

APPEAL NUMBER 94970
FILED SEPTEMBER 7, 1994

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 June 16, 1994, (hearing officer) presiding. The two issues were: on what date did claimant reach maximum medical improvement (MMI), and what is claimant's correct whole body impairment rating (IR). The claimant on appeal challenges the hearing officer's findings that the range of motion (ROM) measurements used by the designated doctor, as well as those of another doctor who assigned the same IR, were contrary to instructions in the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (Guides) and that thus the findings of the designated doctor were contrary to the great weight of the other medical evidence. The hearing officer further found that no useful purpose would be served by requesting further clarification from the designated doctor, and that the findings of MMI and IR by the other doctors involved with the case are not sufficiently in compliance with the Guides or supported by the medical evidence to justify adoption of any one of them. The hearing officer accordingly returned the case to the dispute resolution team for appointment of a new designated doctor.

In his appeal the claimant contends that the great weight of the medical evidence is aligned with the opinion of the designated doctor. He also asks that he be re-examined by the designated doctor, and complains of the hearing officer's reversal of an interlocutory order entered by the benefit review officer (BRO). Finally, he seeks guidance as to the use of computerized range of motion testing, and the need for numerical values to be set to zero before measurements are taken.

The carrier responds that the evidence supports the hearing officer's invalidation of the designated doctor's report. However, it urges that the MMI date and five percent IR of the treating doctor should have been adopted, although this argument is untimely as an appeal. See Texas Workers' Compensation Commission Appeal No. 92193, decided July 2, 1992.

DECISION

The decision and order of the hearing officer are reversed and remanded for the development of further evidence.

The claimant suffered a back injury while employed by (employer), on _____. He treated with Dr. P, who recommended work hardening, but claimant said he was unable to complete that course of treatment. Dr. P diagnosed claimant with muscle ligamentous strain of the lumbar spine, and low back and right leg pain. On September 13, 1993 (all remaining dates are in 1993 unless otherwise indicated), Dr. P wrote that the claimant had missed his latest appointment (and had missed earlier work hardening sessions). He also completed a Report of Medical Evaluation (TWCC-69), finding

claimant had reached MMI on August 30, 1993, with a five percent IR based on Table 49 (Specific Disorders) of the Guides. (Even though records from earlier visits show that Dr. P had, many times, tested claimant's ROM and that he had found it to be within normal limits on July 23rd, nothing about ROM was mentioned in this report, and claimant contended that Dr. P issued the report without examining him.) Dr. P also noted that claimant's last MRI of the lumbar spine was negative for a herniated disk.

At the carrier's request, claimant saw Dr. B. On August 25th, Dr. B wrote that the claimant had mild tenderness at the posterior aspect of the lumbar area and no radiculopathy, and that his straight leg raising test was negative bilaterally and his MRI normal. Dr. B concluded that the claimant had a five percent whole person impairment and had invalidated ROM and had no neurological deficit.

Apparently upon referral from Dr. P, claimant saw Dr. M, who on August 24th gave his assessment as right sacroiliac joint sprain and deep pelvic myofascial pain syndrome with intermittent right lower extremity referred pain. On September 21st Dr. M reviewed Dr. P's TWCC-69 but recommended the claimant have another IR because Dr. P had not assessed ROM and Dr. M felt, based upon his previous physical examination, that claimant had some limitation of lumbar spinal motion. On September 29th, the claimant underwent computerized inclinometry measurements of his lumbar ROM utilizing ARCON software. On October 5th, Dr. M wrote that "[i]n contraindication to [Dr. B's] report from August 25, 1993, [claimant's] lumbar range of motion was valid and limited such that additional impairment is due him . . ." He thus completed a TWCC-69 assigning claimant a 17% IR comprised of five percent diagnosis based impairment and 13% due to loss of ROM. He agreed that claimant reached MMI on August 30, 1993.

Because claimant had disputed Dr. P's IR, the Texas Workers' Compensation Commission (Commission) appointed Dr. K as designated doctor to determine MMI and impairment. Dr. K referred the claimant to the Disability Evaluation Center, which reported that the results of ARCON dual inclinometer studies of claimant's lumbosacral spine were valid, and that he was tested twice to assure validity. Dr. K certified MMI as of October 13, 1993, and assigned claimant a 17% IR, which included 13% due to loss of ROM.

It was carrier's position at the hearing that the ROM studies performed by Drs. K and M were invalid because some of the measurements included negative numerical values. Carrier's witness, Mr. A, a physician's assistant and general manager of a company called Impairment Rating Facts, testified that negative numbers are outside the protocols of the Guides and are an indication that the inclinometers were not returned to zero, as required by the Guides, when the claimant returned to the neutral position. Mr. A cited to page 90 of the Guides, which provides, with regard to measurement of lumbosacral flexion/extension using the 2 inclinometer method:

[after placing the inclinometers at two points on the spine], [t]he subject should be in the standing position, with knees straight, with weight balanced on both feet, with hands on hips for support if necessary to permit greater motion. The trunk should be in the neutral position while the inclinometers are "zeroed out . . ." Ask the subject to flex maximally and record both angles. Subtract the sacral (hip) inclination from the T12 inclination for the true lumbar flexion angle. Return the trunk to the neutral position so that both inclinometers read "0" again . . . Instruct the subject to extend the trunk as far as possible, again recording both inclinometer angles and subtracting the sacral (hip) angle from the T12 inclinometer angle . . . Again ask the subject to return the trunk to the neutral position.

The carrier raised this argument at the benefit review conference, and the BRO subsequently wrote Dr. K, asking him to refer to pages 90 and 91 of the Guides concerning the procedure of "zeroing out" the inclinometers, and asking him to explain his use of negative numbers in measuring ROM.

On January 5, 1994, Dr. K replied as follows:

In reference to Chapt 3.3e (1) on page 90, our inclinometer [sic] were zeroed out before performing the ROM evaluations. The fact that the numbers have a negative sign does not mean they are a negative number. Clearly if this was the case then our combined number from figure 83C under lumbar flexion would not have been added to give us a total for t12 ROM.¹ True lumbar flexion angles were measured with accuracy. The numbers are all true numbers with or without a negative sign. Note over the true flexion, extension, left and right leg raised lateral flexion are all recorded positive and the graphs attached with the report show this measurement.² Therefore a strict application of the tables can be accomplished.

The benefit review officer also enclosed a letter from carrier's doctor, Dr. S, which stated that Dr. K's straight leg raise numbers (15 degrees, 16 degrees, and 15 degrees) "appears to me not to be a clinical situation . . . based on the fact that simple walking requires at least 30 degrees of straight leg raising." In response, Dr. K wrote:

¹In Dr. K's report, which contained a completed Figure 83c from the Guides (Lumbar Range of Motion) the T12 ROM measurement for lumbar flexion was -15, while the sacral ROM measurement was -3. The true lumbar flexion angle, which the Guides say is to be calculated by subtracting the sacral measurement from the T12 measurement, was given as 12.

²True flexion, extension, right straight leg raise, and left straight leg raise were given in Dr. K's report, as 16, 19, 16, and 25 respectively. Negative numbers appeared in the measurements for T12 ROM and sacral ROM (lumbar flexion), sacral ROM (lumbar extension), sacral ROM (lumbar right lateral flexion), and T12 ROM and sacral ROM (lumbar left lateral flexion).

When evaluating the straight leg raise we found the client to have 15, 15 and 16. This is correct and in this case a client gate [sic] could not be assessed with a minimal of 30 degrees to ambulate. If this was the case then almost every ROM of the L-S spine would be invalid. There is no where in the Guides that states a client must have 30 degrees of straight leg raise to ambulate.

Dr. K's letter concluded:

I hope this answers any questions you might have. Furthermore, this particular client should not have to be re-evaluated should any more cost be incurred [sic] for a second impairment evaluation.

In addition, in his December 1, 1993, letter, Dr. S noted that the Guides on page 17 state that neutral equals zero degrees. He stated:

In reviewing the raw data provided by [Dr. K] this does not seem to be the case. This is based upon the fact that several other values appear not to make good clinical sense. Particularly on the raw data sheet (which is a replication of Figure 83c from the Guides), page 2 says lumbar flexion at T12 is a negative 20 degrees, negative 24 degrees, negative 27 degrees. By convention within the medical community, a negative number to one direction is a positive number to the opposite direction. That is to say, minus 20 degrees of flexion is 20 degrees of extension. This is a result of using an inclinometer slaved to a computer and not zeroing out the inclinometer. Moreover, every Table in the Guides that relate [sic] to the spine (cervical, thoracic and lumbar) has all numbers as positive numbers. There is no use of a negative number. This is important in that one refers to Table 56 (page 91), the criteria for using a true lumbar flexion is based on the amount of sacral/hip motion. In as much as all the values are positive numbers (i.e., 0 to 30, 30 to 45, and 45 plus), the use of a negative number clearly confuses the situation. Therefore, a strict application of the Tables cannot be accomplished.

Also made part of the record was a deposition by written questions of Dr. M, which included the following pertinent questions and answers:

Q:State the "sacral number(s)" displayed prior to performing the hip extension movements of [claimant] on September 29, 1993.

A:Negative 8, negative 8, negative 26.

Q:Do you agree that the term flexion involves the movement described in Figure 93(a) to (b) of the Guides to the Evaluation of Permanent Impairment?

A:. . . yes, they do.

Q:Do you agree that the term extension describes the movement in Figure 93(a) to (c) of the Guides . . . ?

A:Yes.

Q:Do you agree that Figure 93(a) of the Guides . . . shows the picture of an individual at the "neutral position"?

A:Yes.

* * * *

[Dr. M went on to state that the claimant's maximum true lumbar extension angle as measured by the computer was 29 degrees; his right straight leg raise was 16 degrees; and his left straight leg raise was 49 degrees.]

* * * *

Q:Do you agree that if a person is walking without assistance that they would have a minimum of 30 degrees straight leg raising angle for each leg?

A:I would state that for a given individual without back pain with a typical stride length, one may have a degree of angulation between 15 and 30 degrees; however, for many patients with back pain, they have a guarded gait with decreased stride length and the actual angle may very well be closer to 15 degrees.

Q:If not, then state how many degrees of straight leg raising angle a person would have while walking.

A:Again, I believe there is a distinct difference between someone who is ambulating with pain and someone who is not ambulating, or someone who is ambulating without pain. If someone is ambulating with pain, their angle may be closer to 10 to 15 degrees, depending on their stride length.

At the hearing, Mr. A also noted that the physical examinations in the reports of Drs. M and Dr. K showed different degrees of flexion, extension, and straight leg raising than was indicated on the ROM examinations. For example, the physical examination in Dr. K's report showed right and left straight leg raises of 25° and 70°, while the values given for purposes of ROM testing were 16° and 25°.

Mr. A also disputed Dr. K's assertion, contained in his January 5, 1994, letter, that the numerical values were not negative, despite the use of a negative sign. As Mr. A pointed out, the Guides require that sacral ROM values be subtracted from T12 ROM in order to arrive at true lumbar flexion and extension. In the report accompanying Dr. K's TWCC-69, however, the sacral ROM of -2 was subtracted from a T12 ROM of 17, yielding a result of 19; Mr. A noted that if the sacral ROM number had been positive the result would have been 15. Similar results were reached on the repetitions of lumbar extension (11 minus -5 = 16; 13 minus -4 = 17), as well as in the calculation of left and right lateral flexion. Based on these calculations, Mr. A concluded that negative numbers had been used.

The hearing officer made the following findings of fact and conclusions of law which are objected to by the claimant:

FINDINGS OF FACT

- 12.The range of motion measurements reported by DEC contained negative numbers, which is contrary to instructions in the Guides.
- 13.The findings of [Dr. M] were also based on measurements using the Arcon software, and suffer the same general defects as those of [Dr. K], and [Dr. M's] personal measurements were at significant variance from those upon which he based his findings.
- 18.No useful purpose will be served by requesting further clarification from the designated doctor.
- 19.The findings of the designated doctor that claimant reached maximum medical improvement on October 13, 1993, with an impairment rating of 17% are contrary to the great weight of the other medical evidence in the case.

CONCLUSIONS OF LAW

3. The findings of the designated doctor that claimant reached maximum medical improvement on October 13, 1993, with a whole body impairment rating of 17% is contrary to the great weight of the other medical evidence in the case.
4. [Dr. K] is disqualified as the designated doctor in this case.
5. The findings of maximum medical improvement and the impairment ratings certified by the other doctors involved with this case are not sufficiently in compliance with the Guides and supported by the medical evidence to justify adoption of any one of them.

We are unable to adequately assess the evidence to support the hearing officer's findings and conclusions regarding the merits of this case because of our concern over Finding of Fact No. 18; that is, that no useful purpose will be served by requesting further clarification from the designated doctor. Many Appeals Panel decisions which have found defects in a designated doctor's report have reversed and remanded to allow the hearing officer to seek further clarification, and have held that the appointment of a second designated doctor should be strictly limited to cases where, for example, the designated doctor cannot comply or refuses to comply with the requirements of the 1989 Act. See Texas Workers' Compensation Commission Appeal No. 93045, decided March 3, 1993. We do not believe that is the case here, where Dr. K responded to the questions as posed by the BRO. In his January 5, 1994, letter Dr. K replied that inclinometers were zeroed out, all numbers were "true numbers with or without a negative sign," and thus, in his opinion, the Guides were complied with. We do not feel that this equates to a refusal to comply with the Act. However, given Mr. A's testimony at the hearing concerning the calculation of the numbers ultimately used to provide the rating (notably those instances, such as with true lumbar extension, where a negative number was subtracted from a positive number), we feel that seeking additional clarification or explanation from Dr. K is preferable, at this point, to jettisoning the process and beginning over with a new designated doctor. We therefore reverse the decision of the hearing officer and remand with instructions to seek further information from Dr. K that would explain why the numbers in his report are both expressed as negative numbers and used in calculations as negative numbers and whether he believes any part of the report should be amended. The hearing officer should also raise any other questions of the designated doctor he feels would shed further light on the arguments raised in this case. Of course, this opinion should not be read as requiring the hearing officer to accept the designated doctor's report should the designated doctor fail to respond to such request or provide acceptable explanations.

The decision and order of the hearing officer are reversed and remanded to allow the hearing officer to seek further clarifying information from the designated doctor, as

provided herein. Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Texas Workers' Compensation Commission's division of hearings, pursuant to Section 410.202. See Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

DISSENTING OPINION:

I respectfully dissent from the majority opinion and would uphold the hearing officer's determination that another designated doctor be appointed at this point in this case. Clarification was specifically sought from the designated doctor and proved to be futile. Other expert opinions tend to discount the procedures and methodology used by the designated doctor and support the hearing officer's concluding that it would be somewhat futile to return once again to the original designated doctor. While we have stated and adhere to our guidance in Texas Workers' Compensation Commission Appeal No. 93045, decided March 3, 1993, that the selection of a second designated doctor should be a rare occurrence and employed in a restrictive manner, I believe there is sufficient support for the hearing officer's determination in this case. The situation here is similar to the situation in Texas Workers' Compensation Commission Appeal No. 94966, decided September 6, 1994, where the Commission's attempt to obtain additional information and clarification from an original selected designated doctor failed to resolve a matter of improperly combining protocols under the AMA Guides. We agreed that it was not unreasonable or inappropriate to select a second designated doctor, the original designated doctor appearing to refuse to correctly observe the AMA Guides' protocols. In my opinion, we are faced with an analogous situation in this case. I would hold there is a sufficient basis in fact and law for the hearing officer's determination to have a second designated doctor selected.

Stark O. Sanders, Jr.
Chief Appeals Judge