APPEAL NO. 070086
FILED MARCH 21, 2007

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 12, 2006. The hearing officer decided that: 1) the compensable injury includes deep vein thrombosis (DVT), peripheral vascular disease (PVD), and phlebitis but not varicose veins; 2) the respondent/cross-appellant (carrier) waived the right to contest the DVT injury by not timely contesting the injury; and 3) the appellant/cross-respondent's (claimant) impairment rating (IR) is 4%. The claimant appealed the hearing officer's determinations that the first designated doctor's IR of 18% was improper and contrary to the preponderance of the other medical evidence and asserted an abuse of discretion by the hearing officer in the appointment of the second designated doctor and adoption of that doctor's 4% IR as corrected by the hearing officer. The carrier responded, urging affirmance of the hearing officer's appointment of the second designated doctor and of the 4% IR. The carrier appealed the hearing officer's determinations on extent of injury and waiver. The claimant responded, urging affirmance of these issues.

DECISION

Affirmed in part and reversed and rendered in part.

FACTUAL SUMMARY

It was undisputed that on _____, the claimant, who worked as a pest control technician, was spraying insecticide outside a home and stepped into a hole with her left foot, sustaining a left distal fibula fracture. Medical records in evidence reflect that the claimant was subsequently diagnosed with DVT in the left lower extremity. There are conflicting medical opinions in evidence regarding whether or not the claimed conditions of DVT, PVD, phlebitis, and varicose veins are part of the compensable injury. The Benefit Review Conference Report stated that the parties verbally agreed there is no dispute with regard to the date of maximum medical improvement (MMI), which is November 14, 2005, as certified by Dr. E, the designated doctor. It was undisputed that Dr. E was the first appointed designated doctor.

The hearing officer determined that the IR of 18%, as certified by Dr. E, was contrary to the preponderance of the other medical evidence and could not be adopted as correct because he failed to properly apply 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)(AMA Guides). The hearing officer did not explain his determination. The hearing officer did state that Dr. E maintained his position (regarding his certification of MMI and IR) after requests to clarify were sent to him. Because there was no other IR that could be adopted in evidence, the hearing officer appointed a second designated

doctor, Dr. L, over the timely objection of the claimant. Dr. L certified an impairment of 10%. The hearing officer determined that Dr. L made an error in failing to convert what he found to be a lower extremity impairment of 10% to a whole person impairment. The hearing officer converted the 10% lower extremity impairment by multiplying the 10% by 0.4 to arrive at a 4% whole person impairment rating (as set out on page 3/75 of the AMA Guides).

EXTENT OF INJURY

We conclude that the hearing officer's extent-of-injury determinations are supported by sufficient evidence and are not so against the great weight and preponderance of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W. 2d 175 (Tex. 1986). We affirm the hearing officer's determination on the issue of extent of injury.

WAIVER

Section 409.021(c), effective for a claim based on a compensable injury that occurred on or after September 1, 2003, provides that if an insurance carrier does not contest the compensability of an injury on or before the 60th day after the date on which the insurance carrier is notified of the injury, the insurance carrier waives its right to contest compensability. The Appeals Panel has held that once a claimant has satisfied the burden of proving the date the carrier received written notice of the claimed injury, the carrier then has the burden of proving the date that it disputed the claimed injury. Appeals Panel Decision (APD) 032862, decided December 19, 2003. In the instant case, there is no evidence or agreement as to the date that the carrier first received the written notice of the claimed injury. *See* APD 051383, decided August 9, 2005. Because the determination on carrier waiver is not supported by the evidence and it is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust, we reverse the decision of the hearing officer that the carrier waived the right to contest the DVT injury by not timely contesting the injury and render a new decision that the carrier did not waive the right to contest the claimed injury by not timely contesting the injury in accordance with Section 409.021.

DESIGNATED DOCTOR AND IMPAIRMENT RATING

Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Texas Department of Insurance, Division of Workers' Compensation (Division) shall base the IR on that report unless the preponderance of the other medical evidence is to the contrary, and that if the preponderance of the medical evidence contradicts the IR contained in the report of the designated doctor chosen by the Division, the Division shall adopt the IR of one of the other doctors. The designated doctor's response to a Division request for clarification is considered to have presumptive weight as it is part of the doctor's opinion.

The hearing officer determined that the first designated doctor, Dr. E, improperly applied the AMA Guides in rating the compensable injury without explaining how Dr. E did so. Page 3/75 of the AMA Guides states (in Section 3.2 The Lower Extremity) that anatomic, diagnostic, and functional methods are used in evaluating permanent impairments of the lower extremity.[1] Dr. E, examined the claimant on February 1, 2006, and based upon his certifying exam, assessed a whole person IR of 18% (combining whole person impairments of 3%[2] and 16%[3]). In his narrative report, Dr. E explained that he rated the claimant in Table 69 as a Class 3 due to "persistent edema in the left leg and DVT in the left thigh and left leg with edema poorly controlled." When provided Dr. O peer review and asked in a letter of clarification as to the reason that Dr. E placed the claimant in Class 3, Dr. E responded on March 2, 2006, that Dr. O had not taken into consideration the 3 centimeter (cm) difference in the claimant's left thigh and the 4 cm difference in the left calf with documented multiple DVTs in the left common femoral and left superficial femoral vein per ultrasound on February 2, 2004. In an August 7, 2006, response to a second letter of clarification regarding the inclusion of the claimant in the Class 3, Dr. E pointed out that in his exam, there was notable edema (patterns) +3 in the left leg poorly controlled with elastic stockings. He also noted that the claimant gave a history of "prolonged standing and/or sitting caused cramping and burning in the left leg." No definitions for "persistent edema" or for "marked edema" are contained in the AMA Guides. Dr. E provided an explanation for his classification of the claimant in Class 3 of Table 69. His rating as to which class was a judgment call and his report as a designated doctor has presumptive weight. Two letters of clarification were sent by the Division to Dr. E, to which he replied to each inquiry about his certification of IR, maintaining that his rating was correct. In APD 960227, decided March 20, 1996, the Appeals Panel affirmed a hearing officer's determination of IR, as certified by the designated doctor, in a case involving rating ROM of the knee and PVD. In that case, the designated doctor acknowledged a significant discrepancy in his rating and in the treating doctor's rating for PVD, noting that the assignment of a numerical rating on that element of impairment was a "judgment call." There is insufficient evidence to support the hearing officer's determination that Dr. E's IR was improperly calculated under the AMA Guides and is contrary to the preponderance of the other medical evidence.[4]

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[1] The AMA Guides further states that, while some impairments may be evaluated appropriately by determining the range of motion (ROM) of the extremity, others are better evaluated by the use of diagnostic categories or according to test criteria. In general, only one evaluation method should be used to evaluate a specific impairment. In some instances, however, a combination of two or three methods may be required. If the patient has several impairments of the same lower extremity part, or impairments of different parts, the whole-person estimates for the impairments are combined by using the Combined Value Chart (CVC) on page 322 of the AMA Guides.

[2] Per Table 42 on page 3/78 of the AMA guides, a 3% whole person impairment is appropriate for ankle extension at neutral (a deficit in the ROM of the left ankle).

[3] Per Table 69 on page 3/89 of the AMA Guides, Class 3, a 40% lower extremity impairment due to PVD is appropriate. Per page 3/75, a lower extremity impairment percent multiplied by 0.4 yields the whole-person impairment of 16%.

[4] The carrier argued that the medical opinions and reports of Dr. F, who examined the claimant for a Required Medical Evaluation on March 27, 2006, and of Dr. O and Dr. H, peer review doctors, explained that Dr. E's IR was improperly calculated because his impairment was not limited to the compensable injury; his rating was based on conditions that were not permanent; and Dr. E failed to base his impairment on objective clinical or laboratory findings. There is sufficient evidence in the medical evidence, which includes the assessment by the second designated doctor, to support the hearing officer's determination that the compensable injury extends to include PVD, DVT, and phlebitis, and that Dr. E documented edema and deficit in the ankle ROM in his certifying exam.

An abuse of discretion is the standard to use in reviewing a decision to appoint a second designated doctor. APD 960454, decided April 17, 1996. An abuse of discretion occurs when a decision is made without reference to any guiding rules or principles. *See* Morrow v. H.E.B., Inc., 714 S.W.2d 297 (Tex. 1986). In APD 011607, decided August 28, 2001, the Appeals Panel held that normally the appointment of a second designated doctor is appropriate only in those cases where the first designated doctor is unable or unwilling to comply with the required AMA Guides or requests from the Division for clarification, or if he or she otherwise compromises the impartiality demanded of the designated doctor. If a designated doctor cannot or refuses to comply with the requirements of the 1989 Act, a second designated doctor may be appointed. APD 961436, decided September 5, 1996. In the instant case, we hold that the hearing officer abused his discretion in the appointment of the second designated doctor, Dr. L because there is no indication that Dr. E, the first designated doctor, was unable or unwilling to comply with the required AMA Guides or to respond to requests for clarification and there is no evidence that Dr. E was not qualified or was unavailable to reexamine the claimant if requested.

In APD 041424, decided July 21, 2004, the Appeals Panel corrected a clerical error made by the designated doctor in using the CVC of the AMA Guides, citing Old Republic Insurance Company v. Rodriguez, 966 S.W. 2d 208 (Tex. App.-El Paso 1998, no pet). In the instant case, the designated doctor, Dr. E, made a clerical error in using the CVC, which we believe should be corrected on appeal to reflect the actual IR determined by Dr. E when the impairments of 3% and 16% are correctly combined. We reverse the hearing officer's decision that the claimant has a 4% IR and we render a decision that the claimant's IR is 19%.

SUMMARY

We affirm the hearing officer's decision that the compensable injury of _____, includes DVT, PVD, and phlebitis but does not include varicose veins. We reverse the hearing officer's decision that the carrier waived the right to contest compensability of the DVT injury by not timely contesting the injury and that the claimant's IR is 4%. We render a new decision that the carrier has not waived the right to contest compensability of the claimed injury and that the claimant's IR is 19%.

The true corporate name of the insurance carrier is **ZURICH AMERICAN INSURANCE COMPANY** and the name and address of its registered agent for service of process is

LEO R. MALO
12222 MERIT DRIVE, SUITE 700
DALLAS TX 75951.

_____
Cynthia A. Brown
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Margaret L. Turner
Appeals Judge