

APPEAL NO. 121823
FILED NOVEMBER 8, 2012

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 commenced on December 15, 2010, with the record closing on August 14, 2012, in [City], Texas, with [hearing officer] presiding as hearing officer. With regard to the disputed issues, the hearing officer determined that the respondent (claimant) reached maximum medical improvement (MMI) on December 31, 2010, and the claimant's impairment rating (IR) is 16%.

The appellant (carrier) appealed, contending that the hearing officer erred in determining the MMI date and IR and in appointing a second designated doctor. The claimant responded, urging affirmance.

DECISION

Reversed and remanded.

The parties stipulated that the claimant sustained a compensable injury on [date of injury]. In a Notice of Disputed Issue(s) and Refusal to Pay Benefits (PLN-11) dated January 5, 2010, the carrier accepted a "lumbar sprain/strain/disc bulge, left shoulder sprain/strain/labral tear, cervical sprain/strain and bilateral knee sprain/strain." The medical records and evidence reflect that the claimant had arthroscopic surgery to the left shoulder to repair the anterior labrum on February 27, 2009. The records further reflect that the claimant also had cervical spinal surgery for herniated discs at C5, C6, and C7 on February 11, 2010. The parties stipulated that [Dr. J] is the Texas Department of Insurance, Division of Workers' Compensation (Division)-appointed designated doctor.

MMI AND IR

Section 401.011(30)(A) defines MMI as "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated" and (B) the expiration of 104 weeks from the date on which income benefits begin to accrue. Section 408.1225(c) provides that the report of the designated doctor has presumptive weight, and the Division shall base its determination of whether the employee has reached MMI on the report of the designated doctor unless the preponderance of the other medical evidence is to the contrary. Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the 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.

Dr. J was the first designated doctor. In a Report of Medical Evaluation (DWC-69) and narrative dated June 18, 2009, Dr. J initially certified the claimant at MMI on June 18, 2009, with an 8% IR based on loss of range of motion (ROM) in the left shoulder. Dr. J subsequently learned that the claimant had undergone left shoulder surgery and, in a DWC-69 and narrative dated April 29, 2010, certified that the claimant was not at MMI. Dr. J again examined the claimant on July 15, 2010, and certified the claimant at MMI on that date with a 0% IR. In a letter of clarification (LOC) dated December 17, 2010, the hearing officer noted that the ROM figures Dr. J had submitted indicated a ratable left shoulder impairment and requested that Dr. J explain why he had determined a 0% IR. The hearing officer, in his Background Information, commented that Dr. J had responded that “there was an omission made when entering the data into the software used to illustrate the [IR] calculation” and that a “complete set of calculations [were] attached. . . .” The hearing officer commented that Dr. J merely sent him the narrative report from the June 18, 2009, certifying exam. The hearing officer, in the Background Information, commented that he would send another LOC to Dr. J.

The hearing officer wrote Dr. J two more LOCs requesting clarification of the ROM figures in Dr. J’s narratives and in his worksheets from 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). In addition, on May 17, 2011, Dr. J, in response to an LOC, submitted a DWC-69 dated July 15, 2010, referencing his July 15, 2010, examination, assessing a 10% IR for loss of ROM of the left shoulder but with different ROM figures than the July 15, 2010, examination. No narrative was attached to that report. No re-examination had been performed. The hearing officer commented, in the Background Information, that there was no explanation of how Dr. J arrived at the new measurement figures and that the hearing officer determined a new designated doctor should be appointed to determine the claimant’s date of MMI and IR.

The standard in reviewing a decision to appoint a second designated doctor is whether there was an abuse of discretion. See Appeals Panel Decision (APD) 960454, decided April 17, 1996; APD 070086, decided March 21, 2007. 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). The Appeals Panel has held that normally the appointment of a second designated doctor is appropriate only where the first designated doctor is unable or unwilling to comply with the required AMA Guides or requests from the Division for clarification. See APD 011607, decided August

28, 2001; APD 070086, *supra*. In this case, Dr. J failed to comply with the hearing officer's repeated requests for clarification. The hearing officer did not abuse his discretion in the appointment of the second designated doctor. In a letter dated May 26, 2011, the hearing officer advised the parties:

As you have no doubt noted, there is no narrative attached to [Dr. J's] response and the [ROM] measurements given by Dr. [J] are different from those provided in the past.

In light of Dr. [J's] failure to answer my question regarding his [IR] evaluation of July 15, 2010, I find it necessary to have a new designated doctor appointed.

Over the carrier's objection, [Dr. WS] was appointed as the second designated doctor.

In a DWC-69 and narrative dated July 2, 2012, Dr. WS noted that an examination was performed on that date. Dr. WS certified statutory MMI on December 31, 2010, with a 16% IR. The 16% IR was based on 7% for loss of ROM of the left shoulder, 5% impairment for Diagnosis-Related Estimate (DRE) Cervicothoracic Category II: Minor Impairment and 5% impairment for DRE Lumbosacral Category II: Minor Impairment which was combined under the Combined Values Chart, page 322, of the AMA Guides to result in the 16% IR. The hearing officer sent Dr. WS a LOC dated July 26, 2012, asking Dr. WS: (1) why he chose the date of statutory MMI date rather than an earlier date (as all the other doctors had); (2) what findings warrant the DRE II ratings for the neck and low back; and (3) what are the measurements for the loss of ROM of the left shoulder together with a worksheet showing how those measurements warranted the impairment assigned. Dr. WS replied that the "MMI date was selected because approximately two years' time was up, and his condition would not be improving." Dr. WS also stated that "abnormal [ROM] was observed, and the others are given to be normal."

We note that statutory MMI was not discussed at the CCH and the hearing officer made no mention or finding when statutory MMI occurred. The carrier, on appeal, contends that the date of injury was [date of injury], that the claimant began to lose time from work on December 23, 2008, and the eighth day of disability (Section 401.011 (B)) was December 30, 2008, and as such, the statutory MMI date would be December 27, 2010.

Despite being requested to do so by the hearing officer, Dr. WS failed to provide shoulder ROM figures and instead only provided left shoulder flexion and abduction figures, saying all others were normal. Dr. WS did not submit a worksheet as requested by the hearing officer. The reason Dr. WS gives for assessing DRE Lumbosacral

Category II: Minor Impairment was “because [the claimant] has one disc.” That reason does not comply with the description and verification criteria listed on page 3/102, of the AMA Guides to warrant a DRE Lumbosacral Category II rating. Further, we note it does not appear that Dr. WS rated the accepted bilateral knee sprain/strain. For these reasons Dr. WS’s certification of statutory MMI on December 31, 2010, with a 16% IR cannot be adopted.

The appeal file contains two other certifications of MMI and IR. [Dr. R], the claimant’s treating doctor, in a report dated August 5, 2010, stated that he examined the claimant on that date and certified MMI on July 15, 2010, with an 18% IR. Regarding the MMI date, Dr. R states only that “I concur with the previously established MMI date of July 15, 2010.” No MMI date had been previously established and Dr. J had listed several MMI dates. Furthermore, the 18% IR was based, in part, on a rating of DRE Lumbosacral Category III: Radiculopathy for a 10% impairment. Dr. R does not cite medical evidence to support the verification criteria of significant signs of radiculopathy such as loss of relevant reflexes or measured unilateral atrophy necessary to support a DRE Lumbosacral Category III: Radiculopathy rating under the AMA Guides. Furthermore, Dr. R diagnoses “post-cervical fusions, C5-6 and C6-7, [s]tatus post-labral repair, left shoulder [and] [b]ilateral lumbar radiculopathy.” Dr. R does not rate the accepted bilateral knee sprain/strain and therefore, has not rated the entire compensable injury. For those reasons Dr. R’s certification of MMI and IR cannot be adopted.

Also in evidence is a DWC-69 and narrative report from [Dr. S]. Dr. S examined the claimant on August 8, 2010, certified MMI on that date and assessed a 15% IR. Although Dr. S checked the box on the DWC-69 that he is a doctor selected by the treating doctor acting in place of the treating doctor, the parties stipulated that Dr. R, the treating doctor, did not ask Dr. S to perform an IR evaluation. (Dr. S performed the claimant’s cervical surgery). 28 TEX. ADMIN. CODE § 130.1(a)(1) (Rule 130.1(a)(1)) provides that only an authorized doctor may certify MMI, determine whether there is permanent impairment, and assign an IR if there is permanent impairment. Rule 130.1(a)(1)(A) further provides that only the following doctors are authorized to determine whether the injured employee has permanent impairment, assign an IR, and certify MMI: (1) a treating doctor (or a doctor to whom the treating doctor has referred the injured employee for evaluation of MMI and/or permanent whole body impairment in the place of the treating doctor, in which case the treating doctor is not authorized); (2) a designated doctor; or (3) a required medical examination doctor selected by the insurance carrier and approved by the Division to evaluate MMI and/or permanent whole body impairment after a designated doctor has performed such an evaluation. In this case, Dr. R is the treating doctor who has given a certification of MMI/IR and who the parties have stipulated did not request Dr. S to perform an IR evaluation. Rule

130.12(c)(3) provides that for a certification of MMI and/or IR to be valid it must be signed by a certifying doctor who is authorized by the Division under Rule 130.1(a) to make the assigned impairment determination. Dr. S's certification was not a valid certification pursuant to Rule 130.12. Consequently, Dr. S was not an authorized doctor pursuant to Rule 130.1(a) and his certification of MMI and IR cannot be adopted.

Accordingly, we reverse the hearing officer's determination that the claimant reached MMI on December 31, 2010, and that the claimant's IR is 16% and we remand the case back to the hearing officer for further action as directed.

REMAND INSTRUCTIONS

The designated doctor for MMI and IR is Dr. WS. The hearing officer is to determine if Dr. WS is still qualified and available to serve as the designated doctor. If Dr. WS is no longer qualified or available to serve as the designated doctor, another designated doctor is to be appointed pursuant to Rule 127.5(c). The hearing officer is to either obtain a stipulation on the date of statutory MMI or make a finding on what the date of statutory MMI is.

The designated doctor is to be requested to give an opinion on MMI and IR for the compensable injury which includes at least a lumbar sprain/strain/disc bulge, left shoulder sprain/strain/labral tear, cervical sprain/strain and bilateral knee sprain/strain, based on the claimant's condition as of the date of MMI (which cannot be after the date of statutory MMI as stipulated or determined by the hearing officer) considering the claimant's medical record and certifying examination, in accordance with the AMA Guides and Rule 130.1(c).

After the designated doctor has given his opinion the parties are to be allowed to comment and present evidence regarding the designated doctor's report. The hearing officer is then to make a determination on MMI and IR that is supported by the evidence and is consistent with this decision.

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 **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

**MR. RON O. WRIGHT, PRESIDENT
6210 HIGHWAY 290 EAST
AUSTIN, TEXAS 78723.**

Thomas A. Knapp
Appeals Judge

CONCUR:

Cynthia A. Brown
Appeals Judge

Margaret L. Turner
Appeals Judge