APPEAL NO. 93752

On July 16, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). The issues at the hearing were: 1) the date of maximum medical improvement (MMI), and 2) the impairment rating. The hearing officer determined that the claimant reached MMI on March 1, 1993, with a 16% impairment rating as reported by (Dr. B), the designated doctor chosen by the Texas Workers' Commission (Commission) to evaluate MMI and impairment rating. The appellant (carrier) asserts that a conclusion of law and two findings of fact are not supported by the evidence and that the conclusion and findings are against the great weight and preponderance of the evidence. The carrier requests that we reverse the hearing officer's decision and render a decision that the claimant reached MMI on October 22, 1992, with a "permanent impairment percentage not to exceed 4%." The respondent (claimant) responds that the disputed findings and conclusion are supported by the evidence, are not against the great weight of the evidence, and requests affirmance of the hearing officer's decision.

DECISION

The decision of the hearing officer is reversed and the case is remanded to the hearing officer for further consideration and development of evidence.

The parties stipulated that the claimant was injured in the course and scope of his employment on (date of injury). The claimant testified that the company truck he was riding in was rear-ended by another vehicle on the highway on that date. The claimant was taken to a hospital on the date of injury and was released the same day. According to (Dr. FI), on August 24, 1991, an MRI scan of the lumbar spine revealed desiccation changes of the L4-5 and L5-S1 discs and a small central bulge or protrusion of the L4-5 disc that minimally indents the ventral aspect of the thecal sac. Dr. FI noted that there was a suggestion of a minimal bulge of the L5-S1 disc.

In a "To Whom It May Concern" letter dated September 16, 1991, (Dr. F), stated that the claimant has degenerative arthritis of the cervical and lumbar spines "the result of which he has been treated for neck and low back pain." No information was imparted at the hearing concerning the claimant's treatment with Dr. F. In a Required Medical Report: Spinal Surgery Recommendations, which the Commission received on November 20, 1991, Dr. F reported that cervical x-rays showed cervical space narrowing at C5-6 compatible with cervical spondylosis and recommended that the claimant undergo a "cervical fusion, C5-6." The carrier requested a second opinion examination by (Dr. H).

Dr. H reported that he examined the claimant on December 16, 1991, for complaints of neck and back pain, and shoulder cramps since an accident on (date), and for a second opinion on proposed surgery. Dr. H said that he would not recommend surgery without an MRI of the cervical spine to confirm that there is a "remedial surgical lesion at the C5-6 level." On January 16, 1992, an MRI scan of the claimant's cervical spine was done which

revealed 1) a left sided protrusion of the C5-6 disc encroaching on the left foramen, 2) a small central and slightly left sided protrusion of the C3-4 disc, and 3) a small central bulge or protrusion of the C6-7 disc which was reported to be of questionable significance.

In a narrative report to the carrier dated April 21, 1992, (Dr. D), reported that he had examined the claimant and the claimant's medical records and diagnostic tests, including the MRI scans of the cervical and lumbar spines, for a third opinion concerning surgery. Dr. D stated that the claimant would not benefit from cervical spine or lumbar spine surgery, and he recommended that the claimant engage in vigorous physical therapy. Dr. D further stated that "[w]hen he [claimant] reaches [MMI], his disability should not exceed 5%."

The claimant testified that in June or July of 1992 he began treatment with (Dr. HL). Dr. HL wrote that he had a consultation with the claimant on June 19, 1992, and after physical and neurologic examinations and review of medical records diagnosed 1) lumbar and cervical syndrome, and 2) headaches. Dr. HL said that there was not a strong indication for surgical intervention, but that he would perform an EMG to see if there was any evidence of radicular injury. Dr. HL suggested physical therapy as it appeared to him that the claimant most likely had a soft tissue injury. Dr. HL reported that EMG studies done on July 24, 1992, were normal, stated that he did not think further diagnostic evaluation was required, and recommended a work hardening program.

Beginning about August 10, 1992, the claimant underwent approximately four weeks of physical therapy and work hardening at a therapy and work hardening clinic (the clinic). The claimant said that (Dr. C), was associated with the clinic and gave him a "quick physical check" when he entered the program and when he was released from the program. The claimant said that the "check" was not an "examination." In a medical record dated August 11, 1992, Dr. C indicates that he did give the claimant a physical examination. Dr. C's impression was cervical and lumbar syndrome with degenerative disc disease. Dr. C recommended that claimant pursue work hardening per Dr. HL's request. In a medical record dated August 21, 1992, AB, who is a psychologist and who is associated with the clinic, wrote that according to psychological test results, the claimant has an extremely low pain profile and a large psychological overlay to his pain. In a medical record dated August 25, 1992, Dr. C indicated that the claimant was making "functional gains" and was getting a benefit out of the work hardening program.

In an undated Report of Medical Evaluation (TWCC-69), Dr. HL certified that the claimant reached MMI on October 1, 1992; however, Dr. HL did not assign an impairment rating. Instead he wrote "To be evaluated on 10/22/92." The claimant testified that Dr. HL referred him to (Dr. V), for an MMI and impairment rating evaluation.

The claimant testified that Dr. V examined him for 30 to 45 minutes on October 22, 1992. In an undated TWCC-69, Dr. V certified that the claimant reached MMI on October 22, 1992, with a zero percent impairment rating. In a narrative report dated October 22, 1992, Dr. V indicated that the claimant was referred by Dr. HL and the carrier for evaluation of the claimant's neck and back pain and to address whether the claimant had reached MMI

and, if so, to determine an impairment rating. Dr. V indicates in his narrative report that he gave the claimant an examination and performed range of motion (ROM) testing. Dr. V's impression was chronic lumbar and cervical pain. Dr. V said that there was evidence of considerable symptom amplification and psychological involvement. He further stated that the claimant's degree of reported dysfunction and pain does not correspond with any findings on objective tests, and that it is highly improbable that the minimal disc bulges in the cervical and lumbar areas could account for the claimant's reported symptoms and physical examination findings. Dr. V stated that in his opinion, the claimant has most likely reached MMI with regard to the treatment of his neck and back problems. Dr. V also said that he agreed that the claimant was not a surgical candidate. Dr. V further stated that in his opinion the claimant has a zero percent whole person permanent impairment. He noted that lumbar extension and flexion testing indicated that ROM measurements he obtained were invalid, and that it is most probable that the abnormalities noted on the MRI studies simply reflect age-related changes, and are not the result of the claimant's accident.

In a letter to the Commission dated November 21, 1992, the claimant's attorney notified the Commission that the claimant disputed Dr. V's certification of MMI and assigned impairment rating and requested the Commission to designate a doctor to resolve the disputes.

The claimant testified that he requested Dr. C to "double check" Dr. V's report of MMI and impairment rating to see if it was done correctly. In a medical record dated December 8, 1992, Dr. C indicated that the claimant came in for a "follow-up" on his own and at the claimant's request he was commenting on Dr. V's report. Dr. C stated that he agreed that the claimant has probably reached MMI, but would "give him the benefit of the doubt that he was, in fact, injured and that he does have some objective findings as I have mentioned above on his MRI scans that would give him some degree of impairment according to the AMA Guides." Dr. C said that he agreed, based on Dr. V's findings, that the ROM measurements found by Dr. V were invalid. He also indicated that in assigning an impairment rating "we are not allowed to use both his cervical and lumbar diagnoses but one or the other." Dr. C stated that he would designate the claimant's impairment as four percent based on the claimant's three level disc disease in the neck, give zero percent for ROM, and zero percent for neurologic dysfunction, which he said resulted in a four percent whole body impairment rating. No TWCC-69 from Dr. C was in evidence.

In a letter dated February 8, 1993, the Commission notified the claimant and the carrier that it had received notice of a dispute over MMI and/or impairment rating and ordered the claimant to attend a medical examination by (Dr. B), pursuant to Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6 (Rule 130.6 relating to designated doctor provisions). (The hearing officer found that the parties could not agree on a designated doctor so the Commission appointed Dr. B.) The claimant testified that he was unable to attend the scheduled afternoon appointment with Dr. B because he had to pick up his child from school in the afternoons so he contacted the Commission to arrange a morning appointment; however, the Commission informed him that Dr. B does not have morning appointments for examinations of the type requested. Consequently, in a letter dated

February 18, 1993, the Commission again notified the parties that it had received notice of a dispute over MMI and/or impairment rating and ordered the claimant to attend a medical examination by (Dr. BL), pursuant to Rule 130.6. The letters of February 8th and 18th stated that the purpose of the examination is to determine "[w]hether or not [MMI] has been reached and, if so, on what date; and the percentage of impairment, if any." Dr. BL was sent a copy of the Commission's letter of February 18th. The carrier does not raise any issue on appeal concerning the appointment of Dr. BL as the designated doctor.

Dr. BL examined the claimant on March 1, 1993 (the appointment was originally scheduled for March 16th but was rescheduled to March 1st at the claimant's request). In a TWCC-69 dated March 21, 1993, Dr. BL certified that the claimant reached MMI on March 1, 1993, with a 16% impairment rating. In the TWCC-69 Dr. BL stated that he did not think that the claimant is a candidate for neck or back surgery and that he did not think that the claimant would show any further benefit from physical therapy. Dr. BL noted that the claimant had not had any therapy or active treatment since September 1992. Dr. BL recommended vocational retraining. In arriving at the 16% impairment rating, Dr. BL assigned six percent for cervical ROM, five percent for "cervical discs C3-4 C5-6, and six percent for "lumbar discs L4-5 L5-S1."

In a narrative report, Dr. BL stated "I think he has reached [MMI]. I think the [MMI] date is 3/1/93. He really hasn't had any therapy or active treatment since September of 1992, however." Dr. BL also stated that he reviewed the MRI scans and that they showed a small cervical disc at C3-4 and a fairly large cervical disc at C5-6 which is "slightly greater to the left than to the right and is pushing both posteriorly and anteriorly." In addition, Dr. BL said that there is a definite compromise of the subarachachnoid space or cervical canal and the neuroforamen are narrowed slightly. Dr. BL said that the lumbar MRI showed desiccation changes at L4-5 with a small protruding disc at L4-5 and desiccation changes at L5-S1 with a minimally protruding disc. Dr. BL said that he understood that Dr. V assigned a zero percent impairment rating but did not have Dr. V's report. Dr. BL further stated:

> Based on Tablet (sic) 49 of the AMA Guides, the patient has a disc at C3-4 and C5-6 well documented by MRI scanning and desiccation changes at L5-S1 and L4-5, again, well documented by MRI scanning. So, he would have 4% for the cervical spine unoperated with residuals and minimal objective findings and one additional disc at C3-4. So, that would give him 5%. He has an L4-5 disc which would give him 5% and an additional disc at L4-5 [note that this appears to be a typographical error as the other lumbar disc identified in the first sentence was L5-S1] which would give him a total of 11% based on diagnoses only. He has no sensory loss and he has not motor loss. So, he would not have any losses based on peripheral pain or sensory loss or motor loss in the arms or legs. His [ROM] of his cervical spine is 6% and his thoracic spine is zero, and lumbar spine (sic) zero. He had an invalid straight leg raising test on three separate occasions. Spinal [ROM] tests of the cervical spine exceeded the 5 percent range test and were therefore invalid.

(underlining added.)

The carrier contends that the following findings of fact and conclusion of law are not supported by the evidence and are against the great weight and preponderance of the evidence.

FINDINGS OF FACT

21.The preponderance of the evidence establishes that the great weight of the other medical evidence is not contrary to Dr. BL's report.

22.Claimant achieved MMI as of March 1, 1993, and the correct impairment rating is 16%.

CONCLUSIONS OF LAW

2.The claimant reached MMI as of March 1, 1993, and his correct impairment rating is 16%.

The carrier contends that the evidence shows that the claimant reached MMI well before March 1, 1993 and that Dr. BL "chose not to assign a MMI date prior to March 1, 1993 for the simple reason that [Dr. BL] never saw claimant prior to that date." The carrier points out that the hearing officer's decision does not mention Dr. HL's TWCC-69 nor Dr. C's medical record of December 8, 1992, except in the list of exhibits. The carrier further asserts on appeal, as it did at the hearing, that Dr. BL did not mention Dr. HL's certification of MMI nor Dr. C's December 8, 1992, medical record, and that Dr. BL noted that he did not have the report of Dr. V. Thus, the carrier concludes that both Dr. BL and the hearing officer ignored the medical evidence showing that the claimant reached MMI before March 1, 1993. The carrier further points out that after Dr. BL stated that the claimant reached MMI on March 1, 1993, Dr. BL stated that the claimant had not had any therapy or active treatment since September 1992.

Pursuant to Section 408.122(b), the report of the designated regarding MMI has presumptive weight and the Commission must base its determination of whether the claimant has reached MMI on that report unless the great weight of the other medical evidence is to the contrary. We have repeatedly emphasized the unique position of the designated doctor under the 1989 Act. *See* Texas Workers' Compensation Commission Appeal No. 92555, decided December 2, 1992; Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. In Appeal No. 92412 we pointed out that to outweigh the report of the designated doctor requires more than a mere balancing of the evidence medical evidence or a preponderance of the medical evidence; rather, such other medical evidence must be determined to be the "great weight" of the medical evidence contrary to the report.

In regard to impairment rating, the carrier contends on appeal, as it did at the hearing,

that the great weight of the medical evidence is contrary to Dr. BL's 16% impairment rating and that Dr. BL did not correctly use the second printing, dated February, 1989, of the Guides to the Evaluation of Permanent Impairment, third edition published by the American Medical Association (AMA Guides) in determining the claimant's impairment rating. The carrier also points out that Dr. BL did not have the benefit of reviewing Dr. V's report wherein Dr. V assigned a zero percent impairment rating and that Dr. BL does not mention Dr. C's report wherein Dr. C indicates a four percent impairment rating.

Section 408.125(e) provides that the report of a designated doctor chosen by the Commission regarding an impairment rating has presumptive weight and the Commission shall base the impairment rating on that report unless the great weight of the other medical evidence is to the contrary. If the great weight of the medical evidence contradicts the impairment rating contained in the report of the designated doctor chosen by the Commission, the Commission shall adopt the impairment rating of one of the other doctors. We have previously held that a designated doctor's report should not be rejected "absent a substantial basis to do so." Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993. We have also observed that medical conclusions are not reached by counting the number of doctors who take a particular position. An opinion must be weighed according to its "thoroughness, accuracy, and credibility with consideration given to the basis it provides for opinions asserted." Texas Workers' Compensation Commission Appeal No. 93493, decided July 30, 1993.

In reviewing the designated doctor's report we note an internal inconsistency which we believe can only be resolved by remand of the case to the hearing officer for clarification by the designated doctor. The inconsistency is simply that the designated doctor found the cervical ROM tests to be invalid, yet assigned a six percent impairment rating for cervical ROM. On remand, the designated doctor should be asked to clarify this matter.

The carrier asserts that according to Dr. C, it is improper to use both the cervical and lumbar diagnoses to determine whole body impairment. While Dr. C did indicate such, we disagree with his opinion on the use of the AMA Guides. At page 72 of the AMA Guides the doctor is instructed to "[s]elect the primarily impaired region (cervical, thoracic, lumbar)." The doctor is then given a set of instructions on how to calculate impairment for that region, with the first step being to use Table 49 to obtain a diagnosis-based percentage of impairment, if applicable. We note that instruction number 7 on page 74 states that to obtain the impairment of the whole person due to the impairment of the region of the spine, use the Combined Values Chart to combine the diagnosis-based impairment(s) with the impairment due to limited ROM or ankylosis. On page 74 of the AMA Guides, the doctor is instructed to "[r]epeat the above steps for secondarily impaired spinal regions (cervical, thoracic, lumbar), if applicable." The doctor is then instructed to "[c]ombine all regional spine impairments into a single impairment of the whole person using the Combined Value Chart." We think that the AMA Guides are quite clear in allowing a whole body impairment rating to be based on specific disorders to more than one region of the spine. Otherwise, the instruction to repeat the calculation process for the secondarily impaired spinal regions would be meaningless.

The carrier next asserts that assuming that Dr. BL's "specific assignments of impairment ratings are correct," then Dr. BL erred in using the Combined Values Chart. Carrier contends that use of the Combined Values Chart results, not in a 16% whole body impairment rating, but in a 12% whole body impairment rating. We disagree. The Combined Values Chart appears on pages 246-248 of the AMA Guides. Combining the six percent impairment rating for limited ROM of the cervical spine (which we assume to be correct only for the purpose of this discussion concerning Combined Values Chart) with the five percent impairment rating for the specific disorder of the cervical spine results in an 11% impairment rating. Combining the 11% impairment rating for the cervical spine with the six percent impairment rating for the specific disorder of the lumbar spine results in a total whole body impairment rating of 16% as determined by Dr. BL. We note that Dr. BL appears to have added the two impairment ratings for the specific disorders together to obtain an 11% impairment rating and then went to the Combined Values Chart to combine the 11% with the six percent impairment rating for limited ROM of the cervical spine to obtain the 16% whole body impairment rating. It appears to us that the instructions in the AMA Guides contemplate in this case that the rating for the specific disorder to the cervical spine be combined using the Combined Values Chart with the rating for the ROM for the cervical spine and that then that rating would be combined using the Combined Values Chart with the rating for the specific disorder of the lumbar spine to obtain the total whole body impairment rating. However, in this case the same whole body impairment rating of 16% is arrived at regardless of which method is used.

Since we are remanding the case to obtain clarification on the designated doctor's assignment of a six percent impairment rating for limited ROM of the cervical spine, we feel it appropriate to note our concern over the fact that the designated doctor did not have Dr. V's report (and may not have had Dr. HL's TWCC-69 and Dr. C's report of December 8, 1992) when he rendered his opinions on MMI and impairment, and that the hearing officer failed to mention the reports of Drs. HL and C in her decision. We observe that it was Dr. V's report that was disputed by the claimant and led to the appointment of the designated doctor. These reports should be sent to Dr. BL when he is asked to clarify his ROM rating, and Dr. BL should be asked whether there is any change in his opinion in light of those reports.

The decision of the hearing officer is reversed and the case is remanded to the hearing officer for further consideration and development of the evidence, as 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.

Robert W. Potts
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Gary L. Kilgore
Appeals Judge