

APPEAL NO. 950068  
FILED APRIL 6, 1995

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was convened on March 8, 1994, and was recessed and re-convened on August 22 and November 21, 1994, with the record closing on the latter date. The two issues from the benefit review conference (BRC) were whether the claimant has reached maximum medical improvement (MMI) and if so on what date, and what is the impairment rating (IR). The claimant appeals the determination of the hearing officer that she reached MMI on April 27, 1993, with a three percent IR, as found by the designated doctor. She contends in her appeal that a third issue, whether it was appropriate for the Texas Workers' Compensation Commission (Commission) to appoint a second designated doctor to examine the claimant, was added at the insistence of the hearing officer, and she questions why the hearing officer ordered the appointment of a second designated doctor while later finding that such was not appropriate. She contends that the examination by the second designated doctor was complete, and she raises concerns about the examination by the first designated doctor. The carrier responds, citing Appeals Panel decisions, that it was not appropriate to appoint the second doctor and argues that, in the alternative, the great weight of the other medical evidence is contrary to that doctor's report. It also contends that the hearing officer correctly concluded that the report of the first designated doctor was not overcome by the other medical evidence.

DECISION

Affirmed.

The claimant, an employee of (employer), was injured on \_\_\_\_\_, when she lifted a corner of a sofa in her employer's waiting room; she testified that she experienced severe neck pain and nausea. A few days later she saw (Dr. J), who became her treating doctor. Dr. J testified at the hearing that he originally treated the claimant for acute paracervical muscular strain and severe migraine headaches, that he had referred her to other doctors for examination and evaluation (including (Dr. O), who administered facet injections), that the current diagnosis was cervical facet syndrome, which involved inflammation of the nerves and muscles of the neck, and that she needed further treatment (although surgery was not recommended) and had not reached MMI.

The claimant saw (Dr. ST) at the carrier's request; he stated his belief that claimant's neck pain and headaches were subjective with no objective evidence of abnormality (a cervical myelogram showed "slight ventral impingement" at C5-6 with no evidence of nerve root compression and a CT scan the findings at C5-6 were "only minimally positive") and he determined that the claimant reached MMI on the date he saw claimant, December 2, 1992, with a zero percent IR. The claimant was dissatisfied with

Dr. ST's evaluation of her and did not agree with his assessment. As a result (Dr. R) an orthopedic and hand surgeon, was selected as designated doctor by the Commission.

Dr. R, who examined the claimant on April 27, 1993, certified that she reached MMI on that date with a three percent IR. In his report, he wrote:

Physical exam shows some guarding in the neck. She demonstrates very little voluntary motion in the neck in any direction and very little rotation. She seems to have some paracervical tightness in her neck and upper back. The motor examination of her upper extremities including shoulder abduction, adduction, elbow flexion and extension, wrist flexion and extension, finger flexion and extension, intrinsic muscle exam is normal and symmetric. The triceps, biceps and brachial radialis reflexes are all brisk and symmetric. She does complain of some intermittent numbness in her left hand and fingers and does have a positive Tinel's sign on that side.

She is being scheduled for EMG and nerve conduction studies and will be seen back after these have been done.

A handwritten notation on the bottom of the report indicated claimant had a three percent IR based upon an injury to her cervical spine.

Dr. J, who is a family practitioner, testified that he accompanied claimant to her examination with Dr. R and that he briefed Dr. R on claimant's medical background and test results while Dr. R was examining the claimant. He said that although Dr. R had claimant move her head, he believed the doctor spent more time examining claimant's wrist and elbow. He also stated that Dr. R did not use an inclinometer and there was no copy of the American Medical Association's Guides to the Evaluation of Permanent Impairment (AMA Guides) in the examination room. While Dr. J conceded Dr. R could have assessed claimant's neurological impairment by examining her extremities, he stated that the doctor also needed to measure the range of motion (ROM) of claimant's neck. Dr. J stated that he did not raise any of these concerns during Dr. R's examination, but that he did so in an August 3, 1993, letter to the Commission. That letter stated, in part:

For his examination [Dr. R] asked the patient to voluntarily move in certain directions with her neck and then he closed by a quick palpation of the paracervical musculature. The remainder of the exam focused on the upper extremities. To completely evaluate a person's lack of [ROM] in the neck, certain instrumentation is recommended, that being an inclinometer and two methods are described using 1 or 2 inclinometers. [Dr. R] used neither. Measurements are to be taken in both flexion and extension and this was not done. Measurements were recommended in the lateral flexion as well with

either one or two inclinometers and this also was not performed. These aforementioned measurements are to be taken 3 times and the final measurement for impairment evaluation is to be the greatest angle measured. Since not even one measurement was taken, it is not possible to arrive at a correct cervical flexion or extension angle much less lateral flexion angle. Cervical rotation was also not measured in any form or fashion.

Dr. J also stated his opinion that the claimant needed further treatment before she could be determined to be at MMI. He agreed that objective studies would not show the nature of claimant's pain, and that claimant's neck is stiff and "frozen" on the right side.

In addition, claimant contended that carrier's rehabilitation nurse, (Ms. JB) had had unilateral contact with Dr. R and thus his report was tainted. While the carrier's objection was sustained to certain testimony concerning the presence of Ms. JB in Dr. R's offices on April 27, 1993, that testimony was subsequently alluded to numerous times during the hearing. It was apparently conceded, however, that no one actually heard or observed Ms. JB speaking with Dr. R. A letter to claimant from Ms. JB indicates that the latter scheduled claimant's appointment of Dr. R. The ombudsman, who was not placed under oath, contended she had been informed by the carrier that Ms. JB planned to be present at the claimant's examination, although both claimant and Dr. R stated she was not present.

According to Dr. J's testimony, following a BRC on November 5, 1993, he verbally approved a list of 31 clarifying questions to be submitted to Dr. R by the benefit review officer (BRO); according to the evidence a November 22, 1993 letter, to Dr. R posed 18 of these questions. Among these questions and Dr. R's responses were the following:

In which medical specialty or subspecialty do you hold certification? Orthopaedics. Do you use a copy of Guides to the Evaluation of Permanent Impairment, Third Edition, February 1989 (Second Printing), American Medical Association? Yes.

Did you measure the [ROM]? If yes, what instrument was used? [no answer]

What were the [ROM] values? No.

If you could not measure to [sic] [ROM], please state why? [no answer]

What diagnostic studies did you have for your consideration? See report.

How did you derive your impairment rating? AMA Book.

Dr. J said that the designated doctor should also have been asked whether he fully followed the AMA Guides in assessing impairment, from which tables or charts in the

Guides his IR came, and his cervical ROM measurements. The hearing officer posed these and other questions to Dr. R in an April 6, 1994, letter, following a recess for that purpose.

On May 4th Dr. R replied in pertinent part as follows:

I examined the claimant on April 27, 1993, and did evaluate the complete clinical and nonclinical history of the claimant's medical condition, and did analyze the medical history including the radiographic studies.

I should note that this claimant has had an extensive evaluation including a cervical myelogram on July 10, 1992, a CAT scan following the myelogram, and an MRI scan on July 9, 1992. The primary finding of all of these studies showed some protruding posterior osteophytes at the C5-6 level without evidence of nerve root compression. These findings are entirely consistent with a chronic pre-existing lesion and are not at all consistent with an acute-type injury.

I did do a motor examination of the upper extremities and did not find any objective abnormalities other than a positive Tinel's sign at the wrist level on the left side. The electrodiagnostic test performed by [Dr. O] were [sic] normal.

If the [IR] of this claimant were based on her subjective ability to move her neck, then I think the impairment would have to be consistent with a spine that was completely fused from the occiput to T1. Since there are no objective clinical findings, electrodiagnostic findings, or radiographic findings that are consistent with a cervical injury, it is difficult for me to understand why there is no voluntary motion in the cervical spine in this claimant.

The 3% [IR] given to the claimant was based on an alleged injury to her cervical spine. Although there were no objective clinical findings, nor were there any objective electrodiagnostic findings, I felt that since there were some very minor radiographic findings that one could give this claimant the benefit of the doubt and asses [sic] a 3% impairment, although I must admit that this is perhaps somewhat tenuous.

On July 6, 1994, the hearing officer once again wrote Dr. R, asking whether the doctor used worksheets, graphs, charts, tables etc. from the AMA Guides, and requesting that he either attach copies or explain why he did not use those portions of the Guides. Dr. R responded on August 12th:

As I stated in my original evaluation . . . the claimant either would not or could not move her neck upon request. There is no objective evidence that this claimant has had an injury, disease or surgical procedure which would restrict all movement of her neck. If, indeed, the claimant does have loss of motion of her neck due to ankylosis, then I would refer you to Table 50, page 79 of the AMA guide which would assess her at 14% permanent impairment based on a complete cervical ankylosis in a favorable or neutral position.

. . . [Y]ou asked for copies of my handwritten measures and values taken on [claimant]. Since she would not move her neck, there was no need to take any notes regarding measurements.

After the hearing reconvened and again recessed on August 22, 1993, the hearing officer on his own motion issued an order directing that a Commission disability determination officer appoint a second designated doctor to evaluate and examine the claimant and determine whether the claimant had reached MMI and the IR, if any. Thereafter, the claimant was seen by (Dr. H) on September 16, 1994. Dr. H wrote that he did not believe the claimant had reached MMI except by operation of law on June 22, 1994. He noted claimant's continued pain and cervical ROM which was "markedly limited in all planes;" however, he said her diagnostic studies, which were appropriate and extensive, were relatively unremarkable "and do not shed light on her cervical dysfunction." He also found no evidence of neurologic loss and stated that no impairment was warranted for a specific disorder of the cervical spine. However, he assessed 13% IR due to loss of ROM.

Following receipt of Dr. H's report, the carrier filed a motion to add as an additional issue whether it was appropriate to appoint a second designated doctor to evaluate the claimant.

In his decision the hearing officer held that the determination of Dr. R, the first designated doctor, is not contrary to the great weight of the other medical evidence, and that it was not reasonable and necessary for the Commission to appoint Dr. H as second designated doctor because the report of Dr. R "provides complete and accurate medical information as is possible from which to take an informed determination if claimant reached [MMI] and claimant's percentage of whole body impairment that resulted from claimant's compensable injury of \_\_\_\_\_." He accordingly determined that the claimant reached MMI on April 27, 1993, with a three percent IR.

In her appeal the claimant challenges Dr. R's report on the following grounds: the carrier's representative, Ms. JB, had unilateral contact with the designated doctor; Dr. R rendered his report before receiving the report of claimant's EMG, and the hearing officer failed to question Dr. R in this regard; Dr. J testified that Dr. R's examination was inadequate; and Dr. R did not produce evidence that he used the proper version of the

AMA Guides. She also argues that the hearing officer himself ordered her to be examined by another designated doctor, although later adopting the report of the first doctor, and states that the hearing officer insisted upon adding the issue of whether the second designated doctor should have been appointed.

With regard to the latter contention, the record of the contested case hearing only reflects that the carrier moved to add this issue, and that the hearing officer did so after neither party objected. The record reflects no coercion by the hearing officer. Further, the 1989 Act and its rules provide that disputes which were not identified as unresolved in the BRO's report may be added at the hearing upon unanimous consent of the parties or upon a determination of good cause by the hearing officer. See Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 142.7(d) and (e). We find no error in the hearing officer's adding this issue.

As to the propriety of appointing a second designated doctor, this panel has strictly limited the circumstances under which that step may be appropriate. Thus, for example, a second designated doctor may be appointed where a previously selected designated doctor is unable or refuses to resolve the medical dispute consistent with the 1989 Act, Texas Workers' Compensation Commission Appeal No. 93906, decided November 19, 1993; or where the first doctor dies or becomes incapacitated, Texas Workers' Compensation Commission Appeal No. 93622, decided August 31, 1993. We have stressed that dissatisfaction with the first doctor's report is not grounds for appointing a second designated doctor. Texas Workers' Compensation Commission Appeal No. 941729, decided February 10, 1995.

In the latter case, the Appeals Panel reversed the decision of the hearing officer rejecting the opinion of the first designated doctor and accepting the report of the second who, apparently, had been selected upon order of the hearing officer. That panel held that the record was devoid of a failure of cooperation by the first designated doctor, and it rejected the hearing officer's underlying reasoning for the second appointment, which related to a disparity between the two IRs in the record (from the treating doctor and the first designated doctor). Likewise, in this case it does not appear that a second designated doctor was selected for any reason sanctioned by the Appeals Panel; the hearing officer's order does not indicate his reasoning, and the record does not demonstrate a refusal on Dr. R's part to cooperate or to resolve the dispute consistent with the 1989 Act. While it is somewhat unfortunate that Dr. H was appointed by order of the hearing officer who later found that appointment to be invalid, Appeal No. 941729 demonstrates that such action by a hearing officer is reviewable both by the Appeals Panel and, as in this case, by the hearing officer himself. We thus find no error in the hearing officer's determination that the appointment as designated doctor of Dr. H was not reasonable, necessary or appropriate.

The hearing officer also determined that the report of Dr. R was not contrary to the great weight of the other medical evidence. In her appeal the claimant contends that his report was tainted by unilateral carrier contact, that he did not follow the AMA Guides, he failed to consider an EMG report, and that he did not evaluate her ROM. This panel has many times cautioned against unilateral communication between a carrier and the designated doctor which, we have said, could tend to compromise the perception, if not the reality, of impartiality on the part of the designated doctor. Texas Workers' Compensation Commission Appeal No. 93455, decided July 22, 1993. However, the evidence in this case did not establish that any such communication took place, and we note that the claimant did not seek to question Dr. R or Ms. JB as to whether and/or to what extent they had communicated. While the claimant questions whether Dr. J's contact with Dr. R would render the latter's report tainted, we observe that neither party raised this argument at the hearing.

The 1989 Act provides that the report of a designated doctor has presumptive weight and "shall" be adopted by the Commission unless the great weight of the other medical evidence is to the contrary. Sections 408.122(b), 408.125(e). Despite claimant's contention, Dr. R stated that he used the statutorily required version of the AMA Guides in assessing the claimant. See Section 408.124(b). In addition, a later response by Dr. R indicates that he had reviewed claimant's later-performed EMG, which was normal. The remaining issue is whether that doctor did not comply with the Guides by failing to measure the claimant's cervical ROM. The evidence in the form of medical reports and the testimony of Dr. J shows that the problem as diagnosed by Dr. J and referral doctors was not reflected in objective studies; it further showed that the claimant's neck was stiff. In response to the hearing officer's questioning, Dr. R indicated that he did not ignore claimant's ROM, but was unable to verify it because of her inability or unwillingness to move. We note that Dr. H commented on claimant's limited ROM, but the fact that he was apparently able to get measurements does not, in our opinion, mean that the report of Dr. R was overcome by the other medical evidence. The Appeals Panel has previously affirmed decisions accepting the report of a designated doctor who invalidated ROM in the face of other medical evidence showing that it was successfully measured. For example, in Texas Workers' Compensation Commission Appeal No. 93681, decided September 20, 1993, we upheld the hearing officer's acceptance of a designated doctor's report which invalidated a claimant's ROM due to minimal effort. And in Texas Workers' Compensation Commission Appeal No. 93123, decided April 5, 1993, we reversed a hearing officer who found the great weight of the other medical evidence (which assigned impairment due to loss of ROM) to be against the report of the designated doctor, who gave no impairment for ROM due to symptom magnification. *And see* Texas Workers' Compensation Commission Appeal No. 93483, decided July 6, 1993, which affirmed the determination of MMI and IR by a designated doctor who examined a claimant for ROM without, it was contended, using any instruments; the Appeals Panel noted that the hearing officer pointed out the absence of objective clinical findings and the fact that the designated doctor's opinion was consistent with that of other doctors who had examined the claimant. We do

not believe that this constitutes error in this case; we find the evidence sufficient to support the hearing officer's decision accepting the report of Dr. R.

The hearing officer's decision and order are accordingly affirmed.

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Lynda H. Nesenholtz  
Appeals Judge

CONCUR:

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Robert W. Potts  
Appeals Judge

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Gary L. Kilgore  
Appeals Judge