APPEAL NO. 94210

On December 10, 1993, a contested case hearing was held in (city), Texas, with the record being closed on January 24, 1994. (hearing officer) presided 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 issue at the hearing was the impairment rating of the respondent (claimant). The hearing officer decided that the impairment rating assigned by the designated doctor chosen by the Texas Workers' Compensation Commission (Commission) is "against" the great weight of the other medical evidence in that the rating was incomplete as to the lumbar spine and failed to take into account the carpal tunnel syndrome (CTS), which the claimant developed during therapy. The hearing officer "returned" the case to the (city), field office for "follow-up with the Commission designated doctor or appointment of a new designated doctor as appropriate." The hearing officer further decided that the claimant has reached maximum medical improvement (MMI) and no additional impairment income benefits are due to the claimant pending "resolution of this dispute." The appellant (carrier) disagrees with the hearing officer's decision and requests that we reverse it and render a decision "adopting" the opinion of the designated doctor. The claimant responds that she agrees with the hearing officer's decision.

DECISION

The hearing officer's decision is reversed and the case is remanded to the hearing officer.

The parties stipulated that the claimant suffered an injury in the course and scope of her employment with her employer, (employer), on (date of injury). The parties did not stipulate as to what injury was sustained on that date.

The claimant testified that on (date of injury), she was working as a licensed vocational nurse for the employer when she prevented an elderly woman patient from falling out of bed. She said she pushed the patient up on the bed and then pulled the patient the rest of the way up on the bed. When she did this, the claimant said she twisted, felt a "popping sensation" in her back, and felt immediate pain in her low back, neck, and in one of her shoulders. By the end of her shift that day, she said she also had a "little burning" in her upper back and neck. The claimant said she continued to work for the employer until March 15, 1991, when she stopped working because of pain. She has not worked since then.

On March 20, 1991, the claimant was examined by her family doctor, (Dr. M), who diagnosed a lumbar strain and an upper respiratory infection. He noted that the claimant told him that she had had pain since she felt the "pop" in her back, but that she had had no numbness or paresthesia. Dr. M recommended no lifting for a week.

Apparently, the claimant was next examined by (Dr. K) whose reports were not in evidence. Dr. K referred the claimant to (Dr. FX) who examined the claimant on May 24, 1991, for complaints of neck and upper back pain with weakness and radiation into the right

arm, as well as, low back pain with radiation down both legs. The claimant told Dr. FX that her pain is always present and is aggravated by all forms of activity. Dr. FX noted that an MRI scan of the cervical spine done on May 13, 1991, was reported as normal and that an MRI scan of the lumbar spine showed early degeneration of the L4-5 and L5-S1 discs with a small central posterior bulge at L5-S1, but did not show pressure on the nerve roots or the dura. Dr. FX diagnosed cervical "radiculo-syndrome" with right radiculopathy, thoracic syndrome, lumbar "radiculo-syndrome" with bilateral sciatica, and facet arthropathy. Dr. FX recommended that the claimant continue with physical therapy and have a bone scan and an EMG of the right arm and right leg performed.

Nerve conduction studies of the right upper extremity were done on June 10, 1991, and the "values" were reported as normal. An EMG done the same day revealed no electrodiagnostic evidence of cervical or lumbosacral (L4-S1) radiculopathy on the right side, thoracic outlet syndrome on the right side, nor of peripheral neuropathy in the right upper extremity.

Dr. FX saw the claimant again on November 25, 1991, and he reported that the claimant had completed four weeks of an "active rehab program" and that the claimant complained of a lot of stiffness, pain, and discomfort in her lower back, and also complained of a painful left knee which he said the claimant stated had developed as a result of increased physical activity "over at the Center." Dr. FX recommended that the claimant continue with the rehabilitation program, but suggested "backing off on weights for about a week." Dr. FX stated that the rehabilitation program would be completed in three to four more weeks.

The claimant testified that the carrier sent her to (Dr. Z) who, in a report dated March 10, 1992, stated that he reviewed the MRI scan of the lumbar spine done on May 13, 1991, and it demonstrated degenerative changes at the L4-5 and L5-S1 levels with "no frank HNP, no extra dural nerve root pressure." He also reported that a CT scan demonstrated that there was "internal disruption of the disc especially at L4-5 and mild at L5-S1, otherwise within normal limits." Dr. Z diagnosed degenerative osteoarthritis of the lumbar spine, degenerative disc disease at the L4-5 and L5-S1 levels without "frank HNP," and degenerative osteoarthritis of the right knee. Dr. Z opined that the likelihood of significant relief with surgical intervention was low. He stated that if the claimant did not have surgery, she had reached MMI "at this stage." However, if she did have surgery, then it would be necessary to "await the outcome of that."

The claimant testified that (Dr. T) is her current treating doctor. In a Report of Medical Evaluation (TWCC-69), Dr. T certified that the claimant reached MMI on April 24, 1992, with a 10% whole body impairment rating. The impairment rating was composed of seven percent for "intervertebral disc disease, unoperated," one percent for "one additional level," and two percent for "decrease in lumbar flexion." In a report dated April 24, 1992, which is attached to the TWCC-69, Dr. T stated that the claimant might benefit from surgery, but that the claimant was unable to decide whether she was willing to undergo surgery. Dr. T also noted that the claimant had been out of work for more than a year and that it seemed

to him that the claimant was "looking for the opportunity to be disabled." He further stated that the claimant had objective evidence of disc disease at the L4-5 and L5-S1 levels. There is no mention of CTS in the TWCC-69 or attached report.

In a report dated July 10, 1992, (Dr. C) reported that he had examined the claimant (it is unclear at whose request the examination took place but a report from another doctor indicated that the claimant saw Dr. C for a second opinion on surgery) and that the claimant complained of pain in the upper and lower back, right shoulder, and neck, as well as knee pain. Dr. C noted that an MRI of the lumbar spine done on June 18, 1992, showed disc degeneration at the L4-5 and L5-S1 levels, but that there was no evidence of true disc herniation or nerve root compression. Dr. C diagnosed mechanical low back pain associated with degenerative disc disease at the L4-5 and L5-S1 levels, facet joint arthritis, post-traumatic myofibrositis, myofibrositis of the right shoulder and paracervical muscles without evidence of deep spinal pathology, and knee pain. Dr. C stated that the knee pain was unrelated to the "recent back injury." Dr. C stated that he saw no specific treatment that would benefit the claimant's neck and shoulder since her problems in those areas were related to a muscular scar tissue irritation. In regard to the back, Dr. C stated that he agreed that a "10-15% permanent impairment to the whole person based upon the objective findings is warranted." Dr. C said that he thought that the best the claimant could expect from back surgery was a 60% chance of improvement.

At the request of the carrier, the claimant was again examined by Dr. Z on October 9, 1992. In a TWCC-69, Dr. Z reported that the claimant reached MMI on October 9, 1992, with a 15% impairment. In arriving at the 15% impairment rating, Dr. Z stated "the category of multiple operation levels surgically treated disc lesion with residual symptoms and this assumes the worse case scenario amounting to approx. 12% permanent partial impairment. We will round off the percentage up to 15% and that would include the difficulty with her knees." The claimant testified that she has not had back surgery. Dr. Z noted in an attached narrative report that the claimant complained of pain in the neck, back, right shoulder, right arm, hips, knees, and buttocks. He also noted that the claimant said her right arm was "numbish and tingling" and that her right leg was weak and her right foot goes to sleep occasionally. Dr. Z said that the claimant was a poor candidate to have a successful outcome with surgery.

Also in evidence was a December 21, 1992, report of the results of a nerve conduction study and EMG. (Dr. W), who performed the tests, stated that the claimant demonstrated a mild to moderate right sensory motor CTS. Dr. W also stated that "[m]any of her hand symptoms and night waking can be explained by the [CTS] on the right. Clinical correlation will be necessary."

In a letter to the carrier dated January 4, 1993, Dr. T, the claimant's current treating doctor, stated that the EMG study demonstrated a mild-to-moderate CTS on the right and that "[i]t is possible that this is in some way related to her work-related injury. She has been complaining of right scapular and right arm pain and heaviness since the onset of her symptom complex."

An MRI scan of the claimant's dorsal (thoracic) spine done on June 18, 1992, was negative, and an MRI scan of the claimant's cervical spine done on January 4, 1993, did not identify any abnormality.

Dr. T examined the claimant on January 15, 1993, and in a report of that date reported that the claimant complained of pain in the neck, back, knees, and ankles, as well as, numbness in both hands, the right more than the left. Dr. T stated that the claimant suffered from cervical myofascial syndrome, from a mild right CTS, and from degenerative disc disease at L4-5 and L5-S1. Dr. T stated that "her impairment rating is 15%," which was five percent more impairment than he reported on April 24, 1992.

On May 24, 1993, the Commission selected (Dr. F) as the designated doctor to determine whether or not the claimant had reached MMI and her impairment rating. In a TWCC-69 dated May 27, 1993, Dr. F certified that the claimant reached MMI on October 28, 1992, with a 13% whole body impairment rating. In a narrative report attached to the TWCC-69, Dr. F reported that imaging studies demonstrated a bulging disc at L5-S1; that an MRI scan of the thoracic spine was normal; and that an electrodiagnostic evaluation in December 1992 demonstrated mild right CTS. He further noted that previous impairment ratings had been assigned between 10% and 15%. In the review of the claimant's past medical history, Dr. F noted among other things that the claimant's past medical history included CTS. Dr. F's assignment of a 13% impairment rating was for abnormal range of motion of the lumbar spine.

In a narrative report dated August 5, 1993, (Dr. P) stated that he had been asked to evaluate the claimant regarding her "overall level of disability," but did not indicate who requested the evaluation. Dr. P stated that the claimant had symptoms consistent with CTS; that EMG studies demonstrated CTS, and that the claimant told him that the symptoms in her right upper extremity were not present prior to her injury. Dr. P then stated that "since they were there with her initial complaints, i.e. shoulder, base of neck, and right arm, I would have to surmise that the carpal tunnel must be considered part of her worker's compensation injury." Dr. P further reported that "x-rays of the low back show a number of changes consistent with aging." Dr. P diagnosed: (1) multilevel lumbar degenerative disc disease, symptomatic following the claimant's injury; (2) possibly two potentially symptomatic lower thoracic discs; (3) diffuse shoulder girdle myositis; (4) symptomatic right sided CTS "which probably should be considered attritional and related to her occupation;" and (5) suboccipital cervicothoracic myositis. Dr. P opined that the claimant has a 30% impairment rating due to impairment of the lumbar, thoracic, and cervical regions, and due to impairment related to the claimant's CTS. In regard to the CTS, Dr. P stated "[t]he [CTS], since it appears to have been accepted as part of her problem by the worker's compensation carrier, is worth an additional 10% total body impairment. The sum total of this overall impairment rating is 30%."

A benefit review conference (BRC) was held on September 27, 1993, to consider the issue of "what is the correct impairment rating?" The BRC report noted that the claimant's position was that the designated doctor's (Dr. F's) impairment rating was not correct because

Dr. F did not "take a thorough exam and in her (claimant's) opinion did not follow the AMA Guidelines." The carrier's position was reported to be that the designated doctor's opinion carried presumptive weight. On September 29, 1993, the benefit review officer (BRO) recommended that the other medical evidence did not overcome the report of the designated doctor and that the correct impairment rating was 13% as assigned by the designated doctor.

On September 29, 1993, the BRO wrote to Dr. F advising him that at the BRC a question was raised "regarding the body parts that you considered when doing your impairment rating." The BRO asked Dr. F to indicate what parts of the body were taken into consideration when he did his impairment evaluation. The BRO also attached a copy of Dr. P's report to the letter and asked Dr. F to respond to the report.

In his response of October 18, 1993, Dr. F stated that:

> My calculation of her impairment rating was based upon low back range of motion measurements, as this was the area entirely involved in therapies as well as invasive procedures [medical reports indicated that the claimant had had epidural steroid injections and a discogram done in 1991]. The only area of pathology demonstrated by imaging studies was in the lumbar region of L5-S1. As noted in my report, MRI scan of the thoracic spine was normal and a cervical MRI scan was normal.
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> Also was noted, previous impairment ratings were 10-15%, therefore, I feel that my evaluation of 13% is a reasonable number in this case.

At the close of the hearing on December 10, 1993, the hearing officer advised the parties that he was going to hold the record open to seek clarification from Dr. F. In a letter to Dr. F dated December 10, 1993, the hearing officer advised Dr. F that the claimant had alleged that she developed CTS as a "result of her physical therapy," and the hearing officer asked Dr. F if there was a reasonable medical probability that the claimant could have developed CTS "this way." The hearing officer also advised Dr. F that if the claimant developed CTS in therapy, she would have a right to a rating on CTS, as well as, on her back. The hearing officer then asked Dr. F what rating he would assign to the CTS and whether this would change the claimant's whole body impairment rating. The hearing officer noted in his decision that no response was received from Dr. F and the hearing record was closed on January 24, 1994.

At the hearing, the claimant testified that she underwent a "work hardening program" from the last week of October 1991 to December 6, 1991. She testified that she believed that it was the work hardening program that caused her to develop CTS as well as knee and ankle pain. She also testified that she believed that she started to have her CTS "problem" during the work hardening program. The claimant further testified that while Dr. F's report mentioned her low back, it did not mention her "other problems" such as CTS, thoracic syndrome, and neck, knee, and ankle pain. The claimant did not indicate which doctor

initially recommended the work hardening program, but she did testify that "it [work hardening program] was kind of like a demand by the insurance company that I would have to undergo that program."

As previously noted, the issue at the hearing was the claimant's impairment rating. The hearing officer made the following pertinent findings of fact and conclusions of law:

**FINDINGS OF FACT**

4.A dispute was raised regarding claimant's impairment rating and [Dr. F] was appointed as the Commission designated doctor to review the case.

5.[Dr. F] did not take claimant's [CTS] into account in rendering his evaluation.

6.Claimant's [CTS] is a result of the therapy she has received for her low back injury.

7.[Dr. F] assigned no value for a specific diagnosis despite objective testing indicating degenerative discs at the L4-5 and L5-S1 level (sic) of claimant's spine and his own assignment of a 13% impairment rating for loss of range of motion.

8.[Dr. F's] impairment rating is against the great weight of the other medical evidence.

**CONCLUSIONS OF LAW**

2.The report of the designated doctor is against the great weight of the other medical evidence but no other impairment rating may be adopted in this case since a Commission designated doctor has not evaluated the carpal tunnel condition.

3.The case is not ripe for determination of impairment rating at this time and the file must be returned to the field office for additional evaluation by the designated doctor or appointment of a new designated doctor.

The carrier contends in its appeal that:

1.The hearing officer erred in disregarding the findings of the designated doctor as to impairment rating.

2.The hearing officer erred in disregarding the findings of the designated doctor because the great weight of the other medical evidence was not contrary to the designated doctor's report.

3.The hearing officer erred in deciding that the claimant had CTS and that the condition stemmed from the claimed injury because this issue was not before him as a disputed issue nor had it been properly raised by the parties. In addition, the evidence does not support the finding.

We first consider the carrier's contention that the hearing officer erred in finding that Dr. F's impairment rating is contrary to the great weight of the other medical evidence. The 1989 Act provides that where a designated doctor is chosen by the Commission to determine an employee's impairment rating, the report of that doctor shall have presumptive weight and the Commission shall base the determination of impairment rating on that report unless the great weight of the medical evidence is to the contrary. Section 408.125(e). We have commented many times on the "special presumptive status" the designated doctor's report is accorded under the 1989 Act, and on the fact that no other doctor's report, including that of a treating doctor, is entitled to such deference. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992; Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992. To overcome the presumptive weight accorded to the report of the designated doctor requires more than a preponderance of the medical evidence; it requires the "great weight" of the other medical evidence to be contrary to the report. Appeal No. 92412, supra. As pointed out by the carrier in its appeal, we have previously stated that a hearing officer who rejects a designated doctor's report because the great weight of the other medical evidence is contrary to the report should clearly detail the evidence relevant to his or her decision, clearly state why the great weight of the other medical evidence is to the contrary, and further state how the contrary evidence outweighs the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 93123, decided April 5, 1993.

In the instant case, the hearing officer based his great weight determination, at least in part, on his finding that Dr. F "assigned no value for a specific diagnosis." In his discussion of the case, the hearing officer stated that it appeared to him that at least a five percent impairment should have been given from Table 49 (Impairments due to Specific Disorders of the Spine) of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). We have previously stated that "[t]he necessity of evaluating the great weight of medical evidence and making findings on that issue is not met by finding, unassisted by any medical evidence or interpretation, that the designated doctor has not properly used the Impairment Guides but that the treating doctor has." (Emphasis in original). Texas Workers' Compensation Commission Appeal No. 92570, decided December 14, 1992. In the instant case, the hearing officer did not note upon what medical evidence he relied in determining that the great weight of the medical evidence was contrary to the report of the designated doctor in regard to the designated doctor's failure to assign an impairment rating for a specific disorder of the spine other than to indicate that the claimant has objective testing indicating degenerative discs. Having reviewed the record and decision of the hearing officer, we conclude that the case should be remanded to the hearing officer for further consideration and development of the evidence and for further

findings in regard to his determination that the great weight of the medical evidence is contrary to the impairment rating assigned by the designated doctor.

We next address the carrier's contention that the hearing officer decided an issue that was not before him. The issue to be determined by the hearing officer was the claimant's correct impairment rating. "Impairment rating" means the percentage of permanent impairment of the whole body resulting from a compensable injury. Section 401.011(24). We have previously determined that a hearing officer erred in determining a claimant's impairment rating based on the report of a designated doctor where the doctor did not give consideration to a part of the compensable injury in assigning an impairment rating. *See* Texas Workers' Compensation Commission Appeal No. 93435, decided July 16, 1993. It is readily apparent to us, as it was to the BRO and the hearing officer, that the claimant's disagreement with Dr. F's report was that he had not evaluated her whole compensable injury, but instead based the rating on only part of her compensable injury. Thus, in order to address the claimant's challenge to the report of the designated doctor, the hearing officer first had to determine whether the designated doctor rated her entire injury. In order to do that, he had to make a determination as to whether the claimant's CTS, which she claimed was part of her compensable injury, was in fact part of her compensable injury. In our opinion, under the particular facts of this case, the issue of whether the claimant's CTS was part of her compensable injury became a part of the disputed issue of the claimant's impairment rating by virtue of the claimant's position that Dr. F had not rated her entire compensable injury. Consequently, under the limited facts of this case, we find no merit in the carrier's contention that the hearing officer decided an issue that was not before him. Texas Workers' Compensation Commission Appeal No. 92268, decided August 6, 1992, cited by the carrier in support of its position, is distinguishable from the instant case. In Appeal No. 92268, the hearing officer on her own motion and over the objection of the carrier in that case, added an issue of whether the carrier had timely contested the claimant's claim based on failure to give timely notice of injury. In the instant case, the hearing officer did not add an issue to be resolved at the hearing, but instead decided the issue before him based on the respective positions of the parties.

Finally, we address the carrier's contention that the evidence does not support the hearing officer's finding that the claimant's CTS resulted from therapy the claimant received for her low back injury. In Texas Workers' Compensation Commission Appeal No. 93861, decided November 15, 1993, we affirmed a hearing officer's decision that an injury to the claimant's left knee, which resulted from a work hardening program which was prescribed to cure and relieve the effects of the claimant's compensable neck injury, was a natural result of the neck injury. In that case, the claimant had neck surgery and his treating doctor prescribed a work hardening program to relieve the effects of the claimant's neck injury and to assist the claimant in returning to the work force. The claimant testified that he injured his left knee while involved in aggressive physical therapy as part of the work hardening program. There was evidence that the injury to the left knee occurred while the claimant was performing knee exercises under the supervision of a physical therapist. We cited the following language from Maryland Casualty Co. v. Sosa, 425 S.W.2d 871 (Tex. Civ. App.-San Antonio 1968, aff'd per curiam, 432 S.W.2d 515 (Tex. 1968)):

The law is well settled that where an employee sustains a specific compensable injury, he is not limited to compensation allowed for that specific injury if such injury, or proper or necessary treatment therefor, causes other injuries which render the employee incapable of work.

What concerns us about the present case is the lack of evidence offered to show that CTS resulted from the claimant's work hardening program and the lack of evidence as to which doctor, if any, prescribed the program and the reason for such recommendation. As was pointed out by Chief Appeals Judge Sanders in his concurring opinion in Appeal No. 93861, *supra*, the decision in that case should not be construed as standing for the proposition that any post injury physical activity by a claimant even under the general auspices of a health care provider, no matter how attenuated from the original injury, will qualify as being "proper or necessary treatment" flowing from the original injury. In the instant case, from the hearing officer's discussion of the case he appears to have based his finding that the claimant's CTS resulted from therapy on the fact that a diagnostic test done on June 10, 1991, showed no CTS, and a diagnostic test done on December 21, 1992, demonstrated CTS (contrary to the carrier's assertion on appeal, the results of the December 21, 1992, nerve conduction and EMG studies were in evidence). We fail to see how the hearing officer was able to draw a causal connection between the work hardening program and the claimant's CTS on the basis discussed in his decision. Other evidence of a causal connection was not well developed. For instance, when the hearing officer asked the claimant how her CTS was related to her injury and whether she had done anything in therapy or in treatment that could have caused CTS, the claimant merely replied "the work hardening program." There was no description of any kind of the type of activities that the claimant undertook in work hardening, the frequency and duration of any such activities, or of how such activities related to the onset of CTS. Also, while Dr. T did say that it was possible that the claimant's CTS may in some way be related to her work-related injury, he did not mention anything about the work hardening program or therapy of any kind. Since we are remanding the case to the hearing officer for reconsideration of the hearing officer's determination that the great weight of the medical evidence is contrary to the impairment rating assigned by the designated doctor, we feel that it is appropriate under the limited circumstances presented in this case, to also remand for further consideration and development of evidence in regard to the claimant's CTS.

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 and for further findings as are appropriate and not inconsistent with this decision. 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.

Robert W. Potts
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Lynda H. Nesenholtz
Appeals Judge