APPEAL NO. 991913

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 23, 1999. The appellant (claimant) and the respondent (carrier) stipulated that "[o]n _____, claimant sustained a compensable injury to left hand, cervical spine, left shoulder and RSD [reflex sympathetic dystrophy]." The hearing officer made the following findings of fact:

FINDINGS OF FACT

2. [Dr. A], the Commission [Texas Workers' Compensation Commission] designated doctor, assigned the Claimant an impairment rating [IR] of 10% on January 28, 1998 and subsequently changed the [IR] to 28% on June 11, 1999.

3. The great weight of other medical evidence is contrary to the designated doctor's assignment of an [IR] of 28%.

4. The great weight of other medical evidence is not contrary to the designated doctor's assignment of an [IR] of 10%.

The hearing officer concluded that the claimant's IR is 10%. The claimant appealed; stated that she disagreed with those determinations; summarized and quoted from evidence favorable to her; urged that the report of Dr. A that her IR is 28% is entitled to presumptive weight, that the great weight of the other medical evidence is not contrary to that report, and that her IR is 28%; and requested that the Appeals Panel reverse the decision of the hearing officer and render a decision that her IR is 28%. The carrier responded, summarized the evidence; urged that the overwhelming weight of the credible evidence supports the findings of fact and conclusions of law of the hearing officer and that the hearing officer did not make errors of law; and requested that the decision of the hearing officer be affirmed.

DECISION

We reverse and remand.

The claimant received an electrical shock when she connected a piece of equipment to an electrical outlet. She was treated by doctors in City, moved to another state to be near her parents, was seen by health care providers in that state, and was evaluated by the designated doctor, Dr. A, in that state. A stipulation on extent of the compensable injury states that the injury includes RSD but does not mention depression.

In a letter dated December 12, 1996, Dr. A stated that he had reviewed medical records and examined the claimant and explained why he did not think she had reached

maximum medical improvement (MMI). In a Report of Medical Evaluation (TWCC-69) dated January 28, 1998, Dr. A stated that the claimant had reached MMI by operation of law and that her IR was 10%. A letter from Dr. A dated January 21, 1998, includes a subjective section in which Dr. A provides what the claimant told him. That letter also includes:

> **OBJECTIVE:** [Claimant] ambulates slowly with a head-flexed-forward posture. *Gentle* pressure applied to the top of the head elicits complaints of left cervical pain. Left Erb's point is markedly painful to *gentle* pressure, while right Erb's point appears to be normal. Tinel's test is negative bilaterally; Phalen's test on the left elicits complaint of "coldness" while on the right it is negative. Strength testing by squeezing of the examiner's fingers reveals an apparent very severe loss on the left, but on the right it appears to be only slightly diminished. Flexion/extension against resistance on the left reveals an inability to generate measurable force, but an increased tremor is noted. Deep tendon reflexes in the upper extremities appear to be equal and within normal limits bilaterally. Pinwheel testing indicates a diminished sensation over the fingers of the left hand but a hyperesthesia over the remainder of the hand. Sensation in the forearms appears to be equal bilaterally. Circumference of the hands, measured at the MP joints through V is 16.5 on the left, 17 centimeters on the right.

Dr. A provided range of motion (ROM) measurements for both shoulders, stated that right ROM measurements were provided for comparison purposes only, and said that 16% impairment of the upper extremity equates to 10% of the whole person.[1]

In a letter dated June 25, 1998, to Dr. A, a Commission benefit review officer (BRO) wrote:

> We ask you to reply to the following:
>
> 1. [Claimant's] injury of _____, extends to include the left hand and depression, as being related to the compensable injury. Please indicate if the claimant's left hand and depression was [sic] included in the whole body [IR], if not, please do so.
>
> 2. Please review the attached medical records from the Clinic dated 07/18/97, 09/09/97, 12/30/97, 01/02/98, 01/13/98, 02/10/98, and 03/09/98.
>
> Please indicate any changes in the [IR] on the enclosed TWCC-69 form.

In a letter dated August 27, 1998, Dr. A wrote:

[1] Dr. C testified that it did not appear to him that Dr. A used upper extremity impairments and converted them to whole body impairments.

- In determining the permanent partial disability (10% of the "whole person") as set forth in my report of 1-21-98, no separate and additional amounts for the left hand and depression were included in the whole body [IR].

- The reports from the clinic attached to your aforementioned letter were carefully reviewed.

- Inasmuch as it appears that the Commission has determined that separate percentages for disfunction of the left hand and for depression should be included, my determination will now be amended.

It is my opinion, to a reasonable medical certainty, that by using the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association [AMA Guides], the assignment of the following levels of impairment is appropriate:

- In accordance with section 4.1a of the aforementioned publication, for "mild to moderate emotional disturbance under unusual stress," 15%.
- In accordance with section 3.1i of the aforementioned publication, for "unilateral brachial impairment" with "complete [ROM] against gravity and some resistance, or reduced fine movements and motor control," 5% of the "whole person".

The above determined percentages, when "combined" with the previously determined 10% impairment of the "whole body" in accordance with the Combined Values Chart contained in the AMA Guides equate to a 28% permanent partial impairment of the whole person.

The carrier sent medical records to Dr. C and asked him several questions. In a letter dated September 15, 1998, Dr. C responded:

SPECIFIC QUESTIONS:

1. Is the methodology applied in determining the employee's whole body impairment in compliance with the [AMA Guides]?

   No. Unfortunately, the designated doctor's documentation was not complete enough to determine how he arrived at this particular impairment. This was because he did not include a detailed narrative delineating exactly how the impairment was calculated. Nevertheless, it does not appear that the *AMA Guides* were appropriately used, as the doctor assigned impairment for [ROM], as well as impairment for unilateral

brachial plexus impairment. The *AMA Guides* state in Section 3.1 that when consideration was given for the impairment of nerve involvement it included any possible [ROM] consequences. Thus, if [ROM] restrictions are secondary to nerve involvement, additional [ROM] impairment is not added. In [Dr. A's] report, it was not clear what was the cause of the patient's [ROM] impairment assigned for the shoulder. If the impairment was secondary to nerve involvement , then the *AMA Guides* do not allow an additional consideration for extra [ROM] impairment.

The doctor also assigned a 15% impairment for depression. However, it was not clear on what criteria this was based. He apparently used Chapter 4 of the *AMA Guides*, which would not technically be correct. Chapter 4 deals with impairment secondary to actual brain injury, such as one would see from head trauma. Since this individual's problems are psychological, as far as the depression is concerned, impairment should have been assigned according to Chapter 14. Unfortunately, as we all know, the *AMA Guides* specifically state that it is not possible to actually assign a percent of impairment for psychological problems. In fact, the *AMA Guides* do not give any actual percentages for the assignment of impairment for a condition such as depression. It appears that that was why this doctor used Chapter 4, as depression is included in one of the considerations under emotional disturbance. However, once again, this is supposed to be for emotional disturbance secondary to actual brain injury. Nevertheless, it was not clear from [Dr. A's] report on what objective criteria this impairment was based. He referred to reviewing information from Clinic, but if it was the same information I reviewed, then there was no indication of objective testing. It was required by Texas law that any impairment assigned by based [sic] objective measurements. The problem with psychological impairments is that the majority of the patient's complaint's are subjective and usually not quantified.

At this time, some specific questions need to be posed to the designated doctor:

1. What is the cause of the [ROM] restrictions in the patient's left shoulder? Is the [ROM] restriction secondary to a unilateral brachial plexus involvement?

2. What objective criteria was the rating for depression based upon? Please list the objective inventories that were performed and please indicate whether or not the objective test was subject to validity evaluation in order to determine if the patient's performance on the objective indices would be reproducible.

3. Please state the criteria used to determine that the impairment for depression was 15%. How was it determined that the impairment was not 5% or 10%.

4. Since the *AMA Guides* require that any impairment assigned be based on a permanent situation, please indicate what criteria you used to determine whether the patient's depressive state is permanent.

Once the doctor responds to these questions, I can better determine whether or not the impairment is plausible.

2. Is the whole body impairment assigned an objective, accurate, fair, and reproducible evaluation of the individual's medical impairments?

No. It does not appear that this impairment, or at least as far as the depression issue would be concerned, was based on actual objective testing. Thus, it would be doubtful that various physicians would be able to reproduce this exact impairment.

3. Is the clinical history presented by the designated doctor's report supportive of the assessed impairment?

No. The doctor's documentation is lacking, as far as the objective evidence would be concerned in the rating of the depression. In fact, the doctor's objective portion of his examination included no mention of the patient's affect or whether there appeared to be any depression. In addition to reports from other medical providers, the designated doctor needs to include in his physical exam any evidence of actual clinical depression.

Medical records dated January 13, 1998; February 10, 1998; and March 9, 1998, make reference to the claimant's psychological condition and include "major depression, recurrent" in the diagnostic impression.

The Commission BRO wrote to Dr. A and on November 3, 1998, Dr. A responded:

> In response to your letter of 10-22-98, I carefully reviewed the medical reports you enclosed from [Dr. C] and respectfully submit the following rebutal:
>
> - Your letter of 6-25-98, addressed to me, stated in sub-paragraph # 1 "please indicate if the claimant's left hand and depression was included in the whole body [IR], if not, please do so."
>
> - Based on the foregoing directive, I computed the whole person impairment of a hand dysfunction stemming from a unilateral brachial plexus impairment and subsequently "combined" that percentage with the previously reported impairment of the upper extremity that equated to ten percent of the "whole person." However, in order to address the concerns of [Dr. C], I recomputed the impairment of the left upper extremity using the *AMA Guides* chapter 3, table 11.a.3 for a grade of 25% and applied it to the unilateral brachial plexus maximum impairment of 60% in table 13, thus again arriving at a "whole person" impairment of 15%.
>
> - With regard to assignment of an impairment for depression, also directed by your letter, [Dr. C] is correct in stating that under chapter 14 "the *AMA Guides* do not give any actual percentages for the assignment of impairment for a condition such as depression." However, mindful of specific instructions to assign a percentage for depression, as well as the general instruction to use the [AMA Guides], I did, indeed, turn to chapter 4, the only source within *the Guides* for rating depression. In determining that rating to be 15%, I considered the reports from the Clinic as well as my own interviews with the patient.

In a TWCC-69 dated June 11, 1999, Dr. A assigned a 28% IR and wrote "[p]lease see my letter dated 11/3/98."

A designated doctor is required to determine whether a claimant has any permanent impairment from a compensable injury and, in doing so, must consider all of the compensable injury. A designated doctor may assign a zero percent impairment for the compensable injury or a part of the compensable injury. Texas Workers' Compensation Commission Appeal No. 970784, decided June 16, 1997. The BRO did not properly advise Dr. A that he was required to consider the injury to the claimant's left hand and her depression and to assign impairment, if any, for those conditions.

In Texas Workers' Compensation Commission Appeal No. 950104, decided March 7, 1995, the Appeals Panel addressed the carrier's contentions concerning objective and

clinical or laboratory findings. Those contentions were similar to those in the testimony of Dr. C in the hearing before us. In Appeal No. 950104, the Appeals Panel wrote:

> As noted above, Dr. BR administered numerous psychological tests on which both he and Dr. BU relied, at least in part, in assigning an IR. The carrier produced no evidence that any of these tests were not "well-standardized," professionally recognized tests administered by or under the direction of mental health professionals, including psychologists and psychiatrists. *See* AMA Guides, Section 14.2. In addition, there was no evidence that the actual test scores were misinterpreted or that the tests themselves did not carry internal indicia of reliability such as control questions that would indicate "gaming" by the claimant. Both Dr. BR and Dr. BU considered the test results consistent with their clinical experience of the claimant.

In Texas Workers' Compensation Commission Appeal No. 951447, decided October 9, 1995, the carrier contended that the designated doctor somehow contaminated his rating under Chapter 14 of the AMA Guides by improperly looking to Chapter 4 for guidance and in the process converted a Chapter 14 rating into a Chapter 4 rating. The Appeals Panel wrote:

> We are unwilling to place such constraints on the professional, clinical judgment of a physician. To the contrary, we believe that an experienced practitioner may seek help and guidance from sources deemed relevant and appropriate in his or her professional opinion. In looking to Chapter 4 for guidance, Dr. P did not thereby turn the claimant's injury into an organic instead of a psychiatric injury. Rather, by his own explanation, he looked to how Chapter 4 rated the effects of an organic condition as reflected in the conduct of a claimant and that claimant's ability to function in the ordinary circumstances of life. Chapter 14 takes a not dissimilar approach and addresses impairment in terms of a claimant's ability to function in daily living and with its associated stresses. We thus cannot conclude that Dr. P did not follow the AMA Guides when he referred to Chapter 4 for whatever information he deemed useful, nor that in doing so he transformed a Chapter 14 rating into a Chapter 4 rating.

When there is more than one report of the designated doctor in evidence and one party contends that the claimant's IR should be based on one report from the designated doctor and the other party contends that the claimant's IR should be based on another report from the designated doctor, the hearing officer should determine which report of the designated doctor is entitled to presumptive weight and then determine if the great weight of the other medical evidence is contrary to that report. Texas Workers' Compensation Commission Appeal No. 960478, decided April 22, 1996. In the case before us, the hearing officer did not do so. In Texas Workers' Compensation Commission Appeal No. 92522, decided November 9, 1992, the Appeals Panel stated that a hearing officer who rejects a report of a designated doctor that is entitled to presumptive weight because the great weight of the

other medical evidence is to the contrary must clearly detail the evidence relevant to his or her consideration, clearly state why the great weight of the other medical evidence is to the contrary, and further state why the contrary evidence outweighs the designated doctor's report. In the case before us, the hearing officer did not do so. A designated doctor is not required to respond to each and every question raised by a party. The hearing officer may consider questions raised, responses to those questions, and any lack of responses.

We reverse the decision of the hearing officer and remand the case to her. She should assure that the designated doctor is properly advised of the law related to the IR that he is to assign. Texas Workers' Compensation Commission Appeal No. 982413, decided November 25, 1998. A designated doctor is required to personally examine the claimant, but is not required to personally conduct all tests, and may rely on specialists. Texas Workers' Compensation Commission Appeal No. 93424, decided July 12, 1993. Dr. A may refer the claimant to a psychiatrist, ask the psychiatrist to assign impairment for the depression, consider the report of the psychiatrist, and personally determine if an impairment for depression should be assigned, and, if so, what percent. Of course, the parties shall be afforded due process after a report is received from Dr. A. The hearing officer shall award the claimant an IR not inconsistent with this decision.

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:

Thomas A. Knapp
Appeals Judge

Dorian E. Ramirez
Appeals Judge