APPEAL NO. 93682

This appeal is brought pursuant to the Texas Workers' Compensation Act of 1989, TEX. LAB. CODE ANN. § 401.001, *et seq*. (1989 Act). This case is before us again following our remand in Texas Workers' Compensation Commission Appeal No. 93170, decided April 22, 1993. The remand was predicated upon our holding that the record did not establish that (Dr. C), upon whose report the hearing officer had based his findings of maximum medical improvement (MMI) and impairment, was an agreed designated doctor due to noncompliance with Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 130.6 (Rule 130.6), which deals with the selection of a designated doctor. The case was remanded for further development and consideration of the evidence concerning MMI and impairment. On remand the hearing officer pursuant to Rule 130.6 provided the parties an opportunity to agree to a designated doctor, and after no agreement was reached, selected (Dr. B) as the designated doctor.

On July 16, 1993, a contested case hearing (CCH) on remand was held in (city), Texas, hearing officer) presiding. The issues at the CCH were: when did the appellant (claimant herein) reach MMI and what was his correct impairment rating? The hearing officer, based upon the report of Dr. B, found that the claimant reached MMI on February 12, 1992, with a five percent impairment rating. The claimant appeals arguing the impairment rating of the designated doctor was not arrived at properly using the American Medical Association Guides to the Evaluation of Permanent Impairment, Third Edition (AMA Guides). The claimant attaches an additional medical report to its request for review in support of its position. The respondent (carrier herein) replies contending the designated doctor properly applied the AMA Guides and that the Appeals Panel should not consider evidence not in the CCH record.

DECISION

Finding sufficient evidence to support the decision of the hearing and no reversible error in the record, we affirm.

The essential facts of the case prior to our earlier remand are detailed in our opinion in Appeal No. 93170, *supra*. To briefly summarize them, we note that the claimant initially alleged he was injured on (date of injury), when he lifted and emptied a cart full of bottles. After initial treatment at a local hospital, (Dr. St) became his treating physician. On February 11, 1992, pursuant to a medical examination order requested by the carrier, the claimant was examined by (Dr. Sa). Dr. Sa certified on a Report of Medical Evaluation (TWCC-69) that the claimant had reached MMI on February 12, 1992, with a whole body impairment of five percent. The claimant, who was at that time unrepresented, contacted the Texas Workers' Compensation Commission (Commission), to dispute Dr. Sa's certification of MMI and impairment rating. The claimant testified at the hearing prior to remand that he was told by the Commission to agree with the carrier on a designated doctor, but he was never informed that if he failed to agree the Commission would choose a designated doctor or that an ombudsman was available to explain the contents of an

agreement for a designated doctor.

The claimant testified that he called the carrier and was told the carrier wanted him to see Dr. C. Claimant testified that had he known if he did not agree to see Dr. C the Commission would have appointed a designated doctor he would have not seen Dr. C. The claimant did see Dr. C who stated on a TWCC-69 that the claimant had reached MMI on June 30, 1992, with zero percent impairment rating. At this point the claimant requested a benefit review conference (BRC), and after the BRC, the case was set for a CCH. Between the time of the BRC and CCH, the claimant retained his present counsel. At the CCH, the claimant introduced a TWCC-69 from Dr. St certifying that the claimant had reached MMI on January 11, 1993, with a nine percent impairment rating.

The hearing officer found at the original CCH that the claimant reached MMI on June 30, 1992, with a zero percent impairment rating based upon the report of Dr. C. The hearing officer found that Dr. C was an agreed designated doctor in that there had been substantial compliance with Rule 130.6 in agreeing to his being a designated doctor. We held that the agreement for Dr. C to be designated doctor violated Rule 130.6 in a number of ways invalidating his status as an agreed designated doctor. We remanded for further development and consideration of the evidence suggesting that the hearing officer give the parties an opportunity to agree on a designated doctor and select a designated doctor if the parties failed to agree.

Upon remand the hearing officer telephoned both counsel of record and advised them that they had 10 days to agree on a designated doctor. When no agreement was forthcoming in 10 days, the hearing officer selected (Dr. B) to be the designated doctor and informed all parties of this in writing as well as that the claimant was to be examined by Dr. B on May 24, 1993. Dr. B certified on a TWCC-69, dated June 16, 1993, and attached to an extensive report, that the claimant reached MMI on February 12, 1992, with a five percent whole body impairment rating.

On June 29, 1993, the attorney for the claimant wrote to the hearing officer with a copy of his letter to opposing counsel. The claimant's attorney stated in his letter that since Dr. B had found that range of motion tests of the claimant to be invalid, under the AMA Guides, the range of motion testing should be redone. Dr. B stated in a letter to the Commission dated July 14, 1993:

> We have been requested to re-examine [claimant] due to deficiencies noted on his spinal range of motion protocol.
>
> [Claimant] has been tested on four separate occasions where it was noted in three of the examinations, the patient did not meet clinical criteria as designated in the AMA Guides for deficiencies in range of motion.
>
> The patient underwent re-testing on 7/8/93, and again invalidated the straight leg

raise rule (SLR). With 3 of 4 testing protocols being rendered invalid no impairment can be granted in Subcategory II of the Spinal Impairment Summary sheet designated as Figure 84 in the Third Edition of the AMA Guides.

Our original opinion regarding the lack of validation without recommending impairment still stands, based on lack of range of motion.

If we can be of any additional service to you in this matter, please feel free to contact me.

On July 16, 1993, a second CCH was held in this case. The claimant testified that his neck as well as his low back was injured in his (date of injury), accident. The claimant testified that all the testing done by and at the request of Dr. B was done on his low back and that there was no testing of his neck. The claimant also testified that he performed the range of motion tests ordered by Dr. B to the best of his ability, but that he had lost strength as a result of his injury. The claimant's attorney argued that Dr. B failed to give the claimant any impairment for his neck (arguing that under the AMA Guides he should have been given an additional four percent whole body impairment for his neck injury), that Dr. B failed to give the claimant any impairment for loss of strength as provided for in the AMA Guides, and that Dr. B improperly invalidated the claimant's range of motion studies.

The carrier introduced a report from (Dr. M) dated June 5, 1992, in which Dr. M stated that the claimant's attorney had referred the claimant to Dr. M for further evaluation. Dr. M stated in his report he thought that was a certain component of symptom magnification in this case (both Dr. B and Dr. Sa had mentioned this problem in their reports). Dr. M also states that any rating should exclude range of motion because it is inconsistent (a problem mentioned by both Dr. B and the claimant's treating doctor, Dr. St). The carrier argued that Dr. B's impairment evaluation was consistent with the six percent rating of Dr. M and the five percent of Dr. Sa. The carrier also argues that Dr. B's report is entitled to presumptive weight since it shows he complied with the AMA Guides in rating the claimant, including in his invalidation of the claimant's range of motion.

The claimant argues in his request for review that the claimant suffered an injury to his neck accompanied by more than six months of medically documented pain, requiring, under the AMA Guides, a four percent whole body impairment rating due to the neck, which the designated doctor failed to take into account. The claimant also argues that the AMA Guides require retesting of range motion until valid results are obtained. (Texas Workers' Compensation Commission Appeal No. 93681, decided this date, September 20, 1993, is dispositive of the notion that retesting must be done until a "valid" result is reached.) The claimant then alleges that a valid range of motion of study was performed by Dr. B showing a 19% impairment for limitation in lumbar range of motion which had not been provided to the claimant, the Commission, or the carrier at the time of the CCH. Claimant alleges that as soon as he received this range of motion study he had forwarded it to the hearing officer

and attaches a copy of his transmittal letter dated July 20, 1993, which states in part:

> Enclosed find a valid lumbar range of motion study on [claimant].
>
> This was done at the direction of Dr. [B], but was not sent to me by Dr. [B] or the insurance carrier. [The claimant] had to get it himself from [the impairment center].
>
> Please note that it gives 19% impairment for lumbar range of motion in the back.
>
> I am extremely upset that this valid test was not even mentioned by Dr. [B] in his letter to you.
>
> Please include this as an exhibit for purposes of the contested case hearing in your ruling.

The carrier contends in its response to the claimant's request for review that the AMA Guides do not require a four percent impairment due to a neck injury unless it is "unoperated with medically documented pain, recurrent muscle spasms or rigidity associated with none to minimum degenerative changes on structural tests." The carrier argues that x-rays and an MRI performed on the claimant's cervical spine were negative and that the MMI date found by both Dr. B and Dr. Sa was within six months of the injury. The carrier asserts that Dr. B was correct in not assessing any impairment to the alleged injury of the claimant's neck. As far as the range of motion testing is concerned the carrier states that the Appeals Panel should not consider an unauthenticated medical record that was not introduced at the CCH, and is therefore, not a part of the hearing record.

In Texas Workers' Compensation Appeal No. 93536, decided August 12, 1993, we summarized our holdings concerning documents attached to a request for review stating:

> As a general rule the Appeals Panel considers only the record developed at the contested case hearing, the request for review and the response thereto. Article 8308-6.42(a) (1989 Act) (now codified as TEX. LAB. CODE ANN. § 410.203(a)); Texas Workers' Compensation Commission Appeal No. 91121, decided February 3, 1992; Texas Workers' Compensation Commission Appeal No. 92147, decided May 29, 1992. Thus we have refused to consider new evidence on appeal. *See* Texas Workers' Compensation Commission Appeal No. 92201, decided June 29, 1992; Texas Workers' Compensation Commission Appeal No. 92400, decided September 18, 1992. We have held that in determining whether evidence offered for the first time on appeal requires that a case be remanded for further consideration, we consider whether it came to appellant's knowledge after the hearing, whether it is cumulative, whether it was through lack of diligence that it was not offered at the hearing, and whether it is so material that it would probably produce a

different result. Texas Workers' Compensation Commission Appeal No. 93111, decided March 29, 1993; Black v. Willis, 758 S.W.2d 809 (Tex. App.-Dallas 1988, no writ). *See* Texas Workers' Compensation Commission Appeal No. 93463, decided July 19, 1993. *Compare* Texas Workers' Compensation Commission Appeal No. 93530, decided August 10, 1993.

In the present case, the claimant has failed to meet at least the last prong of the test enunciated in Black v. Willis, *supra*. We do not believe that the range of motion test, dated July 8, 1993, it attaches to its request for review would have produced a different result. First, it is not clear from the face of the document whether this is actually a valid range of motion test. Second, Dr. B was clearly aware of this test when he wrote his letter of July 14, 1993, and he stated in this letter that his opinion regarding range of motion and impairment remained unchanged. Third, every single doctor who has given an impairment rating (Drs. B, Sa, St and M), including those doctors chosen by the claimant (Dr. St and M), have found the claimant's range of motion to be inconsistent and have refused to consider it in determining each of their respective impairment ratings. Thus, we will not consider the range of motion study attached to the claimant's request for review in reaching our decision.

The 1989 Act provides that the opinion of a Commission selected designated doctor has presumptive weight on both the issues of MMI and impairment and the Commission shall base its determination on these issues on the report of the Commission selected designated doctor unless the great weight of the other medical evidence is to the contrary. TEX. LAB. CODE ANN. §§ 408.122(b) and 408.125(e). In the present case the great weight of the medical evidence is clearly not contrary to the opinion of the designated doctor. Nor is there any evidence that the designated doctor failed to properly apply the AMA Guides as required by § 408.124(b).

The decision of the hearing officer, based upon the report of the designated doctor, is affirmed.

Gary L. Kilgore
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Robert W. Potts
Appeals Judge