

## APPEAL NO. 991672

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 July 7, 1999. The issue at the CCH involved the impairment rating (IR) to be assigned to the appellant, (claimant) who is the claimant, for his compensable injury of \_\_\_\_\_.

The primary dispute involved the refusal of the designated doctor, Dr. T, to perform range of motion (ROM) testing during his third evaluation of the claimant. The hearing officer held that it was not unreasonable nor against the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) for Dr. T not to have done so. Accordingly, the hearing officer found that the claimant's IR was 13%, and was not overcome by the great weight of contrary medical evidence. The hearing officer discusses that he believes that there are medical records indicative of symptom magnification which would in part justify the designated doctor's actions.

The claimant has appealed at length, pointing out that years of medical records would show that the IR is too low. He attaches a number of documents and records that were not offered into evidence at the CCH. He argues that the better IR to have adopted was that of a referral doctor who assessed an IR which included ROM. The respondent (carrier) responds by objecting to the inclusion of new evidence at the stage of appeal. The carrier argues that claimant exhibited symptom magnification; the impact this would have on an objectively established IR is not pointed out. The carrier disputes that the claimant has reflex sympathetic dystrophy (RSD) or neurological effects.

### DECISION

We reverse and remand for further development and consideration of the evidence.

We cannot consider additional evidence that comes for the first time attached to the appeal. When the burden of proof is on the party disputing a designated doctor's report, it behooves that party to fully develop medical records at the time of the CCH. Because only four records were put into evidence by the claimant during the CCH, much of claimant's past history must be reconstructed through narratives in reports of other doctors, including the designated doctor. The claimant sustained a back injury on \_\_\_\_\_. The claimant was apparently first found to be at maximum medical improvement after a course of conservative care, and this was disputed. Dr. T was appointed as designated doctor and first examined the claimant on June 20, 1994. However, claimant by that time was under the care of a surgeon who had recommended surgery following a discogram. Dr. T nevertheless gave an IR, which was nine percent. He refers to the fact that claimant's ROM testing was then invalid.

Claimant subsequently had surgery in the lumbar area, on November 9, 1994, and there was no evidence that the proper procedures were not complied with in advance of

such surgery. Because claimant continued to have pain after his surgery, he came under the care of a pain management doctor, Dr. A. Claimant did not respond well to three ESI injections. Dr. A therefore opined that claimant could have RSD.

Dr. T was asked to reexamine the claimant and did so. This examination took place on September 10, 1996, and claimant was at that point in a wheelchair. Dr. T commented that claimant had considerable "non-organic manifestations." He was unable to conduct ROM because claimant began to fall. In his report, Dr. T noted that this diagnosis seemed reasonable, but there was little clinical evidence to substantiate it. He noted that this might reflect benefits of a spinal stimulator that the claimant had implanted in January 1996. He found no functional impairment during this examination that could be related to RSD. However, Dr. T noted in his diagnoses the presence of "probable" RSD. He stated, in giving claimant a 10% IR with no ROM, that he would be happy to reevaluate claimant for ROM in the future but suggested getting a report from claimant's surgeon that it would be safe to perform such measurements. Dr. T noted a sensory deficit, but so small that it did not merit an IR on applicable portions of the AMA Guides.

Finally, claimant had a third surgery to readjust leads in his spinal cord stimulator. This took place September 18, 1997. He was treated for depression with suicidal ideation on October 7, 1998. Dr. T examined claimant for a third IR on October 1, 1998. Dr. T recorded that claimant was taking eight medications, in addition to a morphine pump. The claimant testified that he brought a note from Dr. A which stated that it would be safe to conduct ROM, but Dr. T refused to do so. (Dr. T's comment was merely that he found it neither prudent nor feasible to conduct ROM at this time, and he did not believe that ROM could ever be measured with any degree of accuracy.) Dr. T noted that claimant's lumbar spine was not tender. His leg raise test was negative while seated "although it did relate to back pain." Dr. T stated that it was not possible to assess supine leg raising because hip flexion was only to 20 degrees, which he said was "probably invalid." He felt that claimant displayed overt pain behavior, but said that he would not characterize this as a "positive nonorganic survey" although it had been positive at prior examinations. Dr. T opined that his lower extremity evaluation did not have changes that could be related to RSD, and there was no atrophy of the lower extremities. According to a psychological evaluation that claimant had undergone, he had a past history of incarceration and drug addiction, and his current behavior pattern was one associated with dependency on medication. Dr. T submitted what should "probably be considered my final opinion" of 13% IR.

Claimant had an earlier IR evaluation performed on January 30, 1998, by Dr. V, because Dr. A did not perform IR assessments. Dr. V assigned 35% IR, which included 26% for lumbar ROM. Dr. V also added 3% for ankylosis, and 10% for specific spinal conditions. (Dr. T's comment was that he "doubted" these measurements could have been accurate.) Dr. V noted that claimant was deconditioned and ROM measurements with the dual inclinometer method were difficult. He recorded three trials of most spinal movement, with four trials being made of lateral ROM.

In the only record from Dr. A in evidence, he commented unfavorably on Dr. T's IR. He referred to a six-inch file on claimant's treatment, which he felt refuted Dr. T's opinions. Dr. A said that RSD was impossible to assess in a one-time evaluation. Dr. A argued that claimant was appropriately medicated for his pain and not drug dependent. He stated that claimant had neurological deficits residuary to his surgery, although this had responded to his medication.

We should first clarify what was not at issue here. Matters relating to the reasonableness or necessity of medical treatment were not in issue; thus, the impressions that the designated doctor or any other doctor in this case may have had about the need for surgeries performed on the claimant, or his pain management program, were somewhat beside the issue. Scope or extent of injury was not before the designated doctor, IR was. While we do not see a provision in the AMA Guides for rating RSD as a condition, the AMA Guides do provide, however, for assessment of sensory loss and muscle strength. It appears that both Dr. T and Dr. V declined to assess, and did not find, any neurological or strength deficits to the degree warranting an IR.

However, our concern with the designated doctor's third IR is that he failed to perform the ROM examination. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6 (Rule 130.6), a comprehensive designated doctor administrative rule, sets out some parameters to be observed during an examination. Rule 130.6(l) states that ROM testing should be performed by the designated doctor, or his qualified referral health care provider, when applicable. Rule 130.6(k) states that if the AMA Guides specify additional testing to be done because of consistency requirements, the designated doctor shall reschedule testing within seven days unless there is no clinical basis for retesting, which must be documented in the narrative notes to the report. We find no such basis or documentation set forth in Dr. T's report. There was evidence that another doctor (Dr. V) had been able to perform ROM testing, albeit with difficulty.

At pages 89-94, the AMA Guides discuss ROM considerations, and are written in terms of repeating measurements when valid measurements can be obtained. The AMA Guides also define ankylosis in terms of immobility in both hips and the lumbar spine. It is further indicated in the AMA Guides that reproducibility of results and the straight leg raising test are validity checks to screen out submaximal effort, the effects of pain and fear of injury, or conscious attempts to influence the results. It is suggested on page 72 that tests be repeated on another date if consistency requirements are not met.

It is obvious that when ROM testing is not performed at all, it cannot be determined if results are consistent or inconsistent. While Dr. T wrote with doubt about Dr. V's ROM data accuracy, this could only be sheer speculation in the absence of Dr. T's own measurements. We find that the according of presumptive weight to Dr. T's third report under these circumstances is contrary to the great weight of the other medical evidence. The problem facing the hearing officer, had he set aside Dr. T's report, is that Dr. V's report combined ankylosis with ROM measurements, which we have held is not a correct interpretation of the AMA Guides. The likelihood of some ROM deficits following three

surgeries would appear to point in favor of putting resolution of the IR in abeyance pending an attempt to measure ROM. It also is obvious that claimant's full cooperation at this point cannot fail to work toward speedy resolution of a case whose course has been unduly prolonged.

Because Dr. T has indicated that 13% should be considered "his final" IR, and he voiced skepticism that ROM could ever be conducted, this may be a case where appointment of a second designated doctor should be considered. We reverse and remand the decision for further development and consideration of the evidence.

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.

---

Susan M. Kelley  
Appeals Judge

CONCUR:

---

Gary L. Kilgore  
Appeals Judge

---

Dorian E. Ramirez  
Appeals Judge