APPEAL NO. 002675

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 September 7, 2000. With regard to the only issue before him, the hearing officer determined that the appellant (claimant) had a 7% impairment rating (IR) and that the designated doctor's 47% IR was contrary to the great weight of the other medical evidence. The parties appear to agree that maximum medical improvement (MMI) was reached on December 2, 1998. The MMI date was neither addressed nor appealed and will not be addressed further.

The claimant appealed the hearing officer's decision, asserting that the designated doctor's report has presumptive weight and that he had clarified (explained) his rating. The claimant also objects to the admission of one of Dr. O's reports on the basis of lack of timely exchange although Dr. O testified at the CCH. The claimant contends that extent of injury was not an issue and that Dr. O's reference to "non-compensable body parts" was error. The claimant requests that we reverse the hearing officer's decision and render a decision in his favor. The respondent (carrier) responds to the points raised by the claimant and urges affirmance.

DECISION

Reversed and remanded.

The claimant did not testify and the only information regarding the circumstances and mechanics of his injury comes from the medical reports. The claimant was apparently working as a "nutritionist" for a health care system (employer) when on _____, "he was lifting a bag of trash/vegetables of about 200 lbs. when he felt his chest close up and was unable to breathe." (The Employer's First Report of Injury or Illness (TWCC-1) in evidence indicates "arms sore from pushing food carts, trash cans & box transporting.") The claimant was seen by a number of doctors, the sequence and in what capacity are not clear.

Dr. G, a medical doctor, examined the claimant on December 2, 1998, on behalf of the carrier, and in a report dated December 14, 1998, certified the claimant at MMI and assessed a 7% IR using the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). Dr. G assessed a 4% impairment for a specific disorder of the cervical spine from Table 49, Section (II)(B), and 3% impairment for cervical loss of range of motion (ROM) based on "(1%) due to cervical right rotation and (2%) for loss of cervical extension." Dr. G goes on to comment that the claimant "has a psychological problem" but concludes that the claimant had a history of psychological problems prior to his injury.

The claimant apparently disputed Dr. G's 7% IR and Dr. B, a chiropractor, was appointed as the designated doctor. Dr. B examined the claimant on March 4, 1999, and in a Report of Medical Evaluation (TWCC-69) and narrative both dated May 11, 1999,

certified MMI and assessed a 46% IR. Dr. B diagnosed a cervical, thoracic, and lumbar sprain/strain and "[p]rolonged depressive reaction." Dr. B assessed a 43% left sensory upper extremity impairment combined with a 4% impairment from Table 49 (apparently Section (II)(B)) for a 36% "**Whole Person Impairment Cervical**," a 4% lower extremity impairment, and a 5% impairment for a lumbar specific disorder, and calculated as follows:

> 36% Cervical combined with 1% Thoracic=37%, combined with 9% Lumbar=43%, combined with 2% Nervous System (Trapezius)=44%, combined with 4% Mental Health=**46% Whole Person Impairment**.

This report, and other reports and medical records not in evidence were sent to Dr. O for a peer review. Dr. O, in a report dated June 23, 1999, noted that a CT scan done of the cervical spine was normal, a lumbar CT scan suggested herniation but a lumbar MRI was normal, a cervical MRI showed a small herniation at C4-5, that "EMG and NCV" testing was normal, and that there was no nerve entrapment or peripheral neuropathy of the upper extremities. Dr. O commented that 4% impairment for the lower extremity is not appropriate. (Only the first page of Dr. O's report is in evidence with one or more subsequent pages not copied.)

Dr. O's report was sent to Dr. B by letter dated November 2, 1999. Dr. B, in a revised report dated November 23, 1999, listed some 10 to 15 other reports and medical records that he relied on (but which are not in evidence), discussed how he arrived at ratings of the various components and gave this calculation:

> 37% Cervical combined with 1% Thoracic=38%, combined with 9% Lumbar=44%, combined with 2% Nervous System (Trapezius)=45%, combined with 4% Mental Health=**47% Whole Person Impairment**.

Regarding the mental health component, Dr. B commented:

> [Dr. G] comments the depression was, in his opinion, not related to the accident since the patient had been getting counseling prior to the injury. This is in opposition to [Psychologist C], who stated that in his opinion it was related to the injury. Weight is given to the Specialists [C] and [N], who state that it was related to the injury. [Neither Psychologist C nor N's reports are in evidence.]

In an undated "Rebuttal to [Dr. O]," Dr. B pointed to some of the other reports, not in evidence, to justify the motor deficit ratings. Dr. B comments:

> [Dr. O] is correct that the Cervical herniation should be rated p. 73, table 49II-C minimum 6 mos. pain, recurrent muscle spasm, or rigidity, with none-to-minimal degenerative changes, including unoperated herniated nucleus pulposus 6% Impairment of Whole Person Cervical. I regret the error.

* * * *

With the change for the disc herniation, my Impairment is changed to **47% Whole Person**.

My thanks to [Dr. O] for pointing out my oversights.

Dr. B's revised report was sent to Dr. O in a letter dated December 6, 1999. Dr. O, in a report dated December 17, 1999, opined that the "5% for specific disorders of the lumbar spine, 6% for specific disorders of the cervical spine and 4% for mental health impairment [to] be appropriate." Dr. O stated that other ratings due to motor and sensory losses (amounting to 38% impairment) were not "clinically reasonable" because the claimant's CT scans, EMG and NCV testing, and an MRI were all normal, except for a "3 mm posterior herniation . . . at the C4-C5 level."

In another report dated May 15, 2000, Dr. O commented on "several inconsistencies" in Dr. B's reports, and using Dr. B's test results and ROM figures states that he would rate the claimant with a 6% impairment under Table Section 49 (II)C) for a specific cervical disorder, 5% from Table Section 49 (II)(B) for a specific lumbar disorder, that no ROM deficits of either the cervical or lumbar spine were noted and that the claimant had a 1% loss of ROM of the thoracic spine for a total of 12% IR. Dr. O comments that "sensory losses appeared to be inconsistent and invalid" and that the claimant, in Dr. O's opinion, did not have a shoulder injury. Dr. O changes his position in that, in the latest report, Dr. O said that he did not believe "mental depression is part of the injury." Dr. O testified at the CCH, emphasized his experience in the arena of training designated doctors, and emphasized that there is "no documentation whatsoever of peripheral nerve injury" to justify the extensive motor deficit rating given by Dr. B. Dr. O explained in some detail the "two-point discrimination" testing performed by Dr. O, that the testing showed "no abnormalities," and that it "doesn't make any anatomical sense" to give motor sensory deficit ratings when all the objective testing was normal.

The hearing officer made the following findings:

FINDINGS OF FACT

7. The [IR] given by the designated doctor is very confusing, difficult to understand, and he rated body parts which are highly questionable.

8. The [IR] assigned by the designated doctor is contrary to the great weight of the other medical evidence.

9. The designated doctor's report was incorrect in the following areas:

    a) The designated doctor noted no abnormalities after using the 2-point discrimination test, but nevertheless went ahead and

rated every finger in the left hand and just the thumb and the little finger in the right hand.

b) The designated doctor awarded 4% for each lower extremity due to motor deficits, but there was no objective test to support an injury to the peripheral nerve.

c) The designated doctor performed a 2-point discrimination test in the hands and noted "no abnormalities". Nevertheless, he rated a sensory deficit in both hands.

d) The designated doctor awarded a 4% impairment for mental health (depression) which was noted as a pre-existing condition by [Dr. G] and therefore not part of the compensable injury.

The claimant's appeal points out that the designated doctor had responded to the requests for clarification and asserts error by the hearing officer in excluded parts of Dr. B's IR because the "body parts that were not compensable." The claimant argues that "an issue of extent of injury [was not] before [the hearing officer]." We disagree. Whenever the issue is an IR, by necessity the extent of injury is subsumed in that issue. Further, it is the Texas Workers' Compensation Commission (Commission) that determines what the injury is and the extent of the injury, not the doctor. While a designated doctor can state an opinion whether a certain condition is or is not part of the injury, the doctor's opinion on extent of injury is not entitled to presumptive weight and ultimately it is the Commission (the hearing officer) that determines what should and should not be rated.

The claimant, on appeal, again raises an objection to Dr. O's May 15, 2000, report as not being timely exchanged. (The hearing officer found good cause for lack of timely exchange.) We have frequently noted that to obtain a reversal of a judgment based upon the hearing officer's abuse of discretion in the admission or exclusion of evidence, an appellant must first show that the admission or exclusion was in fact an abuse of discretion, and also that the error was reasonably calculated to cause and probably did cause the rendition of an improper judgment. Texas Workers' Compensation Commission Appeal No. 92241, decided July 24, 1992; *see also* Hernandez v. Hernandez, 611 S.W.2d 732 (Tex. Civ. App.-San Antonio 1981, no writ). In this case, the hearing officer found good cause for the late exchange in that the report was not in existence until shortly before the initial CCH setting; but, more importantly, it is unlikely that the report changed the outcome of the decision in that Dr. O testified in some detail regarding the matters in that report at the CCH. The claimant's point on this matter is without merit.

Section 408.125(e) provides that, if the designated doctor is chosen by the Commission, the report of the designated doctor shall have presumptive weight, and the Commission shall base the IR on that report unless the great weight of the other medical evidence is to the contrary, and that, if the great weight of the medical evidence contradicts

the IR contained in the report of the designated doctor chosen by the Commission, the Commission shall adopt the IR of one of the other doctors. We have previously discussed the meaning of "the great weight of the other medical evidence" in numerous cases. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992, for example. In this case, we agree with the hearing officer that Dr. B's reports are very confusing and that it is difficult to understand how objective testing such as the EMG and NCV testing and two-point discrimination testing can be normal but still justify a 38% motor deficit impairment. To overcome the presumptive weight of a designated doctor's report requires the hearing officer to detail the evidence why that is so. The hearing officer has done so in Finding of Fact No. 9 (a) through (d). We agree that Dr. B has misapplied the AMA Guides and that his report is not entitled to presumptive weight. Section 408.125(e) then directs the Commission to adopt the IR of one of the other doctors. The hearing officer has done so by adopting the report of Dr. G, which assesses a 7% IR. However, this report is also clearly incorrect as it gives the claimant only a 4% impairment from Table 49, Section (II)(B) whereas both Dr. O and Dr. B agree that the claimant has a 3 mm cervical herniated disc at C4-5 and that the correct rating for that injury should be 6% from Table 49, Section (II)(C). Consequently, Dr. G's rating is incorrect and unacceptable. Dr. O perhaps has the most correct rating but he did not personally examine the claimant and he based his IR on the reports of other doctors; therefore, his report cannot be used to determine the IR.

We are also concerned that there were a number of records and reports referred to by the doctors which were not in evidence and frankly there is no evidence of the claimant's complaints and treatment between the time of his injury on _____, and the time he was examined by Dr. G in December 1998. We can only assume that at some point the treating doctor was a chiropractor, which resulted in Dr. B being appointed as the designated doctor. The parties might well be advised to go back to a benefit review conference and define the extent-of-injury matter and start over with another designated doctor.

If the parties choose to go forward in this case, we are reversing the hearing officer's decision that the claimant has a 7% IR as certified by Dr. G, as being clearly incorrect, not in compliance with the AMA Guides, and incorrect as a matter of law. We remand the case to the hearing officer to first determine the extent of injury and then for the appointment of an appropriate second designated doctor (because Dr. B's reports are so fatally flawed as to not be susceptible of correction) who is to be advised what the extent of the injury is and to be requested to rate only the compensable injury as determined by the hearing officer.

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.

Thomas A. Knapp
Appeals Judge

CONCUR:

Kenneth A. Huchton
Appeals Judge

Gary L. Kilgore
Appeals Judge