APPEAL NO. 931018

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq*. (formerly V.A.C.S., Article 8308-1.01 *et seq*.). On October 8, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. He determined that appellant (claimant) had an impairment rating of 12%, as set forth by the designated doctor, with maximum medical improvement (MMI) having been reached on June 22, 1993. Claimant asserts that the great weight of the medical evidence is contrary to the designated doctor and states that he "raised the issue that the designated doctor did not use the proper AMA Guidelines. . . ." Respondent/ cross-appellant (carrier) asserts that no finding as to MMI should have been made and replies that the decision as to impairment is supported by sufficient evidence.

DECISION

We affirm.

Claimant worked as a bellman at a hotel (employer) when he hurt his back on (date of injury). The claimant's treating doctor, (Dr. E), in December 1991 operated on him by performing a discectomy with "bilateral lateral fusion." A failure of some of the hardware in the fusion caused a second surgery on June 3, 1993. The designated doctor, (Dr. P), states that Dr. E's operative record of the second surgery shows a "solid facet fusion" and that the hardware was removed. Dr. P adds that postoperatively the claimant has had no problems.

After the first surgery in December 1991 (all references to the first surgery place it in December 1991, but the record contains no operative report or medical notes contemporaneous to that time), medical records in evidence begin with the medical evaluation report of (Dr. A). In November 1992 he examined claimant and found "excellent range of motion" and "an excellent result," but notes that his x-rays show "2 plates . . . some breakage of the screws . . . but no evidence of fusion." He found MMI on 11/2/92 with eight percent impairment, specifically referring to "table 49, pg 73, Guide to Impairment Rating, 3rd edition, AMA." (We note that table 49 does appear on page 73 of the "Guides to the Evaluation of Permanent Impairment," third edition, second printing, dated February 1989, published by the American Medical Association (Guides), as set forth in Section 408.124.)

The next medical record, by date, is the TWCC-69 of Dr. E, dated April 6, 1993, which states that claimant reached MMI on December 5, 1992, with 27% impairment.

Next is the report of the designated doctor which was prepared on June 22, 1993, and shows MMI on June 22, 1993, with 12% impairment. As stated, he noted the "solid facet fusion" reported in the operative report of the second surgery. Dr. P states that the second surgery removed the hardware and confirmed fusion. He noted good recovery in claimant and assigned 10% for a "surgically treated disk lesion, with some residual, stiffness and pain." He added two percent for the second surgery to remove hardware, for a total of 12%.

Finally, Dr. E, in a letter of September 2, 1993, reaffirms the 27% impairment he gave prior to June 3, 1993, the date referred to by Dr. P as the time of the second surgery. Basically he added 14%, for treatment of "segmental instability" as set forth in Table 49, Section IV, to the rating provided by Table 49, Section II for disc lesions. (Dr. A referred to disc excision and the same table 49 in giving eight percent; eight percent can be found in Section II for a surgically treated disc lesion with no residual. Dr. P used a TWCC-69 for his impairment rating but did not specifically refer to a table or page of the Guides. He did refer to a "surgically treated disk lesion, with some residuals . . . 10% and `second surgery' 2% for a total of 12%." (His references can be easily followed in Section II of Table 49 of the Guides.)) Dr. E goes into no detail as to when both sections of Table 49 should be used, but observes that Dr. P did not use the instability segment and points out the internal fixation and fusion he provided.

Claimant, during the evidentiary portion of the hearing, did not assert that Dr. P did not use the correct version of the Guides. He did say that he spent limited time with Dr. P and that he had to take certain medical records with him to provide Dr. P. In closing, the claimant stressed Dr. E's reply to the designated doctor's report and observed, "and from the exhibits submitted on behalf of the carrier, I'm not quite sure if they also used the same guidelines." He added that reference to the Guides should have been made. Texas Workers' Compensation Commission Appeal No. 92393, decided September 17, 1992, stated that in the absence of an issue based on failure to use the Guides or in the absence of evidence that the doctor did not use the Guides, a party should not be required to show the Guides were used when the rating is provided on the TWCC-69. The hearing officer did not err in not requiring the designated doctor to provide further evidence that the Guides were used.

The only issue set forth at the hearing called for a determination of the correct impairment rating. Carrier asserts that no finding as to MMI should have been made. Texas Workers' Compensation Commission Appeal No. 92650, decided January 20, 1993, points out, however, that even when the only issue is impairment rating, an MMI date still must be established. Since no date of MMI was found, that case was reversed and remanded for a determination of MMI. While the designated doctor is entitled to no presumption in regard to date of MMI when he is only appointed to decide impairment (*see* Texas Workers' Compensation Commission Appeal No. 93710, decided September 28, 1993), he did provide a date in this case. That date may be weighed, just as any other medical evidence, to determine, based on reasonable medical probability, when further material recovery or lasting improvement can no longer be reasonably anticipated. Without having reached MMI, there can be no impairment rating. With surgery performed after the date that both Dr. A and Dr. E proclaimed MMI to have been reached, the determination by the hearing officer that MMI was reached on June 22, 1993 (after the second surgery), is not against the great weight and preponderance of the evidence.

Finally, claimant asserts that the designated doctor's determination as to impairment is contrary to the great weight of the other medical evidence, stressing that Dr. E refuted the designated doctor's report. This is a matter for the hearing officer as sole judge of the

weight and credibility of the evidence to determine. *See* Section 410.165. The dispute between Dr. E and Dr. P was as to whether Section IV of Table 49 should be considered and added to the relevant data in Section II of Table 49. In addition to Dr. P, Dr. A also used only Section II of Table 49. In this case, considering the reports of the three doctors, the degree of explanation as to why Section IV was used, and current condition of the claimant as reported by the designated doctor, we cannot say that the designated doctor's report has been overcome by the great weight of other medical evidence.

The decision and order of the hearing officer are supported by sufficient evidence and are affirmed. *See* In re King's Estate, 150 Tex 662, 244 S.W.2d 660 (1952).

Joe Sebesta
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Robert W. Potts
Appeals Judge