APPEAL NO. 931040

On September 3, 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 parties stipulated that the respondent (claimant) reached maximum medical improvement (MMI) on February 11, 1993. The issue at the hearing was the claimant's impairment rating. Based on a report of (Dr. G), the designated doctor selected by the Texas Workers' Compensation Commission (Commission), the hearing officer determined that the claimant has a 36% impairment rating. The hearing officer decided that the claimant is entitled to 108 weeks of impairment income benefits (three weeks for each percentage of impairment). The carrier disputes the hearing officer's decision, contending that the claimant has a 19% impairment rating.

DECISION

Determining that the request for review was not timely filed and that the jurisdiction of the Appeals Panel has not been properly invoked, the decision of the hearing officer has become final pursuant to the provisions of Section 410.169.

Section 410.202(a) provides that "[t]o appeal the decision of a hearing officer, a party shall file a written request for appeal with the appeals panel not later than the 15th day after the date on which the decision of the hearing officer is received from the division and shall on the same date serve a copy of the request for appeal on the other party." *See also* Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 143.3(a)(3) (Rule 143.3(a)(3)). Notices and communications, including decisions of hearing officers, are sent to a carrier's (city) representative. Rule 102.5(b) and Rule 156.1. *See also* Texas Workers' Compensation Commission Advisory 92-07 dated November 3, 1992, wherein all carriers and their representatives were advised that effective November 30, 1992, all documents and notices, including hearing decisions, would be placed in the carrier's (city) representative's box in the Commission's Central Office and that no additional copies would be mailed. *See* Texas Workers' Compensation Commission Appeal No. 93353, decided June 21, 1993; and Texas Workers' Compensation Commission Appeal No. 93519, decided July 28, 1993. Section 406.011(a) provides that notice to the carrier's designated agent constitutes notice to the insurance carrier. *See also* Rule 156.1(c) which provides that any notice from the Commission, sent to the designated representative's (city) address, is notice from the Commission to the insurance carrier. Recently, Texas Workers' Compensation Commission Advisory 93-11 dated November 4, 1993, provided that a "courtesy copy" of documents related to a dispute resolution proceeding would be mailed to the carrier's attorney, claimant's attorney, and employer's attorney. Rule 102.5(h) provides that, for purposes of determining the date of receipt for those notices and other written communications which require action by a date specific after receipt, the Commission shall deem the received date to be five days after the date mailed.

In the instant case, Commission records show that the hearing officer's decision was distributed to the carrier's (city) representative's box in the Commission's Central Office on

September 27, 1993, with a cover letter dated September 23, 1993. The carrier's appeal is dated November 15, 1993, and was received by the Commission on November 17, 1993. The date the carrier's appeal was filed clearly exceeded the 15-day time period for filing an appeal, even after adding five days under the deemed receipt provision. With its request for review, the carrier filed a request for consideration of its appeal in which the carrier's attorney asserts that he first learned that a decision had been issued in this case on November 3, 1993, when he contacted the Commission. In an affidavit attached to the request for consideration of the appeal, the carrier's (city) representative states:

> I regularly review decisions and orders by the Commission that are sent to me in Workers' Compensation cases. I feel that I would remember a case such as this one where a designated doctor changed his initial opinion on an impairment rating. I do not remember ever seeing this decision until I obtained a copy of this opinion from the Texas Workers' Compensation Commission on or about November 4, 1993, in response to an inquiry by the attorney for the Carrier.

In our opinion, the mere statement by the carrier's (city) representative that he does not remember seeing a copy of the hearing officer's decision, where Commission records show distribution to him at his box in the Commission's Central Office building on September 27, 1993, does not operate to extend the time period for filing the appeal. While it may well be that the carrier's (city) representative does not remember seeing the decision, that, in and of itself, does not compel a conclusion that the decision was not put in his box on September 27, 1993. The fact that the carrier's attorney did not obtain a copy of the hearing officer's decision until after the time period for filing an appeal had expired did not operate to extend the time period for filing the appeal. *See* Texas Workers' Compensation Commission Appeal No. 93353, decided June 21, 1993. Notice from the Commission to the carrier's (city) representative is notice from the Commission to the Carrier. Rule 156.1. Section 410.169 provides that a decision of a hearing officer is final in the absence of a timely appeal by a party. Having determined that the carrier's appeal was not timely filed, the decision of the hearing officer is final.

Had the carrier's appeal been timely filed, we would have concluded that the hearing officer's decision is supported by sufficient evidence and is not against the great weight and preponderance of the evidence and we would have affirmed the hearing officer's decision in this case.

The claimant testified that on March 4, 1991, he was working as a pipefitter for his employer, (employer). On that day he fell from a ladder 15 feet to a concrete surface and then a 400 pound pipe fell across his right hip. The parties stipulated that the claimant sustained compensable injuries to his right arm, elbow, and shoulder, and to his pelvic bone. (Dr. A), the claimant's initial treating doctor, performed surgery on the claimant's right arm in March 1991, and again in February 1992. The claimant underwent about six months of physical therapy. The claimant said that his physical therapist took range of motion measurements.

At the request of the carrier, the claimant was examined by (Dr. T) on June 4, 1992. Dr. T assigned the claimant a nine percent impairment rating after certifying that the claimant had reached MMI.

The claimant was also treated by (Dr. P), who, in a Report of Medical Evaluation (TWCC-69) dated August 31, 1992, assigned the claimant a 36% impairment rating after certifying that the claimant had reached MMI. Dr. P provided a narrative report with his TWCC-69.

The Commission selected Dr. G as the designated doctor. Dr. G examined the claimant on February 11, 1993, and in a TWCC-69 dated February 11, 1993, assigned the claimant a 36% impairment rating after certifying that the claimant had reached MMI. The parties stipulated that the claimant reached MMI on February 11, 1993. Dr. G provided a narrative report with his TWCC-69.

(Mr. DA) of (employer) (Company A) testified for the carrier. Mr. DA is not a physician and did not examine the claimant. Mr. DA is a certified physician's assistant. He testified that for the last seven years he has calculated impairment ratings using the Guides to the Evaluation of Permanent Impairment published by the American Medical Association. He said that at the request of the carrier he reviewed range of motion measurements obtained by the claimant's physical therapist; an April 6, 1993, letter from Dr. P which clarified how Dr. P arrived at a 10% impairment of the ulnar nerve which was part of Dr. P's 36% impairment rating; and other unspecified medical reports. Based on his review of these measurements and reports, Mr. DA concluded that the claimant has a 19% impairment rating and set forth his findings in a report to the carrier dated May 3, 1993.

The carrier sent Mr. DA's report to Dr. P, and on May 25, 1993, Dr. P wrote that "I still think the 36 percent permanent physical impairment and loss of function to the whole body is appropriate based on the severity of this patient's injury."

The carrier also sent Mr. DA's report to Dr. G, the designated doctor. In an undated letter to the carrier, Dr. G wrote:

> I have reviewed the data provided by [Company A and its address] dated May 3, 1993. It appears that these figures are accurate, and I can find no particular fault with them, except that it might take a degree if (sic) mathematics to do the required calculations. Nevertheless, I recommend that the insurance carrier adopt the nineteen percent whole person impairment provided by [Mr. DA]. However, it does not seem that this number is high enough, given the magnitude of this patient's injury.
>
> As you know, the calculation of an impairment rating is based in part, on subjective findings as well as objective findings, and the participation of the patient in the process is very important for determining an accurate impairment evaluation.

The claimant said that he went back to Dr. A, his initial treating doctor, after he was examined by Dr. G, the designated doctor. In a TWCC-69 dated August 5, 1993, Dr. A assigned the claimant a 36% impairment rating after certifying that the claimant had reached MMI. Dr. A wrote in the TWCC-69 that "I agree with both [Dr. G] and [Dr. P] on the total body impairment of 36%. I feel that this is an appropriate rating based on the severity of the injury."

After making findings of fact, the hearing officer made the following pertinent conclusions of law:

CONCLUSIONS OF LAW

5.The claimant's correct impairment rating is 36% per the first report of the designated doctor in this case. His opinion that the claimant's impairment rating is 36% is not contrary to the great weight of the other medical evidence.

6.The designated doctor's subsequent opinion that [Mr. DA's] assessment of a 19% whole body impairment rating assigned to the claimant should be adopted by the carrier is against the great weight of the other medical evidence.

Section 408.125(e) provides that the report of a designated doctor chosen by the Commission regarding an impairment rating has presumptive weight and the Commission shall 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 it requires more than a preponderance of the medical evidence to overcome the report of the designated doctor; the medical evidence must be determined to be the "great weight" of the medical evidence contrary to the report of the designated doctor. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. We have previously held that a hearing officer may read an initial and subsequent report of a designated doctor together to determine impairment rating. Texas Workers' Compensation Commission Appeal No. 92469, decided October 15, 1992. In Appeal No. 92469, the designated doctor initially reported that the injured employee had a 22% impairment rating, but then, after the carrier sought clarification of his report, the designated doctor issued a report assigning the claimant a seven percent impairment rating. The hearing officer determined that the injured employee had a 22% impairment rating as reported in the initial report. The carrier in that case urged that the second report of the designated doctor superseded the initial report and that the second report was the designated doctor's "final word" which the hearing officer was not free to second guess. In affirming the hearing officer's decision we stated: "[w]e cannot agree with appellant that the hearing officer was required to adopt the determination in [the designated doctor's] second TWCC-69 to the exclusion of the first; nor do we believe he was precluded from considering both TWCC-69 forms together. . . ." *See also* Texas Workers' Compensation Commission Appeal No. 93272, decided May 24, 1993, where the hearing officer based impairment rating on the first, and not the second, report of the

designated doctor and we affirmed.

In the instant case, the designated doctor, Dr. G, reported on a Commission prescribed TWCC-69 form, with a back-up narrative report, that the claimant has a 36% impairment rating. Drs. P and A, who have treated the claimant, agree with the 36% impairment rating. While Dr. G in a subsequent letter recommended that the carrier adopt the 19% impairment rating provided by Mr. DA, he stated in the same letter that he did not think the 19% rating was high enough, given the magnitude of the claimant's injury, thus making it clear that he thought the claimant's impairment was greater than 19%. Mr. DA is not a doctor, thus his assessment of an impairment rating cannot be adopted by the Commission. Pursuant to Section 408.123(a), a doctor must evaluate the condition of the employee and assign an impairment rating. Dr. T's nine percent impairment rating is significantly out-of-line with the 36% rating assigned by Drs. G, P, and A, and does not constitute a great weight of medical evidence contrary to the initial report of the designated doctor.

On appeal, the carrier essentially asserts that Dr. G's initial report of February 11, 1993, should not be given presumptive weight because in his letter to the carrier reviewing Mr. DA's assessment, Dr. G stated that an impairment rating is based, in part, on subjective findings, as well as objective findings. The carrier concludes from that statement that Dr. G must have used subjective findings in arriving at the 36% impairment rating in his report of February 11, 1993. Section 408.122(a) provides that:

> A claimant may not recover impairment income benefits unless evidence of impairment based on an objective clinical or laboratory finding exists. If the finding of impairment is made by a doctor chosen by the claimant and the finding is contested, a designated doctor or a doctor selected by the insurance carrier must be able to confirm the objective clinical or laboratory finding on which the finding is based.

Sections 401.011(32), (33), and (41) provide the following definitions:

> (32)"Objective" means independently verifiable or confirmable results that are based on recognized laboratory or diagnostic tests, or signs confirmable by physical examination.
>
> (33)"Objective clinical or laboratory finding" means a medical finding of impairment resulting from a compensable injury, based on competent objective medical evidence, that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.
>
> (41)"Subjective" means perceivable only by an employee and not independently verifiable or confirmable by recognized laboratory or diagnostic tests or signs observable by physical examination.

In our opinion, the use of the term "subjective findings" by Dr. G does not compel a conclusion that he based the claimant's impairment rating on "subjective symptoms" perceivable only by the claimant and not independently verifiable by recognized laboratory or diagnostic tests or signs observable by physical examination. Dr. P, the claimant's second treating doctor, examined and evaluated the claimant and assigned a 36% impairment rating. Dr. G, the designated doctor, examined and evaluated the claimant and assigned the claimant a 36% impairment rating thus confirming the findings of Dr. P as required by Section 408.122(a). A substantial portion of the 36% impairment rating is based on loss of range of motion in the right shoulder and the right elbow. In Texas Workers' Compensation Commission Appeal No. 92335, decided August 28, 1992, the carrier urged that range of motion tests were non-objective tests and should not be used in determining impairment. In response to that argument we stated:

> We cannot agree with appellant's analysis. The requirement in Article 8308-4.25(a) [now Section 408.122(a)] that evidence of impairment must be based on an objective clinical or laboratory finding was intended to preclude recovery of impairment benefits where the only evidence of impairment is the employee's subjective complaint of pain. Montford, A Guide to Texas Workers' Comp Reform, *supra*, Sec. 4B.25. "Impairment" is defined in the 1989 Act as "an anatomical or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." Article 8308-1.03(24) [now Section 401.011(23)]. Thus, a doctor must determine whether an objective clinical or laboratory finding of impairment exists and document same, before assigning an impairment rating. The existence and degree of impairment are determined in accordance with the appropriate version of the AMA Guides.

That impairment cannot be based solely on a subjective complaint does not mean that subjectivity can play no part in the determination or measurement of impairment. The AMA Guides addresses both the protocols for measurement and the evaluative processes.

Reading Dr. G's comment regarding "subjective findings" in context, it appears that he was alluding to the fact that Mr. DA had not examined the claimant in arriving at the 19% impairment rating and that in his opinion "participation of the patient in the process is very important for determining an accurate impairment rating." Indeed, an examination of the injured employee is required. *See* Texas Workers' Compensation Commission Appeal No. 93095, decided March 19, 1993, and Texas Workers' Compensation Commission Advisory 93-04. Having reviewed Dr. G's TWCC-69 and accompanying narrative report, we are satisfied that his assignment of a 36% impairment rating was not based on "subjective symptoms" not independently verifiable or confirmable, but instead, was based on objective clinical or laboratory findings.

Since an appeal of the hearing officer's decision was not timely filed, the hearing officer's decision has become final under Section 410.169.

Robert W. Potts
Appeals Judge

CONCUR:

Lynda H. Nesenholtz
Appeals Judge

Thomas A. Knapp
Appeals Judge