APPEAL NO. 931008

On October 18, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act) (formerly V.A.C.S., Article 8308-1.01 *et seq*.). The issues at the hearing were maximum medical improvement (MMI) and impairment rating. The parties stipulated that the appellant (claimant) reached MMI on November 9, 1992. The hearing officer determined that the claimant has a seven percent whole body impairment rating as reported by (Dr. T), the designated doctor chosen by the Texas Workers' Compensation Commission (Commission), and decided that the claimant is entitled to impairment income benefits for 21 weeks (three weeks for each percentage of impairment). The claimant requests that we reverse the hearing officer's decision and render a decision that he has a 12% impairment rating as reported by (Dr. S), his treating doctor. The respondent requests that we affirm the hearing officer's decision.

DECISION

The decision of the hearing officer is reversed and remanded for further development and consideration of the evidence.

The claimant testified that on (date of injury), he was injured at work when a pallet fell on his neck and right shoulder. Dr. S, the claimant's treating doctor, diagnosed a cervical sprain/strain and a right shoulder contusion and recommended physical therapy which the claimant undertook. The parties stipulated that the claimant reached MMI on November 9, 1992.

In a Report of Medical Evaluation (TWCC-69), Dr. S assigned the claimant a 12% whole body impairment rating. The carrier disputed Dr. S's rating and the Commission selected Dr. T as the designated doctor to assess the claimant's impairment rating. Dr. T examined the claimant on March 29, 1993. The claimant testified that at the time Dr. T examined him, Dr. T had in his possession a letter from the carrier. The claimant said he did not know the contents of the letter but that Dr. T told him the carrier wanted to know if he needed surgery.

In his initial TWCC-69, Dr. T reported that the claimant had reached MMI and assigned a seven percent whole body impairment rating. The rating was composed of five percent impairment for the upper extremity (right shoulder), which translated into a three percent impairment to the whole body, and a four percent whole body impairment due to impairment to the cervical spine. Dr. T referred to "page 80, table 53" in regard to that portion of the impairment rating relating to the claimant's cervical spine. However, also in evidence was another TWCC-69 from Dr. T which contained the same information and rating as the initial TWCC-69 but which had "page 80, table 53" crossed through and replaced with "page 73, table 49."

In a letter dated August 18, 1993, Dr. S stated that he disagreed with the impairment

rating assigned by Dr. T, that Dr. T's TWCC-69 was "incomplete," and that he stood by his 12% impairment rating. Dr. S did not state in what respects Dr. T's report was incomplete. In a letter dated September 14, 1993, the carrier asked "name" in Dr. T's office to have Dr. T review Dr. S's letter of August 18th and to have Dr. T "prepare a narrative indicating how he reached the 7% rating." In a letter to the carrier dated September 15, 1993, Dr. T stated:

> I have reviewed the records that you have included, as well as the evaluation done by [Dr. S]. My findings of the 7% impairment to the whole person was based on the Guides to the Evaluation of Permanent Impairment, Third Edition, put out by the American Medical Association. The difference in my findings and the findings of [Dr. S] are that, in my opinion, there were no neurological deficits as loss of strength and decreased sensation. The only objective findings in my examination were decreased range of motion in the shoulder and in the cervical spine. As noted in my report dated March 23, 1993, the finding of 4% of impairment for the cervical spine is basically on Table 53, Impairment Due to Specific Disorders of the Spine, No. 2, Line B and I quote, 'Unoperated medically documented injury with a minimum of six months of medically documented pain and rigidity, with or without muscle spasm, associated with none to minimal degenerative changes on structural tests.' I added to that 3% impairment for the whole person related to decreased range of motion in flexion and extension, abduction/adduction, and internal/external rotation which added to 3% of the whole person as per my objective exam.
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> It is, therefore, my opinion that this patient has 7% impairment to the whole person as a result of the injury sustained on (date of injury). It is obvious that the different rating given by myself and [Dr. S] is a matter of medical opinion concerning objective findings during this patient's examination. Patients with severe injuries that require surgical treatment including fusion in the spine are usually awarded no more than 10% whole body impairment and, therefore, I feel that 7% impairment for this case is very fair. (Underlining added).

Pursuant to Section 408.125(e), the report of a designated doctor chosen by the Commission regarding an impairment rating has presumptive weight and the Commission must base the impairment rating on that report unless the great weight of the other medical evidence is to the contrary. We have previously held that a designated doctor's report cannot be overcome by a preponderance of the evidence; the great weight of the medical evidence must be contrary to the report. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992.

Under Section 408.124(b), the "Guides to the Evaluation of Permanent Impairment," third edition, second printing, dated February 1989, published by the American Medical Association (the AMA Guides) must be used for determining the existence and degree of an employee's impairment. Table 49, Impairments Due to Specific Disorders of the Spine, is found on page 73 of the AMA Guides, and Table 53, Impairment Due to Abnormal Motion and Ankylosis of the Cervical Region - Rotation, is found on page 83 of the AMA Guides.

Chapter 3, Section 3.1g of the Guides relates to impairment to the shoulder. Range of motion testing on the shoulder is done for: flexion and extension; abduction and adduction; and internal and external rotation.

On appeal, the claimant disagrees with the following findings of fact:

FINDINGS OF FACT

No. 6.Dr. T properly used the correct Guides in determining the claimant's whole body impairment.

No. 8.The opinions of Dr. T were not overcome by other medical evidence.

No. 9.The carrier did not improperly contact Dr. T

The claimant asserts on appeal, as he did at the hearing, that Dr. T did not properly follow the AMA Guides in evaluating impairment. Having reviewed the record, we conclude that there is merit in the claimant's contention because there is an unexplained discrepancy in the reports of the designated doctor which should be clarified through further development and consideration of the evidence. Simply put, Dr. T appears to have based impairment of the cervical spine on a specific disorder under Table 49 of the AMA Guides (although he refers to Table 53 in his letter, he states that the table he based cervical impairment on was the table for specific disorders of the spine which is Table 49 - he also references Table 49 in his corrected TWCC-69); however, in the letter of September 15, 1993, Dr. T states that there were objective findings of decreased range of motion in the cervical spine, yet he did not assign any impairment for decreased range of motion of the cervical spine and he gave no explanation for not doing so. The three percent impairment to the whole body that he gave for decreased range of motion appears to have been for decreased range of motion of the shoulder, and not the cervical spine, because he references flexion/extension, abduction/adduction, and internal/external rotation in relation to that finding. Under these circumstances, we consider it appropriate to remand the case for further consideration and development of the evidence for clarification of the impairment rating assigned by Dr. T. *See* Texas Workers' Compensation Commission Appeal No. 93735, decided October 4, 1993, where we stated:

> Texas Workers' Compensation Commission Appeal No. 93296, decided May 28, 1993, indicated that range of motion ratings are one of three factors to be added together to reach an impairment rating in regard to the spine; the other two to consider, and to add together when each has some rating, are the diagnosis based percentage and neurological deficits. *See*

Principles of Calculating Impairment at page 71 of the Guides and step-by-step approach of paragraph 3.3a, pages 72 and 74 of the Guides.

In Appeal No. 93735, *supra*, we reversed and remanded the hearing officer's decision on impairment rating, which was based on the report of the designated doctor, where the designated doctor indicated that the injured employee had decreased range of motion but failed to assign any impairment for decreased range of motion. *See also* Texas Workers' Compensation Commission Appeal No. 93769, decided October 11, 1993.

The claimant also asserts on appeal, as he did at the hearing, that the carrier should not have unilaterally contacted the designated doctor. We agree; the carrier should have made its request to Dr. T through the Commission and allowed the Commission to contact the designated doctor. *See* Texas Workers' Compensation Commission Appeal No. 93613, decided August 24, 1993. However, under the circumstances presented we find no basis for concluding that the carrier's unilateral contact resulted in any prejudice, undue influence, or other untoward action. *See* Texas Workers' Compensation Commission Appeal No. 93762, decided October 1, 1993.

The decision of the hearing officer is reversed and remanded for further consideration and development of the evidence, as appropriate, and not inconsistent with this decision. A final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Texas Workers' Compensation Commission's division of hearings, pursuant to § 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

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Robert W. Potts
Appeals Judge

CONCUR:

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Susan M. Kelley
Appeals Judge

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Philip F. O'Neill
Appeals Judge