APPEAL NO. 93769

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq*. On July 27, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. He determined that appellant (claimant) had an impairment rating of five percent. Claimant takes issue on appeal with certain findings of fact relating to maximum medical improvement (MMI), a treating doctor, and the amount of the impairment rating. Respondent (carrier) replies that claimant has no basis to appeal findings as to MMI and treating doctor; it adds that the findings as to impairment rating are sufficiently supported by the evidence.

DECISION

The decision is affirmed as to the date of MMI but reversed and remanded in regard to impairment rating.

At the hearing, the parties agreed that the single issue was the amount of claimant's impairment rating.

Section 410.204(a) of the 1989 Act states that the Appeals Panel "shall issue a decision that determines each issue on which review was requested."

On appeal, claimant asserts that he has not reached MMI, that it is misleading to call (Dr. Be) claimant's treating doctor, that his impairment is not five percent as certified by (Dr. Bl), and that Dr. Bl's report was contrary to the great weight of other medical evidence.

The Appeals Panel determines:

That Findings of Fact Nos. 5 and 6 that state MMI was reached on January 14, 1993, and that Dr. Be was a treating doctor are sufficiently supported by the evidence;

That the report of Dr. Bl appears to use only one factor in stating total impairment when the report indicates that two factors may have contributed to the total rating. This question should be resolved on remand by the hearing officer.

That the appellate issue of whether the great weight of other medical evidence is contrary to the report of the designated doctor (Dr. Bl) cannot be determined based on the present condition of Dr. Bl's report.

Claimant was a route salesman for (employer) on (date of injury), when he hurt his lower back loading five gallon containers onto a truck. He saw (Dr. W) on March 11, 1992, and continued under his care into September 1992. On the suggestion of an employee for carrier, claimant saw Dr. Be in June 1992, and returned to see Dr. Be in October, November, December 1992, and January 1993. In answer to questions from the hearing officer, claimant acknowledged that Dr. W had been his treating doctor, but that Dr. Be

thereafter became his treating doctor. In regard to MMI, claimant orally stipulated at the beginning of the hearing that MMI was reached on January 14, 1993. In addition, Dr. Be and Dr. Bl both stated that MMI was reached on January 14, 1993, and Dr. W estimated in September 1992, that MMI would be reached in November 1992. The evidence sufficiently supports the findings relating to MMI and identity of Dr. Be as a treating doctor.

Claimant, both at the hearing and on appeal, took issue with the amount of the impairment rating, stressing the little time spent by Dr. Bl in doing the impairment evaluation. He acknowledged that Dr. Bl did examine him for about 10 minutes but said that other personnel also tested him for a total of approximately two hours. Claimant did not take issue at the hearing or on appeal with the fact that the Commission order, usually used to designate a doctor, designated a "(city) Impairment Center." Section 408.125(d) and (e) of the 1989 Act appears to give only the parties or the Commission the power to choose a designated doctor; a doctor, per Section 401.011(17) of the 1989 Act is one who is "licensed and authorized to practice" certain health related skills. Since there was no issue raised about whether a "center" can be a designated doctor, or can choose the doctor who will do the evaluation, an issue regarding that questionable practice will not be addressed. We note that the hearing officer in Finding of Fact No. 8 stated that the Commission selected Dr. Bl as the designated doctor; as stated, no error was urged as to this finding of fact.

Claimant did take issue with Finding of Fact No. 12 which read as follows:

> [Dr. Bl] assessed and certified Claimant had a 5% whole body impairment rating due to Claimant's injury sustained on (date of injury).

Carrier's exhibit 2 is the submission of (city) Impairment Center. It contains a Report of Medical Evaluation (TWCC form 69), which is used to certify MMI and an impairment rating. The face of that form 69 is signed by Dr. Bl and dated April 21, 1993. It states, in answer to questions on the form, that MMI was reached on January 14, 1993, with a five percent impairment. The form then requires documentation of objective laboratory or clinical findings of impairment in item 16. This part of form 69 is blank but the attached report may be looked to and read together with the form itself in considering the report of the designated doctor. *See* Texas Workers' Compensation Commission Appeal No. 92613, decided December 28, 1992. Item 17 then instructs the preparer to state the body part/system impaired and its rating. Dr. Bl stated in item 17, "table 49, IIB" and in the next column, on the same level, the number "5." As stated, the attached report may be looked to as part of the opinion of Dr. Bl; that report is neatly divided into sections labelled "opinion, history, lab & x-ray, range of motion, strength and validity." Under "range of motion" entries for "lumbar flexion" and "lumbar extension" are marked "not valid," nothing is entered as to impairment beside either "straight leg raising, right" or "straight leg raising, left." Then "lumbar right lateral flexion" contains a "3" beside the printed words "% impairment," and "lumbar left lateral flexion" contains a "2" beside the printed words "% impairment." The last place on

this form calling for an entry states, "Total lumbar range of motion impairment;" a "5" is entered beside this statement.

Texas Workers' Compensation Commission Appeal No. 93296, decided May 28, 1993, held that in figuring an impairment rating, three factors are to be added together; they are the diagnosis based percentage, the range of motion rating, and neurological deficits. *Also see* "Guides to the Evaluation of Permanent Impairment" third edition, second printing, dated February 1989, published by the American Medical Association (the Guides) at page 71 (Principles of Calculating Impairment) and pages 72 and 74 (the step-by-step approach found in paragraph 3.3a).

Dr. Bl's reference to "Table 49 IIB" refers to page 73 of the Guides and the referenced part states,

II.Intervertebral disc or other soft tissue lesions

* * * * *

B.Unoperated with medically documented injury and a minimum of six months of medically documented pain, recurrent muscle spasm or rigidity associated with none-to-minimal degenerative changes on structural tests.

Beside this description in table 49 are three columns, the last of which is labelled "lumb" and contains the figure "5." (Table 49 does not appear to give consideration to what the range of motion rating is, if one is made.)

As a result it appears as if Dr. Bl assigned a five percent impairment rating based solely on the diagnosis based percentage of impairment contained in table 49 of the Guides, while his attached report also included a five percent rating for range of motion. The combined value chart, page 246 of the Guides, appears to indicate that a value of five percent added to another value of five percent provides an impairment rating of 10%. According to Appeal No. 93296, *supra*, a question arises as to whether the rating for diagnosis should be added to the rating for range of motion.

We also note that page 1 (of 4) under the heading "opinion" in the report attached to the TWCC form 69, refers to the Guides correctly (1989 version), while page 2, under the same "opinion" heading in the report, appears to refer to another version by stating, "[t]he Revised Edition of the AMA Guides states the coefficients of variation in excess of 20% should be considered as invalid and are indicative of lack of maximal effort."

The hearing officer may query a designated doctor in regard to questions raised

about that doctor's report. *See* Texas Workers' Compensation Commission Appeal No. 93045, decided March 3, 1993. This case is reversed and remanded for the hearing officer to inquire of Dr. Bl regarding the basis for his total five percent impairment rating, raising the questions discussed in this opinion. In addition, since the case is being remanded, the hearing officer should also point out the requirement of the 1989 Act that impairment ratings will be based only on the Guides (the definition of which contains no "revised" edition); further, Dr. Bl should be asked if the use of the Guides in place of the "revised edition" in his evaluation would make any other difference in the total impairment rating.

The decision and order are reversed and remanded in regard to the amount of the impairment rating. Reconsideration and development of the evidence, together with additional or different findings of facts and conclusions of law, may be appropriate as determined by the hearing officer in reaching a decision as to impairment rating. 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 of the 1989 Act. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Joe Sebesta
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Thomas A. Knapp
Appeals Judge