APPEAL NO. 94315

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held in (city), Texas, on February 17, 1994, with (hearing officer) presiding as hearing officer. With regard to the single issue of what is claimant's correct percentage of whole body impairment, the hearing officer determined that the report of the designated doctor assessing claimant an impairment rating (IR) of four percent was contrary to the great weight of other medical evidence and further determined that the claimant's correct whole body IR was 35% as assigned by claimant's treating doctor. The appellant (carrier) contends that the decision of the hearing officer is so against the great weight and preponderance of the evidence as to be manifestly unjust. The carrier requests that the hearing officer's decision be reversed and a decision rendered that the designated doctor's opinion is not contrary to the great weight of other medical evidence, that it is entitled to presumptive weight, and therefore, the claimant's correct whole body IR is four percent. Claimant did not file a response to carrier's request for review.

DECISION

We reverse the decision of the hearing officer and remand for further development and consideration of the evidence consistent with this opinion.

It is undisputed that claimant sustained a compensable injury on (date of injury), when he slipped on some algae covered wet concrete while carrying a 50 pound object, falling backward and hitting his head and neck on the ground. Claimant did not lose consciousness after his fall; however, he was dazed and when he became reoriented he had weakness in his arms and legs, followed shortly thereafter by numbness in his arms and legs. Claimant drove himself to the hospital and was seen initially by an emergency room physician. However, because claimant had partial paralysis in his arms and legs, the emergency room doctor requested that (Dr. S), a board certified neurosurgeon, examine the claimant. In the emergency room, Dr. S conducted a routine neurological examination which revealed marked "quadraparasis" (paralysis) that was more impressive in the hands than the legs. Dr. S ultimately diagnosed that claimant had suffered a spinal cord injury without radiological abnormality (SCIWORA), which was the result of a traumatic event, the claimant's fall. (Dr. S explained that the fall had put claimant's neck in a transient abnormal condition and that movement of the bones pinched the spinal cord.) Following his examination in the emergency room, claimant was admitted to the hospital and treated with massive doses of steroids intravenously to protect the spinal cord and in an attempt to improve function in the spinal cord. Claimant remained hospitalized for six days.

Following his release from the hospital, claimant continued his treatment with Dr. S up to and including the time of the CCH; thus there is no dispute that Dr. S is claimant's treating physician. In addition to his treatment with Dr. S, claimant participated in extensive physical therapy and a work hardening program. There is no dispute that claimant has reached maximum medical improvement by operation of law in this case. *See* Section 401.011(30)(B).

At the CCH, claimant testified that he has suffered permanent residual effects from his spinal cord injury. Specifically, claimant stated that he walks with a limp, that he has had bladder and sexual dysfunction from the date of injury through the date of the hearing, that he suffers from fatigue-related symptoms, that he cannot perform repetitive tasks, that his speech is slower and it is more difficult for him to put words together, that he has difficulty sleeping and that it is "difficult to carry on anything approaching a normal life." He further testified that he performs light housework, with difficulty, but he cannot maintain his yard. Finally, claimant testified that he was attending college, but he had to discontinue his studies, following the cessation of his income benefits.

Dr. S's medical records confirm claimant's complaints of gait. Specifically, Dr. S's records reveal that claimant can walk up to a mile but that he is unable to run. In addition, Dr. S's records confirm claimant's complaints of bladder and sexual dysfunction, as well as, his complaints of fatigue and weakness. In an undated Report of Medical Evaluation (TWCC-69), Dr. S reasserted claimant's gait restrictions, as well as, his bladder and sexual dysfunction and assigned claimant a whole body IR of 35%, in accordance with page 99 of the "Guides to the Evaluation of Permanent Impairment" third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), the section of the AMA Guides to be used in assessing impairment resulting from a spinal cord injury.

The carrier filed a timely dispute of Dr. S's IR. Accordingly, (Dr. H) of the Center in (city), Texas, was appointed as the Texas Workers' Compensation Commission (Commission) selected designated doctor to assess claimant's whole body IR. On September 28, 1993, Dr. H conducted an examination of the claimant. In a TWCC-69 dated October 2, 1993, Dr. H assessed the claimant an IR of four percent, referring to Table 49 of the AMA Guides, the table used to assess impairment relating to specific disorders of the spine. In a letter dated January 3, 1994, a Benefit Review Officer of the Commission sent Dr. H a letter noting that claimant had been diagnosed with a spinal cord injury and seeking clarification of whether Section 4.1b of the AMA Guides was used in evaluating claimant's IR and asking if not, whether it should be used and whether an adjustment in the IR was appropriate. Thereafter, Dr. H added an addendum to his TWCC-69 stating "In relation to Section 4.1b the Spinal Cord, page 98 of the AMA Guides I see no documentable reason to increase [claimant's] disability. Symptoms were subjective and physical examination did not confirm any subjective complaints." Dr. H was called as a witness by the carrier at the CCH. He testified that he had no doubt that the claimant sustained a spinal cord injury, noting that it was well-documented in Dr. S's records. Nonetheless, Dr. H stated that in his opinion the spinal cord injury section of the AMA Guides was essentially inapplicable to claimant, because he did not think that claimant had any of the AMA Guides listed symptoms or signs justifying the assignment of an IR under that section. Dr. H noted that his static testing was unremarkable, that claimant did not make specific complaints of his gait problems, although Dr. H observed a slight limp, nor did claimant complain of bladder or sexual dysfunction. To the contrary, Dr. H. said claimant told him he was better. In addition, Dr. H noted his belief that there was no reference to bladder and sexual dysfunction in Dr. S's records after June 1992. Dr. H concluded that the claimant did not meet the

criteria for any disability; however, he assessed a four percent whole body impairment in his discretion as a doctor.

In her decision, the hearing officer noted that Dr. H said he did not consider claimant's complaints of gait problems and bladder and sexual dysfunction because of his belief that those symptoms do not appear in Dr. S's records after June 1992; thus, Dr. H concluded that the problems had been resolved. The hearing officer then noted that Dr. H's thought process would be acceptable if it were substantiated by Dr. S's records. However, the hearing officer referred to Dr. S's undated TWCC-69, containing specific reference to claimant's gait problems and his continuing bladder and sexual dysfunction. She noted that Dr. S's TWCC-69 was received by the carrier on July 28, 1993 and by the Commission on September 1, 1993. As a result, she determined that Dr. S's TWCC-69 was available to Dr. H at the time he conducted his examination of claimant in late September 1993.[1] Thus, she concluded that Dr. H was presented with information indicating that claimant's gait problems and bladder and sexual dysfunction persisted at the time of his examination. She further found that Dr. H's failure to consider that information in evaluating claimant's impairment means that the overwhelming weight of other medical evidence is contrary to Dr. H's certification of impairment and, pursuant to Section 408.125(e), the Commission is required to adopt the IR of one of the other doctors. The hearing officer noted that the only other doctor who had examined claimant and assigned him an IR was Dr. S and as a result, she adopted the 35% whole body impairment assessed by Dr. S as claimant's correct IR.

Upon reviewing all of the evidence in this case, we agree with the hearing officer that contrary to Dr. H's testimony, there was information, perhaps unknown to Dr. H, that claimant's complaints of bladder and sexual dysfunction had not resolved at the time he conducted his designated doctor examination of claimant. However, we cannot agree that Dr. H's omission of those admittedly significant symptoms leads inescapably to the conclusion that the great weight of other medical evidence is contrary to Dr. H's report of IR, requiring rejection of his rating. We believe that with the evidence in this confused posture, it is difficult if not impossible to accurately determine where the great weight lies or whether the presumptive provisions have been overcome. Thus, Section 408.125(e) does not compel the adoption of Dr. S's assigned IR. Given the unique position occupied by the designated doctor's report and our consistent previous acknowledgements that the designated doctor's report should not be rejected absent a substantial basis (more than a mere balancing) to do so, under normal circumstances, we would reverse the decision of the hearing officer and render a decision, consistent with the designated doctor's report, that claimant's correct whole body IR is four percent. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992, and Texas Workers' Compensation Commission Appeal No. 93483, decided July 26, 1993. However, we do

[1]Although Dr. S's TWCC-69 is undated, it is not disputed that claimant reached maximum medical improvement upon the expiration of 104 weeks from the date on which income benefits began to accrue, or in April 1993. Thus, we note that Dr. S's TWCC-69 had to have been completed at some point between the date of statutory MMI and the date the carrier received the report, July 28, 1993.

not find that this case presents the factual circumstances to support such action by the Appeals Panel.

In this instance, it appears that Dr. H acknowledged that claimant suffered a spinal cord injury and, consequently, that claimant's IR must be evaluated in accordance with Section 4.1b of the AMA Guides which relates to spinal cord injuries and not Table 49, which relates to IR due to specific disorders of the spine. Although Dr. H's TWCC-69 refers to both tables and thus it is not entirely clear which table Dr. H used in assessing impairment, his acknowledgement that claimant suffered a spinal cord injury suggests that he utilized Section 4.1b of the AMA Guides and simply determined that claimant did not satisfy the criteria for being assessed an impairment thereunder. Nonetheless, there is a 31% disparity between the IRs of Dr. H and Dr. S, despite the fact that both are ostensibly based upon the same objective guidelines. Dr. H attempted to explain the disparity by addressing each element of the spinal cord injury table, station and gait, use of upper extremities, respiration, urinary bladder function, anorectal function and sexual function, and providing his rationale for why claimant is not entitled to a percentage impairment for that element. However, as noted earlier it appears that his reasoning may be flawed because it is premised on an apparent misunderstanding that claimant's gait problems and bladder and sexual dysfunction problems were resolved. Therefore, we are left in the situation much like the one in Texas Workers' Compensation Commission Appeal No. 92561, decided December 4, 1992, where there is a large unexplained disparity in IRs from two doctors apparently utilizing the same objective guidelines. In Appeal No. 92561, we reversed and remanded for further proceedings to develop evidence relating to the matter of the disparity in ratings. We think such a remand is necessary herein.

In addition, in Texas Workers' Compensation Commission Appeal No. 93062, decided March 1, 1993, we noted that in a particular set of circumstances it might be appropriate to consider the appointment of a designated doctor with a particular specialty. We believe that this case presents just such a circumstance. It is undisputed that claimant suffered a spinal cord injury. His treating doctor, a board certified neurosurgeon, noted that the residual neurological deficits of a spinal cord injury are not easily subject to objective testing and observation. We note that Dr. H concluded in his TWCC-69 that claimant's complaints were subjective and that his testing did not confirm the subjective complaints. Such findings may not be unusual with the type of injury suffered by the claimant herein. When the apparent esoteric nature of spinal cord injuries and their residual neurological effects is considered in conjunction with the unexplained 31% disparity in IRs assessed to claimant in this instance, we believe that the best course of action to follow is to remand the case back to the hearing officer for the appointment of a second designated doctor, a neurosurgeon, if reasonably possible, for an evaluation of claimant and an assessment of claimant's IR. This action is not intended to detract in any way from our previous holdings which acknowledge and accord special consideration to the report of the designated doctor as set forth in the 1989 Act. Rather, it is an attempt to ensure that the hearing officer is provided with as complete and accurate medical information as is possible from which to make an informed determination of the claimant's percentage of whole body impairment that resulted from his compensable spinal cord injury. The specific circumstances of this case,

the wide disparity of the ratings and the esoteric nature of the injury and its resultant neurological deficits, present an unusual set of circumstances which we believe support and indeed necessitate a remand for the appointment of another designated doctor, preferably with a neurosurgical background or specialty, to resolve the IR dispute.

The decision of the hearing officer is reversed and the case is remanded for further consideration and the development of the evidence, as deemed necessary and appropriate by the hearing officer, not inconsistent with this opinion. 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 the 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.

Gary L. Kilgore
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Alan C. Ernst
Appeals Judge