

APPEAL NO. 991745

Following a contested case hearing held on July 14, 1999, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer, resolved the disputed issue by finding that both reports of the designated doctor selected by the Texas Workers' Compensation Commission (Commission) are contrary to the great weight of other medical evidence on the issue of the respondent's (claimant) impairment rating (IR) and are invalid and not entitled to presumptive weight, and by concluding that claimant's IR cannot be determined based on the IRs in evidence. The appellant (carrier) urges error by the hearing officer in not accepting the second report of the designated doctor. Claimant's response urges the sufficiency of the evidence to support the decision.

DECISION

Reversed and a new decision rendered that claimant's IR is zero percent.

The parties stipulated that on _____, claimant sustained a compensable injury; that the Commission-selected designated doctor is Dr. C; and that claimant's date of maximum medical improvement (MMI) is December 22, 1998.

Claimant testified that on _____, while at work, he was walking up the stairs of a machine, lost his footing, grabbed on to a gear to keep from falling, and dislocated his right shoulder. He said he was first treated in an emergency room where, under anesthesia, the shoulder joint was relocated; that he was then treated by Dr. B; and that he subsequently began treatment with Dr. L, an orthopedic surgeon, and opted for surgery on the shoulder by Dr. L. He further testified that Dr. L assigned an IR of five percent; that in January 1998 he was examined by the carrier's doctor, Dr. N, also an orthopedic surgeon, who assigned a seven percent IR which the carrier disputed; that Dr. C, an anesthesiologist and pain management specialist, was appointed as the designated doctor; that Dr. C initially felt that claimant had not yet reached MMI; and that when Dr. C later examined him, he did no testing, did not evaluate the stability of the shoulder, and assigned a three percent IR. Claimant was not asked about his knowledge of the clinical techniques employed to evaluate shoulder stability nor did he indicate that he had any medical training. Claimant further stated that in March 1998, he "just found" Dr. M, an orthopedic surgeon, and changed to him as the treating doctor, and that Dr. M performed a second operation on his shoulder in June 1998. He stated that several months later, Dr. C reexamined him and assigned a zero percent IR. Claimant also stated that he has completed work hardening and that Dr. M, who has not yet assigned an IR, disagrees with Dr. C's IR. Claimant acknowledged that Dr. M was not present for Dr. C's examinations. Claimant, emphasizing that Dr. C was the only physician of those who have assigned an IR who is not an orthopedic surgeon, contended, generally, that Dr. C failed to comply with the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) in that he did not test claimant for the stability of his shoulder.

Dr. L wrote on May 12, 1997, that the clinical examination reflects a stable shoulder with excellent range of motion (ROM) and that claimant is released to work regular duty. Dr. L wrote on December 30, 1998, that claimant was determined to be at MMI on July 7, 1997, and released to return to work; that in August 1998, claimant asked for physical therapy to strengthen his arm; and that he gave claimant a referral for that purpose. Dr. L wrote on January 26, 1998, that he rechecked claimant's right shoulder; that since he last saw him, claimant underwent a left shoulder anterior reconstruction for a nonwork-related dislocation under the care of Dr. M; and that claimant feels he cannot return to work at his prior job because of both his right and more especially his left shoulder. Dr. L further reported that claimant underwent precise dual inclinometry ROM testing of the right shoulder on that date; that claimant is assigned an IR of five percent for the right shoulder "due to cosmetic and mild weakness"; that there is no impairment for loss of ROM; and that the fact that claimant continues to complain of pain does not mean that he has not reached MMI.

In evidence is claimant's Employee's Request to Change Treating Doctors (TWCC-53) signed on "2-2-98" which requests to change treating doctors from Dr. L to Dr. M.

Dr. N's Report of Medical Evaluation (TWCC-69), dated January 15, 1998, certifies that claimant reached MMI on "070797" with an IR of "7%." In his accompanying narrative report, Dr. N wrote that according to his review of the medical records, claimant, after initially being treated by Dr. B, commenced treatment by Dr. L on September 16, 1996; that on October 11, 1996, an MRI of the right shoulder indicated a Hill Sach's lesion and a NEER Type I impingement configuration; that there was indication that claimant had a previous right shoulder dislocation although he denied it; that on December 3, 1996, claimant underwent a right shoulder reconstruction; that claimant, after returning to work, reported falling again on March 14, 1997, and feeling his shoulder "pop"; and that claimant was seen for a final check on July 7, 1997, and assigned an IR of five percent. Dr. N further wrote that on August 20, 1997, claimant was diagnosed with a left shoulder dislocation by Dr. G and that claimant continued to be seen by Dr. L for his right shoulder but was seen by Dr. G for the left and that when first seen by Dr. C on October 24, 1997, he was considered not to be at MMI. Dr. N further stated that claimant has some sort of soft tissue disorder which allows him to have bilateral dislocations and that the x-rays indicate repeated bilateral shoulder dislocations though claimant "is loath to admit it." Describing his examination of claimant's right shoulder, Dr. N states that there is a 2.5 inch scar from previous surgery; that there is no tenderness, redness, heat, swelling, deformity, discoloration, atrophy, weakness, clicking, crepitus or sensory change; that apprehension sign is negative; and that "there is stability on both sides." Dr. N concluded that it is evident from the records that claimant's left shoulder dislocation is not work related and that he has reached MMI for the right shoulder injury and should return to Dr. N for ROM studies.

In a December 18, 1997, letter, Dr. N wrote that claimant came to his office stating that both shoulder dislocations were due to his on-the-job injuries but that a review of his chart convinced Dr. N to the contrary and that claimant has reached MMI for his right shoulder. Dr. N reported on January 6, 1998, that claimant returned for right shoulder ROM

measurements; that claimant qualified for a seven percent IR; that claimant cannot do overhead lifting and his lifting from the ground is restricted to 35 to 40 pounds; and that he disagreed with Dr. C on the need for further surgery. From his worksheets, it is apparent that Dr. N's seven percent IR is for loss of ROM.

Dr. C's report of his February 17, 1998, examination of claimant states that claimant's diagnosis is status post repair of right shoulder following dislocation and that he reviewed claimant's medical records, obtained a history, and conducted a physical examination. Dr. C stated that claimant had no abnormal muscle activity, that his sensory and motor strength examinations were grossly normal, and that "the ROM of the areas related to the injury were measured in accordance with the [AMA] Guides." Dr. C further reported that "all necessary measurements were made using the appropriate techniques according to the [AMA] Guides," that "appropriate forms and tables were used from the [AMA] Guides to tabulate the data and make calculations of the IR," that claimant's total upper extremity impairment for ROM is "5%," and that his whole body IR is "3%." Dr. C's TWCC-69 dated "2/18/98" certifies that claimant reached MMI on "2/17/98" with an IR of "3%."

Dr. M wrote on April 22, 1998, that he had Dr. C's evaluation of claimant's right shoulder; that he disagrees that claimant has reached MMI; that "[i]t is clear that [Dr. C] is not clued in as to what [claimant's] problem is"; and that Dr. C's physical examination "did not even test for any instability." Dr. M further stated that while he is sure that Dr. C is an excellent physician and really good at pain management and anesthesiology, he is not an orthopedic surgeon and is "not qualified to determine whether or not [claimant] continues to suffer with instability of the shoulder." Dr. M concluded that he felt that arthroscopic surgery could potentially make the right shoulder problems, "probably due to instability," better.

Claimant introduced the December 18, 1997, operative note of Dr. M reflecting the pre- and postoperative diagnoses as "multi-directional instability, left shoulder, primarily posterior" and stating that claimant had a history of left shoulder instability and that it was difficult for him to articulate exactly when and how his shoulder went out of place.

Dr. M wrote on September 16, 1998, that claimant is still recovering from right shoulder surgery performed on July 24th, and that while "[t]he result has been quite successful so far," claimant will still need therapy and treatment for up to six months. Dr. M also stated that Dr. C is an anesthesiologist and not trained to evaluate the type of problem claimant has; that during his evaluation, Dr. C did not even perform the physical maneuvers to determine the amount of instability in either of claimant's shoulders; and that claimant "continues to suffer with instability of both shoulders that has been treated surgically, and he is still recovering from those surgeries."

Dr. C's report of his November 22, 1998, examination of claimant states that this examination was conducted in response to a Commission letter of November 17, 1998, indicating that claimant had repeat surgery on the right shoulder since his, Dr. C's, last

examination and asking that he reassess the IR. Dr. C further states that because of continued symptoms, claimant had right shoulder surgery in July 1998; that claimant says his shoulder is better but that he still has problems with it; that he complains of "instability in the back," "pinches in front," "pain in the scar," "pain on reaching," and the whole arm "falls asleep"; and that he takes occasional pain medications. Dr. C reported that, according to the records, the original diagnosis was dislocation of right shoulder, that additional subsequent diagnoses include status postrepair of right shoulder, recurrent dislocation of right shoulder, and status postthermal capsulorrhaphy of right shoulder (performed on July 24, 1998), and that the current diagnosis, based on his review of the records and examination, is status postarthroscopic repair of right shoulder. Dr. C stated that his physical examination of the right shoulder revealed no swelling, no crepitus, no AC joint tenderness, mild subacromial tenderness, no impingements, no muscle atrophy, tenderness of the scar and anterior aspect of the shoulder, mild ROM restrictions but without significant pain, and that "there is no instability. [Emphasis supplied.]" Dr. C further reported that while the right shoulder ROM is generally suboptimal, the abduction and flexion decrease is not due to capsular restriction or muscle weakness but voluntary restriction, that the passive ROM was much better and without significant pain, that nonrequested motion revealed much better internal rotation, that a back scratch with the right hand to the L2 level was possible, and a right shoulder scratch with the right hand was also possible and exhibit significant ROM of external rotation. Dr. C concluded that based on the AMA Guides, "a total impairment of 0% to the whole body is obtained" and stated that "the ROM restriction found on measurement was considered to be due to voluntary suboptimal effort and therefore considered invalid and a zero rating was given for ROM."

Dr. M wrote on April 26, 1999, that he is enclosing a letter to dispute Dr. C's IR (such letter is not attached to Dr. M's April 26, 1999, letter) and that claimant tells him his letter is inadequate because it does not list medical evidence to support his position. Dr. M then asks, rhetorically, "[w]hat kind of evidence to you need to dispute a 0% impairment because the evaluating physicians felt that [claimant] was not making a valid effort?" Dr. M further wrote that he thinks that Dr. C's IR is highly inappropriate and that the only "evidence" he can give is that claimant gave a valid effort for him and for a recent functional capacity evaluation. Dr. M stated that claimant is still recovering from surgery and is not at MMI; that an IR is premature, whether or not claimant was felt to have given a valid effort; that he is sending claimant to work hardening; and that claimant will probably reach MMI in about three months after which time he, Dr. M, will be happy to assign an IR.

Paragraph 3.1a of the AMA Guides states in part that methods for evaluating upper extremity impairment can be divided arbitrarily into anatomic, cosmetic, and functional categories; that a combination of these methods is necessary to show an accurate profile of the patient's condition; that presently, the most objective is the anatomic evaluation; that a system for evaluation of physical impairment in the hand and upper extremity due to amputation, sensory loss, abnormal motion, and ankylosis was developed and approved; and that in addition to the techniques of measurement and values for impairment from amputation, sensory loss, and abnormal motion, specific to the thumb, finger, wrist, elbow, and shoulder, specific impairments of the upper extremity due to peripheral nerve and

plexus lesions, and vascular problems are also discussed and a method to combine and relate various impairments to the whole person is presented.

Paragraph 3.1g pertains to the shoulder and describes impairment for amputation and for abnormal motion, including flexion and extension, abduction and adduction, and internal and external rotation, as well as combining impairments due to abnormal shoulder joint motion.

Paragraph 3.1k provides that other derangements can contribute to impairment of the hand and upper extremity and should be considered in the final impairment determination, including bone and joint deformities (including postreconstructive surgery) and musculotendinous disorders. A subparagraph entitled "Joint Instability" states as follows:

Excessive passive mediolateral motion is evaluated by comparing normal joint stability and graded according to its degree of severity. The percentage of impairment is then multiplied by the relative value of the joint. If other impairment percentages of the same joint are present, the values are combined using the Combined Values Chart.

With respect to the hearing officer's findings of fact, we observe that the first nine findings are simply a near-verbatim recitation of her recital of the evidence. The recitation of the evidence in a decision and order is a distinctly different function than the formulation of findings of fact based on the evidence. The Appeals Panel has had occasion to comment on the nature of a finding of fact. See *e.g.*, Texas Workers' Compensation Commission Appeal No. 991704, decided September 23, 1999. It is singularly unhelpful on appellate review to read a recitation of the evidence in the hearing officer's "Statement of the Evidence" and then read the same recitation, virtually verbatim, a second time as purported "Findings of Fact."

The critical factual findings are as follows:

FINDINGS OF FACT

10. The record showed that [Dr. C] did re-examine Claimant within a reasonable amount of time from the first examination for a reasonable purpose, after the second surgery to the right shoulder.
11. Both of [Dr. C's] reports evidenced that he failed to follow the [AMA] Guides by not testing Claimant's right shoulder for instability.
12. Consistent with the [AMA] Guides are [Dr. M]'s opinion that instability testing should have been performed by [Dr. C] and [Dr. N's] report showing how he tested for instability.

13. Both of [Dr. C's] reports are contrary to the great weight of other medical evidence on the issue of [IR].
14. Neither of [Dr. C's] reports on [IR] are valid or entitled to presumptive weight on [IR].

It is clear that the hearing officer was persuaded that Dr. C somehow failed to test claimant's right shoulder for stability. In her discussion, the hearing officer states as follows:

The "Guides" showed on page 45, that when assessing impairment for joint instability (shoulder) excessive passive mediolateral motion is evaluated by comparing normal joint stability and then it is graded according to its degree of severity. It appears that is what [Dr. M] disputed, [Dr. C's] failure to test for instability.

However, the great weight of the medical evidence does not establish that claimant had excessive passive mediolateral motion nor does the great weight of the medical evidence establish that Dr. C's ROM studies were insufficient to evaluate whether claimant had excessive passive mediolateral motion. As previously mentioned, Dr. M, before performing the arthroscopic surgery he eventually performed, wrote that such surgery would make claimant's shoulder problems, "probably due to instability," better. One would expect that Dr. M would hope that claimant's instability, if any, was thus improved.

We view the hearing officer's Findings of Fact Nos. 11 through 14 as being against the great weight and preponderance of the evidence and we reverse them. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). Claimant's lay testimony that Dr. C did not test him for shoulder joint instability obviously does not suffice. Dr. N reported that his examination revealed that both shoulders were stable. Dr. M performed surgery to make claimant's right shoulder stable. Following that surgery, Dr. C again examined claimant's right shoulder and in his second report states that it was stable. Dr. M does state that Dr. C was not trained as an orthopedic surgeon and does allude to Dr. C's not having performed the maneuvers to evaluate the stability of claimant's shoulder. However, claimant testified that Dr. M was not present at Dr. C's examination; there was no evidence introduced to describe just how shoulder joint stability, as apparently distinguished from the three planes of shoulder joint ROM, is clinically evaluated; and claimant did not ask the hearing officer to take official notice of any particular portion of the AMA Guides which describe just how shoulder stability is to be evaluated.

We reverse the hearing officer's conclusion of law that claimant's IR cannot be determined based on the IRs in evidence and the decision and order to that effect and render a new decision that claimant's IR is zero percent.

Philip F. O'Neill
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Gary L. Kilgore
Appeals Judge