APPEAL NO. 990925

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on April 12, 1999. She determined that the appellant's (claimant) date of maximum medical improvement (MMI) was April 8, 1996, and her impairment rating (IR) was eight percent as certified by Dr. S, a designated doctor selected by the Texas Workers' Compensation Commission (Commission). The claimant appeals this determination, expressing her disagreement with it. The respondent (carrier) replies that the decision is correct, supported by sufficient evidence, and should be affirmed.

DECISION

Affirmed in part and reversed and remanded in part.

The claimant worked as a cashier. She sustained a compensable lumbar and cervical spine injury in a slip-and-fall accident on _____, and thereafter underwent conservative treatment. She was first certified at MMI as of April 8, 1996, and assigned a four percent IR by Dr. B, then the treating doctor. The claimant disputed this certification and Dr. S was selected as the designated doctor by the Commission.

Dr. S examined the claimant on August 6, 1996, and completed a Report of Medical Evaluation (TWCC-69) in which he certified MMI on April 8, 1996, and assigned an eight percent IR. In this report, he stated he agreed with Dr. B's date of MMI and commented that the claimant had no significant improvement with the conservative therapy since Dr. B's examination. Two lumbar ROM worksheets were attached which showed two series of measurements, each of which was seemingly valid. The first test reflected a two percent IR for loss of ROM and the other a zero percent IR. Dr. S adopted the second test results in arriving at his lumbar IR. No reason for the second series was given. Both measurements of cervical ROM yielded a four percent IR. Dr. S also assigned a four percent IR for a specific disorder of the cervical spine, which he described as a soft tissue lesion, unoperated, with none to minimal degenerative changes. He concluded from Dr. B's reports (not in evidence) that the claimant had mild degenerative changes of the lumbar spine and that an MRI showed no definite herniation. He, nonetheless, elected to assign no IR for a specific disorder of the lumbar spine. The MRI on which he presumably relied was done on November 9, 1995. It disclosed an apparent bony lesion at L5 and desiccation with mild bulging at L4-5 and L5-S1.

The claimant then moved from Houston to the Fort Worth vicinity and changed treating doctors to Dr. M. A lumbar MRI on May 18, 1998, showed bulging at L4-5 without herniation and bulging at L5-S1 which "could represent a focal spur or a desiccated disc herniation." Dr. M interpreted this as herniation at L5-S1 and degeneration at L4-5. As a result of an examination of the claimant on December 10, 1998, Dr. M completed a TWCC-69 in which he found MMI as of that date and assigned an 11% IR solely for the lumbar spine, consisting of seven percent for a specific disorder and four percent for loss of ROM.

In doing so, he apparently assumed that Dr. S's IR, to the extent that it applied to the cervical spine, was still valid. In any event, after an examination on February 9, 1999, Dr. M issued a second TWCC-69 in which he found MMI as of that date and assigned a four percent IR. It was the position of the claimant that the two TWCC-69s of Dr. M should be combined, at least with regard to IR, and that the date of MMI should be the statutory date, which, if applicable, the parties agreed would be August 23, 1997.[1]

The carrier also argued that the claimant waived her right to challenge the designated doctor's report because of her delay in doing so from August 6, 1996, the date of the report, until September 18, 1998, when the first benefit review conference (BRC) was held. While the appropriateness of using these dates to calculate waiver was not apparent, the hearing officer acknowledged this position of the carrier, but made no determination of whether waiver applied in this case or not. *See* Texas Workers' Compensation Commission Appeal No. 981291, decided July 30, 1998, and Texas Workers' Compensation Commission Appeal No. 980355, decided April 6, 1998.

Sections 408.122(c) and 408.125(e) provide that the report of a Commission-selected designated doctor is entitled to presumptive weight and the Commission shall base its determination of MMI and IR on this report unless the great weight of the other medical evidence is to the contrary. An IR must be assigned in accordance with the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). Section 408.124. The party challenging the report of a designated doctor has the burden of proving non-compliance with the AMA Guides or that the great weight of the other medical evidence is contrary to that report. The hearing officer, in this case, afforded presumptive weight to Dr. S's TWCC-69 and found that the great weight of the other medical evidence was not contrary to it.

The claimant appeals the determination of MMI, contending that she was not at MMI on the date certified by Dr. S because she was still under the care of Dr. B at the time of Dr. S's certification and Dr. B "had not yet exhausted all forms of care and treatment for my condition and injuries." Section 401.011(30) defines the date of MMI for purposes of this case as the earliest date after which further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated or the expiration of 104 weeks from the date on which income benefits begin to accrue. We have noted in the past that the MMI is not necessarily the achievement of a pain-free status or an indication that further medical care may not be necessary. *See* Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1997, and Texas Workers' Compensation Commission Appeal No. 93489, decided July 29, 1993. In this case, the claimant has gone through conservative care with Dr. B and continues with conservative care under Dr. M. We are aware of no requirement that "all methods of treatment" be exhausted before MMI can be certified. As noted above, MMI connotes a period of more-or-less medical stability. A challenge to the designated doctor's certification must be based on medical evidence, not a

[1]This representation was made at the CCH by the ombudsman. On appeal, the claimant argues for a December 10, 1998, date of MMI.

claimant's lay opinion. Dr. M selected successive dates of MMI based on the dates of his examinations. The hearing officer could consider Dr. M's and Dr. S's opinions on MMI to be no more than a professional disagreement that did not rise to the level of the great weight of the other medical evidence contrary to the report of Dr. S. Whether the great weight of the other medical evidence is contrary to the report of a designated doctor is a question of fact for the hearing officer to decide and her resolution of this question is subject to reversal on appeal only if it is, in turn, against the great weight and preponderance of the evidence. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Pool v. Ford Motor Company, 715 S.W.2d 629, 635 (Tex. 1986). We find the evidence sufficient to support the determination that the claimant's correct date of MMI is April 8, 1996, and affirm that determination.

The claimant's challenge to Dr. S's IR is premised on his failure to assign an IR for the lumbar injury. Clearly, Dr. S recognized the existence of a compensable lumbar injury because he examined the claimant for such an injury. Our concern is twofold: first, the lack of any rationale in not assigning an IR for a specific disorder of the lumbar spine; and, second, the retest of ROM after a valid test which found a two percent IR. In his narrative, Dr. S refers to the MRI and evidence of lumbar degenerative changes, with no definite herniation. In his worksheet, the category of specific disorder for the lumbar spine is not even listed. A comparison to the cervical IR he assigned discloses that, in addition to cervical ROM, he assigned a specific disorder IR for none to minimal degenerative changes and he includes a specific category of cervical specific disorders in his worksheet. This different treatment of this component of the compensable spine injury appears inconsistent and without supporting rationale. With regard to ROM, we have held that, where valid ROM test results have been obtained on the first test, it may be error to retest and substitute invalid test results. Texas Workers' Compensation Commission Appeal No. 951142, decided August 28, 1995. In this case, we have the unusual situation wherein both tests were valid, though with widely varying measurements, but there was no explanation why Dr. S chose the second test results of zero percent IR, instead of the first test results with two percent IR, or why he chose to retest at all. For these reasons, we reverse the determination of the hearing officer that the claimant's correct IR is eight percent and remand this issue to the hearing officer. *See* Texas Workers' Compensation Commission Appeal No. 962329, decided December 17, 1996, where we remanded for an explanation of why a zero percent IR was assigned despite evidence of surgery, and Texas Workers' Compensation Commission Appeal No. 961321, decided August 22, 1996, where we remanded because there was undisputed evidence of a herniation, but there was no specific disorder rating and no explanation of why not. *See also* Texas Workers' Compensation Commission Appeal No. 971776, decided October 24, 1997, where we stressed the need for explanations of seemingly anomalous ratings in designated doctors' reports. On remand, subject to our discussion below, further inquiry should be made of Dr. S. He should be advised that the compensable injury includes the lumbar spine and asked why he included a specific disorder rating for the cervical spine, but not for the lumbar spine , and why he adopted the second lumbar ROM test results when there was already a valid lumbar ROM test. Any amendment of his IR should be done with reference to the date of MMI and all the components of a spine injury should be considered. Further examination of the claimant may be indicated in Dr. S's discretion.

Concurrent with further communication with Dr. S, the hearing officer should address with express findings of fact and conclusions of law the carrier's argument that the claimant, through undue delay, waived her right to contest Dr. S's certification. This "defense" was raised at the BRC and was actually litigated at the CCH, a fact recognized by the hearing officer in her decision and order. The failure of the hearing officer to resolve this question was not raised by the carrier on appeal because it otherwise prevailed on the merits. *See* Buckholts Independent School Dist. v. Glaser, 632 S.W.2d 146 (Tex. 1982). In light of our remand of the IR determination, the waiver issue should also be expressly resolved.

Finally, we note that the claimant is not liable for attorney's fees in this case. Any order to pay these fees will be directed to the carrier.

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 Commission's Division of Hearings, pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

_____
Alan C. Ernst
Appeals Judge

CONCUR:

_____
Tommy W. Lueders
Appeals Judge

DISSENTING OPINION:

I do not necessarily disagree with the majority decision remanding the case for clarification of Dr. S's IR, although I think this case could have been affirmed. It is on the "waiver" issue that I strongly disagree, particularly remanding on an issue that was not appealed. First, I would note that there is nothing in the 1989 Act or the Commission rules which requires that a designated doctor's assessment be appealed within a certain period of time on penalty that failing to do so forever waives a party's right to dispute that rating. The doctrine of waiver is an equitable doctrine and, generally speaking, the Appeals Panel has not often applied equitable doctrines. *See* Texas Workers' Compensation Commission Appeal No. 971351, decided September 2, 1997; Texas Workers' Compensation Commission Appeal No. 960166, decided March 8, 1996. Carrier, in its response, refers to

amendment or revision of the designated doctor's report for a proper reason and within a reasonable period of time. The Appeals Panel has affirmed that proposition in numerous cases. For example, *see* Texas Workers' Compensation Commission Appeal No. 960960, decided July 3, 1996. But that is not the situation here where carrier is arguing that claimant is barred (has "waived") from disputing the designated doctor's report because claimant had not disputed the report within "a reasonable period of time." Carrier goes on to state, "The Commission has set a six-month period in the question resolution logs last year, QRL number 61. . . ." First, Question-Resolution Log (QRL) 98-61 deals with what is a reasonable time for a dispute resolution officer (DRO) to request a clarification from a designated doctor stating "[g]enerally, requests for letters of clarification received more than six months after the date of the examination should be denied. . . ." That has nothing to do with the more stringent penalty that failure to dispute in a certain period of time results in a permanent waiver or ability to ever dispute. Second, while a QRL may serve as guidance I do not consider it binding precedent such as an appellate court decision or even an Appeals Panel decision. While I will concede there are Appeals Panel decisions which have applied, or suggested application of, this doctrine in extreme cases, in this case, it is, at best, an ancillary unappealed matter in which carrier's response cites an inapplicable QRL, which is itself questionable authority. I think it is just plain wrong to require the hearing officer to "resolve" the waiver issue. There was no enunciated waiver issue, the hearing officer addressed the issue appropriately (although I defy the hearing officer to cite where "the 1989 Act applies waiver concepts" in disputing a designated doctor's rating), waiver was not appealed, and carrier cited an inapplicable QRL. Further, equitable doctrines are not viewed with favor and I do not necessarily feel bound by a QRL as binding precedent. Requiring further "resolution" of a purely equitable doctrine in this case merely proliferates further appeals to require a party to dispute a designated doctor's assessment within a certain period of time. For these reasons, I would not require the hearing officer to "resolve" the "waiver issue." There was no waiver issue.

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Thomas A. Knapp
Appeals Judge