APPEAL NO. 931113

This case returns for review pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (formerly V.A.C.S., Article 8308-1.01 *et seq*.) (1989 Act), following this panel's remand for reconstruction of the record. *See* Texas Workers' Compensation Commission Appeal No. 93808, decided October 18, 1993. Because a significant portion of the recorded proceedings of the first hearing were blank, hearing officer convened a new contested case hearing on November 9, 1993, in (city), Texas. With regard to the issues of maximum medical improvement (MMI) and impairment, the hearing officer determined that the appellant, hereinafter claimant, reached MMI on April 13, 1992, with a six percent impairment rating in accordance with the report of the designated doctor appointed by the Texas Workers' Compensation Commission (Commission). The claimant contends on appeal that the report of the designated doctor is faulty and not entitled to presumptive weight. The respondent, hereinafter carrier, responds that the hearing officer's decision is correct and should be affirmed.

DECISION

We affirm the hearing officer's decision and order.

The claimant, who had been employed since 1985 by (employer), was injured on (date of injury) when he fell to the ground from a van. He testified that he landed on his right side, hit his right hip, and snapped his neck.

Claimant's first treating doctor was (Dr. S). On July 7, 1991, Dr. S certified that claimant had reached MMI with a zero percent impairment rating; the Report of Medical Evaluation (Form TWCC-69) filed by Dr. S noted that a June 17 MRI of the lumbar spine showed degenerative disc disease and bulging of the annulus at the L2-3, L3-4, L4-5, and L5-S1 levels. The claimant contended that this report lacks significance because it addresses only his lumbar spine; he said he changed treating doctors, to (Dr. T), because Dr. S failed to examine or treat his neck.

Claimant said after he treated with Dr. S he saw (Dr. Gi), a neurosurgeon, at the carrier's request. He also said Dr. Gi ordered an MRI of his neck and lumbar spine. A December 18, 1991, letter from Dr. Gi states claimant's "permanent partial disability rating" is 15% for the whole body, with 10% for the neck and 5% for the back. On July 7, 1992, Dr. Gi wrote that he first saw claimant in June of 1991; that he prescribed medication but did not feel there was anything he could do for claimant from a neurosurgical standpoint. He also summarized the results of claimant's MRI and said he did not feel he was a candidate for surgical intervention of any type.

The claimant saw (Dr. A) for an independent medical examination on March 20, 1992. Dr. A noted that the lumbar MRI showed degenerative disc disease at the lower four disc levels, and a cervical MRI showed disc bulges at C4-5 and C5-6 with no herniated

nucleus pulposus and no cord compression. Dr. A concluded that the claimant had numerous complaints with "really minimal objective pathology based on his examination today as well as his diagnostic studies of the cervical and lumbar spine," and said he would give claimant a zero percent impairment rating. Three Forms TWCC-69 were signed by Dr. A; all assigned zero percent impairment but the MMI dates were August 30, 1991, and February 26, 1992 (one was undated). The claimant said Dr. A's examination was brief and he denied that Dr. A performed the tests (such as flexion and extension) listed in the report.

(Dr. Gr), an orthopedic surgeon, was appointed by the Commission as designated doctor. In a report dated April 13, 1992, Dr. Gr stated that he found claimant's cervical x-rays to show early cervical spondylosis at C4-5 and C5-6, with the exam being otherwise normal; that claimant's MRI showed minimal bulging disc at C4-5 and C5-6, with no cord compression; that the lumbar spine MRI revealed degeneration of the L2, 3, 4, and 5 discs and minimal bulging without any nerve compression. Because of the degeneration of the discs in the lumbar spine, Dr. Gr found the claimant "would fall into category IIB [u]noperated with medical documented injury . . ." of the American Medical Association's Guides to the Evaluation of Permanent Impairment, page 80 table 53. He went on to say that "[a]ssociated with minimal degenerative structural changes on the MRI, he would not fit the category because of lack in history of rigidity. Thus there is no impairment of the cervical or lumbar spine based on specific disorders of the spine." Dr. Gr went on to say that the claimant's lumbar range of motion tests were within normal limits. He assigned the claimant a six percent whole body impairment, due to extension and flexion of the cervical spine. Dr. Gr's letter also stated that he would have anticipated the claimant to have reached "maximum healing period" by August 1, 1991; however, in an attached Form TWCC-69 he certified MMI as of April 13, 1992.

At some point claimant's treating doctor, Dr. T, referred claimant to (Dr. Gre) for consultation. On February 5, 1993, Dr. Gre reported claimant's EMGs and nerve conduction studies as normal, although he said the claimant questioned the competency of the doctor who apparently performed the studies. Dr. Gre concluded that the claimant had reached "maximum medical healing and I feel that he has absolutely no disability whatsoever related to his on-the-job injury."

Dr. T also referred the claimant to (Dr. L) apparently in May of 1992. While Dr. L wrote that he originally believed claimant had no radicular symptoms and should be treated conservatively, he re-examined him on September 4th following complaints of pain down his right arm. Dr. L ordered an EMG (which showed no evidence of any electrical deficit in the right upper extremity from any impingement syndrome), cervical spine films which showed spondylosis from C5 through C7, and a myelogram which showed anterior indentation at C3-4, to a lesser extent at C4-7, and left nerve root sleeves that were slightly blunted at C5-6 and C7-T1. Dr. L completed an undated Form TWCC-63 (Spinal Surgery Recommendation) recommending an anterior cervical fusion.

On October 15, 1992, (Dr. B), the second opinion spinal surgery doctor, recommended against surgery based on his inability to discern any objective evidence of neurological abnormality or clinically significant radiological abnormality. He said he did not believe the claimant would benefit from a cervical disc operation, and that he was concerned "that there is a tremendous amount of functional overlay in this situation and not any clear pattern either by complaints, examination or x-ray studies to suggest that operation (sic) will solve his problems." The claimant said there were mistakes in Dr. B's report, including the fact that Dr. B said he did not have claimant's MRI report when claimant said he gave it to him. Following receipt of Dr. B's opinion, Dr. L wrote that he, too, initially believed the claimant did not need surgery, but stated that "[i]t has been shown that he subsequently has continued to have problems despite the fact that he has worked on and off." Dr. L also stated that the designated doctor assigned claimant a six percent impairment rating before he had reached MMI.

On November 12, 1992, Dr. T stated that he concurred in Dr. L's surgical recommendation. He also noted that the claimant had been told that some of his studies were normal when, in Dr. T's opinion, they were "very abnormal." On January 13, 1993, Dr. T completed a non-Texas Workers' Compensation Commission form entitled "Attending Physician's Statement of Disability" in which he stated the claimant was "totally disabled."

The Commission appointed (Dr. D) as medical examination order doctor to address whether spinal surgery was medically necessary. Dr. D wrote on February 15, 1993, that he would not recommend surgery without further work-up, including psychological profile and consideration of cervical discography and the possibility of further aggressive non-surgical treatment. (However, on February 24th Dr. D completed a Spinal Surgery Third Opinion Report whereby he checked a space indicating surgery was not medically appropriate, but stated "Pls see attached letter for recommendations - I will evaluate Pt later if above done.") On May 5, 1993, (Dr. Th) (not clear from the record, but apparently not the same as claimant's treating doctor) wrote, among other things, that claimant's physical problems "may be vague, may have appeared suddenly after a period of stress, and may not be traceable to actual organic changes." On June 8, Dr. D wrote that he had reviewed Dr. Th's report, and stated that because Dr. Th did not really address the issue of whether claimant was a candidate for surgery, he was referring that question to (Dr. V). No report from Dr. V appears in the record, although the claimant said she issued a report but Dr. D said he could not determine whether to recommend surgery. (He also said he was unable to have a discogram scheduled.) However, on February 24, 1993, the Commission's Medical Review Division determined that due to Dr. D's nonconcurrence with the need for the proposed surgery, there was no basis for the Commission to order payment of costs for the surgery. At the contested case hearing carrier stated its position that the issue of spinal surgery had been settled by the Medical Review Division. The claimant pointed out that the decision says there is no basis for the Commission to issue an order on spinal surgery "in question at this time," and points to Dr. D's report stating he would evaluate the claimant at a later time. The claimant stated at the November 9th hearing that a December 22nd

hearing was scheduled on the spinal surgery issue.

The claimant notified Dr. Gr of Dr. L's opinion concerning surgery. On February 1, 1993, Dr. Gr wrote the Commission to state he had reviewed the studies performed at Dr. L's request, including cervical and lumbar myelogram and MRI, but stated he did not note any herniation. He said he re-reviewed his assessment and concluded he "[did] not see any changes that could be made based on these studies alone." On February 10th Dr. Gr wrote to say that at claimant's request he reviewed September 28, 1992, myelogram reports by Dr. H: "I reviewed the films and did not (sic) any herniated disc and I certainly do not dispute that this is what [Dr. H] found. He did say an apparent impingement." Dr. Gr concluded, "[a]s far as the treatment of the condition I certainly leave this to [Dr. L] who has made excellent recommendations." Dr. Gr reiterated this opinion in a February 22nd letter to the Commission wherein he said he neither agreed nor disagreed with Dr. H, and that he did not question Dr. L's recommendations. He also said "[m]y rating is still 6% to the body as a whole and I feel that his MHP would have been August 1, 1991."

Because claimant contended at the hearing and in this appeal that Dr. Gr's evaluation was based upon an incorrect version of the AMA Guides (claimant introduced evidence to show that page 80 of the correct version of the Guides did not contain a Table 53), the hearing officer on June 29, 1993, wrote Dr. Gr to ask him to review the statutorily required version and advise whether claimant's impairment rating would be different as a result. The hearing officer also quoted the 1989 Act's definition of MMI and, noting that Dr. Gr's letter used the term "maximum healing period," asked him to clarify his position as to whether the claimant had indeed reached MMI. By letter of July 7, 1993, Dr. Gr responded as follows:

> You are certainly correct the Third Edition Revised was used, Table 53, page 80 because the version that the state of Texas was using at that time was out of print. Since that time we do have the edition and the table which is identical is on Page 73, Table 49. The impairment will be the same. We can certainly change the last paragraph of my report to read maximal (sic) medical improvement.

In his appeal, the claimant contends that Dr. Gr's report should not be considered because he admittedly used the statutorily incorrect version of the AMA Guides. He also points to Dr. L's report, which contradicts the report of Dr. Gr, and notes that Dr. Gr stated that he agreed with the recommendations of Dr. L. The claimant cites two appeals Panel decisions and asks that we review them.

Claimant is correct in asserting that the 1989 Act, and decisions of this panel, require that all determinations of impairment must be made in accordance with the third edition, second printing, dated February 1989, of the Guides. Section 408.124; Texas Workers' Compensation Commission Appeal No. 92335, decided August 28, 1992. However, numerous Appeals Panels decisions have recognized that a designated doctor can change

or amend his opinion of analysis because of matters coming to his attention subsequent to his original determination of MMI and impairment. *See, e.g.*, Texas Workers' Compensation Commission Appeal No. 92441, decided October 8, 1992; Texas Workers' Compensation Commission Appeal No. 93328, decided June 2, 1993. A case similar to this one was Texas Workers' Compensation Commission Appeal No. 93062, decided March 1, 1993, in which a designated doctor stated that the impairment rating he had assigned was not in accord with the correct version of the AMA Guides. He subsequently filed an amended Form TWCC-69, with a new impairment rating, which purported to use the correct version of the Guides. In affirming the hearing officer's determination that the second report was entitled to presumptive weight, this panel said, ". . . a designated doctor can amend his medical evaluation, and we determine that such is the case here where he brings his evaluation into compliance with the statutorily mandated version of the AMA Guides" (citation omitted). Moreover, this panel has emphatically stated that it is the responsibility of the Commission "to ensure that the designated doctor completes the TWCC-69 form or otherwise supplies the information required under [applicable rules]. If information is nevertheless missing or unclear by the time that the contested case hearing officer is asked to evaluate the designated doctor's report, it is appropriate for the hearing officer, in carrying out his or her responsibilities to fully develop the facts required . . . to seek that additional information." Texas Workers' Compensation Commission Appeal No. 92595, decided December 21, 1992. The hearing officer in this case thus acted appropriately in contacting the designated doctor to seek clarification of his report, once the claimant timely raised that issue. With regard to the designated doctor's response to the inquiry about his original report, the hearing officer as sole judge of the relevance and materiality of the evidence and of its weight and credibility, Section 410.165(a), was entitled to weigh such evidence, determine whether it is in compliance with the requirements of the 1989 Act, and determine whether, when compared with the other medical evidence, it is still entitled to presumptive weight. *See* Appeal No. 93062, *supra*.

The claimant also challenges Dr. Gr's report based on the fact that later correspondence from that doctor references the reports of Dr. L, who recommended surgery. Claimant's argument with regard to the designated doctor's report is relevant to the issue of whether MMI has been reached, in light of recommendations for surgery; MMI is defined in the 1989 Act, in pertinent part, as the date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated. Section 401.011(30)(a).

In Texas Workers' Compensation Commission Appeal No. 93293, decided June 1, 1993, the hearing officer determined that the claimant reached MMI in accordance with the report of the designated doctor. The Appeals Panel reversed and remanded, based upon the following facts: medical evidence showed that the claimant was a candidate for spinal surgery, and there was no contrary opinion in the record; the claimant testified that he intended to have the surgery, but was awaiting the opinion of a doctor with whom he had an upcoming appointment; and the designated doctor gave no opinion as to whether the

surgery would result in further material recovery from or lasting improvement to the claimant's injury. Under those circumstances, we reversed to allow inclusion in the record of the opinion of the doctor with whom the claimant had the upcoming appointment, and to allow the designated doctor to review and comment upon that report.

By contrast, the Appeals Panel in Texas Workers' Compensation Commission Appeal No. 93290, decided June 1, 1993, affirmed the hearing officer's decision that the claimant reached MMI based upon the report of the designated doctor. In that case, two doctors opined that surgery was needed, but the designated doctor specifically disagreed that surgery would be effective. *See also* Texas Workers' Compensation Commission Appeal No. 93311, decided June 7, 1993, where this panel upheld the hearing officer's adoption of the designated doctor's report which found MMI but which addressed the possibility of a second surgery, finding that such surgery would be "unlikely to return [the claimant] to an active laboring lifestyle."

While the medical evidence in this case is conflicting and sometimes inexact, we do not believe that this case presents an analogous situation to that which existed in Appeal No. 93293, *supra*. Here, both Drs. L and T said they believed surgery was necessary, while Drs. B and Gi disagreed. It is also noteworthy that other doctors, while not specifically addressing a need for surgery, found little or no objective evidence of a problem. Dr. D's opinions are conflicting in that he finds no need for surgery, although pending re-evaluation by other doctors, and it does not appear in the record that he ever reached a final determination. Thus, unlike the situation in Appeal No. 93293, the record does not contain a documented but unrebutted recommendation for surgery.

To the extent that the designated doctor, Dr. Gr, made statements concerning the opinion of Dr. L, we find that they are at best equivocal. We note that on several occasions after the date on which he certified MMI Dr. Gr references the fact that he has reviewed studies or reports of other doctors and that his opinion has not changed. While he stated that Dr. L had made "excellent recommendations" as regarding claimant's treatment, which he did not question, we find that this only raises an ambiguity which the hearing officer was entitled to resolve. *See* Texas Workers' Compensation Commission Appeal No. 93427, decided July 14, 1993 (designated doctor did not explicitly address either the need or effect of the surgery, but does refer to reports of preceding doctors seen by the claimant and the results of MRI revealing a herniation; held that conflict and inconsistency in the medical evidence was within the hearing officer's province to resolve). We find that the hearing officer's determination in light of this evidence is not so against the great weight and preponderance of the evidence as to be manifestly unjust. Pool v. Ford Motor Co., 715 S.W.2d 629 (Tex. 1986).

In upholding the hearing officer's decision, we nevertheless note that a finding of MMI does not require that the injured employee be free of pain or otherwise restored to his pre-injury condition. As we held in Texas Workers' Compensation Commission Appeal No.

93007, decided February 18, 1993:

When the doctor finds MMI and assesses an impairment, he or she agrees, in effect, that while the injured worker may continue to have consequences, and quite possibly pain, from the injury, the doctor has determined, based upon medical judgment, there will likely be no further material recovery from the injury. Thus, although claimant is unfortunately in pain, this fact alone would not rule out MMI.

We would also note that the claimant is entitled to all reasonable medical care as and when needed. Section 408.021.

The decision and order of the hearing officer are affirmed.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Joe Sebesta
Appeals Judge