APPEAL NO. 93218

On February 16, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The sole issue considered was the extent of permanent impairment sustained by the claimant, Mr. W, due to a back injury he sustained on (date of injury), while employed as a bus driver for (employer). The hearing officer adopted the 28% impairment assessed by a referral doctor for the claimant, after rejecting, for various reasons, the reports of the designated doctor, the treating doctor, and the doctor for the carrier. The report of the designated doctor was found to have been overcome by the great weight of other medical evidence, although the discussion of the decision recites, as the basis for rejecting the designated doctor's report, statements made by the carrier's attorney in argument. The parties had agreed to a date of maximum medical improvement of October 22, 1992.

The carrier has appealed, stating that the hearing officer erred by rejecting the carrier's doctor's TWCC-69 report as unsigned, when the total report was in fact signed, and arguing also that the report adopted by the hearing officer makes erroneous use of the AMA Guides to the Evaluation of Permanent Impairment (Guides). The claimant responds that the decision should be affirmed.

DECISION

We reverse and remand the decision of the hearing officer for further consideration and development of the evidence in accordance with this opinion.

We assign error related to the hearing officer's failure to consider or weigh the report of the carrier doctor for the recited reason that it was not signed. We are also concerned with the conclusion of the hearing officer that the designated doctor did not consider claimant's disc protrusions and radiculopathy in his report, in light of the fact that the complete report was apparently not in the record, and the TWCC-69 and cover letter recite consideration and awareness of the claimant's bulging discs, past medical treatment, and MRI and EMG tests. These are matters that should be dealt with on remand.

The claimant was injured on (date of injury), while pulling a dolly over a step; he felt back pain which ultimately became more severe. Essentially, his pain was treated conservatively, and with physical therapy. The claimant entered into a written agreement with the carrier that he reached MMI effective October 22, 1992.

An MRI examination of claimant's lumbar spine was conducted on July 24, 1991. There is no disc herniation or stenosis observed. At L4-5, a posterior left lateral bulging annular disc was detected effacing epidural space and encroachment in the interior space surface of the left neural foramina. At L5-S1, an annular bulge was detected with no evidence of encroachment. Two EMG studies, performed in July 1991 and January 1993, are referred to in other medical reports but are not separately included as exhibits.

On April 10, 1992, claimant was examined by (Dr. Q), an orthopedic surgeon, who determined that he had reached maximum medical improvement (MMI) on the date of his examination, with an 8% impairment rating. Dr. Q submitted a 3-page report, the last page of which is signed. The cover sheet is an unsigned TWCC-69 form, which clearly references and incorporates the attached narrative. Dr. Q's diagnosis is lumbosacral strain with bulging of L4 and L5 discs. Dr. Q acknowledges claimant's continued pain, although he states that claimant moves freely and has no tenderness in the lumbar area. Dr. Q observed full range of motion, stating that claimant was able to touch the floor with the tips of his fingers, and that he had normal muscle strength. Dr. Q reviewed the EMGs which were suggestive of bilateral S1 radiculopathy. Dr. Q agrees that claimant cannot return to his previous job and will continue to have discomfort.

The insurance carrier paid impairment income benefits based upon Dr. Q's report. (Dr. S), an orthopedic surgeon to whom claimant was referred by his treating doctor, responded to Dr. Q's report by assessing a 28% impairment rating, and agreeing with Dr. Q's MMI finding. However, a February 10, 1993, TWCC-69 report completed by Dr. S assesses the same 28% with an MMI date of "12-21-92." The portion of the TWCC-69 requesting more specific breakdown of ratings over 5% is not completed. Moreover, it indicates impairment is based on objective tests performed in July 1991, which are an MRI and EMG.

A designated doctor was appointed by the Texas Workers' Compensation Commission (Commission), at the request of the claimant. The Commission ordered the carrier to supply all medical records to the doctor. (Dr. RS) examined claimant on October 22, 1992, using an inclinometer as part of his examination. Dr. RS's report indicates that claimant recited pain on and off, with no pain on some days. Dr. RS's cover letter to his report indicates that he reviewed the history and treatment to date, including the MRI and EMG tests performed. Dr. RS noted an annular disc bulge, no herniation, and no impairment. The report in evidence references three pages of attached documentation, but none accompanied the copy of the TWCC-69 in the record.

A January 25, 1993, TWCC-69 report completed by the treating doctor, (Dr. A), a neurologist, states that claimant has not reached MMI and assesses a 31% impairment. Most of the impairment rating is attributed to nerve root injury. As part of this assessment, a new EMG appears to have been performed.

The claimant complained that neither Dr. Q nor Dr. RS examined him for more than 15-20 minutes. He stated that Dr. RS told him that pain didn't matter in his examination.

The claimant said surgery has not been recommended. He worked light duty for the employer from sometime in January through August 1992.

It is clear to us that the case must be remanded, to allow the complete designated doctor's report to be admitted into the record, and then all medical evidence should be reconsidered and weighed in light of applicable law and Appeals Panel decisions. We agree with the carrier that the hearing officer erred in rejecting the report of Dr. Q because the TWCC-69 was not signed. Both Appeals Panel decisions cited by the hearing officer as the basis for her actions involved cases where only the one-page, unsigned TWCC-69 was submitted. In this case, Dr. Q's TWCC-69 was attached to and expressly incorporated his signed narrative reports. Consequently, the signature requirements of Texas W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.1(c)(4) were met in this case.

Because it is clear that the hearing officer did not weigh the report of Dr. Q at all because of this erroneous finding, we remand the decision. We also note that the adoption of another medical report by the hearing officer can only be done, when a designated doctor is involved, and when the report of the designated doctor is overcome by the great weight of other medical evidence. Article 8308-4.26(g). Therefore, the carrier's assertion that Dr. Q's report should be adopted necessarily compels a review of the hearing officer's determination to reject Dr. RS's report. This we are unable to do, because the complete report appears not to be included in the record. The portion of the report that is in evidence appears to contradict the hearing officer's finding that claimant's disc protrusions were not considered. The fact that a 0% rating resulted does not in and of itself indicate lack of consideration, as Table 49 of the AMA Guides to the Evaluation of Permanent Impairment does include a 0% rating for unoperated disc lesions with no residuals. It may be that Dr. RS determined that this was the appropriate category, but without the rest of his report, we are unable to tell.

Regarding the carrier's argument that Dr. S did not properly use the Guides, we observe that final argument is no substitute for expert medical opinion as to the appropriate way to use the Guides. A carrier that does not put into the record opinions of medical experts as to how computations should be performed using the Guides is hardly in a position to complain later should a hearing officer disagree with its unsupported assertions.

Finally, as we have stated before, a decision that rejects a designated doctor's report must detail the great weight of evidence weighing against it. *See* Texas Workers' Compensation Commission Appeal No. 93077, decided March 15, 1993.

The case is reversed and remanded to the hearing officer for actions and consideration consistent with this opinion. 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 Article 8308-6.41. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Susan M. Kelley
Appeals Judge

CONCUR:

Lynda H. Nesenholtz
Appeals Judge

Thomas A. Knapp
Appeals Judge