APPEAL NO. 93870

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act) (formerly V.A.C.S., Article 8308-1.01 *et seq*.). A contested case hearing was held on July 6, 1993, in (city), Texas, with (hearing officer) presiding as hearing officer. The record closed on August 23, 1993. The sole issue at the hearing was the appellant's (claimant) correct impairment rating. The hearing officer found that the 15% impairment rating given by the Texas Workers' Compensation Commission (Commission) designated doctor was not contrary to the great weight of the other medical evidence and was correct. The claimant appeals this determination contending that the great weight of the other medical evidence was to the contrary, that the Commission improperly selected the designated doctor, and that the hearing officer erred in certain evidentiary rulings. The respondent (carrier) urges that the decision of the hearing officer was correct and that any errors made by the hearing officer were not prejudicial or were waived by the claimant.

DECISION

The decision of the hearing officer is affirmed.

There is no dispute that the claimant suffered an injury to his lower back and left knee in the course and scope of his employment on (date of injury). The parties signed a Benefit Review Conference (BRC) Agreement on May 12, 1993, to the effect that claimant reached maximum medical improvement on October 19, 1992. The sole disputed issue before the hearing officer was claimant's correct impairment rating. Before we discuss the correctness of the hearing officer's decision on that ultimate issue, we address the procedural and evidentiary issues raised in this appeal.

The claimant objects for the first time on appeal that he was never given the opportunity by the Commission to agree with the carrier on the selection of a designated doctor and thus possibly obviate the need for the Commission to select the designated doctor.[1] Pursuant to Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6 (Rule 130.6), if there is a dispute over an assigned impairment rating, the Commission is to notify the parties that a designated doctor will be directed to examine the claimant. The parties are to be allowed ten days to agree on a designated doctor. Failing such an agreement, the Commission will choose a designated doctor. Section 408.125(d) provides that if the parties choose the designated doctor, "the commission shall adopt the impairment rating made by the designated doctor." (Emphasis added). However, if the Commission chooses the designated doctor, the impairment rating is presumed valid "unless the great weight of the other medical evidence is to the contrary." Section 408.125(e). The Appeals Panel has held that the Commission must afford the parties the opportunity to agree on a designated doctor. Failure to do so may be reversible error. *See e.g.* Texas Workers'

[1]We note that, unfortunately, the record does not contain a copy of the letter of appointment of the designated doctor. The parties presented their respective positions at the hearing under the assumption that the designated doctor had been selected by the Commission.

Compensation Commission Appeal 93170, decided April 22, 1993. Any such error in this case, however, was waived by the claimant's failure to raise the matter as an additional disputed issue pursuant to Rule 142.7.

The claimant also contends that the hearing officer erred in refusing to admit certain of his documents offered into evidence. In a portion of the hearing officer's Decision and Order entitled "Evidence Presented," the hearing officer mentioned each of claimant's exhibits and indicated they were all admitted except for claimant's Exhibit No. 8 (a note from (Dr. A), the carrier-selected doctor), claimant's Exhibit No. 9 (the claimant's own narrative analysis of the report of (Dr. S), the designated doctor), and claimant's Exhibit No. 10 (medical reports from (Dr. P), the claimant's treating doctor) which were described as "denied." The claimant appeals only the stated denial of the admission of claimant's Exhibits Nos. 8 and 10. In its response, carrier concedes that certain of claimant's documents were not admitted, but addresses only claimant's exhibit Nos. 8 and 9. Our review of the tape recorded transcript of the hearing discloses that none of claimant's tendered exhibits were objected to at the hearing and that all were admitted.[2] The hearing officer's description of the exhibits as "denied" was an obvious misstatement. Claimant's Exhibit No. 8 merely recited that Dr. A saw claimant on two, not three occasions. Claimant's Exhibit No. 10 was obviously considered by the hearing officer since she refers to the content of Dr. P's reports in reciting claimant's evidence. This assertion of error by the claimant is without merit.

Over objection by the claimant at the hearing on the basis of lack of timely exchange and despite an admission by the carrier's attorney without explanation that none of the carrier's proffered evidence had been timely exchanged, all six exhibits offered by the carrier were admitted into evidence. The claimant appeals these evidentiary decisions suggesting that the Commission's rules were not fairly applied by the hearing officer. Section 410.161 provides that a party who fails to disclose information known to that party or documents which are in existence and in the possession, custody and control of that party at the time disclosure is required, may not introduce such evidence at a contested case hearing "unless good cause is shown" for failure to timely disclose. Rule 142.13(c) provides that such exchange shall take place no later than 15 days after the BRC (with an exception in the case of expedited hearings). Additional documentary evidence is to be exchanged as it becomes available. Rule 142.13(c) also requires a hearing officer to find good cause as a pre-condition to the admission of documentary evidence not previously exchanged. Notwithstanding the provisions in the cited statute and rule requiring the hearing officer to make good cause determinations before admitting carrier's exhibits, the record is devoid of the hearing officer's having made such determinations. Accordingly, we conclude that the hearing officer erred in admitting carrier's exhibits, under the particular circumstances of this case, without making the mandatory good cause determinations. *See* Texas Workers'

[2]We note that all the exhibits offered were stamped "for identification" with no indication on the documents themselves that they were admitted or excluded after the hearing officer made a decision. Such procedure may have led to some confusion and inattention upon review, further compounded by the misstatement in the Decision and Order that certain of the claimant's exhibits were "denied."

Compensation Commission Appeal No. 91064, decided December 2, 1991, and Texas Workers' Compensation Commission Appeal 92073, decided April 6, 1992. We are unable to imply findings of good cause on the basis of the facts presented to the hearing officer in this case. *Compare* Texas Workers' Compensation Commission Appeal No. 92225, decided July 15, 1992, and Texas Workers' Compensation Commission Appeal No. 93749, decided October 6, 1993. Here, the record lacks any showing of good cause and the carrier suggests none for its failure to exchange its exhibits within the time period established under Section 410.160 and Rule 142.13(c).[3]

In Texas Workers' Compensation Commission Appeal No. 92068, decided April 6, 1992, we observed the following:

> To obtain reversal of a decision based upon error in the admission of evidence, the appellant must first show that the hearing officer's determination was in fact error, and second, that the error was reasonably calculated to cause and probably did cause the rendition of an improper decision. *See* Hernandez v. Hernandez, 611 S.W.2d 732, 737 (Tex. Civ. App.-San Antonio 1981, no writ). Reversible error is not ordinarily shown in connection with rulings on questions of evidence unless the whole case turns on the particular evidence admitted or excluded. *See* Atlantic Mutual Insurance Company v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.).

Having examined carrier's exhibits, we do not find reversible error in their admission either because they are cumulative of other evidence or because the whole case did not turn on them and they were not reasonably calculated to cause and probably did not cause the rendition of an improper decision.

Carrier's Exhibit No. 1 is Dr. S's transmittal letter of March 9, 1993, which attached and forwarded to the Commission her certification of impairment rating (TWCC-69 and narrative report). The TWCC-69 and narrative report were previously admitted as claimant's Exhibit Nos. 7 and 6, respectively. Carrier's Exhibit No. 1 is an integral part of Dr. S's "medical report" partially submitted by the claimant. We find carrier's Exhibit No. 1 to be essentially cumulative of the information contained in claimant's Exhibit Nos. 7 and 6. The only additional information is Dr. S's assertion that she completed certain tests, and did not find lumbar spine range of motion tests valid. Having reviewed carrier's Exhibit No. 1 we are unable to conclude that the whole case turned on this additional evidence or that it probably caused the rendition of an improper decision.

Carrier's Exhibit No. 2 (Dr. S's narrative report) is identical to claimant's Exhibit No. 6 except that carrier's Exhibit No. 2 has an attachment (raw data for lumbar spine motion) not included with claimant's Exhibit No. 6. On its face, the raw data attachment appears to be an integral part of both carrier's Exhibit No. 2 and claimant's Exhibit No. 6. We do not

[3]The hearing was not held until August 23, 1993, while carrier's exhibits bore dates from September 1991 through March 9, 1993.

consider the erroneous admission of carrier's Exhibit No. 2 to be reversible error because the raw data it contained formed part of the basis for the conclusions stated in the report of impairment (claimant's Exhibit No. 6). Nowhere was it asserted by the claimant that this raw data was misinterpreted by Dr. S or otherwise impeached her report. The case did not turn on this evidence nor did it probably cause the rendition of an improper verdict.

Carrier's Exhibit No. 3 (Dr. S's TWCC-69) is identical to claimant's Exhibit No. 7. As such, it was cumulative in nature and its admission harmless error. *See* Texas Workers' Compensation Commission Appeal No. 92225, decided July 15, 1992.

Carrier's Exhibit No. 4 is identical to claimant's Exhibit No. 2 with one exception. Both are Dr. A's narrative report attached to his TWCC-69. Carrier's Exhibit No. 4 also contains the TWCC-69; claimant's Exhibit No. 2 does not. The TWCC-69 clearly referenced the narrative as "an attached report" and is essentially only a re-statement of conclusions as to impairment rating with some identifying data about Dr. A. Also, carrier's Exhibits Nos. 5 and 6 are reports of MRI testing of the claimant's left knee and lumbosacral spine requested by Dr. P, claimant's treating doctor. The conclusions in each are contained substantially in claimant's Exhibit No. 10. We consider the evidence in carrier's Exhibits Nos. 4, 5, and 6 merely cumulative of other facts contained in other evidence and their admission harmless error.

The claimant's primary contention on appeal is that the great weight of the other medical evidence is contrary to the designated doctor's determination of a 15% impairment rating. Dr. P, claimant's treating doctor, submitted a Report of Medical Evaluation (TWCC-69), dated October 19, 1992, in which he assigns a 31% whole body impairment rating. He assigned a rating of 21% to the lumbar spine, based on an EMG which showed "a mild bilateral L5, S1 radiculopathy" and an MRI (reflected in Carrier's Exhibit 6, discussed above as to the claimant's objection to its admissibility) which revealed "L5-S1 small central subligamentous Type II disc protrusion." He calculated the 21% impairment to the lumbar spine as follows:

BODY PART SYSTEM	RATING
Lumbar spine = 14% + (body Part) disease*lumbar spine 7% *injury due to specific disorders of the spine as per the AMA Book, p. 73, Table 49.	21%
Left Knee = 13%	13%
	31%

Associated with this TWCC-69 were a "Lumbar Test" described as a "quantification of frequent lifting capability" which placed the claimant "at a physical demand level for performing LIGHT work" and a "hand strength" test which was compared with "normal

population strength."[4] No ROM figures from Dr. P were introduced, but he says in an August 15, 1991, Initial Medical Report (TWCC-61) that "range of motion was limited in the forward flexion; it is painful in the lateral ligament and on the zygapophyseal joint rotation test bilaterally." The seven percent rating was for a specific disorder of the spine not otherwise identified beyond the reference to Table 49. We also note that the combined value of 14% and seven percent is 20%, not 21%, and that a combined value of 20% and 13% is 30%, according to the Combined Values Chart in the Guides to the Evaluation of Permanent Impairment, third edition, second printing, published by the American Medical Association (AMA Guides).

Dr. A, a carrier-selected doctor, provided a TWCC-69 with a 15% whole body impairment rating based on 10% assigned to "the lumbar spine body as a whole" and five percent to the left knee. He concludes his report with the statement:

> After the EMG and Nerve Conduction Velocity Studies are performed and if there is anything wrong, (claimant's) disability rating for his low back can be changed.

On March 8, 1993, Dr. S, the designated doctor, completed a TWCC-69 in which she assessed a whole body impairment rating of 14%. She diagnosed lumbar strain "and an exacerbation of a previous knee injury in which (claimant) had an arthropathy." She noted that "there appears to be some loss of range of motion" in both the knee and the spine. The results of spinal range of motion testing, however, "were somewhat inconsistent." Based on the same MRI report presumably relied on by Dr. P, she confirmed "a subligamentous protrusion but no frank herniation." She found EMG and nerve conduction testing "equivocal." Included in Dr. S's report were the results of range of motion tests of the lumbar spine.

At the conclusion of the contested case hearing on July 6, 1993, the hearing officer announced that she would seek clarification from Dr. S about whether the claimant was entitled to an impairment rating for a specific disorder of the spine under Table 49 of the AMA Guides as found by Dr. P. The hearing officer also advised Dr. S that the combined value for a 10% and a five percent rating was 15%, not 14%, and asked Dr. S to also review that portion of her original TWCC-69 for possible errors. By letter of July 13, 1993, from Dr. S to the hearing officer (provided to the parties with the opportunity for comment thereon; no comments were received), Dr. S stated that because the MRI showed a subligamentous injury without frank herniation, she found no basis to conclude that the claimant suffered from a specific disorder of the spine.[5] Therefore, contrary to Dr. P, she did not give a rating

---

[4]Damage to or loss of strength in the hands was never alleged by the claimant as an injury occurring in the course and scope of employment.

[5]The claimant on appeal objects to Dr. S's comment in her letter of July 13, 1993, to the hearing officer that "40% of the population may have assyptomatic (sic) disc bulges or subligamentous herniation" because there was no evidence that he was part of this 40% Because he first raised this objection on appeal and not in a comment on this letter to the hearing officer as he was invited to do, we do not address it on appeal.

for this. Her impairment rating was based on loss of range of motion and torn meniscus in the left knee (10%) and on loss of range of motion of the lumbar spine (five percent) which included "right and left lateral bend only" since the validity criteria for other motions were not met. She agreed that the proper combined value was 15%.

Section 408.125(e) provides that the report of the designated doctor selected by the Commission will be given presumptive weight unless the great weight of the other medical evidence is to the contrary. The final determination of impairment rating by the Commission must be based on medical, not lay evidence. Texas Workers' Compensation Commission Appeal No. 93518, decided August 5, 1993. This great weight determination amounts to more than a mere balancing or preponderance of the medical evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided December 2, 1992. 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. And medical conclusions are not reached by counting the number of doctors who take a particular position. The opinions must be weighed according to their "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. An attack on the validity of the report of the designated doctor based on non-medical issues, such as failure to comply with "the underlying statutory requirements of certification," may be based on lay testimony. Texas Workers' Compensation Commission Appeal No. 93046, decided March 5, 1993. *See also* Texas Workers' Compensation Commission Appeal No. 93483, decided July 26, 1993 and Texas Workers' Compensation Commission Appeal No. 93410, decided July 8, 1993.

The hearing officer gave presumptive weight to the impairment rating given by Dr. S, the designated doctor. She concluded that the great weight of the other medical evidence was not to the contrary. Our review of the evidence and objections made by the claimant supports the hearing officer's findings and conclusions.

The claimant urges the insufficiency of Dr. A's report because Dr. A stated that his rating may increase pending results of EMG and nerve conduction testing. However, the record indicated that these tests were already completed at the time of Dr. A's examination. Such lack of certainty by one doctor does not serve to impeach the credibility of another doctor, whether designated or not. In any event, Dr. A's report is not necessarily even inconsistent with Dr. S's report.

With regard to Dr. S, the claimant makes the following arguments:

(1)That Dr. S was wrong in not finding a specific disorder of the spine. However, the existence or not of a specific injury is a medical determination, not a lay determination. Dr. S reviewed the evidence and provided a reasoned conclusion that no disorder existed. Dr. P's disagreement on this point does not constitute the great weight of the evidence.

(2)That Dr. S did not perform a personal evaluation of the claimant as required by Commission Advisory 93-04. Specifically, the claimant asserts that "[t]here was no integrity involved in my examination by the designated doctor" because the doctor never personally applied any tests, but remained always five or six feet away directing her assistant to perform various physical testing. Claimant also asserted that the entire examination lasted approximately 45 minutes. The Appeals Panel has held that the designated doctor must personally examine and evaluate a claimant. In Texas Workers' Compensation Commission Appeal No. 93095, decided March 19, 1993, the Appeals Panel noted that the designated doctor is not precluded from referring the patient for additional consultations and from relying on tests performed by others, provided "he does not just review records and totally rely on examinations by others." However, the critical determination (in this case, impairment rating) "must ultimately (be) based on his own professional opinion." Texas Workers' Compensation Commission Appeal No. 92627, decided January 7, 1993. We have never held, nor do we do so now, that, absent demonstrated medical necessity, the designated doctor must physically touch the patient and personally manipulate medical instruments applied to the claimant. A doctor may employ the sense of sight in performing an examination just as the sense of touch. What is required is personal involvement in the examination process so that the certification is in fact the professional, medical opinion of the designated doctor, and not merely a rubber stamp approval of the findings and conclusions of other health care personnel. In this case, it is evident that Dr. S was physically present for the claimant's examination and that she committed two hours to her evaluation of claimant including a personal review of previous tests done. Her finding of an impairment rating was clearly her own based on her "sound medical judgment" (TWCC Advisory 93-04). We do not agree that under these circumstances Dr. S did not perform the required examination or inadequately evaluated the claimant's medical condition as he asserts.

(3)The claimant also contends that he told Dr. S and her assistant before the examination that he had previously (within a couple hours) taken pain killers which would invalidate the examination and that he should be rescheduled. We consider this a medical conclusion that must be supported by medical evidence. The claimant's testimony in itself does not establish the invalidity of the tests. See Texas Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992.

The hearing officer, as the sole judge of weight and credibility of the evidence, was able to reach findings and conclusions as to a correct impairment rating. She determined

that Dr. S's impairment rating was not contrary to the great weight of the other medical evidence. Such a conclusion is not so against the great weight and preponderance of the evidence as to be manifestly wrong and unjust. *See* Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

Accordingly, the decision of the hearing officer is affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Joe Sebesta
Appeals Judge