APPEAL NO. 931106

On September 15, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding, to determine the correct whole body impairment rating (IR) of the respondent (claimant). Claimant and the appellant (carrier) stipulated that on (date of injury), claimant sustained a compensable back injury while in the course and scope of his employment and that on September 1, 1992, claimant reached maximum medical improvement (MMI). On November 4, 1993, the hearing was re-opened for the admission of additional hearing officer exhibits and for further argument on the disputed issue. The hearing officer's Decision and Order observed that by the end of the second session of the hearing, it was undisputed that the designated doctor appointed by the Texas Workers' Compensation Commission (Commission) had not used the correct version of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association in assessing claimant's IR at 11%. The Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 408.124(b) (1989 Act) (formerly V.A.C.S., Article 8308-4.24) provides that in determining the existence and degree of an employee's impairment the Commission shall use the "Guides to the Evaluation of Permanent Impairment," third edition, second printing, dated February 1989, published by the American Medical Association (referred to below as mandated AMA Guides or mandated version). The hearing officer concluded that claimant's correct IR was 17% pursuant to the report of his treating doctor and went on to observe that after reviewing the entire record, claimant's treating doctor's report constituted the great weight of the other medical evidence sufficient to overcome the presumptive weight usually accorded the report of the designated doctor. On appeal, the carrier asks the Commission to appoint another designated doctor to assign an IR based on the mandated AMA Guides. The carrier asserts, in essence, that the hearing officer could not properly determine whether the great weight of the other medical evidence was contrary to the designated doctor's report under the circumstances of this case where the designated doctor's report was invalid for not being based on the mandated AMA Guides, and further asserts that to attempt to do so would circumvent the designated doctor procedures established by the 1989 Act to resolve the dispute over claimant's IR. In his response, claimant contends that the hearing officer correctly determined his IR and urges our affirmance.

DECISION

Finding the evidence sufficient to support the challenged determination, we affirm.

Various exhibits in evidence indicated that claimant hurt his back on (date of injury), while working with a jackhammer. According to the undated Report of Medical Evaluation (TWCC-69) from (Dr. J), the doctor claimant indicated was his treating doctor, claimant underwent a bilateral laminotomy and discectomy at L5-S1 on January 10, 1992, which was followed by physical therapy and rehabilitation. Dr. J's TWCC-69 stated that claimant reached MMI on "9-1-92" and it assigned impairment ratings of 10% for the operated disc herniation at L5-S1 with residual symptoms and eight percent for abnormal range of motion (ROM) at the lumbosacral region, which provided a "combined value per AMA Guidelines" of 17% IR.

An undated TWCC-69 from (Dr. B), whom claimant said assisted Dr. J with his spinal surgery, simply stated that claimant reached MMI on "9-1-92" with an 11% IR for his "back." Neither the TWCC-69 nor other reports of Dr. B in evidence further described the 11% rating nor indicated whether it included any impairment values for abnormal ROM or for neurological deficit.

An undated TWCC-69 from (Dr. H), the designated doctor selected by the Commission, indicated that he examined claimant on January 19, 1993. The TWCC-69 was not signed by Dr. H but, rather, contained the entry "signature on file." Dr. H's narrative report accompanying his TWCC-69 was also unsigned. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6(g) (Rule 130.6(g)) provides that the designated doctor shall complete and file the medical evaluation report in accordance with Rule 130.1 which addresses the report and certification of MMI and IR. Rule 130.1(c)(4) requires the doctor's signature on such reports. The Appeals Panel has previously held, where raised, that the signature of the doctor is required for the certification of MMI and IR. *See, e.g.*, Texas Workers' Compensation Commission Appeal No. 92027, decided March 27, 1992; Texas Workers' Compensation Commission Appeal No. 92165, decided June 5, 1992.

Dr. H's TWCC-69 stated that claimant reached MMI on "9-1-92" with an 11% IR for his "lumbar/sacral spinal disk." The TWCC-69 went on to state that the total IR of 11% consisted of "surgically treated disk with residual = 10% plus add 1% per level (L5-S1)." We note that claimant's surgery was on the L5-S1 level and that the records in evidence do not refer to an injury at any other spinal level. Dr. H's TWCC-69 also referred to Table 53, Section II Subsection E, page 80, of the AMA Guides, third edition. Claimant introduced portions of both the Third Edition (Revised) and the mandated version of the AMA Guides. The table entitled "Impairments Due to Specific Disorders of the Spine" is Table 53 in the Third Edition (Revised) but is Table 49 in the mandated version.

Dr. H 's narrative report of January 19, 1993, accompanying his TWCC-69, stated that on examination claimant had symptoms of nerve root irritation, diminished sensation on the right in both the L5 and S1 nerve root distribution, and "pain on the right at 30 degrees and on the left at 40 degrees with straight leg raising, with radiation on the right." The report also made some reference to muscle strength in an incomplete sentence. This report noted that Dr. J had assigned eight percent impairment for abnormal ROM in addition to the 10% assigned for the operative disc herniation with residual symptoms, and stated Dr. H's agreement with Dr. B that claimant's IR was 11%. As noted, Dr. B's report was silent respecting impairment ratings for abnormal ROM and/or neurological deficit.

Dr. H's narrative report stated that "the main point of contention seems to be whether or not the limitation of motion should be added to the disability rating that was rendered because of the continued pain with the patient's back." Dr. H, referring to page 81 of the AMA Guides "Third Edition Revised," opined that tables 53 and 54 on that page are mutually exclusive, that "only one of the tables should be used to determine an individual's impairment," and stated as follows: "In other words, [Dr. J] was not correct in adding the limitation of motion disability to the patient's (sic) because of residual symptoms on an

operated disc."

Page 81 of the Third Edition (Revised) version used by Dr. H states the following in paragraph 3.3b (Impairments Due to Specific Disorders of the Spine): "*Tables 53 and 54* [Table 54 is entitled "Impairment of Cervical, Thoracic and Lumbar Regions Due to Ankylosis Determined by Radiographic Methods"] *are mutually exclusive*: only one of the tables should be used to determine an individual's impairment." Not only is that statement not contained in paragraph 3.3b, page 74, of the mandated version, but there was no reference to claimant's having ankylosis in the evidence.

We have previously noted that the mandated AMA Guides require that in the evaluation of a spinal injury for the assignment of an IR, consideration must be given not only to the specific spinal disorders listed in Table 49 but also to the existence and extent, if any, of abnormal ROM and neurological deficits. In Texas Workers' Compensation Commission Appeal No. 93735, decided October 4, 1993, the Appeals Panel cited Texas Workers' Compensation Commission Appeal No. 93296, decided May 28, 1993, a case which went into the matter in substantial detail, and stated "that [ROM] ratings are one of three factors to be added together to reach an [IR] 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." *See also* Texas Workers' Compensation Commission Appeal No. 93769, decided October 11, 1993, and Texas Workers' Compensation Commission Appeal No. 931008, decided December 16, 1993.

On February 25, 1993, claimant wrote the Commission's Central Office stating that he was receiving impairment income benefits based on Dr. H's IR; that "[e]ssentially the dispute [Dr. H] attempted to resolve is whether the AMA Guidelines allow the combining of an impairment rating due to `specified disorders of the spine' (Table 49) with `Impairment Due to Abnormal Motion' (Table 56);" that Dr. H referred to the Third Edition (Revised) rather than to the mandated version but that Tables 49 and 56 in the mandated version compare with Tables 53 and 60 of the Third Edition (Revised) and that claimant's position is the same using either version; that Dr. J correctly followed the AMA Guides in adding ROM values to the diagnosis-based values from Table 49; and that Table 54 concerning ankylosis was not used by Dr. J and, though referred to by Dr. H, was inapplicable. Claimant closed by asking the Commission "to honor the [IR] assigned by [Dr. J] as the only rating correctly utilizing the mandated guides." On March 24th claimant wrote Dr. H enclosing a copy of his letter to the Commission and advising that the Commission suggested he seek Dr. H's comments "to help resolve this matter." We observe here that various Appeals Panel decisions have stated that the responsibility for clarifying problems with designated doctors reports is that of the Commission and we have strongly discouraged the parties from unilateral contacts with designated doctors. *See, e.g.,* Texas Workers' Compensation Commission Appeal No. 92595, decided December 21, 1992; Texas Workers' Compensation Commission Appeal No. 93762, decided October 1, 1993.

On May 10, 1993, a Commission Benefit Review Officer (BRO) wrote Dr. H stating that his report appeared to indicate that "the wrong edition of the Guides was used," further stating that the mandated version appears to permit the combination of a diagnosis-based rating from Table 49 with values for abnormal ROM or ankylosis using Table 84, and asking Dr. H to provide an opinion and explanation of claimant's IR using the mandated AMA Guides. On May 27th, Dr. H wrote the Commission's Central Office indicating he concurred with Dr. B's 11% and not with the IR of Dr. J. This letter further stated the following: "I base my opinion totally on the percentage allowed for a surgically treated disc lesion with residual medically documented pain and rigidity with or without muscle spasm. I feel this accounts for any `spasm related limitation of motion' (which I did not find on examination) and there is nothing to suggest that the patient has any bony ankylosis either on examination or radiographs." Dr. H's letter failed to address which version of the AMA Guides he used. Claimant wrote Dr. H on May 28th stating that while Dr. H had explained why Table 54 [regarding impairment due to ankylosis in the Third Edition (Revised)] was not appropriate in this evaluation, the question of the use of Table 60 [regarding abnormal ROM in the Third Edition (Revised)] in conjunction with Table 53 still remained, and requested further clarification. No response to this letter was introduced.

At a Benefit Review Conference (BRC) held on July 26, 1993, the BRO, being apprised of claimant's position that his correct IR was 17% as determined by Dr. J, and being further apprised of the carrier's position that claimant's IR was 11% as determined by Dr. H, entered an Interlocutory Order requiring the carrier to pay impairment income benefits (IIBS) based on the 17% rating of Dr. J because the BRO viewed Dr. H as having used "the wrong AMA Guidelines and the wrong table."

At the September 15th hearing claimant urged the hearing officer to adopt Dr. J's 17% IR. He argued that because Dr. H did not use the correct version of the AMA Guides, his IR should be disregarded; that Dr. J best knew his condition; and that Dr. J correctly determined claimant's IR. The carrier, while not conceding that Dr. H failed to use the mandated AMA Guides and asserting that Dr. H's report was acceptable, basically argued that if the hearing officer found that Dr. H failed to use the mandated AMA Guides, she should either arrange for Dr. H to resolve the IR dispute in accordance with the 1989 Act or else arrange for another designated doctor to do so. The carrier insisted that the remedy in these circumstances was not simply to adopt Dr. J's report since to do so would effectively circumvent the designated doctor procedure, a procedure which both employees and carriers had the right to utilize. Section 408.125(e) provides that the designated doctor's report shall have presumptive weight unless the great weight of the other medical evidence is to the contrary in which case the Commission shall adopt the IR of one of the other doctors.

After the hearing closed on September 15th, the hearing officer wrote to Dr. H on September 24th stating that his report indicated he did not use the mandated AMA Guides and asking whether he had the mandated version and, if so, what was claimant's IR pursuant thereto. She also asked Dr. H whether the mandated version instructs that ROM measurements be considered in determining an IR for the spine, and, if so, whether he

needed another visit with claimant for ROM measurements in order to arrive at an IR. Hearing officer exhibits indicate that on October 8th Dr. H's office forwarded to the Commission's field office the first two pages of the AMA Guides used by Dr. H (Third Edition (Revised), and in a phone call on that date indicated confusion over the hearing officer's letter, to wit: the indication that the version used by Dr. H was not the correct version. A Commission letter of October 19th advised Dr. H that another hearing was set for November 4th, that his response to the hearing officer's letter was needed before October 29th so that it could be timely provided to the parties, and that he could obtain a copy of the mandated AMA Guides by calling the Commission's (city) Central Office. Apparently no further response was obtained from Dr. H.

On November 4th the hearing officer on her own motion reconvened the hearing and introduced additional hearing officer exhibits. She stated that it was "pretty clear" that Dr. H had used the wrong version of the AMA Guides; that Dr. B had assigned 11% while Dr. J had assigned 17%; and that the question was whether the Commission should adopt the report of either Dr. B or Dr. J, or select another designated doctor to "properly" resolve the dispute. No new evidence was presented by the parties who simply re-argued their respective positions.

Given the information on the face of Dr. H's TWCC-69 and in his accompanying narrative report, we observe that it seems to have been "pretty clear" from the time such reports were prepared in January 1993, and certainly at the BRC on July 26, 1993, that Dr. H did not use the mandated version of the AMA Guides. Obviously, a substantial amount of time could have been saved for all concerned had such apparent error been verified and rectified in a more timely fashion. In Texas Workers' Compensation Commission Appeal No. 931071, decided January 7, 1994, the Appeals Panel stated that "[t]he hearing officer or other Commission official should appropriately take early action to clarify or cause corrections to be made in a designated doctor's report when it is feasible and reasonably possible to do so expeditiously. (Citations omitted.)" This opinion also observed that "we have emphasized that a good and viable designated doctor program, a very important and significant step in the 1989 Act, is essential. (Citations omitted.)"

In Finding of Fact No. 7 the hearing officer stated that Dr. H assigned claimant's 11% IR "pursuant to the third edition revised of the AMA Guides." Finding of Fact No. 8 stated, in part, that Dr. H disagreed with Dr. J's having included a value for abnormal ROM in the assessment of claimant's IR under the AMA Guides. Based on these and other factual findings the hearing officer concluded both that claimant's correct IR was the 17% determined by his treating physician and that "[t]he great weight of the medical evidence other than the report of the designated doctor was contrary thereto." In her Decision and Order the hearing officer stated that Dr. J's report "was determined to constitute the greater weight of the other medical evidence sufficient to overcome the presumptive weight usually accorded the report of the designated doctor."

In its appeal the carrier states that "it is now undisputed that in making his report" Dr. H did not use the mandated AMA Guides, and the carrier characterizes Dr. H as "a

recalcitrant designated doctor who disregarded the law" and "who refuses to perform his statutory role." The carrier argues that in these circumstances the only remedy fair to the parties and consistent with the purpose and integrity of the designated doctor dispute resolution process is reversal of the hearing officer's decision and remand for the appointment of another designated doctor.

In Texas Workers' Compensation Commission Appeal No. 92335, decided August 28, 1992, the hearing officer determined that the claimant's IR was 17% as assessed by the Commission-selected designated doctor after finding there was no significant difference between the version of the AMA Guides used by the designated doctor and the mandated version. In noting a previous Appeals Panel holding that only the mandated AMA Guides may be used in assessing an IR, we observed that "[t]his is consistent with an apparent Legislative intent to achieve uniformity in permanent income benefits determinations. (Citation omitted.)" This decision went on to state:

> Ordinarily, then, [the designated doctor's] findings would be entitled to presumptive weight, which could be rebutted if the great weight of the other medical testimony is to the contrary. However, we find that a designated doctor's findings cannot rise to the level of presumptive weight unless they comply with the appropriate statutory requirements. This obviously includes use of the correct AMA Guides as discussed herein. However, it also includes compliance with Commission rules concerning certification of MMI and assignment of impairment ratings, ...

The Appeals Panel reversed and remanded that case to allow the designated doctor an opportunity to properly certify MMI and assess an IR. This decision, unlike the case under consideration, did not indicate that any prior efforts had been made by the Commission to obtain an IR from the designated doctor based upon the mandated version.

In Texas Workers' Compensation Commission Appeal No. 93932, decided November 29, 1993, a BRO apparently corresponded with the designated doctor concerning whether the mandated AMA Guides were used and whether ROM had been considered in arriving at the IR of nine percent. The designated doctor responded that he had not used the mandated version. He was later contacted by the hearing officer about the matter and merely referred the hearing officer to his prior response. The hearing officer, finding that the designated doctor's IR was invalid because the designated doctor failed to measure the claimant's ROM as required by the mandated AMA Guides, concluded that the IR assessed by the designated doctor was invalid and that his report was not entitled to presumptive weight. The hearing officer then adopted the 19% IR of another doctor. The carrier's appeal contended, among other things, that the hearing officer erred in not according presumptive weight to the designated doctor's report and in declaring it invalid instead of returning it for correction by the designated doctor or for the appointment of another designated doctor. This opinion noted that if the designated doctor has failed to use the mandated version and the matter is not corrected or clarified, then the report is not entitled to presumptive weight. The opinion further noted decisions where the Appeals Panel has

required the hearing officer to attempt to clarify the designated doctor's report before invalidating the report and distinguished the case from those on the basis that the BRO (and the hearing officer) did in fact attempt to obtain clarification from the designated doctor who clearly indicated that he did not use the mandated AMA Guides and that he did not read the AMA Guides as requiring that ROM be tested using "machinery." At that point, the Appeals Panel saw the hearing officer as having several options including that of going back to the designated doctor still a third time, appointing a second designated doctor to determine the IR, or invalidating the designated doctor's report as being against the great weight of the other medical evidence and adopting the IR of another doctor. The Appeals Panel found no error in the hearing officer's opting to find the designated doctor's rating invalid and adopting another doctor's rating as required by Section 408.125(e), stating it knew of no authority requiring the appointment of a second designated doctor when the first failed to render a proper report. *See also* Texas Workers' Compensation Commission Appeal No. 931038, decided December 27, 1993, where the hearing officer determined that the great weight of the other medical evidence was contrary to the designated doctor's report and adopted another doctor's report. In affirming, the Appeals Panel noted that in addition to problems concerning whether the designated doctor had reviewed a CT scan, and concerning his apparent limiting of his impairment evaluation to neurological problems, the designated doctor's opinion was not based upon the mandated AMA Guides.

In the case under consideration, Dr. B's report was silent with respect to any impairment for abnormal ROM. Dr. J, noting "stiffness at the L-S spine," measured ROM at the waist and stated: "40 [degrees] forward flexion, 20 [degrees] extension, right lateral and left lateral bending. Rotation was fine." Dr. J assigned eight percent for abnormal ROM at the lumbosacral region. Dr. H recognized that Dr. J had included an impairment rating for abnormal ROM in addition to the 10% for the specific spinal disorder, indicated his misunderstanding that an impairment rating for abnormal ROM could not be combined with a diagnosis-based rating from the table of specific spinal disorders, and yet in his report also reflected that claimant "has pain on the right at 30 degrees and on the left at 40 degrees with straight leg raising, with radiation on the right." Further, Dr. H not only apparently believed he could not add more to the diagnosis based rating for abnormal ROM but added one percent for an additional spinal level when there was no evidence that more than one level was involved. Also, Dr. H not only made an unintelligible reference to muscle strength but also referred to claimant's diminished sensation in his L5-S1 nerve root distribution and apparently added no additional impairment for any neurological deficit. We have observed that a designated doctor's own report can be a part of the great weight of the other medical evidence. *See* Texas Workers' Compensation Commission Appeal No. 92621, decided December 23, 1992; Texas Workers' Compensation Commission No. 931085, decided January 4, 1994.

Under the circumstances of this case, we find no error in the hearing officer's adopting the 17% IR of Dr. J pursuant to Section 408.125(e). Section 408.124 provides that an award of impairment income benefits by the Commission shall be made on an IR determined using the mandated AMA Guides. While it was "pretty clear," as the hearing officer observed, that Dr. H did not use the mandated version, there was no indication that

Dr. J had not, and there was sufficient evidence for the hearing officer to determine that Dr. H's report was contrary to the great weight of the other medical evidence. The hearing officer resolves conflicts and inconsistencies in the evidence. Garza v. Commercial Insurance Co. of Newark, N.J., 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). The hearing officer also judges the weight to be given expert medical testimony and resolves conflicts and inconsistencies in the testimony of expert medical witnesses. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ); Atkinson v. United States Fidelity Guaranty Co., 235 S.W.2d 509 (Tex. Civ. App.-San Antonio 1950, writ ref'd n.r.e.); Highlands Underwriters Insurance Co. v. Carabajal, 503 S.W.2d 336, 339 (Tex. Civ. App.-Corpus Christi 1973, no writ). We will not disturb the hearing officer's findings unless they are so against the great weight and preponderance of the evidence as to be manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 715 S.W.2d 629 (Tex. 1986).

The decision of the hearing officer is affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Lynda H. Nesenholtz
Appeals Judge