APPEAL NO. 950289

This appeal is considered in accordance with the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held in (city), Texas, on June 13, 1994, and January 9, 1995, with (hearing officer), hearing officer, presiding. The issues under consideration as reported from the benefit review conference (BRC) were claimant's correct impairment rating (IR), and whether he had eligibility for supplemental income benefits (SIBS) for the second quarter. At the second session of the CCH, a third issue was added, not by agreement of the parties but upon a finding of good cause by the hearing officer, as to whether it was appropriate for the Texas Workers' Compensation Commission (Commission) to appoint a second designated doctor. The appellant (claimant), the claimant herein, had been injured on (date of injury), and, according to the stipulation of the parties, had reached maximum medical improvement (MMI) on February 10, 1993.

The hearing was recessed in order to have the claimant reexamined by the first designated doctor, (Dr. S). The reexamination did not take place, and the hearing officer ascertained that there was a refusal of Dr. S to continue to serve as designated doctor and the Commission appointed (Dr. E) to serve as a second designated doctor. The hearing office determined that this appointment of Dr. E was appropriate, that Dr. E's 10% IR was entitled to presumptive weight, and that the great weight of contrary medical evidence was against Dr. S's 15% IR. The hearing officer determined that Dr. S admitted he had not rendered his IR in accordance with the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). The hearing officer found, as fact, that the claimant had not commuted his impairment income benefits (IIBS), and that he had in good faith attempted to obtain and retain employment commensurate with his ability to work.

The claimant has appealed this decision. He argues that the third issue should not have been added because it was not included as a dispute at the BRC, nor did he agree to add the issue. Further, he argues that the IR of the first designated doctor is not contrary to the great weight of other medical evidence. He points out that he received a 15% IR from his own treating doctor, and a 22% IR from the carrier's doctor who examined him pursuant to a required medical examination order. He argues that the second designated doctor's report is contrary to the great weight of other medical evidence. He argues that he should have been sent back again to the first designated doctor rather than have a second one appointed. The carrier responds that the appointment of a second designated doctor was appropriate, and that the decision on IR is correct. The carrier argues that the treating doctor and its own doctor failed to comply with the AMA Guides in rendering their IRs. The carrier asks that the decision be affirmed.

DECISION

We affirm.

There was little testimony in either session of the hearing. Claimant stated that he was injured on (date of injury), while employed by the employer; (employer) He said that although he had tried, he had not been able to work since the date of his accident. Claimant testified briefly that the second designated doctor, Dr. E, had not personally examined him but agreed that Dr. E was in the room watching while an assistant had him bend in different directions and lift his legs.

Most of the record consists of documents. Claimant fell in some water while lifting pipe plugs and injured his back, hip, and legs. On October 7, 1991, claimant had a CT scan of the lumbar spine that was pronounced normal. On November 25, 1991, claimant was being treated by (Dr. G), who diagnosed on that date a low back strain. The records show that claimant had been examined by (Dr. O) in September 1991, and then again on January 6, 1992, when he performed an EMG. The EMG was normal. Dr. O gave claimant a steroid injection on January 20, 1992, and stated he was capable of sedentary work at that time, but deferred to Dr. G. Effective January 24, 1992, Dr G released claimant to work. Claimant filed a request in April 1992 to change his treating doctor to (Dr. O), which was granted.

The record indicated that Dr. O filled out a Specific and Subsequent Medical Report (TWCC-64) in early 1992 predicting that claimant would reach MMI in June 1992, and that he had chronic low back pain and possible facet arthropathy. Various medical records comment that claimant's obesity (weight in excess of 300 lbs) contributed to or exacerbated his condition.

On March 23, 1992, he was examined at the request of the carrier by (Dr. M), who opined that claimant had not reached MMI. Dr. M stated that he believed claimant could do some light duty, and further could benefit from "proper" rehabilitation which could avoid permanent impairment.

On June 29, 1992, Dr. O certified that claimant reached MMI with a 15% IR, attributable to his lumbar spine. Dr. O's report stated compliance with the Guides. Dr. O calculated a 14% IR relating to abnormal range of motion (ROM), which he rounded off to 15% (the nearest 5%). Dr. O continued to treat claimant (and at the time of the hearing was identified as his treating doctor) and did not retract his IR or MMI certification.

Although not made clear, the carrier apparently disagreed with Dr. O's IR. A Payment of Compensation or Notice of Refused or Disputed Claim (TWCC-21) filed by the carrier on July 17, 1992, states that the rating was questioned but that carrier had begun payment of IIBS. This form does not identify carrier's reasonable assessment of impairment. The Commission appointed a designated doctor, Dr. S, in October 1992. Dr. S examined claimant on February 10, 1993, and determined that he had a 15% IR for various limitations on lumbar ROM. He certified MMI as of the date of his examination.

On May 18, 1993, an MRI was conducted on claimant's lumbar spine which was determined to be normal. No herniation was observed, and no sizable bulges at any level.

In June 1993, a letter from the adjuster was written to Dr. S, asking a series of questions about his opinion. On August 12, 1993, the disability determination officer (DDO) for the Commission wrote to Dr. S forwarding this letter. The record includes a brief memo from Dr. S to the field office of the Commission, date-stamped as received on October 27, 1993, which says:

Re: (CM). Yes, 02-13-93 is the correct date of MMI. Yes, we used the third edition of the AMA guidelines. Yes, 15% whole person impairment is correct based on objective findings.

The record contains a BRC agreement (but no BRC report) dated August 6, 1993, in which the parties agreed that the date of MMI was February 10, 1993, as specified by Dr. S. The carrier agreed to continue payment of IIBS pending the outcome of Dr. S's IR.

A BRC was held on December 10, 1993; although a report is not in evidence, a letter of December 14, 1993, from the carrier's attorney refers to the request of the BRO for the carrier to write a letter to Dr. S questioning the basis for his rating.

On January 3, 1994, although there was ongoing controversy over the correct IR, the Commission nevertheless determined that the claimant was eligible for SIBS. Although no dispute as to this expressly appears in the record, the Commission ordered the carrier on February 4, 1994, to pay the first and second months of the first quarter of SIBS, and amended this on March 4th to include the last quarter. (The claimant's applications for SIBS detail his efforts at finding employment).

The BRC report leading to the contested case hearing was dated May 3, 1994. On May 18, 1994, the attorney for the carrier moved for permission to take Dr. S's deposition on written questions. At the same time, Dr. S's records concerning claimant were subpoenaed. Both motions were granted by the hearing officer on May 25, 1994.

On June 17, 1994, the Commission ordered a medical examination of claimant sought by the carrier to "determine if claimant has reached MMI. If so, determine PPI." Pursuant to this, claimant was examined by Dr. R, whose specialty was orthopedic surgery. Dr. R certified that claimant had reached MMI on August 30, 1994, with a 22% IR. Dr. R stated that he used an inclinometer to measure ROM, and that claimant's IR was based on "strictly loss of motion". However, Dr. R noted that claimant could almost touch the floor, had fairly good motion in his lower back, and extension and lateral bending were similarly appropriate. Carrier argued at the hearing that Dr. R had not complied with the Guides.

The record includes the answers to deposition on written questions. Dr. S described his examination procedure.

Question 8 of the deposition asked specifically if he had determined his IR by using the Guides. The answer recorded was "No". Subsequent questions regarding the use of an inclinometer, or the measurements of specific ranges of motion, were answered "N/A". These questions were answered June 10, 1994, and the record shows that these were "faxed" to the carrier's attorney by the court reporter taking the deposition that same day.

In spite of this, on June 17, 1994, the attorney for the carrier wrote another letter to the hearing officer, sent by "fax", advising that more questions should be propounded to Dr. S "in light of the problems associated with receiving an answer . . . as to several points of contention concerning the doctor's examination . . . " These questions were essentially the same, in different format, as those already answered in the deposition on written questions. A letter from the hearing officer to Dr. S, although dated July 7, 1994, states that the carrier has requested that certain questions be submitted, which are the same questions contained in the June 17th letter from carrier's attorney. In this same letter, the hearing officer requested Dr. S to reexamine claimant, and, expressing concern that Dr. S stated that he had not used the Guides, proceeded to outline 11 points to Dr. S as to how to conduct his examination and what information to provide. The record indicated that on August 22, 1994, Dr. S's secretary "faxed" a memo to the Commission stating that Dr. S would no longer "treat" claimant for his injury. This apparently followed claimant's arrival at Dr. S's office on August 18, 1994, when Dr. S declined to see him.

On September 8, 1994, the hearing officer directed the DDO to appoint a second designated doctor. The Commission appointed (Dr. E), who examined claimant on October 6, 1994. Dr. E's report is detailed, and includes his ROM measurements. Dr. E noted that claimant gave good effort and that his measurements were consistent and valid. Essentially, Dr. E determined that there was no objective evidence of organic etiology for claimant's continued back pain, and he noted that there was evidence of symptom magnification. Dr. E noted that claimant, based upon review of his records, had reached MMI on May 18, 1993, and that he had a 10% IR for ROM. Dr. E described why he did not believe that a specific diagnosis IR from Table 49 was warranted. (We note that none of the doctors who assessed an IR for claimant gave a rating from Table 49). Dr. E noted that claimant did not evidence sensory or strength loss.

On June 13, 1994, the first session of the hearing was convened; the hearing officer began the hearing by admitting several hearing officer exhibits, one of which was the deposition on written questions of Dr. S. At this point, the hearing officer stated that there had been "extensive" conversations before going on the record about this exhibit, and the courses of action to follow[1]. The hearing officer announced his decision that claimant should

[1] We have before disapproved such off-record discussions, especially regarding the matters for which the hearing is being held. *See* Texas Workers' Compensation Commission Appeal No. 92195, decided July 1, 1992.

be reexamined by Dr. S in accordance with the AMA Guides to the Evaluation of Permanent Impairment. The parties, with claimant being assisted by an ombudsman, agreed. The hearing officer announced twice during this session that if Dr. S did not co-operate, he would "have no other alternative" than to dismiss the proceeding and send the case back to the benefit review officer (BRO) for appointment of a second designated doctor.

At the second session of the hearing, the hearing officer raised *sua sponte* the necessity of adding a third issue as to whether it had been appropriate to appoint a second designated doctor. Claimant, after conversing with the ombudsman, declined to agree to the inclusion of this as an issue. The hearing officer therefore stated that he found good cause to add the issue and did so. The claimant sought a continuance in order to be examined again by Dr. S, based upon a statement by the ombudsman that Dr. S was not willing to serve. The hearing officer denied this request, noting that the continuance had not been sought prior to the second session.

APPOINTMENT OF THE SECOND DESIGNATED DOCTOR

The claimant argues that he did not agree to the third issue regarding the appointment of a second designated doctor, and then also argues that it was not necessary to appoint a second designated doctor. We agree that the record reflects that claimant was confused about the import and necessity of the third issue proposed by the hearing officer. We will review the hearing officer's inclusion of this issue based upon the statute that applies. This is Section 410.151 (b)(2), which states that an issue may be added if the commission determines there was good cause for not raising the issue at the BRC. In this case, we note that the appointment of the second designated doctor took place well after the BRC, and as it would have been impossible to raise the issue at that time, the hearing officer did not abuse his discretion in adding the issue, especially one which arguably safeguards the claimant's right to raise the issue.

We are concerned that the appointment of the second designated doctor occurred out of the hearing officer's conviction that it would be his "only alternative" in the event of Dr. S's unwillingness to reexamine claimant. We note that even when it is desirable for a hearing officer to seek additional or clarifying information from a designated doctor about his or her report, this process is not open-ended, and at some point it becomes appropriate for the trier of fact to weigh the evidence and reject the designated doctor's report when the great weight of other medical evidence is contrary. *See* Texas Workers' Compensation Commission Appeal No. 941323, decided November 16, 1994; Section 408.125(e). Neither is a hearing officer under the obligation to repeatedly ask questions already answered. The appointment of a second designated doctor should be undertaken only under limited and extraordinary circumstances. Even in the case of unwillingness of the designated doctor to conduct a second examination, the advisability of appointing a second designated doctor should be analyzed in light of the existence of other medical opinions from which to resolve the issue, and whether dispute resolution in a case has already been protracted.

However, we note that claimant did not object to the hearing officer's statement at the first hearing, that a second designated doctor would be appointed in the event Dr. S did not agree to reexamine claimant. Although we feel Dr. S's further co-operation could have been solicited differently, we cannot say that the hearing officer abused his discretion by appointing Dr. E. It was the claimant's proposal at the second session of the hearing that Dr. S be given another opportunity to reexamine him, but we note that the appointment of Dr. E had the effect of removing Dr. S as a designated doctor by the time of the second hearing. We do not find that the appointment of Dr. E, although not the hearing officer's only alternative, was tantamount to reversible error in this case.

THE IMPAIRMENT RATING

The report of a Commission appointed designated doctor is given presumptive weight. TEX. LAB. CODE ANN. §§ 408.122(b), 408.125(e). The amount of evidence needed to overcome the presumption, a "great weight", is more than a preponderance, which would be only greater than 50%. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992. As of the conclusion of the contested case hearing, the designated doctor was Dr. E; Dr. S had been removed as designated doctor. We cannot agree that the hearing officer erred by finding that the great weight of other medical evidence was not contrary to Dr. E's report. His is the only report detailing ROM measurements, which was the only difference among the doctors in this case. The medical evidence does not indicate an objective specific condition or radiculopathy which would merit an additional rating.

We affirm the hearing officer's decision and order, for the reasons stated above, on the matters which have been appealed.

Susan M. Kelley
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Lynda H. Nesenholtz
Appeals Judge