APPEAL NO. 991898

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 July 28, 1999. The appellant (carrier) and the respondent (claimant) made stipulations related to jurisdiction and venue and stipulated that the claimant sustained a compensable injury on _____; that he reached maximum medical improvement on July 30, 1996; and that Dr. B is the Texas Workers' Compensation Commission (Commission)-selected designated doctor. The hearing officer made the following findings of fact and conclusions of law:

FINDINGS OF FACT

2. Claimant had an injury on _____ to back his [sic] while at work. Claimant had a lumbar laminectomy in 1994 and a fusion in February 25, 1997 for the _____ back injury. Claimant has had subsequent surgery for pain management.

3. [Dr. K] was Claimant's treating doctor. On April 13, 1998 [Dr. K] submitted a TWCC-69 [Report of Medical Evaluation] in which he assigned Claimant a 37% IR [impairment rating]. The report in the administrative record is incomplete as no narrative describes the assignment of an IR for a specific disorder, loss of motion, or neurological impairment.

4. [Dr. B], a commission designated doctor, examined Claimant on July 29, 1998. At the time of the examination [Dr. B] was not aligned with either the Claimant or the Carrier. [Dr. B] assigned an IR of 13% for a specific disorder based on two surgeries and an additional level. [Dr. B] made a neurological examination and did not find a basis for a neurological impairment. [Dr. B] did not assign any impairment for loss of range of motion [ROM] in lumbar flexion and extension as the measurements did not meet validity criteria, and found no impairment in the left and right lateral flexion. [Dr. B] filed a TWCC-69 and narrative report certifying an IR of 13%.

5. Claimant filed a request for a benefit review conference [BRC] with the commission after [sic] received [Dr. B's] report, and requested a repeat study by the designated doctor, because the [ROM] testing was invalidated.

6. On September 28 1998 the commission wrote [Dr. B] asking if he thought it was appropriate to retest Claimant.

7. On November 30, 1998 [Dr. B] reexamined Claimant. [Dr. B] noted a history of weakness, and numbness in the lower extremities. [Dr. B] again assigned a 13% IR for a specific disorder, and found no valid loss of [ROM] based on measurements using double inclinometers in [sic] the lumbar spine. ([Dr. B] assigned an IR under Table 50 as a substitute for loss of motion of 6%, which is not contemplated by the Guides [Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides)] and is disregarded). [Dr. B] performed a neurological examination and found loss of strength and sensation in the lower extremities that totaled to a 24% whole body IR. [Dr. B] certified an IR of 38% based on the November 30, 1998 examination.

8. [Dr. B's] assignment of a 6% IR under Table 50 is disregarded as an inappropriate solution for loss of [ROM].

9. Under the combined value chart of the Guides IRs of 24% and 13% equals an IR of 34%.

10. Claimant's IR is 34% in accordance with the determinations of [Dr. B], a commission designated doctor.

11. [Dr. B's] determination that Claimant has a 34% IR is not against the great weight of other medical evidence.

CONCLUSIONS OF LAW

5. The use of Table 50 of the Guides to assign an impairment for loss of motion is against the requirements of various Appeals Panel decisions, and [Dr. B's] use of Table 50 to assign such impairment is therefore disregarded.

6. Because [Dr. B] served as a commission designated doctor, whose report assign [sic] Claimant a 34% whole body IR, and [Dr. B's] determinations are not against the great weight of other medical evidence, [Dr. B's] determination is presumed to be correct, and therefore Claimant has a 34% IR from the _____ injury.

The carrier appealed, contended that the Commission set up the second examination by Dr. B without a proper basis, urged that the hearing officer erred in "cutting and pasting" the second report of Dr. B to award a 34% IR, and requested that the Appeals Panel reverse the decision of the hearing officer and render a decision in its favor. The

claimant responded, urged that the hearing officer did not commit error, and requested that his decision be affirmed.

DECISION

We reverse and remand.

The findings of fact set forth earlier in this decision present much of what occurred in this case. Some additional details will be presented. An undated Request for Benefit Review Conference (TWCC-45) signed by the attorney representing the claimant indicates that the block before "[d]isputing the findings of the designated doctor on Maximum Medical improvement or impairment" was checked and that "[ROM] studies were invalidated by DD [designated doctor] & claimant would like to request a repeat study be conducted by the DD" was written on the form. An entry in the Commission's Dispute Resolution Information System (DRIS) indicates that the TWCC-45 was received on September 9, 1998, and was forwarded to a Commission dispute resolution officer. A DRIS entry dated September 24, 1998, states that a letter of clarification will be sent to the designated doctor. In a letter to Dr. B dated September 28, 1998, a Commission disability determination officer (DDO) wrote:

> The parties have reviewed your designated doctors [sic] report of 7/31/98 and it reflects that lumbar [ROM] was invalid. Per the AMA Guides is it your opinion that [claimant] is a candidate for [ROM] retesting? If you feel it-necessary to re-examine [claimant], please inform me so another appointment may be rescheduled. Also, please copy the injured worker and insurance company of your response.

The record does not contain a response to that letter. A DRIS entry dated November 16, 1998, indicates that a designated doctor appointment had been set for November 30, 1998, for repeat ROM examination. In a DRIS note dated November 19, 1998, the DDO wrote:

> ADJ [MR. H] CALLED UPSET BECAUSE THE COMMISSION HAD SET UP A DD APT FOR THIS CLMTS ROM RETESTING. HE STATED THAT HE HAD NOT BEEN NOTIFIED THAT A LETTER OF CLARIFICATION WAS GOING TO BE WRITTEN TO THE DD. I ADVISED HIM THAT OUR LETTER HAD GONE OUT ON 9/28/98 ADVISING ALL PARTIES OF THIS. I TOLD HIM THAT THE CARRIER REP SHOULD HAVE FORWARDED THE LETTER TO HIM. HE ALSO WANTED TO KNOW WHY THE DR. DID NOT GO INTO MORE DETAIL ABOUT WHY HE WANTED TO RETEST. I EXPLAINED THAT THE DD'S REPORT SHOULD EXPLAIN WHY THE ROM STUDIES WERE INVALIDATED. I WAS TRYING TO EXPLAIN THAT HE COULD ASK FOR BRC, IF HE WAS IN DISAGREEMENT WITH THE APT. AND HE HUNG UP ON ME. I CALLED HIM RIGHT BACK AND LEFT MESSAGE ON HIS VOICE MAIL THAT HE DID NOT LET ME FINISH

> TALKING, BUT I WAS WILLING TO WORK WITH HIM. I ALSO CALLED HIS SUPERVISOR AND LEFT MESSAGE FOR HIM TO CALL ME. ALAN CALLED ME BACK TO APOLOGIZE FOR HANGING UP ON ME. I TOLD HIM THAT I WOULD CHECK AND SEE IF SETTING THE CASE FOR BRC ON THE ISSUE OF INS DISPUTING THE APT FOR RETESTING OF ROM WOULD BE APPROPRIATE AND IF SO THE APT COULD BE CANCELLED UNTIL THE BRC. CHECKED WITH BENEFIT REVIEW OFFICER AND WAS TOLD THAT THE GUIDES ALLOW FOR ROM RETESTING AND IF THE CARRIER HAS DISPUTE ABOUT THIS, THEY CAN REQUEST BRC AFTER THE EVAL. CALLED ALAN AND LEFT MESSAGE OF THIS. HE DID NOT CALL BACK.

In a TWCC-45 dated November 19, 1998, the carrier requested a BRC and gave as the reason that the carrier disputed the scheduling of reexamination by the designated doctor. Dr. B rendered his second report on November 30, 1998. In a letter dated March 14, 1999, Dr. B wrote:

> I have been notified that the insurance carrier does not wish to pay for the second examination on [claimant]. I do not know what basis they wish to avoid payment; however, on the first examination which was conducted according to the [AMA Guides], six measurements for flexion and extension of the lumbar spine were taken, and straight leg raising measurements were done and repeated until consistent results could be obtained. This is according to the AMA Guidelines. The flexion and extension measurements were not valid because they failed the straight leg raising single motion test according to the guidelines. This indicates an inconsistent effort on the part of the examinee, according to the guidelines and, therefore, have to be discarded. It is noted that the extension measurements also in and among themselves were never consistent enough to meet the first validity test that is of consistent measurements within 10 degrees of each other. Therefore, the first measurements had to be considered invalid. The guidelines themselves indicate that when this happens a second examination on another day may be indicated. This was done at the request of the carrier and the commission. This is not part of the first examination which was in itself according to the guidelines complete, even though the results in this instance were invalid. Therefore, I think payment is in order for the additional services rendered which were rendered at the request of the involved parties.
>
> I did not request doing a second examination. I merely offered to do one if the parties involved wished to have one done.

The following, concerning lumbosacral flexion and extension, appears on page 90 of the AMA Guides:

> Suboptimal effort on repeated tests may still show a "normal" pattern to the spine/hip ratio consistent with Figure 92. Even if this "normal" pattern is seen, the persistence of suboptimal effort of spine motion should result in the examiner deferring the examination to a later date when valid measurements can be obtained (unless the visualized true spine motion is high enough to warrant a 0% impairment).

Additionally, the following concerning ROM appears on page 94A of the AMA Guides:

> 4. If consistency requirements are *not* met, perform additional tests up to a maximum of six until reproducibility criteria are satisfied. If testing remains inconsistent after six measurements, consider the test invalid and re-examine at a later date.

The Figure 83c, Lumbar [ROM] completed by Dr. B on July 29, 1998, contains six measurements for lumbar extension with the word "invalid" written above them and statements that the straight leg raising test was invalid and that the validity test was failed. The carrier quotes from dicta in Texas Workers' Compensation Commission Appeal No. 981778, decided September 17, 1998, and argues that the DDO should not have sought clarification from the designated doctor and that if clarification was to be sought, it should have been sought by a benefit review officer or a contested case hearing officer. We do not find that argument to be persuasive. Disputes should be resolved at the earliest possible time. While DDOs are not specifically mentioned in the 1989 Act, they are often able to informally resolve disputes and preclude the need for a BRC or a contested case hearing. The TWCC-45 contains "[b]y my signature below, I certify that a good faith effort has been made to resolve the issues identified above." DDOs and dispute resolution officers are instructed to attempt to resolve disputes before setting a BRC. No useful purpose would be served by waiting until a BRC to seek clarification from a designated doctor. Under circumstances such as those in the case before, if the disputed issue of IR goes to a BRC, the dispute resolution process may be expedited by having two reports from the designated doctor so that reasons for adopting the IR in one or the other of them may be presented at the BRC. The DDO should be commended for the action that she took in an effort to resolve the disputed issue of what is the claimant's IR. The carrier also contended that any change to the IR rendered by the designated doctor should be limited to a change in the impairment for loss of ROM and that it was improper to include impairment for neurological deficit since impairment for that was not included in the first report rendered by the designated doctor. The designated doctor was to assign an IR for the compensable injury and was not limited to retesting only ROM when he again examined the claimant. The carrier also argued that the great weight of the other medical evidence is not contrary to the first report of Dr. B. However, that is not a question that the hearing officer had to address since he did not make determinations that the first report of Dr. B was a valid report and that it was entitled to presumptive weight.

However, a careful review of the second report from Dr. B should have revealed that further clarification from Dr. B should have been sought. The following concerning ankylosis appears on page 91 of the AMA Guides:

> Ankylosis in the lumbosacral spine has significance only if immobility occurs in *both* the hips and the lumbar spine region, so that neutral position cannot be attained in the sagittal plane. This is a very rare event. Isolated fusions of either a hip or two to three spinal levels place additional stresses on adjacent segments, but do not lead to biomechanical failure of the functional unit. Thus, impairments related to fusion of part of the lumbar/hip motion complex are treated only under the Abnormal Motion Section of Table 56.

The Addendum to Chapter 3 of the AMA Guides also addresses ankylosis. Thoracolumbar Region–Flexion and Extension Abnormal Motion is addressed on pages 94E and 94F. The following appears on page 94F:

> **Ankylosis**
>
> 1. Place the goniometer base as if measuring the neutral position (Figure A8). Measure the deviation from the neutral position with the goniometer arm and record the reading.
>
> 2. Consult the Ankylosis Section of Table A1 to determine the impairment of the whole person.
>
> *Example*: A thoracolumbar region with ankylosis at 20% flexion is equivalent to 24% impairment of the whole person.
>
> Consult Table 50 (p.79) if radiographic methods are chosen to determine impairment due to ankylosis.

Table 50 provides for impairment of the whole person for favorable (neutral) position ankylosis and unfavorable position ankylosis for any 2, 3, 4, or 5 lumbar vertebra.

Reports from Dr. K indicate that the claimant had fusion performed at L4-5 and L5-S1. In a letter dated November 30, 1998, attached to a TWCC-69 with the same date, Dr. B stated:

> I did an impairment evaluation according to the [AMA Guides]. All spinal measurements were done with the twin inclinometer method. Once again, flexion and extension did not pass the test of validity. Therefore, my impairment on loss of motion is based upon Table 50 values for lumbar fusion.

In Texas Workers' Compensation Commission Appeal No. 970202, decided March 24, 1997, the Appeals Panel discussed ankylosis and the use of Table 50 of the AMA Guides; made references to provisions in the AMA Guides; noted that different doctors have given different interpretations of the use or nonuse of Table 50; and concluded that assignment of three percent impairment for ankylosis using Table 50 was error in the case before it. In Texas Workers' Compensation Commission Appeal No. 982413, decided November 25, 1998, the Appeals Panel reversed the decision of the hearing officer, stating that it appeared that the reason the designated doctor chose to assess impairment under Table 50 was not because he found ankylosis but because part of the claimant's ROM testing was invalid, and remanded, stating that the hearing officer should inform the designated doctor that the Appeals Panel has stated that a rating for ankylosis cannot be given to "make up for" invalid measurements of ROM and point out the quotation from page 91 of the AMA Guides set forth earlier in this decision. In Texas Workers' Compensation Commission Appeal No. 981474, decided August 17, 1998, another case involving an IR for a back injury, the Appeals Panel stated that a hearing officer cannot pick and choose parts of an IR and reversed and remanded the case to the hearing officer, noting that the hearing officer may go back to the designated doctor a third time and advise him of the law. We reverse the decision of the hearing officer and remand for the hearing officer to provide the designated doctor information concerning assigning an impairment for ankylosis, seek clarification from the designated doctor, and request that he assign an IR in accordance with the provisions of the AMA Guides and for the hearing officer to make findings of fact, conclusions of law, render a decision, and enter an order that determine the claimant's IR for the compensable injury.

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.

Tommy W. Lueders
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Dorian E. Ramirez
Appeals Judge