his fingers occurring primarily in the right hand. Dr. E noted "no" weakness in hand grip or proximal muscles in upper extremity, restriction in the cervical range of motion to 60% of normal, a C5-6 disc herniation with some nerve encroachment, and right C6 radiculopathy with mild thecal sac compression.

Dr. E referred claimant to (Dr. N), a neurological surgeon. Dr. N, in a letter dated January 23, 1992, also noted complaints of intermittent tingling in some fingers of the right hand, but indicated that the remainder of his sensory examination is normal. Range of motion of the neck was found to be decreased by 30%. Like Dr. E, Dr. N indicated that he reviewed the MRI and found a right-sided C5-6 herniation with compression of the right C6 nerve root. The letter recommended continuation of conservative treatment "before definitely deciding on his need for disc removal at C5-6".

The claimant testified that because the doctors he saw were telling him he would need surgery, he felt that he wanted to have a second opinion. He selected Dr. S, an orthopedic surgeon, who he first saw on November 12, 1991. Dr. S noted that surgery was not recommended at the present time though he speculated that it could be required in the future, and suggested that an EMG should be conducted prior to any surgery. He placed claimant on light duty status with restrictions on lifting and repetitive stooping, turning, and twisting of the head, and gave claimant samples of Lodine for pain relief. Dr. S noted a diagnosis of "HNP" (herniated nucleus pulposus) at the C4, 5, and 6 levels. On March 31, 1992, Dr. S determined that maximum medical improvement (MMI) had been reached, and assigned an impairment rating of 18%. He also noted that claimant would be "continued" on his medication of Darvocet, Parafon, and Lodine. He stated that he had assessed 6% for each disc, using page 73, Table 2c of the Impairment Guides.

The table at page 73 of the Impairment Guides is "Table 49. **Impairment Due to Specific Disorders of the Spine**." Section 2 of this table is entitled "Intervertebral disc or other soft tissue lesions." The table lists whole body impairment ratings under columns for three regions of the spine: cervical, thoracic, and lumbar. Section II, C lists the ratings for "[u]noperated with medically documented injury and a minimum of six months of medically documented pain, recurrent muscle spasm, or rigidity associated with moderate to severe degenerative changes on structural tests, including unoperated herniated nucleus pulposus, with or without radiculopathy."

The insurance carrier disputed this impairment rating; neither party disputed the achievement of MMI by the claimant. Correspondence from the adjuster indicates that the carrier felt that a more accurate rating was either in the 8-10% range, or the 6-8% range. The Texas Workers' Compensation Commission (Commission) appointed (Dr. A) as the designated doctor to resolve the dispute over the impairment rating. Dr. A examined claimant on June 5, 1992, and determined that he reached MMI effective that date, with a 7% impairment rating. Dr. A's report noted the medications being taken by the claimant, stated no evidence of muscle spasm or tenderness on palpation of the

neck, and found normal range of motion of the cervical spine, with perhaps a slight restriction to extension only. Dr. A noted claimant's complaints of intermittent pain, tingling, and loss of sensation on some fingers of the right hand (not present all the time). Dr. A stated: "I was unable to elicit any motor or sensory loss of either upper extremity." Dr. A indicated (and the claimant did not dispute) that he evaluated previous tests and doctors' records. He stated that he agrees with a diagnosis of disc herniation of the C5-C6 level "with some spondylosis" and also a small herniation of the C6-7 level. He agreed with non-surgical treatment. Dr. A stated that he rendered his impairment rating using Table 49, although the exact section used is not specified.

At the contested case hearing, it was agreed that the carrier had paid impairment income benefits based upon a 7% rating. The claimant said he disagreed with this rating because he felt that Dr. A's examination had not been as thorough as the one by Dr. S. He stated that Dr. S had him bend different ways two times, while Dr. A did this one time. He stated that both Dr. S and Dr. A used an object on the back of his neck. He said that he has been told by Dr. E and Dr. S that he has three herniated discs, not just two. Claimant stated that Dr. S told him his impairment would be the same even after surgery, although some of his pain might be relieved. He felt that the difference in the 18% rating and the 7% rating was because he was under medication when Dr. A examined him. At the hearing, the claimant stated that Dr. S had revised the impairment rating upward, since his examination by Dr. A. Consequently, the record was held open to receive the new report.

Dr. S, in his subsequent TWCC-69 report, extended the date for achievement of MMI from March 31 to July 17, 1992 and increased the impairment rating from 18% to 23%. Dr. S's accompanying letter indicated that he derived this rating differently from his previous 18% rating, in that he considered the results of an EMG that was ordered June 30th, and conducted July 9, 1992. (The EMG indicated that there is some sensory loss involving the C5, C6, and C7 motor fibers.) Dr. S stated that, for purposes of using Table 49, "the problem seen at the three levels on the MRI could be interpreted as a cervical segment; therefore, being only 6% rather than the previously estimated 18%." He stated that he also used Table 12, on page 41 of the Impairment Guide, (Unilateral Spinal Nerve Root Impairment Affecting the Upper Extremity) to derive additional impairment percentages for C5 of 5%, C6 of 8%, and C7 of 5%. The methodology for assigning these percentages is not otherwise explained. His report then indicated that he used the Combined Value Table to derive the whole body impairment yielded by use of both tables.

The hearing officer invalidated the report of the designated doctor finding that it was not rendered in accordance with the Impairment Guides. Her Finding of Fact No. 11 states :

11. [Dr. A's] impairment rating of June 5, 1992, did not include peripheral

nerve injury impairments, did not include three (3) herniated discs revealed by the MRI, and did not properly total the percentages which should have been assigned to each of the three (3) discs; his impairment rating of June 5, 1992, is invalid.

Further, she finds proper use of Impairment Guides by the treating doctor in his second effort:

12. [Dr. S] assigned an impairment rating of 23% on September 14, 1992, which was determined by assigning an impairment percentage to each of three (3) herniated discs and combining the total of those percentages with the peripheral nerve injury impairments revealed by the EMG conducted on July 9, 1992; this percentage of permanent impairment was correctly determined as required by the [Impairment Guides].

There are no findings that the great weight of other medical evidence is contrary to the designated doctor's opinion such that its presumptive weight can be overcome. However, the basis for the above-cited findings is revealed somewhat in the statement of the evidence. The hearing officer states that Table 49, Section 2 "requires" that each disc be separately evaluated: "if this were not so, the plural of the word disc would be used." Notwithstanding medical evidence characterizing the MRI as indicative of "a" herniated disc (from Dr. M, Dr. N, Dr. E and the City 1 Radiological Association), and Dr. A's findings of two herniated discs, the hearing officer states that the MRI is "clear" that there are three herniated discs (perhaps equating disc bulge with herniated disc). The hearing officer indicates that Dr. A should have taken the value she derives from her review of Table 49 and multiplied it by three. However, this was not the approach ultimately taken by Dr. S in rendering his 23% rating, a fact on which the hearing officer fails to comment. Finding of Fact No. 12 does not accurately characterize the methodology described by Dr. S in his second report, because the three separate disc impairment values assigned were for peripheral nerve damage derived from Table 12, and did not come from multiplying the value from Table 49 by three.[1] The opinions of other physicians who examined the claimant are relegated by the hearing officer to footnotes.

[1]Dr. S's use of Table 12 of the Impairment Guides has not undergone the scrutiny of inference applied to Dr. A's report. The impairment percentage used by Dr. S for each disc is the same number listed in the column on Table 12 for maximum % loss of function due to sensory deficit. The underlying text indicates that use of this maximum % from this column would be appropriate for 100% sensory loss due to nerve root injury. Lesser grades of sensory loss would compel a smaller value. Additional computations are indicated for loss of muscle strength, which the EMG indicates claimant may have, or for bilateral involvement. The Impairment Guides indicate that further computations should then be made to convert the total value to an upper body and then to a whole body impairment percentage. The fact that Dr. S's disc impairments correlate exactly to these numbers on the chart could lead a finder of fact to infer that Dr. S may not have properly used Table 12.

At the outset, we would note that the use of a designated doctor is clearly intended under the 1989 Act to assign an impartial doctor to finally resolve disputes over MMI and impairment rating. To achieve this end, the report of a Commission appointed designated doctor is given presumptive weight. Articles 8308-4.25(b) and 4.26(g). Only the great weight of other medical evidence can counter this presumptive status. As the Appeals Panel has stated before, this requires more than a mere balancing of the evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Lay testimony or evidence does not provide sufficient basis to overcome this presumption. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992.

The hearing officer has erred by failing to properly apply the statutory standard set forth in Article 8308-4.26(g) for overcoming the presumption accorded to the designated doctor's report. The necessity of evaluating the great weight of medical evidence and making findings on that issue is not met by finding, unassisted by any medical evidence or interpretation, that the designated doctor has not properly used the Impairment Guides but that the treating doctor has. This is especially true when the treating doctor and the designated doctor appear to have made a similar use of Table 49 in the Impairment Guides that the hearing officer opined was defective.

We commend the hearing officer for taking official notice of the Impairment Guides, 3rd edition. However, we would note that when evaluating and determining the proper medical applications of this book, the invalidation of a designated doctor's opinion must be based upon stronger evidence than the hearing officer's observation that "disc" is used in the singular, rather than plural, form.[2] An endorsement of a treating doctor's use of the Impairment Guides, when used to overcome the presumptive weight required by Article 8308-4.26, should be supported by findings of fact that indicate a clear understanding of the methods used and choices made by that doctor in exercising his judgment. Where, as here, other medical evidence appears to more closely support the designated doctor's conclusions regarding the number of herniated discs present in claimant, findings should be made as to why such evidence was found inadequate.

The carrier correctly notes in its appeal that there is no medical evidence to substantiate an incorrect use of the Impairment Guides by Dr. A. We find Table 49, from a lay review, somewhat ambiguous. Any unanswered questions in this regard should be ascertained by the hearing officer through requests for clarification directed to the designated doctor. Because the designated doctor serves by the appointment of the

[2]The word "disc" in Table 49, II modifies the plural word "lesions". We would note that a lay review of the chapter in which Table 49 is located could equally support the inference that spinal impairment is based upon regions of the back, not individual discs, and that modifiers for multiple discs are accounted for in Table 49. Given the designated doctor's 7% rating, and his finding in claimant of spondylolysis, it is also possible to infer that his professional judgment directed him toward Section III of the chart, not Section II.

Commission, it is appropriate for the finder of fact to directly seek out the doctor's answers to medical questions that are deemed essential to understanding the report (through holding the record open in order to seek written clarification, for example), rather than relying solely on either party to present evidence supporting or refuting that report. Likewise, the hearing officer has the authority, in the interest of making a complete record under Article 8308-6.34(b), to direct either party to seek similar clarification from the doctors who serve as their expert witnesses.

The hearing officer also invalidated both Dr. A's report and Dr. S's first report for not including peripheral nerve damage. However, a cursory review of the applicable sections of the Impairment Guides, page 40-41, indicates that such consideration is made in terms of measurable sensory loss or muscle strength loss. Dr. A's report, on its face, indicates that he did not find that either existed at the time of his examination; it appears he did consider, and did not fail, to evaluate such factors. Chapter 3.3 of the Impairment Guides for rating Spinal Impairment indicates on page 74 that peripheral nerve damage impairments should be identified "if applicable." Dr. A may have determined that any impairment resulting from nerve root impingement was not present or not permanent, and consequently did not rate it. *See* Article 8308-1.03 (24) & (25). Dr. A should not be faulted for failure to consider an EMG test not in existence when he performed his examination.

Resolution of questions of MMI and impairment should not be indefinitely deferred to an open-ended series of testing. *See* Texas Workers' Compensation Commission Appeal No. 92275, decided August 11, 1992. Recognizing this, we nevertheless remand to allow the designated doctor the opportunity to consider the impact, if any, of the EMG test report on his impairment rating. The Commission should assure such is done expeditiously.

Finally, we note that the hearing officer failed to make any findings on the date that MMI was reached. Although there was ostensibly not a dispute over Dr. S's initial determination that MMI was reached on March 31, 1992, the hearing officer has apparently invalidated that TWCC-69 report in total. A party must be able to ascertain from the hearing decision the date on which temporary income benefits cease, and impairment income benefits accrue i.e., the MMI date, and this should be addressed in the decision on remand.

The decision of the hearing officer is reversed and the case is remanded for the expedited development of further evidence, as appropriate, and for reconsideration and such additional findings as are appropriate and not inconsistent with this opinion. Pending resolution of the remand, a final decision has not been made in this case.

_____
Susan M. Kelley
Appeals Judge

CONCUR:

_____
Stark O. Sanders, Jr.
Chief Appeals Judge

_____
Philip F. O'Neill
Appeals Judge