APPEAL NO. 93328

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. arts. 8308-1.01-11.10 (Vernon Supp. 1993) (1989 Act). A contested case hearing was held on March 30, 1993, to determine whether the claimant had impairment as the result of his compensable injury and, if so, what his impairment rating was. The appellant, hereinafter carrier, appeals hearing officer's determination that claimant's impairment was 32% as assigned by a Commission-appointed designated doctor, challenging the disparity between the designated doctor's rating and that of the other doctors, and contending that the designated doctor gave separate ratings to body parts which should not have been rated separately. The respondent, hereinafter claimant, requests that this panel affirm the hearing officer's determination.

DECISION

We affirm the decision and order of the hearing officer.

The claimant since 1979 had been employed by (employer), hereinafter employer (at the time of the hearing, the company had been acquired by (employer 2), for whom claimant continued to work). On _____, a part came out of an assembly he was working on, throwing him down and causing him to hit a steel stake. He hit his back and neck and broke two ribs. At the time of injury he was 58 years old.

Claimant was sent to an emergency room and saw at least two doctors before he began treating with Dr. S on March 18, 1991. On that date Dr. S wrote of claimant's complaints of recurring lower back pain radiating into his right foot, and numbness and weakness in his lower back. Dr. S examined x-ray reports and stated his opinion that claimant had degenerative disc disease of L5-S1 in the lumbar spine, degenerative disc disease of the dorsal spine and degenerative joint disease of both hips. Dr. S also noted that claimant had had lower back surgery in 1981. He recommended a CT scan of the lumbar spine, the report of which stated the following conclusions:

> Apparent postoperative changes at L5-S1, with epidural fibrosis, no definite evidence of recurrent or residual disc protrusion. The disc space is narrowed with a vacuum phenomenon and there is spurring causing encroachment upon the right neural foramen and the overall findings produce probably mild stenosis of the canal, although the confines of the thecal sac are difficult to delineate due to the fibrosis . . . Minimal annular bulge at L3-4 and L4-5 with mild to moderate stenosis of the central canal at L4-5. No evidence of disc herniation seen on the current study.

MRIs of the cervical and lumbar spines also were performed on April 19th. The cervical MRI found degenerative changes most prominent at C4-5 and C5-6 and C6-7 with a reversed curvature to the cervical spine; also, a disc herniation centrally and to the right at C4-5 with smaller broad-based central disc herniation at C5-6 and C6-7. The lumbar

MRI found as follows:

> . . . degenerative disc changes and/or postoperative changes most prominent at L5-S1 with spondylotic (sic) narrowing of the L5-S1 formaman (sic) on both sides. Degenerative disc changes are present at L4-5 with a probable tear in the annulus fibrosis centrally. There is a small bulge or central protrusion that minimally indents the ventral surface of thecal sac at this level.

Dr. S found claimant to have reached maximum medical improvement (MMI) on December 31, 1991, with a 15% whole body impairment, based on 10% for claimant's neck and 5% for his back. The Report of Medical Evaluation (Form TWCC-69) completed by Dr. S states "see attached" under the blank stating "[p]lease complete narrative history of employee's medical condition . . ." and, at least for purposes of claimant's exhibit at the hearing, Dr. S's March 28, 1991 report and the above-referenced studies were attached. The blank stating "[d]ocument objective laboratory or clinical finding of impairment" was not completed. Carrier introduced additional documents from Dr. S which indicate claimant was seen on September 4, October 2, October 31, and December 5, 1991, and on January 14, 1992. In letters written on each of those dates, Dr. S measured claimant's cervical and lumbar range of motion (ROM) and flexion and extension. A May 22, 1991 report to Dr. S from (health center) discussed ROM and flexion and extension tests, but much of this report is poorly copied and unreadable.

Because the carrier disputed Dr. S's impairment rating, it requested that the Texas Workers' Compensation Commission (Commission) appoint a designated doctor. In the meantime, claimant was seen by Dr. G, carrier's doctor, who found claimant to have reached MMI on May 28, 1992, with a 5% whole body impairment. Dr. G's report stated that Dr. S apparently discussed the possibility of surgery with the claimant, then found him to have reached MMI when claimant elected against surgery. Dr. G's report also stated that since the time Dr. S found MMI claimant's neck pain had improved and the majority of his pain was lower back pain, stating also that his upper back pain had improved. Dr. G also stated that claimant had had a discectomy in 1981, apparently at L5-S1. He reviewed claimant's lumbar MRI showing "degenerative disc disease at L5-S1 as well as somewhat at L4-5 [b]oth with tears in the annulus and significant internal disc disruption." He also noted the cervical MRI showing degenerative changes at three levels and herniation on the right at C4-5, as well as the CT scan showing degenerative or postoperative changes at L5-S1.

Dr. G concluded that claimant probably had mechanical low back pain from L4-5 and L5-S1, and that he "would concur in general with [Dr. S's] recommendations that if he does not elect surgery . . . there is nothing further to do and he has reached MMI." Dr. G also noted claimant's impairment rating for low back as 5% and said, "[o]bviously this is a very subjective area, due to his previous discectomy, without fusion, and his mechanical

problem that pre-existed, but I would not be violently opposed to a roughly 5% estimate . . . ." He said claimant's cervical spine "at this point would seem to be much less as far as symptomatology goes, and we will ask that the therapist look at this a little closer, but in general I would concur with the figures." Nevertheless, Dr. G's whole body impairment for claimant was 5%.

On November 20, 1992, a Commission order was entered appointing Dr. B as designated doctor. On December 7, 1992, Dr. B issued a lengthy report summarizing claimant's history, current complaints, and medical treatment and diagnoses (the claimant testified that he was seen by Dr. B between the hours of 8:30 a.m. and 5:30 p.m.). Following his assessment of ROM and other tests, as well as assignment of impairment according to the specific disorder table of the American Medical Association's Guides to the Evaluation of Permanent Impairment, Third Edition, Second Printing, February 1989 (AMA Guides), Dr. B assigned claimant a 38% whole body impairment rating. This was comprised of unoperated residuals, cervical discs C4-5, C5-6, and C6-7, 8%; unoperated residual, L4-5 disc, 5%; spinal ROM, 15%; left upper extremity (whole person), 2%; right upper extremity, 10%; and right and left lower extremities, 6%. The values for upper and lower extremities were based on ROM and/or muscle weakness.

On January 26, 1993, Dr. B issued a revision of his prior opinion on claimant. He stated that his original opinion included ROM deficits in claimant's arms and legs not due to "frozen shoulders" or specific problems with the hips, knees, ankles, wrists, or fingers. Dr. B said claimant did have ROM deficits, but he believed these to be secondary to radiculopathy which he said, under the AMA Guides, should not have been rated. As a result, he deleted all the ratings for ROM losses in the arms and legs and recomputed the impairment rating for a revised whole body impairment of 32%. His revised TWCC-69 still found an MMI date of December 7, 1992.

On February 11, 1993, Dr. O, apparently at carrier's request, reviewed Dr. B's findings (claimant testified that Dr. O did not examine him). Dr. O stated that claimant's injury had not resulted in surgery, yet Dr. B had given impairment for multiple levels which, he contended, the AMA Guides allow only after surgical intervention. He also claimed diffuse degenerative changes in a neck would result in 6% impairment and not 8%, which he said is given for surgical correction.

Dr. O also contended Dr. B's ROM studies were invalid because "the tightest straight leg at 74 degrees exceeds the sum of the sacral flexion extension by more than the 10 degrees allowable," and that the disparities between ROM readings require that they be repeated. He also criticized Dr. B's use of Baltimore Therapeutic Equipment for test-retest reliability and inner-test reliability, and said "[i]t is very precarious, in my opinion, to make a strict diagnosis based on this without cross-validation." However, he concluded, "[Dr. B] could certainly be correct with some of these observations, but I have a hard time following his results, particularly when the AMA Guide forms are not used, and particularly giving the

impairment for multiple levels for a degenerative disc, which I don't know of anyone doing, and when I see invalidation of the lumbar inclinometer read as normal, or when I see giving loss of [ROM] in the extremities when the condition was supposed to be a nerve root condition." Dr. O signed a TWCC-69 which gave claimant a 6% whole body impairment (based on cervical spine), with the notation "no comment" under MMI.

Having reviewed Dr. O's letter, which Dr. B said he received on March 25th, Dr. B on March 26th answered Dr. O's assertions, in summary, as follows:

1. There is no requirement that the AMA forms be used.

2. Pursuant to consultation with Dr. D, head of the AMA's Impairment and Evaluation Center in Chicago, it is proper to add 1% for more than one level of cervical disc problems, whether or not surgery was performed.

3. Dr. B agreed that claimant's straight leg raising test was invalid, and was repeated; he also repeated ROM tests of the lumbar spine. Because of his reduction of values to the thoracic and lumbar spine, however, the claimant's whole person impairment remained 32%.

4. With regard to the BTE for test/retest for reliability and/or test reliability, Dr. B said in his opinion "the BTE machine is a little more accurate and calculates the coefficient of variations automatically rather than having to do them manually which one would have to do with the Jamar test."

5. Dr. B said it was unclear how Dr. O arrived at a 6% impairment for claimant, although it was apparently based on single level disc with residuals, whereas Dr. B repeated his statement that the claimant has three level cervical disc disease. Dr. B went on to state, "I very conservatively gave the [claimant] a 2% rating for the C5 root on the right arm, 4% for the C6 root on the right arm and 5% for the C7 root on the right arm, and 0% for the C8 root on the right arm. Again, I very conservatively gave the [claimant] 1% impairment rating for persistent pain and numbness in the C6 nerve root distribution and this adds to 12% impairment rating for the right arm which then converts to 7% whole person impairment of the right arm. On his clinical examination, the [claimant] clearly had weakness of the great toe extensors . . . I think that the weakness that was clearly

demonstrated on the great toe extensors was clearly there and, again, I conservatively gave him just a 4% loss for function in the right L5 nerve root."

The carrier challenges the following findings of fact and conclusions of law by the hearing officer:

FINDINGS OF FACT

5. The Commission Designated Doctor, [Dr. B], found the Claimant reached [MMI] on December 7, 1992, with 32% impairment.

7. [Dr. B] properly used the correct AMA Guide in arriving at his impairment rating of 32%.

CONCLUSIONS OF LAW

2. The presumption accorded the opinion of the Designated Doctor has not been overcome.

3. The Claimant reached [MMI] on December 7, 1992.

4. The claimant has 32% impairment.

In its appeal, the carrier argues that the presumptive weight normally accorded to the designated doctor should be overcome in this case because the designated doctor's impairment rating is so contrary to the medical evidence, and so out of proportion to the previous impairment ratings given to the claimant that it "shocks the conscience." The carrier notes that claimant's treating doctor gave him a 15% impairment rating, and carrier's choice of doctor, Dr. G, assigned 5%. It also argues that Dr. B gave separate ratings to the arm, shoulder and leg for weakness and sensation loss, but that this is a symptom of the underlying spinal disorder and should not be rated separately. It further contends Dr. B's ROM tests were invalid, as demonstrated in Dr. S's report.

This case is analogous to Texas Workers' Compensation Commission Appeal No. 92561, decided December 4, 1992. In that case, we pointed out that, while we were not retreating from prior decisions acknowledging the special consideration given the designated doctor's opinion, we nevertheless held that a 22% disparity in the impairment

ratings assigned by two orthopedic surgeons (29% by the treating doctor and 7% by the designated doctor) called for further evidence to explain such disparity. In this case there was a 17% disparity between Dr. S, the treating doctor, and the designated doctor; a 27% disparity exists if one considers the report of the carrier's doctor, Dr. G. The hearing officer discounted the report of Dr. O since he did not examine the claimant; the carrier argues that the opinion of Dr. O is evidence of why Dr. B's report should not be given presumptive weight.

Our review of the record shows that Dr. S is an orthopedic surgeon and Dr. B a neurologist (although the cover page of the report attached to his first TWCC-69 also states, "American Back Society. Medical Director and Chief Evaluating Physician"). Dr. O's and Dr. G's specializations are not given, although documents in evidence show Dr. G is associated with the (Clinic). (It should be noted that Dr. G's report, while addressing claimant's studies, appears to rely heavily on Dr. S's report and does not appear to independently measure ROM. Dr. G's statement in his report assessing "a roughly 5% estimate" of impairment, along with a vague statement that claimant's cervical spine "would be looked at a little closer" renders this doctor's opinion of dubious value.) In addition, Dr. O clearly rated claimant's cervical spine while Dr. G only rated the low back; while Dr. S gave impairment ratings for the "back" and "neck," it does not appear that he considered the same levels of the spine as did Dr. B.

The basic distinction between the impairment ratings of the treating and designated doctors boils down to Dr. B's inclusion of values for parts of the body other than the cervical and lumbar spine. It is not clear which of the ROM and other tests Dr. S used in determining claimant's 15% impairment rating (especially confusing where Dr. S addressed ROM on every documented visit and continued to measure ROM on one post-MMI occasion); however, it appears that except for an initial reference to pain radiating into claimant's right foot, Dr. S did not measure or consider claimant's upper or lower extremities. Dr. B, on the other hand, assigned impairment due in part to nerve root impairment of the extremities. His subsequent revision corrected his original assessment and deleted that portion of the impairment rating attributable to range of motion losses in arms and legs. This panel has previously held that it is permissible for a designated doctor to amend his report. Texas Workers' Compensation Commission Appeal No. 92441, decided October 8, 1992. Further, Dr. B responded to the criticisms of his report by Dr. O, which closed a gap which might otherwise have required explanation to make the record complete. Given the fact that Dr. B used the correct version of the AMA Guides, see Article 8308-4.24, and that he thoroughly explained the basis for his rating (with reference to testing methods and results, and to the Guides themselves), rebutting Dr. O's contentions that his report was faulty, we affirm the hearing officer's determination that Dr. B's findings and conclusions on impairment were not overcome by the great weight of the medical evidence to the contrary. *See* Article 8308-4.26(g); Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992.

The carrier additionally argues that the claimant has not raised the issue of MMI, and has thus waived this issue; the carrier also contends the MMI date should be December 31, 1991, and not December 7, 1992, because Dr. B's report states that MMI was before the date of the examination on December 7, 1992. Despite the fact that the issue framed in this case concerned claimant's impairment rating, we do not agree that claimant waived the issue of MMI nor that the hearing officer cannot decide that issue. While the statute provides that issues not raised at the benefit review conference may not be considered at the contested case hearing except by agreement of the parties or a finding of good cause, Article 8308-6.31, this panel has repeatedly held that a finding of MMI is necessary to give rise to the entitlement to impairment income benefits, and that MMI is the threshold issue to a finding of impairment. *See* Texas Workers' Compensation Commission Appeal No. 92366, decided September 17, 1992, and Texas Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992. For that reason, where impairment was the stated issue, MMI was of necessity a part of that issue, unless specifically resolved, such as where the parties had stipulated to an MMI date, and any issues with regard to MMI should have been raised by the carrier at the hearing.

In summary, we find that the record contains sufficient explanation of the disparity between the various doctors' findings in this case, and that the hearing officer's decision accepting the date of MMI and the impairment rating of the designated doctor is supported by sufficient evidence. We accordingly affirm the hearing officer's decision and order.

_____
Lynda H. Nesenholtz
Appeals Judge

CONCUR:

_____
Philip F. O'Neill
Appeals Judge

_____
Gary L. Kilgore
Appeals Judge