APPEAL NO. 991404

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on June 4, 1999. The Decision and Order of the hearing officer indicates that the appellant (claimant) and the respondent (carrier) stipulated that the claimant sustained a compensable injury to her low back on (incorrect date of injury), and that income benefits began to accrue on March 21, 1996. The claimant appealed two stipulations that state that the date of injury is (incorrect date of injury), pointing out that the date of injury is _____. The record indicates that the parties stipulated that the claimant sustained a compensable injury on _____, and we reform the Decision and Order to indicate that the claimant sustained a compensable injury on _____.

The hearing officer made the following findings of fact and conclusions of law:

FINDINGS OF FACT

5. On May 7, 1997, [Dr. A, Dr. AC] certified that the Claimant reached maximum medical improvement [MMI] on September 23, 1996 and assigned the Claimant an 11% impairment rating [IR], totally from Table 49 of the Guides [Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides)].

6. On September 15, 1997, the Commission's [Texas Workers' Compensation Commission] designated doctor, [Dr. L, Dr. LC], certified that the Claimant reached [MMI] on September 12, 1996, which he thought was the statutory date of [MMI], and assigned the Claimant a 12% [IR]. This consisted of 11% from Table 49 of the Guides and 1% for lumbar left lateral flexion range of motion [ROM].

7. When the designated doctor was advised that he was mistaken about the statutory date of [MMI], [Dr. LC] amended his report to read that September 15, 1997 was the date of [MMI]. The statutory date of [MMI] is March 17, 1998.

8. On March 10, 1998, [Dr. A] certified that the Claimant reached [MMI] that day and assigned her a 23% [IR]. His rating consisted of 11% from Table 49, 4% for lumbar lateral flexion [ROM], and 5% for motor loss from Tables 45 and 11 of the Guides.

9. Neither [Dr. AC] nor [Dr. LC] found objective clinical findings of neurological deficits of sensory or motor loss.

10. The Claimant developed mental depression, diagnosed in May 1997, as a result of her chronic pain from her compensable injury. The depression was not a permanent impairment.

11. The great weight of the evidence is not contrary to the report of [Dr. LC], the designated doctor, and his amended report of April 10, 1998 concerning the date of [MMI].

CONCLUSIONS OF LAW

2. The date of Claimant's [MMI] is September 15, 1997.

3. The Claimant's [IR] is 12%.

4. Presumptive weight of the evidence is given to the report of [Dr. LC], the designated doctor, concerning the [IR], and his amended report concerning the date of [MMI].

The claimant appealed Findings of Fact Nos. 8, 9, 10, and 11. She pointed out that the report of Dr. A states that he assigned 10% for motor loss. We reform Finding of Fact No. 8 to state that Dr. A assigned 10% impairment for motor loss.

The claimant extensively reviewed the medical evidence; opined that Dr. LC did not have all of the claimant's medical records to review when he issued his report; urged that the hearing officer erred in not seeking clarification from the designated doctor and abused his discretion in admitting unspecified carrier's exhibits; contended that Findings of Fact Nos. 9, 10, and 11 are against the great weight and preponderance of the evidence; and requested that the Appeals Panel reverse the decision of the hearing officer and render a decision that she reached MMI on March 10, 1998, with a 28% IR. The carrier responded; urged that the hearing officer did not err in not seeking clarification from the designated doctor or in admitting exhibits offered by the carrier, that there is no indication that the designated doctor did not have all of the medical records when he rendered his report, and that the evidence is sufficient to support the decision of the hearing officer; and requested that it be affirmed.

DECISION

We reverse and remand.

At the hearing, the claimant objected to the exhibits offered by the carrier, contending that they were not timely exchanged. The carrier mailed its exchange of information on the 15th day after the benefit review conference (BRC). The attorney representing the claimant stated that she received the documents five days later. The

carrier obtained documents from the Commission and apparently mailed those documents and the documents that had been previously exchanged to the attorney representing the claimant. The attorney representing the claimant complained that mailing all of the documents caused extra work by her and her staff. The hearing officer did not abuse his discretion in admitting the documents offered by the carrier.

The claimant sustained a compensable low back injury on _____; she continued to work and for some time performed light duty; and she began to miss work on March 13, 1996. Dr. OG performed three-level lumbar surgery on June 27, 1996. At the request of the carrier, Dr. AC examined the claimant and rendered a Report of Medical Evaluation (TWCC-69) dated May 12, 1997, in which he certified that the claimant reached MMI on September 23, 1996, with an 11% IR. In a narrative attached to the TWCC-69 Dr. AC said that he assigned 11% under Table 49 of the AMA Guides, invalidated ROM tests because of the straight leg raise criteria, and did not assign impairment for neurological deficit because there was not objective and measurable evidence of motor or sensory deficits. Dr. AC also wrote "[m]edical review is positive for diabetes and depression" and "[c]laimant complains of emotional upset including concentration and worrying," but does not again mention depression in his report. Dr. DG, the claimant's treating doctor, indicated on the TWCC-69 that he disagreed with both the certification of MMI and the IR assigned. In a TWCC-69 dated September 15, 1997, Dr. LC certified that the claimant reached MMI on September 12, 1996, with a 12% IR. In a narrative attached to the TWCC-69 Dr. LC reported that the examination was confined to the claimant's lower back; that Dr. OG performed surgery on June 27, 1996; that she continued to have lower back pain; that she had been to rehabilitation and was currently under the care of Dr. DG; that the claimant complained of pain in her back, right calf, and occasionally into her left lower extremity; that a recent MRI showed no evidence of recurrent disc herniation; that he reviewed outside medical records; that she currently takes Lortab, Paxil, and Amebien; that she has diabetes controlled by diet; that the claimant had a questionable area of hypesthesia on the proximal medial calf which was felt to be due to residual of sensory neuropathy; that there was no evidence of motor weakness or muscle wasting; that ankle and knee jerk were intact, sensation on the plantar aspect of both feet was normal, and there were no pathological reflexes; that his impression was postoperative previous multilevel laminectomy and mechanical low back pain; that the claimant did not experience any impairment as a result of the hypesthesia in the posterior tibial nerve; that lumbar flexion and extension tests were invalidated because of the straight leg raising tests; and that he assigned a 12% IR consisting of 11% under Table 49 of the AMA Guides and one percent for decreased left lateral flexion. Dr. LC does not mention depression in his report. In a letter dated March 5, 1998, a Commission disability determination officer wrote to Dr. LC, advising him that the claimant would reach MMI by operation of law on March 16, 1998, and asking him to make necessary amendments to his report concerning MMI. Dr. LC issued a TWCC-69 dated April 10, 1998, in which he certified that the claimant reached MMI on September 15, 1997, with a 12% IR and in a letter dated April 10, 1998, said that it was his opinion that the claimant did not reach MMI until the date of the examination he performed on September 15, 1997.

Medical reports in evidence that are dated prior to the examination by Dr. LC on September 15, 1997, contain limited references to depression. The claimant was referred to Dr. WSA, a neurologist, for pain management. In a consultation report dated May 19, 1997, Dr. P, a psychologist with a Ph.D., said that Dr. WSA referred the claimant to him as part of the pain management program; briefly reviewed the history of the claimant's injury and treatment; diagnosed chronic pain and depression secondary to chronic pain; and recommended a comprehensive pain program and a psychiatric referral to determine the need for psychotropic medications. In a psychiatric IR dated January 13, 1999, Dr. N, a psychiatrist, stated that the claimant was referred to him; that his initial evaluation took place on May 22, 1997; and that he found her to be suffering from a "Major Depression, Single Episode, Moderate Degree." The only report from Dr. N in the record is the report dated January 13, 1999. In that report Dr. N said that he began treatment with antidepressant medication, her mood and outlook improved remarkably, and without providing a date wrote:

> At this point, the major depression was almost completely resolved, although with a very small amount of lingering, mild depression on some days, but generally the patient having very good days, psychiatrically.
>
> Since that time, the patient has had a number of exacerbations, or relapses, of her major Depression. We have tried some change of medications, but these have generally proved less effective than Paxil.
>
> * * * * *
>
> While generally in full remission, her depression does have some occasional relapses, though these are generally to a mild degree. Due to the length of time that her depression has persisted, this condition is determined to be permanent.
>
> After consulting the AMA guide, Chapter 14, Mental and Behavioral Disorder, Table 1, page 233, it is determined that the patient has a 5% permanent [IR] from her psychiatric condition alone.

In progress review notes dated May 29, 1997; June 26, 1997; and July 3 and 10, 1997, Dr. WSA wrote:

> **Problem #3 - Depression**
>
> Present medications include: TENS unit with simple analgesics. Will add Skelaxin 100mg. up to t.i.d. for muscle spasms, and Relafen 500mg. Two each a.m. for pain and anti-inflammatory purposes.

In a report dated July 14, 1997, Dr. WSA reported that Dr. N has the claimant on a number of medications to help her sleep and tolerate pain and recommended that she continue her follow-ups with Dr. N. In a progress review note dated August 21, 1997, Dr. WSA wrote:

> **Problem #3 - Depression**
>
> Present medications include: TENS unit and simple analgesics. Skelaxin 100mg. up to t.i.d. for muscle spasms, and Relafen 500mg. two each a.m. for pain and anti-inflammatory purposes. [Dr. N] prescribed Paxil 20 mg. a.m. for injury related depression. Other medications include: tylenol prn and Lortab HS. [Claimant] had an increase in depression this week and is scheduled to see [Dr. N] regarding this.

A progress review note from Dr. WSA dated September 4, 1997, under Problem #3 - Depression simply states "[p]resent medications include: Paxil 20mg, Tylenol ES and Lortab."

In a TWCC-69 Dr. WSA assigned a 23% IR. In a letter to the Commission dated May 20, 1998, the attorney representing the claimant requested that the TWCC-69 and attached report from Dr. WSA be sent to the designated doctor for review. In a letter to the attorney dated May 26, 1998, a Commission disability determination officer wrote:

> This is to inform you that the information you requested be forwarded to the designated doctor cannot be forwarded at this time, since it is considered to be new medical. Since you did not submit a Request For a [BRC] (TWCC-45), your request could not be forwarded to a proceeding at this time.

In a TWCC-45, the claimant requested a BRC and stated the reason as a request that new medical evidence be forwarded to the designated doctor. A BRC was held on July 15, 1998, and apparently the benefit review officer (BRO) advised the claimant to obtain a report from Dr. N on the question of whether the depression was permanent. A report was obtained and another BRC was held on April 7, 1999. At the BRC, the claimant requested that a letter of clarification be sent to the designated doctor for review of the psychological condition. The second BRO denied that request. In a May 6, 1999, response to the BRC report, the attorney representing the claimant stated that the designated doctor reported that he considered outside medical records; that it is not known what records the designated doctor considered; that in a report dated January 13, 1999, Dr. N assigned a five percent impairment for depression. In that response, she also requested that Dr. WSA's and Dr. N's reports be sent to the designated doctor to consider neurological and behavioral impairment. At the hearing, that request was renewed.

Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE §130.6(h) (Rule 130.6(h)) provides that the treating doctor and the insurance carrier are responsible for sending to the designated

doctor all the employee's medical records relating to the medical condition to be evaluated by the designated doctor that are in their possession. In the case before us, neither Dr. WSA nor Dr. N was the claimant's treating doctor and it is not clear which reports were in the possession of the treating doctor and the carrier immediately prior to the examination by the designated doctor. It is clearly preferable for the designated doctor to have all of the medical records, but there is not an absolute requirement in the Commission's rules that the designated doctor have all medical records. In the case before us, the designated doctor conducted a neurological examination, commented on a questionable area of hypesthesia, noted that a recent MRI showed no evidence of recurrent disc herniation, and did not assign an impairment for neurological deficit. The hearing officer determined that the report of Dr. LC is entitled to presumptive weight, considered the other medical evidence, and determined that the great weight of the other medical evidence is not contrary to the report of Dr. LC. The evidence concerning neurological deficit is sufficient to support those determinations as related to neurological deficit. However, the report of Dr. LC in no way indicates that he considered the claimant's depression in rendering his report that the claimant's IR is 12%. Since there is no indication that Dr. LC considered all of the claimant's compensable injury when he assigned the 12% IR, his report was not made in compliance with the AMA Guides and is not entitled to presumptive weight. The designated doctor did not consider the claimant's depression in determining that the claimant reached MMI on September 15, 1997. The depression must be considered to determine whether impairment should be assigned, and if so, how much. We reverse Conclusion of Law No. 4 that presumptive weight is given to the reports of Dr. LC concerning MMI and IR and Finding of Fact No. 11 that the great weight of the medical evidence is not contrary to those reports. Without the benefit of an opinion from the designated doctor concerning depression, the hearing officer determined that the claimant's depression was not a permanent impairment. We reverse that part of Finding of Fact No. 10. We also reverse Conclusion of Law No. 2 that the claimant reached MMI on September 15, 1997, and Conclusion of Law No. 3 that the claimant's IR is 12%. We affirm Finding of Fact No. 9 that neither Dr. AC nor Dr. LC found objective clinical findings of neurological deficits of sensory or motor loss.

We reverse and remand to the hearing officer. He should send the medical records concerning the claimant's depression to the designated doctor for his consideration in determining when the claimant reached MMI and whether the claimant should be assigned an impairment for depression. Dr. LC should issue another TWCC-69 certifying the date the claimant reached MMI and her IR. He should attach a narrative report explaining why he did or did not make changes in the date the claimant reached MMI and her IR. Since Dr. LC is not a psychiatrist, he may send the records of the claimant to a psychiatrist for his consideration, request that the psychiatrist examine the claimant, and ask that the psychiatrist provide his opinion concerning the date the claimant reached MMI and an impairment as they relate only to the depression.

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

Tommy W. Lueders
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Dorian E. Ramirez
Appeals Judge