APPEAL NO. 93286

A contested case hearing was held in (city), Texas, on January 4, 1993, with (hearing officer) presiding as hearing officer, and the record was closed on March 12, 1993. The two disputed issues before the hearing officer were whether the appellant (claimant) had reached maximum medical improvement (MMI) and claimant's correct whole body impairment rating. The hearing officer gave presumptive weight to the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission) to examine claimant and determined that claimant reached MMI on April 22, 1992, with a nine percent (9%) whole body impairment rating. Claimant disputes these determinations contending he did not reach MMI until October 30, 1992, as determined by his treating doctor, and that his treating doctor's impairment rating of 14 percent was the correct rating because the designated doctor did not perform the required impairment evaluation as did his treating doctor. Claimant certified that he served a copy of his request for review on respondent's attorney by certified mail on April 9, 1993. While carrier's response failed to state the date the request for review was received by respondent, the response, due 15 days after receipt of the request for review, was not filed until May 3, 1992, and appears untimely.

DECISION

We reverse the decision of the hearing officer and remand for further development of the evidence respecting whether the designated doctor's determination of impairment was made in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February, 1989, as required by the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-4.24 (Vernon Supp. 1993) (1989 Act).

Claimant testified he was injured on (city), missed two days of work, and was laid off in month/day. Documentary evidence indicates that claimant was injured when struck in the neck and upper back area and knocked to the ground by a falling 16 foot steel ladder. He was thereafter seen periodically by (Dr. G), who diagnosed a contusion and abrasions to the back, and a left lower leg contusion, and who treated claimant with Motrin 400. He was referred by Dr. G to (Dr. K), an internist and rheumatologist, with complaints of continued pain in the lower part of the posterior neck, upper back, and interscapular area. According to Dr. K's report of November 2, 1991, upon physical examination, Dr. K noted "mild restriction of lateral flexion and rotation motion of cervical spine." His impression was post-traumatic left distal forearm and wrist pain, cervical spondylosis (C4-5 level), and degenerative disc disease at the T3-T4 level with posttraumatic flare-up of symptoms. Dr. K prescribed a wrist splint, Lodine, and neck and back exercises. Claimant said he "gave up on" Dr. G, apparently was not seen further by Dr. K, and began to see William Summers, D.C. (Dr. S), and that he has not been released to work by Dr. S who continues to provide him with chiropractic treatment three times a week. Dr. S's Initial Medical Report reflected claimant's visit on November 6, 1991, a diagnosis of multiple cervical disc herniations, severe cervical sprain, and low back sprain. An MRI report of November 20, 1991,

obtained by Dr. S, revealed subligamentous disc herniations at C2-3, C3-4, C4-5, and C6-7 with varying characteristics. Electrical studies of claimant's upper extremities obtained by Dr. S on December 2, 1991, were normal.

On February 13, 1992, claimant was examined by (Dr. W), apparently at the carrier's request, who prepared a Report of Medical Evaluation (TWCC-69), accompanied by a detailed narrative report, certifying that claimant reached MMI on February 13, 1992, with a zero percent whole body impairment rating. Dr. W's report noted that his examination revealed "a fairly adequate range of motion at his neck with a little bit of pain at the extremes. There is no tenderness at all." On March 7, 1992, Dr. S wrote the Commission stating his disagreement with Dr. W's determination of MMI.

There was no dispute that the Commission selected (Dr. R), as the designated doctor; however, no evidence was offered respecting the date, manner, and content of the Commission's communication with Dr. R concerning his selection as the designated doctor and what he was instructed to do. Claimant offered two reports of Dr. R. Each exhibit contained the single page typewritten report of "4-22-92" stating the details of Dr. R's examination including a history, the examination, the review of x-rays ("showed early degenerative joint disease between 4 and 5"), the review of an MRI report ("shows . . . bulging in this region with a possible osteophyte"), and Dr. R's conclusion that claimant has "a chronic fibromyositis." Dr. R felt surgery was not indicated and recommended anti-inflammatory medication and isometric exercises which would "hopefully . . . resolve his symptoms for him to return to work." One of these exhibits contained an additional note at the bottom, dated "8-26-92," which stated that claimant "has 9% whole body impairment as a result of his injury." Carrier introduced a TWCC-69 signed by Dr. R which stated that claimant reached MMI on "4-22-92" with a nine percent whole body impairment rating. Attached to Dr. R's TWCC-69 was the narrative report with the notes of 4-22-92 and 8-26-92.

Claimant introduced a TWCC-69, dated November 2, 1992, from Dr. S which stated that claimant reached MMI on October 30, 1992, with a 14 percent impairment rating. This exhibit stated "see attached" and had attached the following three forms which Dr. S seemed to indicate were from the AMA Guides (Guides to the Evaluation of Permanent Impairment, published by the American Medical Association): a printed sheet entitled "Spine Impairment Summary" which reflected a nine percent impairment due to specific disorders (cervical), a five percent impairment for range of motion (ROM), and a total spine impairment of 14 percent; a sheet entitled "Cervical Range of Motion" which contained various ROM measurements ostensibly resulting in the five percent ROM rating; and a sheet entitled "Table 49. Impairments Due to Specific Disorders of the Spine" which apparently depicted how Dr. S determined the nine percent impairment for a cervical disorder. The carrier's attorney objected to the introduction of the attachments saying he did not have them and was seeing them for the first time. Dr. S testified the forms were "sent to everybody" and

that his office customarily attached such forms to the TWCC-69 forms sent by his office to carriers but that such forms often thereafter become separated from the TWCC-69 forms for reasons unknown to Dr. S. Claimant stated he did not send the forms to the carrier because "they had more stuff than I did." The hearing officer made no further good cause inquiry or determination and summarily rejected the exhibits.

The hearing officer introduced his letter of January 26, 1993, to Dr. R which recited it had attached a copy of Dr. R's report of April 22, 1992, and the August 1992 follow-up report. In the letter, the hearing officer stated that Dr. S had testified that Dr. R had not performed an impairment evaluation on claimant, that Dr. R's TWCC-69 states a nine percent impairment rating with no ROM component, and that Dr. S had added five percent for ROM restrictions. The letter then asked why Dr. R did not evaluate ROM on April 22nd, whether he agreed with Dr. S's five percent rating for ROM, and, if not, whether he could assign a value without another appointment with claimant. On the bottom of the letter in evidence, above the apparent signature of Dr. R, was the handwritten notation, "normal motion was noted therefore no special mention was made about motion."

Dr. S testified that he accompanied claimant to Dr. R's examination and that Dr. R "did a fairly decent exam." He said that the AMA Guides require the examiner "to do specific disorders" as well as "to do ROM," and to use an inclinometer, and that neither Dr. W nor Dr. R did so. Dr. S said that while Dr. R did observe claimant's flexion, extension, and lateral ROM, he did not use an inclinometer, and that "you can't put any numbers on that [visual testing]." Dr. S stated that while an examiner can visually determine that ROM is restricted, the law requires the use of the AMA Guides, that the AMA Guides require the use of an inclinometer, and that use of an inclinometer results in a better exam than a visual exam which is not considered a valid ROM test by the AMA Guides. He stated he had attended a course and was trained in the use of the AMA Guides, and that he abides by those guides "while the M.D.'s for some reason do not." Dr. S testified he used an inclinometer to measure claimant's ROM and wrote down the results which were later typed (apparently the exhibits attached to his TWCC-69). Article 8308-4.24 provides that the Commission shall use the second printing, dated February, 1989, of the American Medical Association Guides and that all determinations of impairment under the 1989 Act must be made in accordance with those Guides.

As for his opinion that claimant did not reach MMI before October 30, 1992, Dr. S stated that his therapy program had improved claimant's upper body strength to the point that by October 30th, claimant was "as good as he is going to get." Dr. S further stated that he tested claimant's pain tolerance with an algometer, that it tested extremely high, that such a high pain tolerance may have masked symptoms one would expect given the extent of claimant's neck injury, and that this could explain why Drs. W and R found that claimant had reached MMI at earlier dates. Dr. S also asserted Dr. R's report indicates claimant had not reached MMI because Dr. R recommended anti-inflammatory medication and exercise.

The hearing officer found that Dr. R certified claimant as having reached MMI on April 22, 1992, with a nine percent whole body impairment rating and that the great weight of the other medical evidence is not to the contrary of his opinion. We agree with the hearing officer that Dr. R's report was entitled to presumptive weight insofar as it concerned claimant's MMI date. MMI does not necessarily equate to the absence of pain or the total restoration of strength. *See* Article 8308-1.03(32); Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993, and Texas Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992. Dr. R's MMI date of April 22, 1992, found support in Dr. W's determination of a February 13, 1992, MMI date, and we have said that a "great weight" determination amounts to more than a mere balancing or preponderance. *See, e.g.,* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992.

Article 8308-4.25(a) provides that "a claimant is not entitled to recover impairment income benefits unless there is evidence of impairment based on an objective clinical or laboratory finding." Article 8308-1.03(35) defines "objective clinic or laboratory finding" to mean "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 employee's subjective symptoms." In his discussion, the hearing officer noted that both Dr. R and Dr. S gave claimant nine percent for his specific spinal disorder and that the only difference in their impairment ratings was the ROM component. He commented that Dr. R "states he observed normal [ROM] and therefore did not comment on it." The hearing officer made no effort to address the gist of claimant's position to the effect that Dr. R failed to perform an impairment evaluation consistent with the requirements of the AMA Guides. Instead, the hearing officer simply observed that the Appeals Panel "has made it quite clear" that the designated doctor's opinion can only be overcome by the great weight of the other medical evidence, and that Dr. R's four month tardiness in filing his TWCC-69 can be addressed as a possible administrative violation. Article 8308-4.26(g) does indeed give presumptive weight to the designated doctor's report concerning the impairment rating which can only be overcome by the great weight of the other medical evidence. In this case, however, the hearing officer had testimony from Dr. S which clearly raised a question as to whether Dr. R failed to fully and correctly apply the specific protocol of the AMA Guides respecting the performance of an impairment evaluation to determine, with inclinometer measurements, claimant's loss of ROM, if any. With the medical evidence in this posture and the questioned validity of Dr. R's report unaddressed by the hearing officer, we must reverse and remand for the further development of the evidence respecting claimant's impairment rating. *See* Texas Workers' Compensation Commission Appeal No. 93296, decided this same date, May 28, 1993.

Based on the foregoing, the decision of the hearing officer is reversed and the case is remanded for the expedited development of such additional evidence as is appropriate, and for such additional consideration and findings as are appropriate and not inconsistent

with this opinion.

Pending resolution of the remand, 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 8308-5.41. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Philip F. O'Neill
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Gary L. Kilgore
Appeals Judge