APPEAL NO. 001384

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 May 18, 2000. The hearing officer determined that the appellant (claimant) reached maximum medical improvement (MMI) on March 3, 1999, with a nine percent impairment rating (IR) as assigned by the designated doctor, Dr. B. She held that the great weight of contrary medical evidence was not against this report.

The claimant appealed and argues that the hearing officer erred in failing to address the lack of stability in the claimant at the time of her first evaluation by the designated doctor. The claimant further asserts that the determination that the designated doctor's report was entitled to presumptive weight is against the great weight and preponderance of the evidence. The claimant argues that her MRI testing was not unremarkable or negative as the hearing officer found. The claimant contends that the designated doctor improperly invalidated her range of motion (ROM) testing results. Finally, the claimant argues that the hearing officer should have appointed a second designated doctor who was an orthopedic surgeon or neurologist. The respondent (carrier) responded that the designated doctor's opinions on IR and MMI are fully supported by other doctors' reports in evidence. The carrier points out that the rules of the Texas Workers' Compensation Commission (Commission) require appointment of a designated doctor who is of the same discipline as the treating doctor, in this case a chiropractor. The carrier states that a designated doctor may invalidate ROM based upon clinical observation. The carrier states that the hearing officer's determination that the designated doctor's opinion was entitled to presumptive weight was legally and factually sound.

DECISION

Reversed and remanded.

It was stipulated that the claimant injured her low back, neck, and right shoulder on _____, while employed by (employer). She fell from a swivel chair which "gave" when she attempted to sit in it. She slammed her arm on the desktop and fell between the chair and her desk against the wall. She argued at the CCH that she was misdiagnosed at the time of her injury and that it went well beyond sprains and strains. She was initially told that she had sprains and strains by the company doctor but the pain became progressively worse, affecting her ability to work.

Claimant's treating doctor became Dr. C, who ordered MRIs. She also had EMG and nerve conduction testing performed and underwent pain management therapy under the supervision of. Dr. J. Claimant was referred for her low back and neck to Dr. M and Dr. G and to Dr. BK for her shoulder.

On April 6, 2000, Dr. M stated that claimant had not reached MMI with regard to her cervical and shoulder areas. Dr. B (in April 2000) found positive signs of shoulder

impingement and tendinitis. The claimant agreed she was referred by Dr. C to Dr. ML, who released her back to full duty effective January 6, 1999. He noted then that while the claimant had chronic pain in her right shoulder, she then had only occasional flare-ups.

Dr. C testified at the CCH. He himself served as a designated doctor for the Commission and was familiar with the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). He described the claimant's condition as cervical radiculopathy, right shoulder impingement with internal derangement, rotator cuff tendinitis, C6-7 annular tear, herniated discs at three cervical levels, and a herniated disc and radiculopathy involving the lumbar spine. He made referrals for conditions for which he did not or could not provide treatment.

An MRI of the cervical spine was reported on August 26, 1998, as normal. No protrusions were observed. A repeat cervical MRI performed on August 9, 1999, showed small bulges at two levels and concluded that they could not be considered insignificant, in light of claimant's continued pain, until a discogram was performed. The report opined that such minor findings and continued pain could be consistent with an annular tear.

A lumbar MRI performed on April 20, 1999, was reported as showing mild central canal stenosis and bulging at L4-5. No herniation was seen. However, a discogram performed on October 26, 1999, at the request of Dr. G found abnormalities at three levels Dr. GR, one of the second opinion doctors, expressed his opinion on December 20, 1999, that he felt claimant would not benefit from surgery and noted that there were no obvious problems on her MRI although the discogram and EMG showed some C5-6 nerve root involvement.

Dr. C noted that Dr. G had recommended the claimant for spinal surgery. Neither second opinion doctor concurred with the need for surgery.

On January 11, 1999, Dr. K, an orthopedic surgeon, performed an independent medical examination on the claimant. He found that she had normal ROM of the cervical spine on clinical evaluation. On evaluation by inclinometer, he found that she demonstrated seven percent ROM loss. Dr. K said he did not award for this measured loss because it was not borne out on clinical examination. While most of the lumbar ROM testing was invalid, the claimant demonstrated a two percent lateral lumbar loss. He found equal grip strength. There was no ROM loss in the shoulder. Ratings were assessed for specific injuries to each spinal level. Dr. K's diagnosis was cervical and lumbar strain and he assessed an 11% IR, with MMI certified as having been reached on January 5, 1999.

The designated doctor was Dr. B, who saw the claimant on March 2, 1999. Dr. B noted that he initially did not have medical records but was sent some from Dr. C by "fax" on March 5. He noted from the records that were sent that the claimant=s EMG "did not

appear to be" a needle EMG test. He said that it showed C5-6 nerve root irritation. An MRI of the right shoulder from September 21, 1998, was normal. Also, Dr. B said that an August 26, 1998, MRI of the cervical area was normal. Dr. B stated in the introduction to his narrative that the claimant was "very co-operative" during the examination. Dr. B, near the conclusion of his report, expressed a desire for more medical records and named a particular report:

> With this report and a re-examination of this patient, I can then evaluate the cervical spine, right shoulder, and lumbar spine and assess [MMI]. I hope to do this at the earliest convenience. Therefore, at this time I am not assessing [MMI] but reserve the right to assess [MMI] on this date ***with a further examination and further medical records.*** [Emphasis added.]

On examination, Dr. B found mild spasm in the left trapezius muscle, no lumbar spasm, some low back pain, normal straight leg raising test, mildly limited cervical ROM, and normal motor and sensory examination of the upper extremities. He noted some right hand discoloration and diminished grip strength secondary to pain. He noted that he did not evaluate her shoulder because he had not known before receiving Dr. C's records whether it was part of the injury. The Report of Medical Evaluation (TWCC-69) of Dr. B dated March 6, 1999, stated that claimant had not reached MMI pending records and reexamination.

On July 20, 1999, without conducting a reexamination, Dr. B filed a TWCC-69 certifying that MMI was reached on March 3, 1999, with a nine percent IR. He noted that a March 2, 1999, EMG was normal. He noted that she had undergone ROM testing for the cervical and lumbar spines at another facility on June 3, 1999. Conceding that her measured ROM would result in a nine percent IR, he stated that he was disallowing this, as well as lumbar ROM, because he did not believe that she exhibited full effort during his earlier examination and during "previous examinations," which are not identified in his report. The nine percent IR certified by Dr. B consists only of specific conditions of the cervical and lumbar spine. He assessed a zero percent IR for the shoulder, noting that her MRI and ROM were normal. A concluding paragraph noted that this IR was based on a "thorough medical examination."

Dr. B explained his conclusions about the claimant's "effort" in a letter received by the field office of the Commission on October 26, 1999:

> In my opinion with these negative tests [referring to shoulder and cervical MRIs] there is no reason for this patient to have such a high impairment and therefore it was my opinion with [sic] this patient did not exhibit full effort.

The only records from the clinic that performed the claimant's ROM consist of the bare figures from ROM testing, with no calculations as to the resulting IR. There is no narrative describing the claimant's effort.

Dr. C felt that the AMA Guides were violated because the claimant was not sent for ROM testing for three months after her examination by Dr. B. He said that these ROM measurements were valid. Dr. C objected that Dr. B "threw out" these studies because they were not consistent with what he observed when he examined the claimant three months earlier. He disputed this and the fact that Dr. B stated that claimant's strength and sensation testing was normal. Dr. C testified as to his own recomputation of the ROM figures rejected by Dr. B. His recomputed figures in evidence are not accompanied by a certification that the claimant has reached MMI. Dr. C said that claimant's condition deteriorated after she was seen by Dr. B. He disputed that the MRI was normal and pointed out that a repeat MRI showed some problems that were followed up on by discogram. Dr. C said that, contrary to Dr. B's assertions, the EMG was a needle EMG.

Dr. C disputed that claimant was at MMI on March 3, 1999, because he felt there was further medical treatment that would benefit her that had not yet been performed. Dr. C said that claimant's condition had not stabilized.

While we can appreciate the greatly conflicting evidence in this case as to the severity of the claimant's injury with respect to MMI and IR, we are not persuaded that the designated doctor's examination and later assessment have resolved the problem as the designated doctor process is designed to do and cannot agree that, given the events here, the addendum report of Dr. B was entitled to presumptive weight.

Tex. W.C. Comm=n, 28 TEX. ADMIN. CODE ' 130.6 (Rule 130.6) is the Commission's very comprehensive rule concerning examinations of a designated doctor. The obligation to send medical records to the designated doctor is on both the treating doctor and the carrier. Rule 130.6(h). The designated doctor should contact the field office of the Commission if he/she has not received such records three days prior to the examination. This provision of the rule was not followed by any of the principles in this case.

The designated doctor "shall" conduct a physical examination and is responsible for the integrity of the evaluation process. Rule 130.6(j). Any testing, such as ROM, that is not performed personally by the designated doctor "must" be completed within seven days of the designated doctor's examination. Rule 130.6(l). Likewise, the designated doctor's report must be filed within seven days of any referral or retesting. Rule 130.6(n). Neither provision was followed in this case.

Because we regard Dr. B's assessment of IR as flawed, we reverse and remand for further evaluation of the claimant. Our reasons for remanding are:

1. Dr. B performed no examination of the shoulder, and yet assessed a zero percent IR. An IR must be based upon examination.

2. Dr. B documented full cooperation from the claimant during the only time she was examined. His October 1999 letter indicates that he has "backed into" a conclusion that she expended less than full effort because of an opinion that the resulting IR was "too high." There is no evidence to support the disallowance of valid ROM measurements on the basis that claimant gave less than full effort.

3. Dr. B did not conduct the reexamination that his first report indicated was necessary to assess both MMI and IR. A fair reading of Dr. B's initial narrative is that the lack of complete medical records caused him to perform less than a thorough examination.

4. The ROM examination was not performed within seven days of Dr. B's examination. Although this factor standing alone would not cause Dr. B's report to be disregarded, it is part of the overall reason why we believe his report cannot be given presumptive weight.

While it appears that some resolution of MMI will also have to be made as well, we do not necessarily accept the claimant's argument that "stability" must be shown in order for an IR to be assessed. MMI is defined as "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated. . . ." Section 401.011(30)(A). If this status is not achieved before 104 weeks from the date income benefits accrue, then it is achieved by statute at that point. Section 401.011(30)(B). The presence of pain is not, in and of itself, an indication that an employee has not reached MMI. A person who is assessed to have lasting impairment may indeed continue to experience pain as a result of an injury. Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1993. The fact that an employee still requires treatment for an injury does not mean that he or she is not at MMI. Texas Workers' Compensation Commission Appeal No. 94045, decided February 17, 1994.

We remand with the suggestion that Dr. B be instructed to either recompute the claimant's ROM (and MMI date) based upon the measurements done or reexamine the claimant for the shoulder and ROM. Because the designated doctor must be, to the extent feasible, of the same discipline as the treating doctor, Rule 130.6(b)(4), we cannot agree that the hearing officer erred by not appointing an orthopedic doctor as a designated doctor. At this point, there does not appear to be a basis for appointing a second designated doctor.

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.

Susan M. Kelley
Appeals Judge

CONCUR:

Alan C. Ernst
Appeals Judge

Robert W. Potts
Appeals Judge