APPEAL NO. 93927

This appeal arises 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 in (city), Texas, on August 23, 1993, with the hearing and the record being closed on September 17, 1993. The sole issue before hearing officer (hearing officer) was: what is the proper impairment rating for the claimant's injury of (date of injury)? The appellant, hereinafter claimant, appeals the hearing officer's determination that the designated doctor was improperly appointed, and that therefore the case must be sent back to a disability determination officer for the selection of a designated doctor in accordance with rules of the Texas Workers' Compensation Commission (Commission). The respondent, hereinafter carrier, basically argues that the hearing officer's determination is correct and should be affirmed.

DECISION

We reverse the hearing officer's decision that the designated doctor was improperly appointed and remand for a determination, pursuant to Section 408.125(e), of claimant's correct impairment rating.

The parties stipulated that the claimant was an employee of (employer) on (date of injury), and that on that date she sustained a compensable injury while in the course and scope of her employment with employer. Claimant's injury was to both of her knees, and she has not returned to work since taken off work by her treating doctor on December 17, 1991. The parties further stipulated that the claimant reached maximum medical improvement (MMI) on February 23, 1993, per the report of (Dr. J), who is the Commission-appointed designated doctor in this case.

The claimant testified through an interpreter that the first doctor she saw was Dr. S; no reports from this doctor were in evidence. Her employer sent her to (Dr. F), who on December 4, 1991, wrote that he found no objective evidence of demonstrable ongoing neuromuscular dysfunction, that he presumed she had a soft tissue injury, and that he did not believe surgery was indicated. On December 17, 1991, claimant began treating with (Dr. S), who ordered an MRI of the right knee which he said disclosed a torn medial meniscus and tear of the anterior cruciate ligament. (The report of an MRI of the left knee stated "small area of moderate increased signal noted within the posterior horn of the medial meniscus can be related to a discrete area of intrasubstance degeneration or to a Grade I meniscal tear. No definite evidence for discontinuity of the contour of the meniscus is seen.") On January 16, Dr. S performed arthroscopic surgery on claimant's right knee.

At carrier's request, claimant was examined by (Dr. X), who on August 28, 1992, pronounced claimant to have reached MMI as of July 20, 1992, with a four percent whole person impairment rating. Dr. X's report also stated that, for the sake of completeness, he would obtain an MRI of her left knee. On November 16, 1992, Dr. S said he had reviewed Dr. X's report and did not concur with his finding of MMI due to the unavailability of claimant's left knee MRI. In a letter dated May 27, 1993, Dr. X wrote that he had reviewed claimant's

left knee MRI, found them to be basically normal, and stated that he stood by his previously stated MMI date and impairment rating.

On February 23, 1993, the claimant was seen by Dr. J, a designated doctor appointed by the Commission. Dr. J found the claimant to have reached MMI as of that date, and assigned a 15% whole body impairment rating. The carrier had Dr. J's report reviewed by (Dr. B), who did not examine claimant but who arrived at a 14% impairment rating. His report stated "[t]he above impairment rating was based on specific diagnosis as outlined in [Dr. J's] record as calculated independently. I think mine and his are in fact correct."

(Mr. C), carrier's claims representative, testified at the hearing that carrier had requested claimant be examined by Dr. X; that Dr. X's report certifying MMI and impairment was sent to Dr. S, claimant's treating doctor, who disagreed with Dr. X's findings; that carrier notified the Commission of its dispute over MMI and impairment; and that carrier never received from the Commission any notification that the carrier and the claimant had 10 days in which to agree on a designated doctor or the Commission would appoint such doctor. Mr. C testified, and the record reflects, that carrier completed a Form TWCC-21 (Payment of Compensation or Notice of Refused/Disputed Claim) disputing Dr. J's impairment rating and stating carrier's reasonable assessment as four percent.

The carrier's position at the hearing was that since Dr. J was not a properly appointed designated doctor, his opinion on impairment cannot be given presumptive weight, as provided by Section 408.125(e). Specifically, the carrier argued that the evidence showed that the Commission failed to notify the parties of their right to agree upon a designated doctor in conformance with Tex. W.C. Comm'n, 28 TEX, ADMIN. CODE § 130.6 (Rule 130.6), which provides in pertinent part that if the Commission receives a notice that either party disputes MMI or an impairment rating, it shall notify the parties that a designated doctor will be directed to examine the employee. It further provides in subsection (b) that:

> After notifying the employee and the insurance carrier, the Commission shall allow the employee and insurance carrier ten days to agree on a designated doctor. The Commission shall inform an unrepresented employee that an OMBUDSMAN is available to explain the contents of the agreement for a designated doctor.

The carrier further relied upon Texas Workers' Compensation Commission Appeal No. 93099, decided March 25, 1993, as standing for the proposition that that portion of Rule 130.6 is mandatory and not directory.

Following the close of the hearing, the hearing officer, on her own motion, reopened the hearing record to take official notice of certain enumerated items in claimant's file at the Commission. The record reflects no objection by either party to the inclusion of this evidence into the record. Among the items included were Commission telephone logs reflecting conversations between Commission personnel and both claimant and Mr. C on

various subjects, including appointment of a designated doctor. The evidence further includes a December 29, 1992, letter to claimant, copy to carrier, from a Commission disability determination officer directing claimant to be seen by a (Dr. E) as designated doctor. Because, as the telephone logs reflect, Dr. E could not immediately see the claimant, carrier on January 14 and 28, 1993, wrote claimant to inform her that a "designated examination" had been scheduled for her with Dr. J. Also in evidence is the carrier's request for a benefit review conference or appointment of a designated doctor.

In her discussion, the hearing officer wrote as follows:

> In its totality, the evidence credibly suggests that the carrier and the claimant were not interested in mutually selecting a doctor, and likely would not have agreed upon one had they been so directed by the Commission. The parties certainly had, between October, 1992 and February, 1993, the opportunity to agree upon a designated doctor. It also appears that the carrier did not formulate its contention that the Commission failed to allow the parties to agree on a designated doctor until after the Benefit Review Conference since no mention of this theory is reflected in either the carrier's request for a Benefit Review Conference or the Benefit Review Officer's report. Indeed, it further appears as through there was, in fact, no agreement forthcoming on a designated doctor, that [Dr. J] was appointed, and that [Mr. C] knew this and had no complaint until [Dr. J] assessed a 15% impairment rating . . . None of this, however, obviates the Commission's duty to follow its own Rules or the Texas Workers' Compensation Act in resolving this dispute. Because the Commission failed to give the parties an opportunity to mutually select a designated doctor before appointing one, the process must be done again in accordance with the law to determine the claimant's impairment rating.

We have reviewed Appeal No. 93099, *supra*, and find it factually distinguishable from the instant case. There, the carrier disputed the impairment rating assigned by the claimant's treating doctor on April 23, 1992; on April 29th, the Commission wrote the carrier that a designated doctor had been appointed, and on the same date it issued a medical examination order pursuant to Article 8308-4.16 (now Section 408.004) ordering the claimant to see a Dr. A. The Appeals Panel upheld the hearing officer's determination that Dr. A was not a designated doctor because he was not appointed pursuant to the provisions of Rule 130.6. The summary of the evidence indicates that the process used in having the claimant examined by Dr. A was totally outside the procedure for appointing a designated doctor contemplated by the statute and by Rule 130.6. Among other things, the parties were given no opportunity to agree on a designated doctor, a requirement the Appeals Panel found to be mandatory and not directory. That that portion of the statute and rule were not complied with in that case is evident by the fact that the order appointing Dr. A was made within 10 days of carrier's dispute of the first impairment rating. Moreover, the Appeals Panel in that decision made clear that the purpose of the 10 day agreement period was to enhance swift resolution of disputes.

The record in this case, on the other hand, demonstrates substantial compliance with the statute and rule concerning the appointment of a designated doctor. The record shows a dispute raised by the carrier as early as October 1, 1992, on which date the carrier completed a Request for Setting a Benefit Review Conference (Form TWCC-45), copy to claimant, giving the following reason: "MEO doctor [Dr. X] found the claimant to have reached MMI on 7-20-92 with 4% impairment. The treating doctor, [Dr. S], has not responded, but has requested authorization to proceed with another surgery which would seem to indicate a non-concurrence. If a BRC cannot be set, the carrier requests resolution by designated doctor." Attached to this form was a note, in an unidentified handwriting, which stated in part, "No mutual." The record in the case also includes telephone logs which show conversations between Commission representatives and both carrier and claimant between the time the carrier's TWCC-45 was filed and the time that the claimant was notified on December 29, 1992, that Dr. E had been appointed as the original designated doctor. When that appointment was not effectuated, due to Dr. E's inability to see claimant for several months, the carrier notified the claimant in letters dated January 14 and 28, 1993, of an appointment for February 23rd with Dr. J.

Although the adjuster testified at the hearing that he could not locate a written notification from the Commission in his file regarding the 10 day agreement period, there is no testimony that the adjuster was unaware of this requirement or had not discussed this with the Commission. Given the passage of time between the carrier's raising of dispute and appointment of the designated doctor, the contact that occurred between the Commission and the parties, and the contact between the carrier and the claimant, as well as the unqualified stipulation on the date of MMI by Dr. J, "a designated doctor," we are unwilling to void the designated doctor procedures that occurred in this case simply based upon the carrier's argument, raised for the first time at the contested case hearing, that the parties were not allowed 10 days to agree on a designated doctor, as provided by Rule 130.6. Perhaps additional actions could have been taken by the Commission in this case to prevent potential problems; however, our review of the procedures that did take place convinces us that they adequately "parallel those set forth" in Rule 130.6. *See* Texas Workers' Compensation Commission Appeal No. 92312, decided August 19, 1992.

For the foregoing reasons, the hearing officer's determination that Dr. J was not properly appointed as a designated doctor is reversed. The case is remanded to the hearing officer for her determination, pursuant to Section 408.125(e), as to whether the claimant's impairment rating will be based on the presumptive weight accorded that doctor's report, or whether the great weight of the other medical evidence is to the contrary.

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 Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Susan M. Kelley
Appeals Judge