APPEAL NO. 950073
FILED FEBRUARY 28, 1995

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On June 13, 1994, a contested case hearing (CCH) was commenced. The record was left open to allow the hearing officer to correspond with the designated doctor who ultimately reexamined the claimant. The record was closed on December 14, 1994. The disputed issues at the CCH were:

1. What is the correct date of maximum medical improvement [MMI]?

2. What is the correct impairment rating [IR]?

3. Did the Claimant have disability as a result of the _____, injury during the period from May 18, 1993, to November 30, 1993?

The hearing officer determined that the claimant reached MMI on May 17, 1993, with a 14% IR as certified by the Texas Workers' Compensation Commission (Commission)-selected designated doctor, and determined that that report was not contrary to the great weight of other medical evidence. The hearing officer further determined that while claimant had disability, as defined in Section 401.011(16), from May 18, 1993, to November 30, 1993, claimant was not entitled to temporary income benefits (TIBS) because he had reached MMI on May 17, 1993.

Appellant (claimant) contends that the designated doctor's report is in error, that the designated doctor had not specified what charts and tables he had used and that the designated doctor had initially assessed an 11% IR, changed it to a 33% IR and finally revised that down to a 14% IR. Claimant further contends that the designated doctor's report is overcome by the opinions of the carrier's Required Medical Examination (RME) doctor and claimant's treating doctor, whose IRs are essentially in agreement. Claimant complains the proceeding, has taken too long and requests that another designated doctor "be assigned" for an IR. Respondent (carrier) responds that the decision is supported by the evidence and requests that we affirm the decision.

DECISION

The decision and order of the hearing officer are reversed and the case is remanded for the appointment of a second designated doctor.

It is undisputed that claimant was employed as a concrete plant manager and that on _____, he sustained a compensable low back injury cleaning concrete. Claimant saw his family doctor, (Dr. HB), who took claimant off duty one day and returned him to light duty on March 31, 1992. A few weeks later Dr. HB referred claimant to (Dr. E) for

surgery and claimant underwent a lumbar laminectomy on September 11, 1992. Dr. E referred claimant back to Dr. HB for follow-up care and released claimant to light duty work. Claimant testified that the employer did not have light duty at the concrete plant. Claimant was receiving physical therapy (PT) during this time. Carrier in May 1993 referred claimant to (Dr. FB) for an RME evaluation. Dr. FB on a Report of Medical Evaluation (TWCC-69) dated May 1, 1993, and narrative dated May 17, 1993, certified that claimant had reached MMI on "5/[date left blank]/93," with a 21% IR. Dr. HB, in a letter dated February 10, 1994, stated (Dr. HB did not certify MMI and did not use a TWCC-69) that claimant had a 22% IR. Carrier disputed the IRs and (Dr. G) was appointed as the Commission-selected designated doctor by a Commission letter dated November 1, 1993.

Initially, Dr. G, in an unsigned TWCC-69 dated "18 FEB 1994" and an unsigned narrative dated November 30, 1993, certified MMI on November 30, 1993, with an 11% IR. A Commission representative requested clarification of that report and in a letter dated April 28, 1994, and TWCC-69 dated May 11, 1994, Dr. G increased claimant's IR from 11% to 33% stating that his initial report did " . . . not necessarily include any impairment which might be the result of loss of motion" and that he has now assessed claimant "taking into consideration the loss of lumbar motion." Dr. G further stated:

> Using the motion data and the specific disorder data, and combining them in accordance with the AMA Guidelines using the appropriate tables for combined values of these impairments, it is my estimate that his total body impairment is thirty-three percent.

The hearing officer, in his statement of evidence, characterizes this IR as "a [sic] estimate." There are several copies of the April 28th letter and May 11th TWCC-69 in the file, some are signed, others are not. By letter dated May 4, 1994, the disability determination officer (DDO) returned what was apparently the original report(s) for signature and requested "a copy of the tables and charts indicating your finding to support the whole body rating of 33%." Dr. G apparently returned signed copies, in that the DDO, by letter dated May 31, 1994, acknowledged receipt of the signed TWCC-69, asked for a signed copy of the April 28th letter " . . . and a copy of the charts giving the figures and measurements attained during [claimant's] physical examination." Apparently, no additional information was available when the CCH commenced on June 13, 1994. After hearing testimony the hearing officer announced he was leaving the record open in order that he could obtain further clarification from Dr. G. The hearing officer allowed the parties to submit questions to him (the hearing officer) for the designated doctor and by letter, dated July 6, 1994, submitted 17 questions to Dr. G. Dr. G in a response dated July 21, 1994, replied, in part:

> I attempted to reestimate [claimant's] impairment evaluation based on my recollection of his lack of motion and comparing this to the appropriate tables in the AMA guidelines for range of motion. At best, this estimate would be only

> approximate, but with the information I had to use, it was the best estimate possible at that time.

Dr. G goes on to say that he does not believe the use of inclinometer to be "particularly reliable to measure motion." Dr. G recommended that claimant be "sent to a qualified occupational therapist for computerized and mechanical testing . . . so . . . a more accurate estimate of his lumbar motion could be obtained . . . ." Dr. G conceded an inclinometer was not used in claimant's November 30th evaluation. Dr. G did however offer to reevaluate claimant using an inclinometer. The hearing officer requested Dr. G reexamine and reevaluate claimant using the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). By letter dated September 13, 1994, from the Commission, Dr. G was asked to reexamine claimant to determine MMI and the IR.

Dr. G, in an unsigned narrative dated October 13, 1994, and unsigned TWCC-69 dated October 19, 1994, again certified claimant reached MMI on May 17, 1994, but with a 14% IR. The hearing officer sent the reports back to Dr. G for signature on November 4, 1994, and eventually received signed copies. The reports again did not contain charts and figures on how Dr. G arrived at his rating but it did contain a narrative regarding the process how the doctor had arrived at the rating. A portion of the narrative states:

> There is a validity criterion which must be met before the flexion and extension data is valid. For a male patient, the validity tests requires that the sacral hip flexion measurement plus the sacral hip extension measurement, must exceed 55 degrees. This was measured carefully for [claimant] on two occasions during his recent office visit, and the validity test was not met. This means that the flexion/extension measurements are invalid according to the AMA Guidelines since his sacral hip flexion plus extension measurement did not exceed 55 degrees, but was, indeed, approximately 30 degrees. Again, this invalidated the flexion and extension measurement, and requires that, according to AMA Guidelines, the flexion and extension measurement should not be used in calculation of the impairment rating.

We are unaware of a "validity criterion" for male patients where the sacral hip flexion plus the sacral hip extension "must exceed 55 degrees." We could speculate what Dr. G meant, however, it would be inappropriate for us, as lay persons, to try to guess what the doctor intended.

As previously noted, the hearing officer determined MMI and the IR based on Dr. G's report dated October 19, 1994, and claimant appealed on several grounds. We agree that this process has taken longer than usual. The Appeals Panel has long held that the designated doctor occupies an important and unique position under the 1989 Act. Texas Workers' Compensation Commission Appeal No. 92417, decided September 17, 1992.

The Appeals Panel has further held that while a designated doctor may within reasonable time, change or amend a report for proper reason, repeated changes may call into question the efficacy of the designated doctor program under the 1989 Act. Texas Workers' Compensation Commission Appeal No. 941087, decided September 26, 1994; Texas Workers' Compensation Commission Appeal No. 93837, decided October 29, 1993; Texas Workers' Compensation Commission Appeal No. 93328, decided June 2, 1993; Texas Workers' Compensation Commission Appeal No. 931071, decided January 6, 1994. The Appeals Panel stated that the hearing officer or other Commission official should take early and appropriate action to clarify or cause corrections to be made in the designated doctor's report. This was done in the instant case as evidenced by the DDO's letters of May 4, 1994, May 31, 1994, and the hearing officer's letter dated July 6, 1994, the order to reexamine claimant dated September 13, 1994, and further hearing officer's letter dated November 4, 1994. In this case, Dr. G's original report assessed an 11% IR based on an examination of November 30, 1993, this assessment was changed to a 33% IR based on lack of ROM testing and Dr. G's estimate in April/May 1994, and was changed again to 14% IR based on an October 1994 reexamination. We are not saying that two changes over an eleven month period will, per se, invalidate a designated doctor's report, but together with the doctor's repeated failure to provide tables and charts to the Commission, after having been requested to do so, along with the designated doctor's reference in his latest report to a "validity criterion" for male patients which requires sacral hip flexion plus extension measurements to "exceed 55 degrees" without reference to a specific table or provision in the AMA Guides, would indicate to us that the designated doctor may be unfamiliar with the AMA Guides.

We are cognizant that a designated doctor should not be replaced absent a substantial basis for doing so. And, the Appeals Panel has frequently emphasized that a good and viable designated doctor program is very important and essential in the 1989 Act. Texas Workers' Compensation Commission Appeal No. 93105, decided March 26, 1993; Texas Workers' Compensation Commission Appeal No. 93062, decided March 1, 1993. In the instant case, the designated doctor raised his initial 11% IR to 33% without providing a good basis for doing so, apparently based on his "recollection of [claimant's] lack of motion." It is clear that in his first and second assessments the designated doctor did not comply with the AMA Guides in assessing an IR. *See* Texas Workers' Compensation Commission Appeal No. 93296, decided May 28, 1993, for the elements of an IR. In the designated doctor's latest report he refers to a male patient validity test which requires certain measurements to exceed "55 degrees" before validity can be determined. As previously noted, we could speculate what the doctor meant, direct that the hearing officer or other Commission official go back to Dr. G, yet a fifth or sixth time in an effort to have the doctor comply with the AMA guides and directions, however, under the circumstances of this case we believe it appropriate for the Commission to appoint another designated doctor. Texas Workers' Compensation Commission Appeal No. 931071, decided August 6, 1994. For the above reasons, in conjunction with each other, we disagree with the carrier that the appointment of a second designated doctor is unwarranted. In that no

other doctor's report meets validity criteria, Section 408.125(e) (which provides that if the great weight of medical evidence contradicts the designated doctor's report, the IR of one of the other doctors shall be adopted) cannot be used as there is no IR which can be adopted by the Commission.

Claimant asks for an explanation why certain medical reports referred to certain doctors, stating "I have no medical reports and have never seen these Doctors." The carrier's explanation that these were doctors who read the myelogram reports, pathology reports or was a resident in the hospital appears correct. The fact that claimant was unaware that these doctors had made entries or rendered opinions does not make those records inadmissible.

We reverse the hearing officer's decision and remand the case for the appointment of a second designated doctor, having determined that the initial designated doctor had not complied with the AMA Guides, failed to provide charts and tables when requested to do so and in his final report referred to "a male patient . . . validity test" for which we find no authority in the AMA Guides.

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.

Thomas A. Knapp
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Tommy W. Lueders
Appeals Judge