APPEAL NO. 091660
FILED DECEMBER 30, 2009

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 29, 2009. The disputed issues at the CCH were: (1) the date of maximum medical improvement (MMI); and (2) the appellant's (claimant) impairment rating (IR).

The hearing officer determined that the claimant reached MMI on September 17, 2008, and that the IR is 7%.

The claimant appeals, contending that the designated doctor (whose opinion is the basis of the hearing officer's determinations) had a disqualifying association pursuant to 28 TEX. ADMIN. CODE § 180.21 (Rule 180.21) and that the claimant is not at MMI. The respondent (self-insured) responds, contending that the designated doctor was appointed before the required medical examination (RME) doctor and therefore the designated doctor was not influenced by the RME doctor. The self-insured urges affirmance of the MMI date and IR.

DECISION

Reversed and remanded.

The parties stipulated that the claimant sustained a compensable injury on _____. The medical records indicate that the claimant, an assistant cook, slipped on a tray and did the "splits" injuring her low back and right hip. A Benefit Dispute Agreement (DWC-24) effective February 26, 2009, states that the parties agreed that "the compensable injury DOES extend to and include the L3-4 & L4 disc bulges with nerve root compression as well as lumbar radiculopathy." After the date of injury the claimant saw several doctors, received conservative treatment and physical therapy and one epidural steroid injection on August 6, 2008.

(Dr. NP) was the designated doctor appointed to determine MMI and IR. In a Report of Medical Evaluation (DWC-69) and narrative dated September 17, 2008, Dr. NP certified that the claimant reached MMI on that date with a 7% IR. The IR was calculated using 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). The IR consisted of a 5% whole person impairment for Diagnosis-Related Estimate Lumbosacral Category II: Minor Impairment and a 2% impairment for loss of range of motion of the right hip.

Subsequently, an orthopedic surgeon, in a report dated October 9, 2008, stated that while another surgeon did "not believe surgery will help" he would do "an EMG/NCV

if positive then L3-4, L4-5, and L5-S1 Posterior lumbar interbody fusion." An EMG/NCV performed on November 7, 2008, showed "right-sided L5 radiculopathy."

The DWC-24 agreement was entered on February 26, 2009. (Dr. SP), the self-insured's RME doctor, in a report dated April 2, 2009, states that he was asked to examine the claimant to determine if the length and frequency of treatment was appropriate. The letterheads on the reports of Dr. NP, the designated doctor, and Dr. SP, the RME doctor, show the same address, the same suite number, and the same telephone and fax numbers. The claimant's attorney called himself as a witness and under oath testified that he had personal knowledge that Drs. NP and SP are employed by (Healthcare Provider) and they share the same physical location, same office, and same record keeping, billing, collection and 100% clerical support.

Subsequently, on May 1, 2009, the Texas Department of Insurance, Division of Workers' Compensation (Division) sent Dr. NP a letter of clarification forwarding the DWC-24 agreement and asking Dr. NP to rate the entire compensable injury. Dr. NP replied by letter dated May 6, 2009, that his opinion on MMI and the IR had not changed because there was no objective evidence of radiculopathy. In an Addendum to his original report, dated June 1, 2009, Dr. SP, the RME doctor, stated that while "the disc bulges, radiculopathy, and nerve impingement have reportedly been accepted as part of the compensable injury, these conditions must have improved or resolved and were not clinically evident at the time of my examination."

DISQUALIFYING ASSOCIATION PURSUANT TO RULE 180.21

The claimant, as early as the benefit review conference, contended that both the designated doctor and the RME doctor work out of the same facility and that created a conflict of interest and asked that a new designated doctor be appointed. Although not specifically listed as a separate issue, a disqualifying association was litigated at the CCH. The hearing officer only addresses the potential disqualifying association by finding: "Although an RME doctor later examined [c]laimant on April 2, 2009, there is no evidence reflecting that the designated doctor was aware of that examination or of the results of that RME."

Rule 126.7(h)(2) references Rule 180.21 with regard to disqualifying associations. Rule 180.21(a)(2) pertaining to the designated doctor list defines a disqualifying association:

> (2) Disqualifying association - Any association that may reasonably be perceived as having potential to influence the conduct or decision of a doctor, which may include:
>
> * * * *
>
> (D) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, or

> warranties, or any other services related to the management of the doctor's practice.

In a similar situation in Appeals Panel Decision (APD) 091210, decided October 16, 2009, the Appeals Panel cited several cases which basically held that there is a disqualifying association where the RME doctor and the designated doctor shared the same office space and telephone line. In APD 971088, decided July 28, 1997, an earlier case involving disqualifying association under a different rule, the Appeals Panel commented on the "Commission's," now Division, concerns about even an appearance of impropriety. In that case, the Appeals Panel further commented that "the mere fact that the carrier doctor and the designated doctor shared offices, telephone numbers, and perhaps support personnel was sufficient to establish a reasonable perception of a disqualifying association to a lay claimant not knowledgeable in how complex medical management services may work." In APD 971088, both the designated doctor and the RME doctor had contracted with a service "which offered not only billing services but 'facilities to work at and a structured environment.'" The self-insured contends that the cases cited by the claimant have certain factual distinctions, and that in this case the designated doctor's report was not influenced by the association. The self-insured further points out that the designated doctor had not requested a re-examination and his opinion had not changed. While that may be true, the fact is that Rule 180.21(a)(2) defines a disqualifying association as any association that **may reasonably be perceived** as having potential to influence the conduct or decision of a doctor which includes agreement for space, personnel services or any other services related to the management of the doctor's practice. In this case, it is undisputed that Dr. NP and Dr. SP had the same address, the same suite number and the same telephone and fax number. There was no contradicting evidence that the doctors shared billing and collection services and support personnel. We hold that Dr. NP had a disqualifying association and therefore his report cannot be adopted. There is no other report of MMI and IR that can be adopted in evidence. Accordingly, we reverse the hearing officer's determination that the claimant was at MMI on September 17, 2008, and that the claimant's IR is 7%. We remand the case for the appointment of another designated doctor. The parties are to be given the designated doctor's report and are to be given an opportunity to comment and present evidence regarding the designated doctor's report.

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 Division, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* APD 060721, decided June 12, 2006.

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

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

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

Veronica L. Ruberto
Appeals Judge

_____
Margaret L. Turner
Appeals Judge