APPEAL NO. 94237

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held in (city), Texas, on August 23, 1993, with (hearing officer) presiding, to consider the sole disputed issue, namely, the correct impairment rating (IR) for the appellant (claimant). There were no disputed issues concerning claimant's having reached maximum medical improvement (MMI) and the parties stipulated that he sustained a compensable low back injury on (date of injury). The hearing reconvened on January 12, 1994, for the hearing officer to introduce his correspondence with the designated doctor selected by the Texas Workers' Compensation Commission (Commission) and to hear the parties' comments thereupon. Finding, among other things, that the report of the designated doctor was not contrary to the great weight of the other medical evidence (Section 408.125(e)), the hearing officer concluded that claimant reached MMI on March 30, 1993, with an IR of zero percent.

In essence, claimant's appeal challenges the hearing officer's having given presumptive weight to the designated doctor's report because it was substantially flawed. Claimant specifies the brevity of the designated doctor's examination, his failure to use an inclinometer to measure claimant's loss of range of motion (ROM), his failure to perform isometric strength testing, his reputation for giving low impairment ratings, his lowering of claimant's IR from 24% to zero percent after being contacted by the carrier, his failure to state that he used and to explain his use of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) in determining claimant's IR, and his failure to state how he dealt with the contribution to claimant's impairment of claimant's prior low back injury of (year). Claimant requests on appeal, as he did at the hearing, that the designated doctor's report be "set aside" and that the Commission have him examined by another designated doctor who "will be more thorough and evaluate all his clinical and non-clinical medical records." Claimant maintains he has "lost all confidence" in the designated doctor's ability to fairly evaluate him for his current injury.

The respondent (carrier) asserts the sufficiency of the evidence to affirm the hearing officer's determinations and cites Texas Workers' Compensation Commission Appeal No. 92255, decided July 27, 1992, as dispositive in not permitting a claimant's multitude of complaints about the thoroughness of the examination to overcome the presumptive weight given a designated doctor's report.

DECISION

Finding error in the decision and order of the hearing officer, we reverse and remand.

It was not disputed that claimant sustained a compensable low back injury at work on (date of injury), while helping to transplant a tree for (employer). According to one medical history, claimant had his arms wrapped around a tree, pulled up on it, and felt "tremendous pain in his lower back and down both of his legs." Further, claimant testified, and the documentary evidence indicated, that he had sustained a prior work-related back

injury in (month year) while working for another employer which resulted in lumbar spine fusion surgery. Claimant and his treating doctor, (Dr. B), both testified that claimant had fully recovered from the prior injury and surgery, had resumed regular work, had worked for employer for five years driving and assisting landscaping crews, and had remained asymptomatic except at times of occasional overexertion.

After his (date of injury), accident claimant commenced treatment with Dr. B on April 22, 1992, and was initially diagnosed with lumbar facet syndrome, low back pain, and lumbar sprain/strain. Dr. B's x-rays revealed a solid fusion of L4 to the sacrum, a list from L5 to L1, and subchondral sclerosis and subluxation of the facet joints at L1-L4. Dr. B noted evidence of loss of intersegmental motion at L1-L4 in right and left lateral bending and commented: "[s]uch hypomobility can indicate restrictions of the normal joint motion due to scar tissue (fibrosis) and/or muscle spasm. . . . It is highly likely that future post-traumatic arthritis will develop as a result of the abnormal joint motion and soft tissue injury. The past back surgery and L4-sacrum fusion is a complicating factor likely to extend treatment and/or reduce the likelihood of a complete resolution." Dr. B took claimant off work and commenced a course of chiropractic treatment which, according to Dr. B's testimony, had involved approximately 80 visits by the date of the hearing.

In a subsequent medical report of June 11, 1992, Dr. B added the diagnosis of neck pain and cervical sprain/strain and stated that claimant reported having recently attempted to return to light duty work, developing increased low back pain and neck pain, and being unable to continue to work. As above noted, the parties stipulated to claimant's having a compensable "low back injury" on (date of injury), and there was no disputed issue concerning the extent of claimant's injury, such as whether it included a neck injury.

A CT scan of June 26, 1992, obtained by Dr. B found bilateral fusion changes at the L4-L5 and L5-S1 disc levels, slight bulging of the L4-5 and L5-S1 discs without evidence of significant thecal sac or nerve root compression, and unremarkable L2-3 and L3-L4 discs.

The carrier had claimant examined by (Dr. A), on August 13, 1992. Dr. A obtained an MRI of the lumbosacral spine on August 24, 1992, which showed a posterior fusion of L4, L5, and S1 and degenerative disk disease at the level of L5 and S1. Dr. A signed an undated Report of Medical Evaluation (TWCC-69) stating claimant reached MMI on "10-21-92" with an IR of four percent. Dr. A's report stated no diagnosis. Further, it did not indicate whether claimant's (month year) injury aggravated his (year) injury nor did it indicate the basis for or body part covered by the four percent IR.

In a subsequent medical report of January 11, 1993, Dr. B's diagnosis continued to reflect "neck pain" but did not include the "cervical sprain/strain" diagnosis added in June 1992. In the January 11th report, Dr. B made reference to claimant's reporting that "his exacerbation of 3 weeks ago is continuing." There was no evidence concerning the nature of such exacerbation.

Dr. B signed a TWCC-69 on January 11, 1993, stating that claimant reached MMI on "01-08-93" with 11% impairment for cervical ROM, 21% impairment for lumbar ROM, and five percent impairment for "lumbar soft tissue lesion" which, according to Dr. B's testimony, amounted to a total whole body IR of 33% using the Combined Values Chart in the AMA Guides. Dr. B testified that he used the inclinometer method prescribed by the AMA Guides to measure claimant's ROM and he attached cervical and lumbar ROM charts taken from the AMA Guides showing three measurements for each motion. He also testified he did isometric static strength testing.

In a Notice of Refused/Disputed Claim (TWCC-21), dated "01-19/93," the carrier disputed Dr. B's 33% IR for the reasons that the calculations were not in accordance with the AMA Guides, the carrier had no notice of a cervical injury, and Dr. B's IR "does not differentiate between previous impairment (surgical intervention) and current injury." At the hearing, there was no express disputed issue, as such, concerning contribution and claimant's prior low back injury. Section 408.084(a) provides that at the request of an insurance carrier the Commission may order that impairment income benefits and supplemental impairment income benefits be reduced in a proportion equal to the proportion of a documented impairment that resulted from earlier compensable injuries. The Appeals Panel has stated that this statute provides that it is the income benefit and not the IR that is reduced. Texas Workers' Compensation Commission Appeal No. 92610, decided December 30, 1992. The Appeals Panel has further stated that it is the Commission, not a doctor, which determines the extent of contribution and that the statute does not provide that the doctor is to exclude the effect of a prior compensable injury in calculating the current impairment. Texas Workers' Compensation Commission Appeal No. 93272, decided May 24, 1993. There was no evidence that the carrier made a request to the Commission for contribution. Rather, it appears from the TWCC-21 forms and correspondence to the designated doctor that the carrier perceived claimant's back injuries of (year) and 1992 to be essentially unrelated injuries which were required to be kept separate for purposes of determining his IR from the later injury.

Dr. B testified that in January 1993 he referred claimant to (Dr. J), of the (city) for a second opinion. Dr. J signed a TWCC-69 stating that claimant reached MMI on "2-8-93" with an IR of 18% for his lumbar spine and allocating 10% for "L5-S1 fusion" and eight percent for "L4-5." Dr. J's accompanying narrative report of February 8, 1993, stated that claimant's cervical and thoracic spines were within normal limits but that his lumbar spine had decreased ROM in all planes and that his straight leg raising (SLR) was positive bilaterally. Dr. J's impression was chronic lumbar pain syndrome, lumbar radiculopathy with new left radicular pain, and aggravation of previous right lumbar radiculopathy. Noting that Dr. B gave claimant an IR of "32 percent (sic)" while Dr. A had assigned four percent, Dr. J's report stated that his review of the AMA Guides "Third Revised Edition" indicated claimant qualified for an 18% IR for his surgically treated disc lesions.

Dr. B testified that Dr. J's IR was in error because it was rating claimant's prior back injury and consequent fusion surgery. Dr. B did not testify to nor was he asked questions regarding whether the 1992 injury aggravated the 1992 injury. As the Appeals Panel stated

in Texas Workers' Compensation Commission Appeal No. 92515, decided November 5, 1992, "there is abundant authority that an aggravation of a preexisting condition is an injury in its own right and can be compensable." That decision further stated that "[w]here there is a preexisting injury and the carrier contends that the preexisting injury is responsible for the claimant's incapacitating condition, the carrier has the burden to prove that it is the sole cause rather than any subsequent accident or incident. *See* Texas Employers' Insurance Association v. Page, 553 S.W.2d 98 (Tex. 1977)." The carrier in the case we consider did not raise a sole cause defense.

In a TWCC-21 dated "03/01/93," the carrier contested any injury to any part of the body except claimant's lumbosacral area. The carrier also disputed Dr. J's IR stating that Dr. J was not a designated doctor but a referral doctor from Dr. B who had himself already assigned an IR. The carrier further requested appointment of a designated doctor and the Commission, on March 12, 1992, selected. (Dr. R and/ or designated doctor). Dr. B testified that Dr. R was an orthopedic surgeon whose specialty he understood to be hand surgery.

Dr. R signed a TWCC-69 stating that claimant reached MMI on "3-30-93" with an IR of 24%. This form referred to "attached notes" and the exhibit had attached a single page narrative report referencing claimant's "3/30/93" visit. Dr. B testified that both Dr. J and Dr. R would have had available for review all of Dr. B's records and test results on claimant including the ROM charts. Dr. R's narrative report of March 30, 1993, accompanying the TWCC-69 indicated that he was aware of the CT scan of June 1992 showing "no significant findings other than the residuals from a previous effusion in (year)" and an August 1992 MRI confirming the effusion but not showing any thecal sac or nerve root compression. Dr. R also reported that on exam claimant demonstrated some degree of guarding and had approximately 20 degrees of forward flexion, zero degrees of extension, and 15 degrees of lateral bending, and that claimant's SLR was positive bilaterally.

Claimant testified that Dr. R entered the room and looked at the x-rays; that he had claimant lay on his stomach with his shirt off and "mashed a couple of times on my back," a process lasting just a few seconds. He said that Dr. R then had him turn over and tried to raise claimant's legs but claimant registered pain, also a process lasting but a few seconds. Claimant said that Dr. R's entire exam lasted no longer than five minutes, that he only "touched me" for about 30 seconds, and that Dr. R did not use an inclinometer to measure him nor perform isometric strength testing.

Dr. R further reported that claimant's motor examination of the lower extremities including ankle and toe extension and flexion was normal and symmetric and that claimant's patellar and Achilles' reflexes were brisk and symmetric. Dr. R's report then stated the following:

> Based on his previous surgery and the residual loss of motion, there is a 24% partial permanent impairment of the body as a whole. I think that his injury in [month, year], exacerbated his prior injury but I cannot find any objective

increase in his impairment from his original injury as his electrodiagnostic and radiographic studies do not demonstrate any involvement of his thecal sac or nerve roots.

Dr. B testified that prior to his (month year) injury claimant's condition would be considered as "normal," that he had recovered from his (year) injury and could perform his work, and that he had no "residuals" or permanent impairment from the earlier injury. Dr. B said he did not "utilize" the prior injury is assigning his 33% IR, that it would be "improper" to use the old injury in rating the new injury, that it is appropriate only to assign an IR for "the injury on hand," and that to base the rating on a prior injury "would improperly inflate the impairment rating." As noted, there was no mention at the hearing by anyone of the potential issue of the carrier's seeking contribution for the prior injury under Section 408.084. According to Dr. B, both Dr. J and Dr. R erred in their determinations of claimant's IR since their reports indicated they rated claimant's earlier injury. Both Dr. B and the ombudsman referred to and felt supported by Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 130.1(g)(2) (Rule 130.1(g)(2) concerning the Medical Evaluation Report form's containing "an instruction to the doctor that the impairment rating shall be based on the compensable injury alone."

Dr. B was further critical of Dr. R's report for failing to indicate on the TWCC-69 his allocation of the 24% rating, and for failing to indicate that he used the AMA Guides and used an inclinometer to measure ROM. Dr. B said he had attended a training session on the AMA Guides sponsored by the Commission and felt he well understood the requirements of the AMA Guides in determining a claimant's IR for spinal injury.

Dr. B also testified that he was not present when Dr. R examined claimant. However, he had been present when Dr. R examined another claimant and while Dr. R's orthopedic examination was adequate, he did not use an inclinometer to measure ROM but simply "eyeballed it." Dr. B surmised that while the "eyeball method" may be sufficient for a surgeon to determine whether a patient required surgery, it falls far short of the type of ROM examination required by the AMA Guides which, he noted, takes 30 to 45 minutes and some equipment to do correctly.

A Commission disability determination officer (DDO) note to the carrier dated "4/20/93" attached a copy of Dr. R's TWCC-69 and stated: "Clarified with his [Dr. R's] office this is 24% to (date of injury) injury. Per Rule 130.6(1) you have 10 days from the receipt of [Dr. R's] report to reinstate IIBs." This exhibit was not mentioned at the hearing.

On April 29, 1993, the carrier wrote Dr. R "to question how you arrived at the 24% [IR]." This letter, which did not reflect copies to either the Commission or the claimant, stated that claimant's "previous surgical procedures were done under a different claim and [claimant] has already received compensation for those injuries." The carrier further advised that claimant's latest injury date was (date of injury), that an IR "should be accessed for any new impairment from that date of injury," that "any pre-existing surgical lesions or diseases should not be a factor in determining [Dr. R's] rating for [claimant], and that he "is only entitled to receive compensation for a new injury or aggravation of previous conditions."

The Appeals Panel has repeatedly stressed its concern with unilateral contact by a party with the designated doctor who is the agent of the Commission, has noted that unilateral communications "can tend to compromise the perception, if not the reality, of impartiality on the part of the designated doctor . . ., and has urged parties to communicate with designated doctors through Commission personnel. *See e.g.* Texas Workers' Compensation Commission Appeal No. 93613, decided August 24, 1993. *And see* TWCC Advisory 94-02 entitled "Communications with Commission Designated Doctor," signed on March 14, 1994, by the Commission's Executive Director. *See also* Texas Workers' Compensation Commission Appeal No. 94240, decided March 31, 1994, for further discussion of this issue.

On June 14, 1993, the carrier again wrote Dr. R, with no copies shown to have been sent to the Commission or the claimant, advising that he had assigned claimant an IR for "previous surgery and the residual loss of motion," advising him that the IR "shall be based on the compensable injury alone," and that "[t]he 24% indicated on your TWCC form 69 should be only for the impairment [claimant] sustained as a result of his (month year) accident." The letter then asked that Dr. R "correct this information as soon as possible and indicate only the new impairment [claimant] sustained in Box 14." The letter also queried Dr. R as to how he arrived at claimant's MMI date. Since MMI was not in issue in this case, however, we need not discuss it further.

Dr. R then signed another TWCC-69 on June 21, 1993, stating that claimant's IR was "0%" and also referring to the "attached notes," apparently the same March 30th narrative report attached to his earlier TWCC-69. There was no indication claimant was re-examined by Dr. R nor was there any further information added to his report. At the hearing, the carrier, who put on no evidence of its own, stated that Dr. R's second TWCC-69 was "in response to a request by [carrier]."

On July 6, 1993, Dr. B wrote the Commission to disagree with Dr. R's zero percent IR. Dr. B pointed to Dr. R's failure to report any ROM values or consider any impairment from loss of cervical or lumbar ROM, and to his failure to consider any soft tissue lesion impairment under AMA Guides' table for specific spinal disorders (Table 49). Dr. B opined that Dr. R's IR was invalid in that it did not meet the requirements of the AMA Guides.

After recessing the hearing on August 23, 1993, the hearing officer wrote Dr. R on September 7, 1993, posing seven questions in an effort to obtain clarification of Dr. R's report, and also asking for additional medical details and records concerning Item 15 on the TWCC-69 form (narrative history of medical condition) and for additional medical details and records in documenting objective laboratory or clinical findings of impairment as required in Item 16 of the TWCC-69. The hearing officer's letter also stated he understood that Dr. R had available to him all medical reports, tests, records and examinations performed by claimant's providers, including Dr. B, at the time of Dr. R's examination and report. Dr. R (presumably) wrote "yes" underneath the questions on the letter and returned it to the hearing officer with no additional information. The hearing officer then wrote Dr. R on September 30th pointing out that question No. 3 called for an IR value, not a "yes" answer,

and provided a blank to fill in that value. Again, Dr. R (presumably) wrote "0%" in the blank space provided and returned the hearing officer's letter.

The hearing officer once again wrote Dr. R on November 30th stating that Dr. R had previously answered his questions by merely writing on the face of the hearing officer's letters. The hearing officer enclosed a letter to himself from Dr. R which restated the questions, indicated they were to be answered simply "yes or no," and stated three additional questions. Dr. R answered them all "yes" and signed the letter on December 14, 1994.

The particularly pertinent questions and answers were as follows:

3.[Claimant's] whole body [IR] based on [claimant's] compensable injury alone was? 0%

4.I used as required under the Texas Workers' Compensation Act the [AMA Guides] for the determination of the existence and degree of [claimant's] impairment? Yes

5.I conducted a physical examination of [claimant]? Yes

6.I evaluated [claimant's] complete clinical and non-clinical history of Claimant's medical condition? Yes

7.I analyzed [claimant's] medical history with the objective clinical and laboratory findings? Yes

8.I had available to me at the time of [claimant's] examination all medical reports, tests, records and examinations performed by [claimant's] health care providers including his treating doctor [Dr. B]. Yes

9.In figuring [claimant's] [IR], I utilized three factors - diagnosis based percentage, the [ROM] rating and neurological deficits. Yes

We are persuaded, from the record as a whole, that the designated doctor's report assigning zero percent IR must be rejected. In our view, the carrier's unilateral communications with Dr. R created the substantial potential for misleading Dr. R with respect to his evaluation of claimant's impairment from both the old and new injuries insofar as they may have been related. It would not be appropriate under the circumstances of this case to render a decision adopting the report of another doctor (*see* Section 408.125(e)). Dr. B's report contained impairment for a cervical injury which was not part of the stipulated low back injury and his testimony indicated he, too, may have failed to appreciate the concept that claimant's prior back injury may have resulted in a new back injury by aggravation and, thus, to that extent should be considered in determining claimant's IR. Dr. A's report provided no information concerning the basis for his four percent IR. Dr. J's report stated

he used the "Third Edition Revised" of the AMA Guides in arriving at his 18% IR for claimant's surgically treated disc lesions. We remand this case so that the Commission can arrange for claimant's examination by a designated doctor to determine claimant's IR for his low back injury. As the Appeals Panel observed in Appeal No. 94240, *supra*, "[u]nder the circumstances, it might be appropriate to agree upon or designate another designated doctor to examine the claimant and review the medical records with an opportunity for both parties to present, through the Commission, pertinent information to be considered."

For the reasons above set forth, the decision and order of the hearing officer are reversed and the case is remanded for further consideration and development of the evidence. 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.

Philip F. O'Neill
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Alan C. Ernst
Appeals Judge