APPEAL NO. 92627

A contested case hearing was held on August 5, 1992, reconvened on September 9th and concluded on October 19th in (city), Texas, (hearing officer) presiding. Two issues were before the hearing officer: when did claimant reach maximum medical improvement (MMI), and what is claimant's impairment rating. The appellant, hereinafter carrier, is appealing the hearing officer's determination that the claimant had a 29% whole body impairment rating and that the carrier is ordered to pay benefits consistent with the decision and the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 *et seq*. (Vernon Supp. 1992) (1989 Act).

The carrier argues in its request for review that the hearing officer erred in determining that the claimant has a 29% whole body impairment rating, because the report of the designated doctor, as well as claimant's treating doctor, were improper, incomplete, and not based upon the 1989 Act or the rules of the Texas Workers' Compensation Commission (Commission). The carrier also contends the hearing officer erred in refusing to admit medical records documenting claimant's prior injuries and impairment ratings. No response was filed by the claimant.

DECISION

We reverse the decision and order of the hearing officer and remand this case to allow a designated doctor to certify MMI and to cure other defects in the prescribed report, as detailed herein.

It was not in dispute that the claimant, who was employed by (employer), injured his right wrist and arm, neck, and left shoulder in the course and scope of his employment on (date of injury).

At the request of the carrier and apparently pursuant to a Commission order under Article 8308-4.16, claimant was examined by (Dr. G) on June 11, 1991. On November 29, Dr. G issued a report certifying MMI as of that date, with a 14% whole body impairment rating. (Claimant stated that Dr. G originally had assigned a 10% impairment rating, but that it had later been revised to 14%. No document indicating a 10% impairment was included in the record, although the narrative attached to Dr. G's Report of Medical Evaluation (TWCC-69) states that it is an addendum to claimant's independent medical evaluation of June 11th.) Thereafter, claimant's treating doctor, (Dr. H), stated his disagreement with Dr. G's impairment rating. In a letter dated March 4, 1992, Dr. H stated in part, "[i]n order to achieve an impairment rating that involves the cervical spine, range of motion measurements must be done with an inclinometer using the guidelines in the evaluation of permanent impairment, 3rd edition, of the American Medical Association. This was not done in this case. Also an impairment has to be done for any type of radiculopathy which is present in this patient. Therefore, I do not agree with his impairment as I do not feel it complies with the AMA guidelines."

Dr. H went on to state that he had not seen the claimant since November 20, 1991, and as such did not know his current condition. However, he offered to provide an impairment rating using the correct guidelines, if the claimant would return for another appointment. Dr. H thereafter certified that claimant reached MMI on June 22, 1992 with a 44% whole body impairment rating. In answers to a deposition on written questions propounded by the carrier, Dr. H stated that he was familiar with the requirements and methods of determining impairment under the American Medical Association's Guides to the Evaluation of Permanent Impairment (AMA Guides), Third Edition, Second Printing, February 1989. When asked which edition of the AMA Guides he had used to arrive at his impairment rating, he replied Third Edition, revised.

Claimant was also seen by (Dr. B) for what was apparently a Commission-ordered medical examination.[1] Dr. B certified MMI as of April 15, 1992, with a "C spine total body" impairment rating of 15% and a "total body for right arm" impairment rating of eight percent. Dr. B's TWCC-69 stated the impairment ratings were taken from "the orthopedic guidelines to physical impairment." However, an attached report dated May 21, 1992 stated that Dr. B recommended a repeat EMG, an MMPI evaluation, and a functional capacity evaluation of the cervical spine and right upper extremity before claimant's impairment rating could be completed. A May 18, 1992 functional capacity assessment from the (center) was also attached, but it was not clear whether that report played a part in the impairment ratings assigned by Dr. B. At the hearing, claimant contended that Dr. B's report was invalid because it did not correctly utilize the AMA Guides.

Because of this dispute, the Commission appointed (Dr. O) as designated doctor. According to claimant, Dr. O did not examine him because he said he would be unable to issue a report within seven days. Thereafter, the hearing officer appointed (Dr. P) as designated doctor. Dr. P, in a TWCC-69 dated September 25, 1992, assessed a 29% whole body impairment rating but did not certify a date of MMI. An Initial Medical Report (TWCC-61) dated August 25, 1992 and attached to the TWCC-69, gave the anticipated date of MMI as "[p]ending wrist clearance with [Dr. H]."

The hearing officer made findings of fact and conclusions of law in pertinent part as follows:

FINDINGS OF FACT

6.After examining claimant on June 11, 1991, at the request of the carrier, [Dr. G] issued a report on November 29, 1991, certifying that claimant reached maximum medical improvement on November 29, 1991, with a 14% whole body impairment rating.

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[1]It was not clear from the record what Dr. B's status was. Claimant said he was a designated doctor, while carrier said Dr. B examined claimant under an Article 8308-4.16 order.

7.Although on the proper form, [Dr. G's] report did not otherwise meet the requirements of 28 T.A.C. § 130.3.

8.On March 4, 1992, [Dr. H] stated he would evaluate claimant for a proper impairment rating without disputing [Dr. G's] certification of maximum medical improvement.

9.Subsequently, [Dr. H] certified that claimant reached maximum medical improvement on June 22, 1992, with a 44% whole body impairment rating.

10.[Dr. P], commission-appointed designated doctor, assessed a 29% whole body impairment rating in a report dated September 25, 1992, without certifying date of maximum medical improvement.

CONCLUSIONS OF LAW

2.The great weight of the medical evidence indicates that claimant reached maximum medical improvement on November 29, 1991.

3.The designated doctor's assessment of a 29% whole body impairment rating is not contrary to the great weight of the other medical evidence and shall be adopted by the commission.

Carrier's first point of error concerns the hearing officer's determination that the claimant has a 29% whole body impairment rating. The carrier does not contest or dispute the finding and conclusion that the claimant reached MMI on November 29, 1991; however, it argues that Dr. P's report is defective for a number of reasons, essentially causing it to be outweighed by the other medical evidence. The defects in Dr. P's report include the following: it was not based upon the statutorily required version of the AMA Guides; it made no reference to previously assigned impairments to the claimant's whole body, despite the fact that the claimant stated at the hearing that he had furnished medical records from prior injuries to all the doctors; it failed to certify MMI prior to assessing impairment, contrary to Commission rule; it fails to affirmatively indicate that there is evidence of impairment based on an objective clinical or laboratory finding; and the designated doctor referred the claimant to a hospital for impairment rating assessment, then added "about ten percent" to the cervical area without explanation as to how that figure was derived. In sum, carrier contends, Dr. P's report is invalid and should be disregarded. Likewise, it argues, Dr. H's report has some of the same shortcomings (e.g., use of wrong version of the AMA Guides and failure to consider impairment from prior medical conditions), leaving Dr. G's report as the only probative evidence upon which the hearing officer's decision could be based. We will address each of these arguments in turn.

The 1989 Act requires that all determinations of impairment under the Act must be made in accordance with the second printing, dated February 1989, of the AMA Guides, third edition. *See* Article 8308-4.24. This panel has held that, where not made an issue at the hearing, a party should not be required to present evidence that the AMA Guides were used when a doctor's assigned impairment rating is reported on a Commission prescribed TWCC-69. *See* Texas Workers' Compensation Appeal No. 92393, decided September 17, 1992. However, where timely raised as an issue we have considered whether the AMA Guides, or the proper version of the guides, were used. *See* Texas Workers' Compensation Commission Appeal No. 92335, decided August 28, 1992. In this case, as carrier argues, evidence in the record indicates that Dr. H used the AMA Guides, "Third Edition, Revised" in assigning an impairment rating. The TWCC-69 signed by Dr. P does not on its face reference the AMA Guides or any version thereof, although an attached report from the (rehabilitation hospital) cites "AMA Guides, Revised Third Edition" and "Guides to the Evaluation of Permanent Impairment, Revised 3rd Edition. Copyright (c) 1990. American Medical Association." The latter indicates that the statutorily prescribed version of the AMA Guides was not used, at least by the rehabilitation hospital. As we will discuss further herein, a separate narrative documenting Dr. P's objective laboratory or clinical findings of impairment was not included. Because it is not clear whether the designated doctor adopted the report of the rehabilitation hospital in its entirety, and because this issue was raised at the hearing and preserved on appeal, it is necessary that the TWCC-69, or a narrative appended thereto, clarify that the proper edition of the AMA Guides was used in arriving at an ultimate whole body impairment rating.

The carrier also argues that Dr. P improperly referred the assessment of impairment to the rehabilitation hospital, stating that "since the [1989 Act] would not allow the Commission to designate a non-doctor as a designated doctor under the statutory provisions, it is difficult to understand how a properly appointed designated doctor can refer a claimant out to a non-doctor for purposes of impairment assessment." We are not willing to say that a designated doctor could not consult with other, qualified experts in making a determination of impairment. However, as with medical reports and the findings of previous examinations by other doctors, the designated doctor must evaluate the findings and recommendations of other experts in developing a recommendation that is ultimately based upon his own professional opinion; he cannot abdicate this role to another. Whether Dr. P relied entirely upon the analysis of the rehabilitation hospital is questionable, however, as the whole body impairment rating he assigned differed from that of the rehabilitation hospital, which is another point of error assigned by the carrier.

For the reasons stated in the foregoing paragraph, we do not find it improper for the designated doctor, following any consultations, to make his or her own determination of impairment, based upon all the information available. From the TWCC-69 and its attachments, it appears that Dr. P adopted the 19% whole body impairment rating assessed by the rehabilitation hospital, but added "about 10%" for the cervical spine (the rehabilitation hospital had assessed 0%) based on the results of Dr. P's neurological examination of claimant as detailed in the attached narrative report. This appears to be a sufficient

documented laboratory or clinical finding of impairment as required by Rule 130.1(g) and TWCC-69, text under Item 16. Because Dr. P's finding of impairment was an unequivocal 29%, we distinguish this case from prior cases where imprecise determinations of impairment have been invalidated. *Compare* Texas Workers' Compensation Commission Appeal No. 92384, decided September 14, 1992.

With regard to Dr. P's failure to certify MMI on the TWCC-69[2], we initially note that we have previously indicated there may be occasions where a designated doctor could be asked to assess impairment without having certified MMI. *See* Texas Workers' Compensation Commission Appeal No. 92595, decided December 21, 1992. We have also declined to hold that MMI and impairment cannot be individually considered, while acknowledging that they can become "somewhat inextricably" tied together. Texas Workers' Compensation Commission Appeal No. 92561, decided December 4, 1992. However, given the fact that the hearing officer in this case appointed the designated doctor for both purposes, we believe this situation analogous to that contained in Appeal No. 92595, *supra*, where we held the Commission responsible to go back to the designated doctor to develop further information as needed. This is especially necessary because of the presumptive weight accorded the designated doctor's opinion, which can be overcome only where "the great weight of the other medical evidence is to the contrary," Articles 8308-4.25(b) and 4.26(g). *See also* Texas Workers' Compensation Commission Appeal No. 92546, decided November 23, 1992, where we held the hearing officer improperly rejected the designated doctor's determination of impairment while adopting his certification of MMI.

Carrier also argues that Dr. P failed to limit his assessment of whole body impairment to the compensable injury alone, and that Dr. P's report "fails to affirmatively indicate that there is evidence of impairment based on an objective clinical or laboratory finding." We disagree. We note that the TWCC-69, per Rule 130.1(g), instructs the doctor as follows: "Impairment rating shall be based on the compensable injury alone. As described in Art. 8308-1.03 of the [1989 Act] objective laboratory or clinical finding is defined as `a medical finding of impairment resulting in 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'." In the absence of evidence to the contrary, we are unable to conclude that Dr. P failed to follow these instructions. There is no requirement that the designated doctor affirmatively state that his impairment rating was based on objective clinical or laboratory findings. Indeed, proper completion of the TWCC-69 and reliance on the proper version of the AMA Guides should

[2]Apparently the hearing officer did not conclude, and the carrier did not contend, that Dr. P's notation with regard to MMI on the TWCC-61 stood for an MMI determination. We would agree, in that this panel has held that the proper form for certifying MMI is the TWCC-69, and that an anticipated date of MMI is not a statement that MMI has been reached. *See* Texas Workers' Compensation Commission Appeal No. 92127, decided May 15, 1992; and Texas Workers' Compensation Commission Appeal No. 92198, decided July 3, 1992.

ensure compliance with this requirement. *See* Appeal No. 92335, *supra*.

With regard to assessment of the compensable injury alone, the carrier argues that the designated doctor's report makes no reference to previously assigned impairments to the claimant's whole body despite the fact that claimant stated at the hearing the these reports had been provided to the designated and other doctors. A somewhat related argument is carrier's second point of error, which concerns the hearing officer's excluding from evidence certain medical records documenting such prior injuries, conditions, and impairment. We have previously held that an impairment rating under Articles 8308-4.24 and 4.26 is rendered based upon the physical condition of the claimant resulting from the compensable injury at the point that he reaches MMI. Texas Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992. That opinion determined that another statutory provision, Article 8308-4.30, allows a carrier to request the Commission to order a reduction of impairment or supplemental income benefits equal to the proportion of a documental impairment that resulted from earlier compensable injuries, and that the procedure allows reduction of the benefit and not the rating. The carrier may wish to invoke the provisions of Article 8308-4.30 at some point in the future, after an impairment rating has actually been determined. At that point, it may be that the medical records from the prior injuries would be relevant. For purposes of our review, it appears that all the appropriate records were supplied to the designated doctor. Without more, we are unwilling to conclude that Dr. P's impairment rating was not based "on the compensable injury alone." Likewise, for the foregoing reasons, it was not error for the hearing officer to exclude records of the claimant's prior injuries.

Based on all the foregoing, we reverse the decision and order of the hearing officer and remand to provide the Commission with the opportunity to allow the designated doctor to certify MMI, to confirm whether he used the statutorily prescribed version of the AMA Guides in determining impairment, and to take such other steps as the hearing officer deems necessary, including the development of additional evidence as appropriate. Pending resolution of the remand, a final decision has not been made in this case.

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Lynda H. Nesenholtz
Appeals Judge

CONCUR:

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Philip F. O'Neill
Appeals Judge

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Thomas A. Knapp
Appeals Judge