

APPEAL NO. 023024
FILED JANUARY 10, 2003

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 6, 2002, with the record closing on October 30, 2002. With regard to the two issues of maximum medical improvement (MMI) and impairment rating (IR) before her, the hearing officer determined that the issues were not ripe for resolution and that the Texas Workers' Compensation Commission (Commission) would appoint a second designated doctor to assess MMI and the IR.

The appellant (claimant) appeals, asserting that the hearing officer erred in denying her discovery request (to take the designated doctor's deposition by written questions) and that the designated doctor's amended report of February 9, 2000, assessing on MMI date of June 16, 1998, with a 30% IR should be adopted. The file does not contain a response from the respondent (carrier).

DECISION

Affirmed.

It is undisputed, and another Appeals Panel decision indicates, that the claimant sustained a compensable right hand injury "on _____ [sic?] _____, while working as a waitress." The parties in this case stipulated that the claimant "sustained a compensable right upper extremity [UE]/RSD [reflex sympathetic dystrophy] injury on _____." The parties also stipulated that Dr. RS was the Commission-appointed designated doctor.

Initially there was a dispute as to whether the claimant's compensable injury included RSD. The hearing officer's Statement of the Evidence (and Dr. RS's narrative of February 17, 2000) sets out some of the doctors and their assessments. Initial reports assessing various MMI dates with a 0% or a 4% IR did not include an assessment for right UE RSD, which the parties now have stipulated is part of the compensable injury. Other reports, including a report assessing MMI on June 19, 1998, with a 43% IR, are not in evidence. An "Impairment Testing Worksheet," dated September 3, 1998, assessing a 30% IR is in evidence but that worksheet does not certify an MMI date and is not done by a doctor.

At some point it was determined or agreed upon that the compensable injury included right UE RSD and the claimant was reexamined by Dr. RS, the designated doctors on February 9, 2000. On a Report of Medical Evaluation (TWCC-69) of that date, and a narrative dated February 17, 2000, the designated doctor certified MMI on June 16, 1998 (perhaps thinking that was the statutory MMI date), and assessed a 30% IR. Dr. RS concluded:

I measured the range of motion of the wrist, elbow and fingers. For determination of her impairment, I am going to use the information that can be obtained on page 37 of the Guides to the Evaluation of Permanent Impairment, Third Edition, Second Printing [dated February 1989 published by the American Medical Association (AMA Guides)]. I am going to concur with the diagnosis of causalgia. Though my observation and seeing her ability to move the extremity (with the benefit of the function of the spinal cord stimulator), I have chosen to provide her with 50% impairment of the right upper extremity. This equals a 30% impairment of the whole person. The date of MMI is June 16, 1998. I could find no evidence of sensory or motor deficits.

The pertinent part of page 37 of the AMA Guides states, "Major causalgia that persists despite appropriate treatment can result in loss of function of the affected extremity and impairment that is as great as 100%." The carrier asserts that is insufficient explanation of how the designated doctor arrived at a 50% impairment of the right UE and the 30% IR.

The hearing officer, on more than one occasion at the CCH, expressed her concern about the lack of medical documentation. The hearing officer also acknowledged that she had denied the claimant's request to take Dr. RS's deposition by written questions as "too broad." At the conclusion of the CCH the hearing officer advised the parties that she would keep the record open and contact the designated doctor by letter and facsimile transmission (fax) to obtain clarification how he arrived at the 30% IR.

In evidence are copies of a letter and fax sent to the designated doctor on September 10, 2002, as well as Dispute Resolution Information System (DRIS) notes documenting telephone attempts to contact the designated doctor asking for "worksheets and/or supporting data detailing how the [IR] was calculated." Dr. RS apparently refused to respond and the hearing officer, on October 24, 2002, wrote the parties stating:

As you are aware, I wrote the designated doctor, [Dr. RS] after the close of the [CCH] on this matter. As of the date of this letter I have not received any documentation from [Dr. RS's] office regarding the above claim. I also enclose for your review DRIS entries made by myself regarding contact with [Dr. RS]. I will be adding as additional hearing officer exhibits the initial letter sent by me to [Dr. RS], this letter and the DRIS entries. As there is no new information, I am also closing the record as the close of business on Wednesday, October 30, 2002 if I do not hear from the parties by that time.

The hearing officer further stated in her decision that efforts to obtain the records were made for several weeks and that since "the designated doctor cannot or will not cooperate. . . the only answer [is] to appoint another designated doctor."

The claimant appeals the hearing officer's decision pointing to the claimant's request to take the designated doctor's deposition on written questions as the claimant "was prevented from gaining command and power over the Designated Doctor to command him to appear and answer" and that if the designated doctor is "a reluctant witness, he can be compelled to be cooperative through the administrative procedures set in place for such situations."

As an aside, we will note that the hearing officer's ruling on the carrier's timeliness and for proper purpose of a designated doctor's amended report argument was exactly correct in that that line of Appeals Panel decisions have largely been overcome by the adoption of the Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6(i) Rule 130.6(i). We review the hearing officer rulings on the issuance or refusal to allow written deposition questions on an abuse-of-discretion standard. Rule 142.13(e) provides that a party seeking to take a deposition must obtain permission from the hearing officer. Under the circumstances of this case, and without having all the information the CCH provided, we find no abuse of discretion in the hearing officer's denial of claimant's request for the deposition. We would also note that another attorney who was representing the claimant at the time may have improperly made direct contact with the designated doctor.

Whether the designated doctor's explanation of how he calculated the 30% IR was adequately explained in his report of February 17, 2000, lay in the discretion of the hearing officer. The hearing officer obviously did not believe that the designated doctor's comment adequately explained his rating and sought to contact him for further explanation or clarification. In light of the hearing officer's repeated attempts to get a response from Dr. RS, we do not find it reversible error for the hearing officer to conclude that the designated doctor could not or would not cooperate and to have the Commission appoint a second designated doctor.

Accordingly the hearing officer's decision and order are affirmed.

The true corporate name of the insurance carrier is **CONTINENTAL CASUALTY COMPANY** and the name and address of its registered agent for service of process is

**CT CORPORATION SYSTEM
350 NORTH ST. PAUL STREET, SUITE 2900
DALLAS, TEXAS 75201.**

Thomas A. Knapp
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Roy L. Warren
Appeals Judge