APPEAL NO. 92611

On September 30, 1992, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as hearing officer. The hearing officer determined that the appellant (claimant below) had reached maximum medical improvement (MMI) on June 16, 1992 and had an impairment rating of five percent and ordered the payment of applicable benefits pursuant to the Texas Workers' Compensation Act (TEX. REV. CIV. STAT. ANN. art 8308-1.01 *et seq*.) (Vernon Supp. 1992) (1989 Act). On appeal the claimant contested the designated doctor's ratings, alleging the American Medical Association's (AMA) Guides to the Evaluation of Permanent Impairment, third edition, had not been used and alleging the great weight of the other medical evidence is contrary to the finding of the designated doctor. The respondent (carrier) filed an untimely response.

DECISION

Determining the hearing officer erred in relying on an incomplete report, we reverse and the case is remanded for development of appropriate evidence, if any, and reconsideration not inconsistent with this opinion.

Addressing the untimely response by the carrier we note that Article 8308-6.41(a) states in part:

> The respondent party shall file a written response with the appeals panel not later than the 15th day after the date on which the request for appeal is served . . ."

The Texas Workers' Compensation Commission (Commission) has interpreted this statute in its agency rules, Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 143.4(c)(1) and (2) which provide that a response made under this section shall be presumed to be timely filed if it is:

> (1)mailed on or before the 15th day after the date of receipt of the appellant's request . . . and
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> (2)received by the commission or other party not later than the 20th [fifth] day after the date of receipt of the appellant's request [mailing].

Claimant filed his handwritten request for review on November 13, 1992. The record indicated that it was faxed to the carrier's attorney on November 16, 1992. Fifteen days from that date would be Tuesday, December 1, 1992. Carrier's response was faxed and mailed on December 3, 1992. The faxed copy was received December 3, 1992 and the mailed copy was received December 7, 1992. Carrier's adjustor also filed a response which recites service on the claimant on November 30, 1992, but which apparently was not sent directly to the Commission and was not received until December 9, 1992. Consequently, the response is not timely filed as it was not mailed on or before the 15th day after receipt of claimant's request for review. We will not consider the carrier's response but will review the points raised on appeal.

The issues on appeal before us are the same as those framed at the contested case hearing (CCH), which were:

Has Claimant reached the point of maximum medical improvement?

What is Claimant's whole body impairment rating?

Claimant is a 33-year-old male who injured his back on (date of injury) while turning over an I-beam that he was welding while in the course and scope of his employment.

Claimant selected (Dr. SD), an M.D., as his treating doctor.[1] Dr. SD submitted two reports, one dated 7/30/92 and the other dated 8/13/92. In the 7/30/92 report, Dr. SD recites the patient's history, physical examination, diagnosis of "Spondylosis at L4-L5" and gives an impairment rating of seven percent due to the spondylosis "and loss of range of range (sic) of motion is 8%, giving him an impairment of 15% to the body as a whole." Dr. SD further opines in his 7/30/92 report "[p]atient has recovered to a large extent" and states "[p]atient is not anticipated to be able to return to more than sedentary work." In an August 13, 1992 letter to the Commission, Dr. SD references the designated doctor's report and explains in some detail how he (Dr. SD) arrived at the 15% impairment rating and how the designated doctor's five percent impairment rating might be in error.

Claimant also saw (Dr. M) an M.D., neurosurgeon, who was the carrier's required medical examination doctor, on November 8, 1991. By letter report, Dr. M recites that "[r]eview of the various tests including CT scans and MRI of the spine fail to reveal any disabling abnormalities." Dr. M agrees that proposed rehabilitation of the claimant's back is in order, and that "it would be wise for [claimant] to avoid circumstances that led to his present trouble" and predicts no "permanent partial disability . . . secondary to the (month) injury."

Because of the differences in opinion, the Commission appointed (Dr. RD) as the designated doctor. Dr. RD submitted a narrative (Carrier's Exhibit No. 2) report dated 6-16-92 which recites the claimant's medical history, states the tests performed and the doctor's observations and gives an assessment of "a chronic interspinous ligament sprain." Dr. RD concludes that claimant has "a 5% whole body permanent physical impairment . . . some changes of a degenerative nature . . . that comes under the AMA guidelines as a permanent physical impairment." Dr. RD also filed a TWCC-69 which indicated an MMI date of 6/16/92 and five percent whole body impairment rating.

Claimant apparently was visiting in (state) and saw (Dr. C), a chiropractic physician. Dr. C submitted a September 25, 1992 letter report "To Whom it (sic) May Concern" where

[1]On cross-examination it appears claimant saw another doctor, apparently on the carrier's recommendation. Claimant apparently saw this doctor only once and no report, evidence or documentation regarding the findings, if any, are in the record; therefore, references by the carrier what this doctor may have found will not be considered.

Dr. C states he "reviewed all of his [claimant's] past medical records that pertain to this case" and notes claimant "has 2 different impairment ratings." It is Dr. C's opinion "that Dr. SD's rating is more accurate."

The carrier also submitted as Carrier's Exhibit No. 4 an August 6, 1991 MRI scan of the thoracic spine showing no abnormalities and Carrier's Exhibit No. 5, a June 29, 1991 MRI scan of the lumbar spine showing no abnormalities.

Claimant briefly testified at the CCH to the effect that he believes he is still unable to work, is in severe pain, believes he was disadvantaged because he did not have an attorney representing him, that Dr. RD, the designated doctor, did not give him an adequate examination and that he has 15% impairment rating as given by Dr. SD.

The hearing officer accepted the MMI and five percent impairment rating of the designated doctor, stating that he does not find the great weight of the other medical evidence to be to the contrary. Claimant appeals, stating that the designated doctor's ratings were wrong because the range of motion tests on pages 54 and 72 through 81 of the AMA Guides to the Evaluation of Permanent Impairment, third edition (AMA Guides), were not used. Page 54 of the AMA Guides deals with impairment of the foot. Perhaps claimant believes his foot is involved; however, the medical evidence concentrates on the spine. Page 72 (actually 71) of the AMA Guides through page 83 deal with general and cervical spine measurements and impairment ratings. It is not at all clear from the designated doctor's narrative how he arrived at a five percent impairment rating and which, if any, of the AMA Guides he may have used. Dr. RD, the designated doctor, based his five percent impairment on "the fact he had a documented injury . . . followed for six months by muscle spasms and discomfort and also had some changes of a degenerative nature on his x-ray . . ." The issue in this case is not merely whether the correct edition of the AMA Guides was used but rather whether the designated doctor used the AMA Guides at all in determining impairment. The only portion of the designated doctor's report that even mentions the AMA Guides states the five percent impairment is ". . . based on . . . a documented injury . . . six months [of] muscle spasms and discomfort and . . . some changes of a degenerative nature on [claimant's] x-ray . . ." The impairment rating was specifically challenged by claimant at both the CCH and on appeal. Claimant produced detailed reports from the treating doctor, an M.D., which specify degrees of flexion and extension and specifying tables in the AMA Guides based on loss of range of motion detailing how the 15% impairment is arrived at.

Of some further consternation is the lack of comment in item 15 of the designated doctor's TWCC-69. Item 15 states "[i]f impairment rating is 5% or greater (which it was), list specific body part/system and rating." It is not unusual for this section to be left blank if the TWCC-69 is accompanied by a narrative which provides that information, although the TWCC-69 will usually reference the narrative, which this one did not. Even assuming that Dr. RD's narrative dated 6-16-92 is incorporated into the TWCC-69, as we have previously noted, that narrative does not list specific body part/system and rating or specify whether the AMA impairment guidelines were used.

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.

Texas Workers' Compensation Commission Appeal No. 92335, decided August 28, 1992, affirms that requirement and states:

> 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 Commission Appeal No. 92074 . . ., 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).

This case is distinguished from Texas Workers' Compensation Commission Appeal No. 92393, decided September 17, 1992, which held:

> . . . there is no requirement in Rule 130.1 relating to reports of medical evaluation that the Medical Evaluation Report form inquire of the doctor whether the doctor used the AMA Guides in determining impairment, nor does this rule contain a requirement that the doctor state on the form that he or she used the AMA Guides in determining impairment.

It is our specific holding, in this case, that where there is a challenge regarding the designated doctor's rating and where the challenge specifically attacks how the rating was determined using the AMA Guides, the designated doctor should provide some information how the impairment rating was arrived at, particularly when the treating doctor specifies measurements, AMA Guides and tables used.

In this case claimant specifically challenged the designated doctor's impairment rating, both at the CCH and on appeal, stating the designated doctor had not considered the loss of range of motion used by the AMA Guides. As noted previously, there is nothing in the designated doctor's narrative which indicates how the AMA Guides had been used, or how the impairment rating was determined. Also, as noted previously, item 15 of the TWCC-69 was left blank, with no reference to the narrative. We will infer such a reference; however, the narrative is not helpful in concluding how the impairment rating was determined other than being based on an injury and six months of discomfort.

We are very mindful that we have strongly supported the designated doctor's ratings. In Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992, we said that Articles 8308-4.25 and 4.26 of the 1989 Act, which give presumptive weight to the designated doctor's report, require ". . . not just equally balancing evidence or a preponderance of evidence that can outweigh such (a designated doctor's) report, but only the `great weight' of other medical evidence that can overcome it." A recent Appeals Panel decision, Texas Workers' Compensation Commission Appeal No. 92570, decided December 14, 1992, reversing a hearing officer's decision which invalidated a designated doctor's impairment rating and adopted the treating doctor's impairment rating merits consideration here. In that case we held:

> . . . 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.
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> 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 affirm that conclusion. It is noted in the instant case that we do not necessarily adopt the rating of the treating doctor but only require that in the face of specific challenge that the AMA Guides were not properly used or were used incorrectly, there be some showing by the designated doctor how his impairment rating was arrived at using the AMA Guides. Nothing in this opinion should be construed in any way to change the weight given to the designated doctor's report. The designated doctor's report, to be accorded presumptive weight, must however meet the requirements of the Act. We have held in Texas Workers' Compensation Commission Appeal No. 92027, decided March 27, 1992, Texas Workers' Compensation Commission Appeal No. 92165, decided June 5, 1992, and Texas Workers' Compensation Commission Appeal No. 92546, decided November 23, 1992 that an unsigned TWCC-69 does not constitute certification under Texas Workers' Compensation Commission (TWCC) Rule 130.1(c)(4). Similarly, we hold that if the designated doctor fails to use the AMA Guides in determining impairment as required by Article 8308-4.24 that impairment rating is vulnerable to challenge. The claimant's contention that the AMA Guides were not properly used by the designated doctor are not contradicted by either the

medical reports or other evidence. Consequently, we find the designated doctor's report did not comply with Article 8308-4.24 and is incomplete in establishing the impairment rating.

We reverse and remand for development of appropriate evidence, if any, regarding clarification of how the designated doctor arrived at the five percent impairment under the AMA Guides and reconsideration not inconsistent with this opinion. Pending resolution of the remand, a final decision has not been made in this case.

Thomas A. Knapp
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

DISSENTING OPINION:

I respectfully dissent. While there certainly are instances where this panel may choose to remand for further consideration a hearing officer's finding of maximum medical improvement and impairment based upon a designated doctor's report (*see* Texas Workers' Compensation Commission Appeal No. 92561, decided December 4, 1992), I believe that in the majority of cases neither the fact finder nor this panel should interfere in the substance of the designated doctor's opinion. Where other medical opinion diverges with that of the designated doctor, the 1989 Act provides a remedy to the extent that the designated doctor's determination may be overcome by the "great weight of the other medical evidence," Articles 8308-4.25(b), 4.26(g). Otherwise, the opinion of the designated doctor is entitled to presumptive weight (or conclusive weight, in the case of an impairment rating assigned by a doctor agreed to by the parties). I stress that I believe there may be cases, even in the absence of medical evidence to the contrary, where egregious error on the part of a designated doctor may be cause for remand. However, I am concerned that second guessing the meaning of the language used by a designated doctor in his report may lead to the slowing down of a process that is intended to result in speedy resolution of a dispute. In this case, though awkwardly worded, the designated doctor described the results of his examination and his findings, and referenced the AMA Guides. Under these circumstances I would affirm the decision and order of the hearing officer.

Lynda H. Nesenholtz
Appeals Judge