APPEAL NO. 001203

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 April 24, 2000. The hearing officer determined that the appellant (claimant) reached maximum medical improvement (MMI) on March 28, 1998, with an impairment rating (IR) of 10% as certified by the designated doctor; that claimant had disability beginning March 23, 1996, and continuing through the date of the hearing; and that the claimant was entitled to temporary income benefits from March 23, 1996, through March 28, 1998, and impairment income benefits beginning March 29, 1998, for 30 weeks.

The claimant appealed, contending that the hearing officer should not have given presumptive weight to the designated doctor's report because the report was not timely filed, and there was no signature or date on the Report of Medical Evaluation (TWCC-69); that the designated doctor had a disqualifying association; that the respondent (self-insured) failed to timely raise a dispute of statutory MMI; the designated doctor improperly rejected range of motion (ROM) values for the lumbar spine; and the issues of MMI and IR were res judicata because they had previously been litigated at a prior CCH with no appeal having been taken. The self-insured responded that the Appeals Panel should affirm the hearing officer's decision.

DECISION

Affirmed as reformed.

The parties stipulated that the claimant sustained a compensable injury on _____, and the Texas Workers' Compensation Commission (Commission) appointed Dr. E as the designated doctor. The claimant testified that he had surgery to repair his lumbar spine which included a fusion and removal of a disc and insertion of screws. The claimant testified he began losing time on March 23, 1996, and has not returned to work since this date.

On June 30, 1998, Dr. K, the carrier-selected required medical examination (RME) doctor, certified the claimant to have reached MMI on June 30, 1998, with a 13% IR, which included a 12% impairment for specific disorders and a 1% impairment for loss of ROM. The certification was disputed by the claimant and the Commission appointed a designated doctor. Prior to the CCH on April 24, 2000, another CCH was held to adjudicate whether the rating of Dr. K had become final under the provisions of Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)) and whether the claimant had disability. The hearing officer determined that the date of MMI and IR had not become final and that the claimant had disability from March 22, 1996, through the date of the hearing on March 29, 1999. The decision was not appealed by either party and became final by operation of law under the provisions of Section 410.169 of the 1989 Act.

On May 28, 1999, the claimant was examined by Dr. E, the designated doctor. Dr. E filed a TWCC-69, which was unsigned and undated, with the Commission on June 9, 1999, in which he indicated that the claimant had reached MMI on June 25, 1998, with an IR of 10%. Attached to the TWCC-69 was an electronically signed narrative dated May 28, 1999, from Dr. E, discussing his examination of the claimant and assigning the 10% IR and the date of MMI. This report recites that the claimant was initially seen by Dr. D and was conservatively treated and placed in a therapy program. The claimant continued to work light duty. The conservative treatment was determined to be unsuccessful and the claimant began seeing Dr. M and eventually had surgery in 1996 undergoing an anterior diskectomy and posterior fusion which were performed on separate days. The surgery was followed by additional therapy which the claimant reported to Dr. E as not successful. The claimant continued to complain of lower back pain.

During the examination on May 28, 1999, Dr. E noted that the claimant had difficulty going from a sitting to a standing position and that his movements were very slow. Dr. E wrote that sensation was grossly normal to light touch in both lower extremities and that reflexes were symmetrical. Straight leg testing caused lower back pain. Dr. E noted the claimant's surgical history and imaging tests performed in 1996 and 1997. He also discussed that the claimant had undergone a successful work hardening program.

Dr. E invalidated the flexion and extension ROM measurements on the claimant's lumbar spine because the sum of the sacral flexion and extension was less than 10E of the tightest straight leg raise test (45E). Dr. E noted that the right and left lateral flexion angles were not physiologic and he therefore declined to rate them. Dr. E observed during the examination that the claimant had much more movement than the 2E of right lateral flexion and more than 5E of left lateral flexion. Dr. E wrote that the ROM testing and performance during the physical examination did not correlate with the work hardening program final results. Dr. E assigned the claimant a 10% impairment of the whole person under Table 49, Section II E of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) for specific disorder of the spine.

The Commission sent Dr. E a letter of clarification on August 19, 1999 asking him to review additional medical records from Dr. M and whether additional testing was necessary. By letter dated August 20, 1999, Dr. E replied that he had reviewed the additional materials and believed that his date of MMI was appropriate and he would not change his IR. On November 3, 1999, the Commission sent Dr. E another letter of clarification asking Dr. E whether retesting was necessary and whether he had any association with Dr. K because the office addresses were the same. By letter dated November 5, 1999, Dr. E responded that retesting was not done because of such a large difference between the sum of the sacral flexion and extension compared to the straight leg test and he believed retesting would not produce any different results. Dr. E explained that he and Dr. K did not have any association at all; that he merely had taken over the office space that was once occupied by Dr. K. In response to Dr. E's letter, the benefit review officer by letter dated December 14, 1999, instructed the field office and Dr. E to

reschedule an appointment for repeat ROM testing to be performed on the claimant by Dr. E. The claimant was examined by Dr. E on January 17, 2000. By letter of the same date, Dr. E wrote that the claimant still did not meet the validity criteria. The maximum sacral flexion and extension was 27E, yet the tightest straight leg raise test was 55E. Dr. E did not assign any measurements for right and left lateral flexion. He declined to change his rating and left the 10% IR as final.

Sections 408.122(c) and 408.125(e) provide that the report of the designated doctor has presumptive weight, and the Commission shall base its determination of whether the employee has reached MMI on the report unless the great weight of the other medical evidence is to the contrary. An IR must be assigned in accordance with the AMA Guides. Section 408.124. The party challenging the report of a designated doctor has the burden of proving noncompliance with the AMA Guides or that the great weight of the other medical evidence is contrary to that report.

In this case, the claimant asserted that because the TWCC-69 provided by Dr. E was not signed or dated, it was invalid. This would be true had Dr. E not also attached a narrative report, which was signed and dated, to the TWCC-69. It is well-settled that a signature is required in order for there to be a "certification" of MMI and IR. Texas Workers' Compensation Commission Appeal No. 950704, decided June 20, 1995. A TWCC-69 normally provides written notice of the IR, but a writing that amounts to the "functional equivalent" of a TWCC-69 will suffice as written notice. Texas Workers' Compensation Commission Appeal No. 961257, decided August 5, 1996. The signature on the narrative provided by Dr. E was submitted as an electronic signature. However, no evidence was presented at the CCH to indicate that the signature appearing on the document is not Dr. E's and we have also stated "we cannot agree, for example, that a stamped signature that is not deemed to be 'original' absent evidence that indicated unauthorized execution by someone other than the doctor, constitutes a basis for invalidating a certification." Texas Workers' Compensation Commission Appeal No. 960777, decided June 14, 1996 (Unpublished). We find no reversible error in the hearing officer according presumptive weight to Dr. E's report on these grounds.

The claimant also contends that Dr. E filed the TWCC-69 and narrative untimely because the report was dated on May 28, 1999, and not filed with the Commission until June 9, 1999. We have previously considered and rejected this argument. Texas Workers' Compensation Commission Appeal No. 92511, decided November 12, 1992.

The claimant contends that Dr. E had a disqualifying association with Dr. K, the self-insured's RME doctor, because Dr. E's office address was the same as Dr. K's at the time the claimant was examined by Dr. K. Rule 126.10 addresses "disqualifying association" and states that a disqualifying association is one that may reasonably be perceived as having potential to influence the conduct or decision of the designated doctor and may include office sharing agreements. When responding to the Commission's inquiry regarding why his office address appeared to be the same as Dr. K's, Dr. E explained that he simply had taken over the office space when Dr. K moved to a different address.

Reasonable discretion is given the hearing officer in determining whether the designated doctor has a disqualifying association. Although no specific finding of fact was made by the hearing officer, the matter was litigated at the hearing and it may be reasonably inferred that the hearing officer took into account Dr. K's explanation when she accorded presumptive weight to his report. The hearing officer is the sole judge of the weight and credibility of the evidence. Section 410.165(a).

The claimant contended that the issues of MMI and IR were res judicata because the issues were litigated at a prior hearing and the self-insured did not raise the issue of statutory MMI at the prior hearing. A copy of the hearing officer's prior Decision and Order was admitted at the hearing. Two issues were to be decided: 1) Did the first certification of MMI and IR assigned by Dr. K on June 30, 1998, become final under Rule 130.5(e); and 2) Did the claimant have disability? The hearing officer wrote that prior to the beginning of the hearing, the self-insured, by and through its representative, notified the Commission, by letter dated March 18, 1999, that it was withdrawing its dispute regarding the issue of finality of the first certification of MMI and IR. Both the self-insured and the claimant were informed that the issue would be resolved in favor of the claimant and a finding of fact was entered that the self-insured agreed that the first certification of MMI and IR by Dr. K did not become final. The parties represented that no appeal was taken and the finding became final. Section 410.169. The Commission properly appointed a designated doctor because a dispute still existed as to whether the claimant had reached MMI and IR. Section 408.122(c).

An additional finding of fact was made by the hearing officer at the prior hearing that the claimant had disability from March 22, 1996, through the date of the hearing on March 29, 1999. This finding also became final by operation of law when the Decision and Order was not appealed. Therefore, Finding of Fact No. 6 in the present Decision and Order, although unappealed, must be addressed to reach the issue of MMI. The hearing officer found that the claimant was unable to obtain and retain employment at wages equivalent to his preinjury wage beginning on March 23, 1996, and continuing through the date of hearing on April 24, 2000. This finding is reformed to reflect disability only from March 30, 1999, through the date of the hearing on April 24, 2000, which excludes the period of disability (March 22, 1996, to March 29, 1999) previously adjudicated that became final by operation of law.

The claimant contends that MMI should have been assessed at a date later than March 28, 1998, and/or the date certified by Dr. E of June 25, 1998, was correct. Section 401.011(30) defines the date of MMI for purposes of this case as the earliest date after which further material recovery from or lasting improvement to an injury can no longer be reasonably anticipated or the expiration of 104 weeks from the date on which income benefits begin to accrue. Income benefits begin to accrue on the eighth day of disability. Rule 124.7.

In this case, the hearing officer found that the claimant began losing time from work and income benefits began to accrue on March 23, 1996. The hearing officer found that the claimant reached MMI on the statutory date of March 28, 1998. However, she did not discuss or make a finding of fact regarding how this date was determined. If the claimant began losing time from work on March 22, 1996 (according to the prior Decision and Order which became final by operation of law), the eighth day of disability would be March 29, 1996, and the statutory date of MMI would be March 29, 1998, which is 104 weeks after the eighth day of disability. Despite Dr. E's certification of June 25, 1998, after the statutory date, the claimant reached MMI by operation of law 104 weeks after the date which income benefits began to accrue, or March 29, 1998. Section 401.011(30)(B). Texas Workers' Compensation Commission Appeal No. 971814, decided October 24, 1997. The claimant's argument that his MMI date should be extended beyond the statutory 104 weeks because Dr. E certified it occurred that day is without merit. Accordingly, the hearing officer's Conclusion of Law No. 3 is reformed to reflect the correct statutory date of March 29, 1998.

Claimant asserted that Dr. E should have included an impairment for abnormal lumbar ROM measurements. The claimant refers to the proposition that the SLR test does not invalidate lateral flexion ROM. However, in this case, Dr. E made clear that such ROM impairments were not assessed because of direct clinical observations made during the examination that were not compatible with work hardening results. We have upheld hearing officers' decisions giving presumptive weight to the report of a designated doctor who invalidated ROM based on clinical observation of the employee's mobility during the physical examination, the observation of the employee's efforts during repeat testing, and a comparison of the ROM with prior testing. Texas Workers' Compensation Commission Appeal No. 951283, decided September 19, 1995; and Texas Workers' Compensation Commission Appeal No. 971309, decided August 18, 1997. We have stated that under the provisions of the AMA Guides, the SLR test does not invalidate the test for loss of lumbar left and right lateral flexion. Texas Workers' Compensation Commission Appeal No. 950472, decided May 8, 1995. However, we have recognized that lumbar left and right lateral flexion measurements may be invalidated for other reasons such as clinical observations. *See, e.g.,* Texas Workers' Compensation Commission Appeal No. 961568, decided September 20, 1996.

In the final analysis, the hearing officer determined that the great weight of other medical evidence was not contrary to the report of Dr. E even without further explanation. As the designated doctor, her report was entitled to presumptive weight. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. We

conclude there was sufficient evidence to support the hearing officer and that she correctly applied the law. We cannot conclude that her determinations were against the overwhelming weight of the evidence (Cain v. Bain, 709 S.W.2d 175, 176 (Texas. 1986)) and accordingly affirm, as reformed, the decision and order.

Kathleen C. Decker
Appeals Judge

CONCUR:

Elaine M. Chaney
Appeals Judge

Susan M. Kelley
Appeals Judge