APPEAL NO. 031205
FILED JULY 3, 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 was held on April 17, 2003. The hearing officer determined that the appellant (claimant) reached maximum medical improvement (MMI) on January 16, 1998, with a 5% impairment rating (IR) as certified by the designated doctor appointed by the Texas Workers' Compensation Commission (Commission). The claimant appeals, asserting that the designated doctor does not possess the necessary qualifications and his certification is contrary to the great weight of other medical evidence. The respondent (self-insured) did not file a response.

DECISION

Reversed and remanded.

The claimant sustained a compensable injury to his left ankle on _____, when he fell from a ladder at work. The medical records show that the claimant suffered an open fracture of the left distal tibia and fibula. The claimant underwent surgery to repair the injury.

The claimant was certified by his treating doctor at MMI on January 16, 1998, with a 24% IR under the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (Third Edition AMA Guides). The self-insured disputed the rating and a designated doctor was appointed by the Commission. In a report dated June 15, 1998, the designated doctor certified the claimant at MMI on January 16, 1998, with a 5% IR for loss of range of motion (ROM) under the Third Edition AMA Guides. Notwithstanding, the designated doctor stated, "If the patient does undergo an ankylosis (fusion) of the ankle at some point in the future, then his impairment rating would need to be re-evaluated and redone."

On August 21, 1998, the claimant underwent a second surgery to remove the hardware in his left ankle which had become painful. Following this surgery, the claimant developed a progressive deformity and varus posturing of the left hindfoot with gross swelling and pain that precluded him from ambulating in a comfortable fashion. The claimant's treating doctor recommended amputating the left lower extremity. The claimant changed treating doctors and underwent a left ankle fusion with hardware on November 8, 2000, for a Charcot arthropathic left ankle associated with the compensable injury. The claimant underwent further ankle surgeries on April 5, 2001, December 21, 2002, and January 29, 2003.

The claimant's new treating doctor certified the claimant at MMI on November 20, 2001, with a 25% IR under the Guides to the Evaluation of Permanent Impairment,

fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes, as issued by the American Medical Association prior to May 16, 2000) (Fourth Edition AMA Guides). The new treating doctor opined that the designated doctor's ROM measurements were not supportable given the claimant's condition and that the designated doctor failed to give a rating for sensory impairment. The Commission sought clarification of the designated doctor's certification in view of this report. In his response dated December 31, 2002, the designated doctor maintained the accuracy of his rating but stated,

> If I had been asked to determine whether [the claimant] was at [MMI] or not, and that was not an option for me because I was not asked, *I would have probably found him not to be at [MMI] when I saw him*. [Emphasis added.]

The claimant contends that the designated doctor does not possess the necessary qualifications pursuant to Section 408.0041(b) and Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(d)(2)(C) (Rule 130.5(d)(2)(C)). Section 408.0041(b) provides in relevant part that the designated doctor should be one:

> [W]hose credentials are appropriate for the issue in question and the injured employee's medical condition. The designated doctor doing the review must be trained and experienced with the treatment and procedures used by the doctor treating the patient's medical condition, and the treatment and procedures performed must be within the scope of practice of the designated doctor.

Rule 130.5(d)(2)(C) provides that:

> If at the time the request is made, the commission has previously assigned a designated doctor to the claim, the commission shall use that doctor again, if the doctor is still qualified as described in this subsection and available. Otherwise, the commission shall select the next available doctor on the commission's Designated Doctor List who:…has credentials appropriate to the issue in question, is trained and experienced with the treatment and procedures used by the doctor treating the patient's medical condition, and whose scope of practice includes the treatment and procedures performed. In selecting a designated doctor, completed medical procedures may be considered secondary selection criteria.

Whether the designated doctor is qualified to serve is a threshold issue that must be resolved before the question of whether the rating is entitled to presumptive weight is reached. We have said that the burden of establishing that the designated doctor is not qualified rests with the party disputing the qualifications. Texas Workers' Compensation Commission Appeal No. 031015, decided June 9, 2003. The claimant did not develop the evidence regarding the medical qualifications of the designated doctor. In view of

the evidence presented, we cannot conclude that the designated doctor was not qualified to serve in this case.

Notwithstanding the above, the hearing officer erred in determining that the claimant reached MMI on January 16, 1998, with a 5% IR as certified in the designated doctor's initial report. We have said that the designated doctor's response to a request for clarification is considered to have presumptive weight as it is part of the designated doctor's opinion. Rule 130.6(i); *see also*, Texas Workers' Compensation Commission Appeal No. 013042-s, decided January 17, 2002. In his most recent clarification, the designated doctor made clear that the claimant was not at MMI "when I saw him." Accordingly, we reverse the hearing officer's MMI/IR determination and remand for further consideration. On remand, the claimant should be reexamined by the designated doctor for MMI and IR, under the Third Edition AMA Guides, and determine MMI in accordance with Section 401.011(30)(A) or (B). The hearing officer must determine whether the great weight of the other medical evidence contradicts the designated doctor's amended report, considering the presumptive weight afforded to that report under new Rule 130.6(i).

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 (amended June 17, 2001). *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **(a self-insured governmental entity)** and the name and address of its registered agent for service of process is

MB
(ADDRESS)
(CITY), TEXAS (ZIP CODE).

_____
Edward Vilano
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Veronica Lopez-Ruberto
Appeals Judge