APPEAL NO. 94072

On December 13, 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 impairment rating of the appellant (claimant); and (2) whether an agreement signed by the parties on September 14, 1993, is valid. The hearing officer determined that the claimant's impairment rating is seven percent and that the agreement is valid. The hearing officer decided that the claimant is entitled to 21 weeks of impairment income benefits (IIBS). The claimant states that she is dissatisfied with the decision and requests our review. The claimant indicated in the appeal that additional pages were attached to the one page that was filed but no additional pages were attached to the page that was filed. The attorney for the respondent (carrier) advised the clerk of the Appeals Panel that he too received only the one page appeal. No response has been filed.

DECISION

The hearing officer's determinations that there is no good cause to set aside the agreement of September 14, 1993, and that the claimant has a seven percent impairment rating are reversed and a decision is rendered that there is good cause to set aside the agreement of September 14, 1993; that the agreement is set aside; and that the claimant is entitled to be examined by a designated doctor whose status as a designated doctor is established before the doctor's examination of the claimant.

The claimant was injured at work on or about (date of injury), when she lifted three boxes of flashlights and then bent over to set the boxes down. Her treating doctor is(Dr. P), a chiropractor, whom she initially saw on January 28, 1991. Dr. P referred the claimant to (Dr. R) who diagnosed the claimant as having L5 radiculopathy, left side; mild left carpal tunnel syndrome; and probable thoracic outlet syndrome, left side, involving the C8-T1 roots. Dr. P then diagnosed the claimant as having a lumbar sprain/strain, subluxation lumbar vertebrae, and lumbar disc syndrome. Dr. P has been treating the claimant with chiropractic manipulation, and traction and acupuncture therapy.

In August 1991, the claimant was examined twice by (Dr. A). The record does not reflect who, if anyone, requested the claimant to go to Dr. A. Dr. A reported that the claimant appeared to be improving from chiropractic manipulation and that the claimant had not reached maximum medical improvement (MMI). Dr. A noted that the claimant was unwilling to consider surgery as an alternative treatment and did not want to have a referral for neurological consultation. In October 1991, Dr. P added cervical sprain/strain to his previous diagnoses. Dr. P continued to treat the claimant throughout 1991 and 1992 and continued to report that the anticipated date of MMI was "unknown." On August 31, 1992, the Texas Workers' Compensation Commission (Commission) advised Dr. P that the carrier had "identified" that the claimant had been released to return to work, and the Commission requested Dr. P to provide an "evaluation" on whether the claimant had reached MMI, and, if so, to determine an impairment rating. In September 1992, Dr. P reported that it would be necessary to perform manipulation under anesthesia for the claimant to have a more

complete recovery, but that "precertification" for the procedure had been refused even though a (Dr. B) had also recommended the procedure.

Dr. P referred the claimant to (Dr. N) and in a Report of Medical Evaluation (TWCC-69) Dr. N certified that the claimant reached MMI on November 20, 1992, with a 42% impairment rating. Dr. N referred the claimant to (Dr. SV) who performed a neurological examination and reported on December 22, 1992, that the claimant had neck and lower back pain with no evidence of radiculopathy. Dr. SV stated that in the absence of strong, neurological deficit and/or radicular syndrome, he saw no indication for further testing or surgery. Dr. SV advised continued conservative treatment.

On April 7, 1993, Dr. P responded to the Commission's request of August 31, 1992. Dr. P stated that he had not released the claimant to return to work and that the claimant had not reached MMI because the carrier had refused to authorize manipulation under anesthesia.

On April 13, 1993, the carrier advised the Commission that it had been paying impairment income benefits to the claimant as of January 23, 1993, based on its assessment of a five percent impairment rating. The carrier noted that Dr. P had never submitted a TWCC-69.

In a "Dispute Resolution Form" dated June 1, 1993, a disability determination officer (DDO) recorded that the claimant had requested a benefit review conference (BRC) because she had not been receiving benefits and further noted that the "resolution" of the issue was that the Commission needed to order an "RME" (required medical examination) because the claimant had reached statutory MMI on January 27, 1993.

On June 4, 1993, Dr. P advised the Commission that the claimant had reached statutory MMI (he didn't give a date), and further advised that he was unable to assign an impairment rating due to the carrier's refusal to authorize "certain procedures, diagnostic and therapeutic." Dr. P opined that the procedures would greatly minimize permanent impairment.

On July 21, 1993, a BRC was held to consider the issue of "[w]hat is the correct impairment rating?" The claimant was assisted by Commission ombudsman (DM), and the carrier was represented by an adjustor. The claimant's position was that she should be examined "by another doctor to determine an impairment rating" because her doctor had refused to assign an impairment rating. The carrier's position was that its reasonable assessment of a five percent impairment rating had not been contested within 90 days and therefore, the impairment rating was five percent. In a disputed issue form dated July 23, 1993, the benefit review officer (BRO) recommended that the carrier's assessment was not a "certified impairment rating rendered by a medical doctor," and that the impairment rating should be determined by a medical doctor.

In evidence was a Request for Medical Examination Order (TWCC-22), which showed that on July 30, 1993, at the Commission's request, the DDO ordered the claimant to be examined by (Dr. AR) "[t]o determine the whole body impairment rating." The order noted that the claimant had reached statutory MMI on January 25, 1993. The TWCC-22 directs that "[t]his request must comply with Art. 8308-4.16, Rule 126.5." Effective September 1, 1993, Article 8308-4.16 was codified as Section 408.004. The order does not refer to Dr. AR as a designated doctor.

In a TWCC-69 dated August 24, 1993, Dr. AR did not state that the claimant was at MMI nor did he give a date of MMI (he stated that he was not requested to give the date of MMI). Dr. AR assigned the claimant a seven percent impairment rating in the TWCC-69. In a narrative report attached to the TWCC-69, Dr. AR stated that he believed the claimant reached MMI on December 31, 1991, since she had shown no appreciable, lasting improvement prior to or after that date. In a "Notice of Dispute" dated August 31, 1993, which was signed by the claimant, the claimant stated that she was notifying "all parties" that she was disputing the 7 percent impairment rating given to her by Dr. AR.

Apparently, after the BRC of July 21, 1993, a contested case hearing was set for September 14, 1993, and the parties showed up for the hearing on that date. However, the hearing was reset for a date in October 1993 and then the October hearing was reset for December 13, 1993. In evidence was a TWCC-24, Benefit Review Conference Agreement form. Except for the title of the form, the abbreviation "CCH" is written over the abbreviation "BRC" wherever the latter abbreviation appears on the form. For example, "Date of BRC" is changed to "Date of CCH 9-14-93." This document indicated that the claimant was assisted by DM, the ombudsman who assisted her at the July BRC, and that the carrier was represented by the same attorney who later represented the carrier at the December 1993 contested case hearing. The document further stated that the disputed issue was "[w]hat is the status of [Dr. AR]," and that "[t]he parties agree that [Dr. AR] is the designated doctor." The document is signed by the claimant, the carrier's attorney, and the hearing officer. All parties dated the document September 14, 1993.

In a report dated September 21, 1993, Dr. N, who had assigned the claimant a 42% impairment rating, stated that he disagreed with Dr. AR's assignment of a seven percent impairment rating. Also, the carrier had (Dr. O) review the medical reports and in a report to the carrier's attorney dated September 30, 1993, Dr. O expressed disagreement with the 42% impairment rating but stated that it would be appropriate to assign the claimant at least a seven percent rating, as reported by Dr. AR, because of L5-S1 disc problems.

The hearing officer noted in her decision that a second BRC was held on December 10, 1993. Although no BRC report for the December BRC was in evidence at the December 13, 1993, contested case hearing, the hearing officer noted that the second issue at the hearing which was "[i]s the agreement signed by the parties on September 14, 1993, valid?" was brought forward as the unresolved issue from the December BRC (she indicated that the first issue concerning the claimant's correct impairment rating was brought forward as the unresolved issue from the July BRC).

At the hearing held on December 13, 1993, both parties represented to the hearing officer that the claimant had reached statutory MMI. Pursuant to Section 401.011(30), MMI is defined as the earlier of: (a) the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated; or (b) the expiration of 104 weeks from the date on which income benefits begin to accrue. The latter part of the definition of MMI is referred to as statutory MMI. *See* TWCC Advisory 93-01, dated January 11, 1993 (Statutory MMI at 104 Weeks).

The carrier's position at the hearing was that the September 14, 1993, agreement is binding and that pursuant to that agreement Dr. AR is a designated doctor. The carrier further contended that Dr. AR's impairment rating of seven percent was not against the great weight of the other medical evidence.

The ombudsman who assisted the claimant did not testify. However, he made several representations to the hearing officer. He represented that on September 14, 1993, he asked the claimant to sign the agreement that Dr. AR is the designated doctor. He also represented that he gave the claimant "wrong information" in regard to signing the agreement because he, the ombudsman, did not have "all the points on the issue." The ombudsman explained that the "wrong information" he gave to the claimant was that since Dr. AR was an RME doctor whose rating the claimant disputed, the next step would have been to have a designated doctor appointed to resolve the dispute, instead of simply agreeing that Dr. AR is the designated doctor. The ombudsman stated that he should have "instructed" the claimant to leave Dr. AR as an RME doctor and have the claimant request appointment of a designated doctor. The ombudsman further stated that "[n]ow why the designated doctor had not been assigned since June or July since this has been kicking on I don't know, but when it came about that we made [Dr. AR], which was an RME doctor, we made him a designated doctor, it would simplify things for everybody, that would have been the next logical step and that's the erroneous information that I gave her."

The claimant's testimony was translated from Spanish to English. Dr. AR noted in his medical report that the claimant speaks very little English. The claimant testified that she did sign the agreement in question, that before she signed the agreement the ombudsman explained what the agreement was (neither the claimant nor the ombudsman said exactly what was explained), and that neither the carrier's attorney nor the carrier did anything to force her to sign the agreement. However, she also testified that before she signed the agreement she told the ombudsman that she "was not in agreement to sign that paper," and that the ombudsman told her that "that wasn't anything that would get me in trouble that's why I trusted what he told me." The claimant said that she did not want to sign the agreement because she had disputed Dr. AR's rating and she "knew that they were going to give me another doctor." The claimant further testified that she was confused when the ombudsman asked her to sign the agreement because the ombudsman "didn't explain it well to me--he gave me the wrong, the incorrect information."

The claimant also indicated that the hearing officer gave her the agreement to sign. The ombudsman represented that while he asked the claimant to sign the agreement, he

was not the one who suggested the agreement be made. The hearing officer represented that she wrote the agreement on September 14, 1993, only after the ombudsman and the carrier's attorney advised her that they had reached the agreement that Dr. AR is the designated doctor. The carrier's attorney represented that the parties did so agree and that they represented the same to the hearing officer on September 14, 1993. The carrier's attorney further represented that when the claimant entered into the agreement, the claimant indicated that she would attempt to present evidence at the next setting of the contested case hearing that the great weight of the medical evidence was contrary to the seven percent impairment rating assigned by Dr. AR.

The hearing officer made the following pertinent findings of fact and conclusions of law:

FINDINGS OF FACT

5.The claimant reached statutory MMI in January 1993, but her treating doctor, [Dr. P], continues to refuse to assess an impairment rating.

8.On July 30, 1993, [Dr. AR] was appointed to assess an impairment rating for claimant.

9.[Dr. AR] assessed an impairment rating of 7%.

10.On August 30, 1993, claimant disputed the impairment rating assessed by [Dr. AR].

11.On September 14, 1993, claimant and carrier entered into an agreement that [Dr. AR] was the designated doctor.

12.Although claimant did not agree with making [Dr. AR] the designated doctor, she signed the agreement of her own free will and it was not signed mistakenly, fraudulently or under duress.

13.There is no good cause to set aside the agreement signed by the parties on September 14, 1993.

14.The report of [Dr. AR], the designated doctor, is not contrary to the great weight of the other medical evidence.

CONCLUSIONS OF LAW

2.The agreement signed by the parties on September 14, 1993, is valid.

3.Claimant's impairment rating is 7%.

Based on her findings and conclusions, the hearing officer decided that the agreement signed by the parties on September 14, 1993, is valid; that the claimant's impairment rating is seven percent; and that the claimant is entitled to 21 weeks of IIBS. The claimant states in her appeal that she is dissatisfied with the decision of the hearing officer and requests that we review the decision.

TWCC Advisory 93-01 states that, if the treating doctor has not provided an impairment rating at the end of the 104th week, the Commission shall require the employee to submit to a medical examination by a doctor selected by the Commission as provided in Article 8308-4.16(a) (now Section 408.004(a)) or, if requested, shall require the employee to submit to an examination by a doctor selected by the insurance carrier, for an assessment of impairment.

In this case, Dr. P, the claimant's treating doctor, had not provided an impairment rating at the end of the 104th week from the date income benefits began to accrue so, following TWCC Advisory 93-01, the Commission required the claimant to submit to a medical examination by Dr. AR under the provisions of Article 8308-4.16(a) for assessment of impairment. Neither party asserted that MMI was reached on November 20, 1992, as certified by Dr. N. The parties simply argued their respective positions on the issues before the hearing officer from the standpoint of the claimant having reached statutory MMI. The TWCC-22 on which the Commission's order appears specifically references Article 8308-4.16. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 126.6 (Rule 126.6) relates to an order for a required medical examination. Subsection (f) of that Rule specifically provides that "[a] doctor who conducts an examination solely under the authority of an order issued according to this rule shall not be considered a designated doctor under the Act, Section 4.25(b) or Section 4.26(g). Articles 8308-4.25(b) and 8308-4.26(g) are now codified as Sections 408.122(b) and 408.125, respectively. We have previously held that a doctor who is requested to examine an employee under the provisions of Article 8308-4.16 is not a designated doctor and the doctor's opinions on MMI and impairment rating are not entitled to the presumptive weight accorded to the report of a designated doctor. *See* Texas Workers' Compensation Commission Appeal No. 92233, decided July 16, 1992; Texas Workers' Compensation Commission Appeal No. 92500, decided October 30, 1992. Thus, at the time the Commission ordered the claimant to be examined by Dr. AR under the provisions of Article 8308-4.16 for the purpose of determining impairment, Dr. AR was not a designated doctor. Furthermore, it is clear from the record that the parties had not reached an agreement to have Dr. AR be an agreed designated doctor prior to the time he examined the claimant on August 16, 1993, and issued his opinion on impairment on August 24, 1993. The claimant disputed Dr. AR's impairment rating on August 31, 1993.

Section 408.125(a) provides that, if an impairment rating is disputed, the Commission shall direct the employee to be examined by a designated doctor chosen by the mutual agreement of the parties, and Subsection (b) provides that, if the parties are unable to agree on a designated doctor, the Commission shall direct the employee to be examined by a designated doctor chosen by the Commission. Section 408.125(d) provides that, if the designated doctor is chosen by the parties, the Commission shall adopt the impairment

rating made by the designated doctor. In Texas Workers' Compensation Commission Appeal No. 92511, decided November 12, 1992, we reversed a hearing officer's decision that a doctor was an agreed designated doctor. In doing so, we stated as follows:

> At the outset we would note that the use of a designated doctor is clearly intended under the Act to assign an impartial doctor to resolve disputes over MMI and impairment rating. To achieve this end, his/her report is given at least presumptive weight, and possibly conclusive weight on the issue of impairment rating, this distinction depending upon whether he/she is appointed by the Commission or selected through agreement of the parties. Art. 8308-4.26(g) [now Section 408.125]. The status of a doctor as "designated" as opposed to a medical examination order doctor appointed under Art. 8308-4.16 [now Section 408.004], or a carrier-recommended treating doctor, should be established prior to the date the examination is conducted. The applicable statutes contain no language upon which we can detect a legislative intent that appointment of a designated doctor is retrospective, after an opinion has been rendered or after the sentiments of the prospective doctor have been ascertained by either party in advance. [Underlining added.]

Section 410.030 relates to the binding effect of an agreement, and Subsection (b) provides, in part, that, if the claimant is not represented by an attorney, the agreement is binding on the claimant through the conclusion of all matters relating to the claim while the claim is pending before the Commission, unless the Commission for good cause relieves the claimant of the effect of the agreement. Although Section 410.030 refers to an agreement signed in accordance with Section 410.029, which section relates to BRC agreements, we treat the agreement in this case, which was actually signed after the July BRC and on the date the hearing was originally to be held on September 14, 1993, as the equivalent of a BRC agreement.

We have previously held that parties can reach agreement on MMI and impairment rating. Texas Workers' Compensation Commission Appeal No. 93706, decided September 27, 1993. Of course, any such agreement would have to comply with applicable provisions of the 1989 Act and applicable provisions of the Commission's rules. However, in this case, the parties' agreement concerned Dr. AR's retroactive status as a designated doctor and did not specifically set forth an impairment rating that was being agreed to, and, in fact, the claimant continued to dispute the seven percent rating assigned by Dr. AR.

In Texas Workers' Compensation Commission Appeal No. 92426, decided October 1, 1992, we applied an abuse of discretion standard in our review of a hearing officer's determination that there was good cause to set aside a BRC agreement. We stated that the determination of good cause is a decision best left to the discretion of the hearing officer, and that the hearing officer's determination will only be set aside if that discretion has been abused. In Morrow v. H.E.B., 714 S.W.2d 297 (Tex.1986), the Supreme Court of Texas

stated that "to determine if there is an abuse of discretion, we must look to see if the court acted without reference to any guiding rules and principles."

While we recognize that the hearing officer is the judge of the weight and credibility to be given to the evidence under Section 410.165(a), we nonetheless conclude that the hearing officer's finding that there is no good cause to set aside the September 14, 1993, agreement of the parties, and her conclusion that the agreement is valid constituted an abuse of discretion in light of our decision in Appeal No. 92511, *supra*.

In Appeal No. 92511, *supra*, we stated that the status of a doctor as a designated doctor should be established prior to the date the doctor examines the claimant and that the applicable statutes contain no language upon which we can detect a legislative intent that appointment of a designated doctor is retrospective. We observe that the procedures for appointment of a designated doctor set forth in Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6 (Rule 130.6) clearly contemplate that the appointment of a designated doctor, either through mutual agreement of the parties or by the Commission, will be done before the doctor examines the employee. Rule 130.6(a) provides that, if the Commission receives a notice from the employee or the insurance carrier that disputes either MMI or an assigned impairment rating, the Commission shall notify the employee and the carrier that a designated doctor will be directed to examine the employee. Furthermore, Rule 130.6(c) requires the carrier to provide the employee with the time and date of the examination by the designated doctor in its confirmation letter, and Rule 130.6(d) provides that where the Commission chooses the designated doctor, the examination shall be made within a reasonable time after the order is made. Thus, there can be no question but that the examination by the designated doctor is to take place after his appointment, whether the appointment is by mutual agreement or by the Commission. In this case, Dr. AR was selected by the Commission to examine the claimant under the provisions of Article 8308-4.16. His opinion on impairment rating rendered in his status as a required medical examination order doctor under Article 8308-4.16 did not carry presumptive or conclusive weight. It was not until three weeks after he examined the claimant and rendered his medical report that the parties stated in an agreement that he was a designated doctor. Under the facts of this case, such a retrospective appointment, which is not contemplated by the 1989 Act or Commission rules, is good cause for setting aside the agreement of September 14, 1993, because the status of a doctor as "designated" is to be established prior to the date the examination is conducted. Appeal No. 92511, *supra*. We observe that our decision in this case concerns the retrospective appointment of a designated doctor who was not a designated doctor, and should not be read to curtail the right of parties to agree on MMI and impairment rating, so long as such agreements comply with applicable provisions of the 1989 Act and rules of the Commission.

For the reasons set forth above, we hold that the agreement of September 14, 1993, is not valid and it is set aside. Since the hearing officer's conclusion that the claimant's impairment rating is seven percent as reported by Dr. AR is based on the retrospective agreement to have Dr. AR be the designated doctor, which agreement we have set aside, the hearing officer's decision that the claimant has a seven percent impairment rating is

likewise reversed. We render a decision that Dr. AR is not the designated doctor and that the claimant is entitled to be examined by a designated doctor whose status as a designated doctor is established before the examination by the doctor.

Robert W. Potts
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Lynda H. Nesenholtz
Appeals Judge