APPEAL NO. 93706

On July 14, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding, to determine whether the claimant, (Ms G), who is the respondent in this case, had good cause for setting aside a benefit review conference (BRC) agreement. Two additional issues were the correct date that claimant reached maximum medical improvement (MMI) and her correct impairment rating. The claimant had sustained an injury to her upper back and shoulder on (date of injury), while employed by (employer).

The hearing officer set aside the BRC agreement, which contained provisions in which the parties agreed to the date of MMI and percentage of impairment, finding that good cause existed to set aside the agreement because the designated doctor who examined claimant had once been her treating doctor. The hearing officer determined that claimant "had a right" to be examined by a doctor who was neither associated with the carrier nor who had examined her before. The hearing officer further found that a dispute therefore still existed regarding the date on which claimant reached MMI and her impairment rating. The hearing officer ordered that the case be returned to claimant's disability determination officer for further resolution through appointment of another designated doctor.

The carrier has timely appealed this decision, arguing that it had a binding agreement that should not have been set aside, and further arguing that the evidence did not demonstrate good cause to support the hearing officer's decision. The carrier further challenges the order appointing a second designated doctor, noting the lack of provision in the 1989 Act (TEX. LAB. CODE ANN § 401.001 *et seq*.) for doing this. The carrier argues that the overwhelming weight of the evidence was against the hearing officer's determination that claimant raised a timely dispute to the designated doctor's appointment. The carrier points out that there has been no showing of prejudice to the claimant regarding the examination and opinion by the designated doctor.[1]

The claimant responds that claimant was in a "David and Goliath" situation when the BRC agreement was made. Claimant argues that she was not given the option of accepting both the designated doctor's MMI date and impairment date when the agreement was made. Claimant argues that she needs to be seen by a fair and impartial doctor, and that Dr. O is not impartial because he once treated her. The response does not specifically assert how prejudice occurred in the designated doctor's examination. Claimant argues that the decision should be upheld.

DECISION

We affirm the determination of the hearing officer to set aside the BRC agreement,

[1] The carrier further argues matters concerning the reputation of claimant's treating doctor and the prevalence of Spanish speaking adjusters in the geographical area, but such matters are not in the record and are not considered here. *See* TEX. LAB. CODE ANN. § 410.203(a)(2).

although we reform the basis for doing so. We reverse her determination that a second designated doctor should be appointed and remand the case for determination of the two issues regarding the date of MMI and impairment rating which she did not decide.

FACTS

The claimant stated that she injured her neck, shoulder, and upper arm on (date of injury), while engaged in pushing heavy carts for the employer. Thereafter, she saw a doctor in (city). (She did not contend in testimony, nor is it indicated on her BRC reports, that the injury extended into her lower back.)

Claimant said that she called the adjuster for a recommendation as to a doctor to see and that he gave her the name of (Dr. O). She saw Dr. O two or three times, and was dissatisfied because he told her she had only an inflammation and told her she could work. Two medical reports from Dr. O are dated March 16, 1992 and April 2, 1992. Dr. O diagnosed supraspinatus syndrome, left shoulder, and carpal tunnel syndrome, left upper extremity. The reports indicate that Dr. O told her to try light duty work, with a follow-up examination due in four or five weeks. He recommended further evaluation and arthroscopy of the shoulder if her condition did not improve in that time. An MRI examination of the left shoulder dated March 19, 1992 noted no significant abnormality.

Claimant thereafter went to (Dr. H), and first saw him April 21, 1992. At that time, he diagnosed cervical and thoracic sprain, lumbar discogenic syndrome, and carpal tunnel syndrome. Dr. H continued to treat claimant. Claimant underwent physical therapy.

The claimant was examined on September 20, 1992 by (Dr. B), a carrier medical examination order doctor, who stated that claimant had reached MMI effective August 18, 1992, with a four percent whole body impairment. The doctor's report, which is seven pages, indicated that he was a Fellow of the American Academy of Disability Evaluating Physicians. Dr. B noted that claimant could return to work with essentially no restrictions. He noted that limited range of motion was essentially due to arthritic changes.

Dr. H filed a TWCC-69 form noting that claimant reached MMI on October 27, 1992, with a 32% impairment rating. Although claimant (even at the contested case hearing) has not asserted that she injured her lumbar spine, Dr. H's rating documents 19% impairment (objective condition plus range of motion limitations) attributable to the lumbar spine.

The claimant filed a dispute of Dr. B's rating on November 12, 1992. Because of her request, Dr. O was appointed as designated doctor by the Commission on November 17, 1992, to review the issues of MMI and impairment rating. The examination appointment was scheduled for January 12, 1993. Claimant stated that she did not believe that this was the same Dr. O because his address was different, but that she realized he was the same doctor when she arrived at his office. She stated that he said, "You again, (G)?" and seemed cross to see her.

However, claimant said she did not refuse to be examined or question his examination at this time. She stated that it was her understanding after this that her checks would begin the day after his examination. Claimant said that she contacted the Commission about fifteen days after Dr. O's examination to indicate that she did not want him, and was told she could appeal this. Although the carrier argued on appeal that a BRC request did not list Dr. O's appointment as an issue, the record does not include either the first BRC report or request for it.

A BRC was held on March 17, 1993. According to the claimant, she talked with the ombudsman, DM, for only five minutes before the conference. She maintained that she questioned why Dr. O had been appointed, but was told by the ombudsman that they would discuss only her checks at the BRC. Claimant stated that the benefit review officer "said nothing" during the proceedings, that she understood only that the carrier was to cut off her benefits in April, and that signing an agreement would extend her checks until July. She stated that when she questioned the insurance company's adjuster, RC, about why Dr. O had been appointed as designated doctor, Mr. C replied that it must have been their lucky day. She stated that she also signed the agreement, which was not translated for her, because Mr. M said there was nothing they could do.

The agreement is in evidence. It reflects that the resolution was that the October 27, 1992, MMI date of Dr. H, the treating doctor, was accepted. The 13% impairment rating of the designated doctor, Dr. O, was accepted. Impairment income benefits would be paid until July 27, 1993. It was signed by the claimant, by the ombudsman, by Mr. C, and by the benefit review officer.

A second BRC report is in evidence. It was held May 18, 1993. The report indicated that claimant's sole basis for asserting that the agreement be set aside was that Dr. O had treated her before. However, her position on the correct date of MMI was that if Dr. O was the designated doctor, his date of MMI should be accepted. Her position on impairment rating was that Dr. H's impairment rating should be used.

The first BRC was attended also by adjuster (Ms. V) who testified at the contested case hearing. She stated that she understands Spanish, but not perfectly. She translated into Spanish the terms "impairment rating" and "maximum medical improvement" at the hearing. She stated that claimant never raised any dispute about Dr. O at the first BRC. She stated that claimant was under no pressure to enter into an agreement. Ms. V testified that all three dates of MMI were discussed, and that the time periods for payment of all three impairment ratings and MMI dates were discussed. She stated that the April date for ending impairment income benefits was what would result by using Dr. O's impairment rating but Dr. B's MMI date, and that the July date would result from using Dr. O's rating with Dr. H's MMI date. She stated that the carrier felt that Dr. H's MMI date was accurate because Dr. H was "on top of" the situation, but that his impairment rating was not acceptable because he did not properly use the AMA Guides to the Evaluation of Permanent Impairment (Guides). Ms. V said that the terms of the agreement were reviewed line by line, in Spanish, with the claimant by the ombudsman prior to her signing the agreement,

and that the consequences of the agreement were fully explained to the claimant. Ms. V stated that the first disagreement with Dr. O's appointment of which she was aware came about after the claimant hired an attorney and challenged the BRC agreement.

THE BENEFIT REVIEW CONFERENCE AGREEMENT

As a conclusion of law, the hearing officer found that "claimant" had good cause for setting aside the BRC agreement.[2] The hearing officer does not, however, make any factual findings that claimant failed to understand the agreement or that it was not explained to her; the sole fact findings underlying the good cause finding are:

10. Claimant does not speak, read, or understand English.

11. At the benefit review conference held on March 17, 1993, claimant attempted to bring up the problem with [Dr. O] being the designated doctor, but was told by the ombudsman that there was nothing to be done and the benefit review officer, not understanding Spanish, was unaware that claimant was trying to raise this issue.

12. Claimant exercised due diligence to raise the issue of the designated doctor at the benefit review conference.

13. Claimant has the right to be examined by a designated doctor who has never examined her before and is not associated with the carrier.

If the BRC agreement of March 1993 was subject to being set aside, it was not for the reasons stated in Finding of Fact No. 13. The agreement did not involve appointment of a designated doctor; by its terms, it resolved issues relating to the date of MMI and the impairment rating. Because parties can reach such agreement whether or not a designated doctor has been involved in a case, or can decline to reach agreement at all, arguments relating to the validity of a designated doctor's appointment have little, if anything, to do with good cause for setting aside such an agreement. However, we can imply a finding from Findings of Fact Nos. 10, 11, and 12 that the claimant did not understand the agreement she entered into on March 17, 1993, and therefore had good cause to be relieved of the agreement.

To premise good cause on finding that a party has "rights" with respect to the identity of a designated doctor, (which were, in some manner not specified in the decision, apparently violated), and then void the agreement on that basis, was error. We further note that there has been no assertion, let alone a showing, that the fact that Dr. O had earlier treated claimant for her injury actually resulted in prejudice, or negatively influenced, Dr. O's evaluation. The report on its face is detailed, sets forth a thorough evaluation of all of

[2] We would note that it is the Commission which must set aside agreements upon a finding of good cause, not either of the parties.

claimant's past medical records, and derives an impairment rating in excess of three times that stated by the carrier's doctor. However, claimant was free, in negotiating an agreement with the carrier, to reject all or part of Dr. O's determination.

Good cause for setting aside the agreement exists based upon testimony of what claimant knew and understood the agreement to mean, not on the identity of one of the doctors involved in the claim.

With respect to the circumstances of the first BRC, the hearing officer apparently believed that claimant tried to raise an issue regarding Dr. O but was essentially ignored, and that there was a failure of communication at the BRC.

There was evidence that claimant had little understanding of the practical consequences of the agreement signed at the first BRC proceeding, and she was unrepresented at the time. The 1989 Act specifically sets a lower standard for setting aside an agreement by allowing for a finding of "good cause." Section § 410.030(b) (formerly Art. 8038-6.15(c)).

Notwithstanding the fact that claimant had been examined by a designated doctor, whose report would ordinarily be given presumptive weight, the agreement adopted only his rating but incorporated an earlier MMI date rendered by the treating doctor. Claimant's testimony indicates her understanding that her "election" as to the date that temporary income benefits would end was between sometime in April 1993 and July 1993,
and that she did not understand that adoption of Dr. O's report in total would allow payment of impairment income benefits until 39 weeks from January 12, 1993. This, coupled with the fact that claimant was also unrepresented, supports a finding of good cause to set aside the benefit review conference agreement.[3]

ISSUES RELATING TO DATE OF MMI AND IMPAIRMENT RATING

Once the hearing officer found good cause to invalidate the agreement, it was incumbent upon the hearing officer to determine the other issues in the case, rather than leave the parties with the remaining issues unresolved. We would observe that because the status of MMI is not in issue, only the date, the practical effect of the hearing officer's decision is arguably to leave claimant in a status whereby no further temporary income benefits are due, but neither are impairment income benefits.

We agree, and have stated before, that the designated doctor is intended to be the impartial, non-aligned doctor to resolve disputes of impairment. Texas Workers' Compensation Commission Appeal No. 92495, decided October 28, 1992. Although not in issue in this case, we have, for example, viewed with concern cases where unilateral

[3] We caution that we are not saying that parties could never agree to something other than a designated doctor's report. Parties may agree to resolve impairment before a designated doctor has been appointed.

contacts have occurred between a designated doctor and a party (aside from the examination) that involve substantive discussion of the evaluation. Texas Workers' Compensation Commission Appeal No. 93613, decided August 24, 1993. We would generally agree that for appearances sake it is not advisable to appoint a doctor that has previously treated a claimant when it is possible to avoid doing so, although the party that would typically be expected to assert prejudice would be the carrier, not the claimant. If a claimant or carrier protest such an appointment at the time it is made, prior to an examination, the Commission could set aside this appointment and make another one.

In this case, however, the hearing officer was confronted with an accomplished fact. The claimant stated that she did not understand that the Dr. O who had been appointed as designated doctor was the same Dr. O who treated her until she attended the examination because his address was different. However, the address on the medical reports from Dr. O from the time he treated claimant is the same one as that on the order appointing him as designated doctor. Claimant maintained she contacted the Commission to complain about Dr. O's appointment within fifteen days after the examination and was told she could appeal. There is no evidence of a separate appeal. Claimant asserted that she then tried to raise this point at the benefit review conference.

Even according her testimony full weight, her "complaint" was limited to questioning why the same doctor had been appointed. Although she testified generally at the contested case hearing that she thought Dr. O was unhappy to see her, she agreed that he did an examination. Indeed, she testified that she understood after the examination that her checks would start the day after. She did not testify in any manner that his examination and evaluation were influenced negatively by his previous examinations. Absent allegations or a showing of prejudice, claimant's complaint about Dr. O's involvement does not establish error, even if the hearing officer believed that the issue was timely raised with the exercise of "due diligence."

Given all this, we believe that the hearing officer was in error to set aside the actual appointment of Dr. O as designated doctor. We have noted before that the Act does not appear to contemplate appointment of a second designated doctor, although in an extraordinary circumstance, we could envision that a second appointment would be in order. *See* Texas Workers' Compensation Commission Appeal No. 93040, decided March 3, 1993. We believe the hearing officer may properly consider assertions that a designated doctor had a bias or prejudice that influenced his or her opinion, or did not perform an adequate examination, as part of the analysis of whether the "great weight" of other medical evidence is contrary to his or her opinion. Texas Workers' Compensation Commission Appeal No. 92495, decided October 28, 1992. Such a course of action should be considered before an appointment of a doctor is invalidated, especially when the entitlement of the claimant to payment of benefits is left up in the air as it is in this case.

In our opinion, it was also error for the hearing officer to order appointment of a second designated doctor. As we have stated in the context of a case involving asserted finality of a first impairment rating, there is an element of estoppel in allowing a designated

doctor to be appointed, and to render an opinion, and then raise a dispute over his appointment only after the results of his examination are announced. Texas Workers' Compensation Commission Appeal No. 93501, decided August 2, 1993.

This case is reversed and remanded for further resolution in accordance with this decision. 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 Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Susan M. Kelley
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Thomas A. Knapp
Appeals Judge