APPEAL NO. 93290

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 through 11.10 (Vernon Supp. 1993). On March 12, 1993, a contested case hearing was held in (city), Texas, with (hearing officer), presiding. He determined that appellant (claimant) reached maximum medical improvement (MMI) on June 22, 1992 with 0% impairment resulting from a (date of injury) injury. Claimant appeals stating that several findings of fact made by the hearing officer are in error and that the opinion of the designated doctor was contrary to the great weight of other medical evidence, adding that the designated doctor took it upon himself to decide that certain anomalies in claimant's back preexisted the injury. Respondent (carrier) argues that other medical reports are consistent with the designated doctor and also cites portions of the 1989 Act relevant to the issues.

DECISION

Finding that the decision and order are supported by sufficient evidence of record, we affirm.

Claimant worked for (employer) for about one year as an armed frame foamer when, she testified, she was hit by two frames that fell about 10 feet and hit her on the lower back. She was first seen by (Dr. B), who noted on (date of injury), a history of "arm frame fell from pallet and hit me on the upper part of right hip." (emphasis added) He described a contusion of the hip and tenderness and pain in the pelvic area. He referred claimant to (Dr. W) at the Clinic to be seen on March 22, 1991. Dr. W's records stated that claimant said she was struck in the back, but also said that she described the area as her "right hip bone." He noted that she had back pain and wrote, "x-rays do surprisingly show a great deal of far-advanced degenerative L5, S1 disc disease, almost suggestive maybe of a discitis. . . ." He added, "[f]rom the type of injury she sustained, you would expect her maybe to have a contusion or deep bruise, but there does not appear to be a twisting or compressing injury to her low back and after this period of time, she does not appear to be getting any better. . .the only thing I can come up with is degenerative disc disease at L5, S1."

Claimant introduced 129 pages of medical records which also indicated that she saw (Dr. S) during much of her treatment. His first record is dated (date). Dr. S shows that claimant was complaining of her right hip and right leg. He related that she had seen Dr. B, who sent her to Dr. W, who "said I had kind've something on my disc, lower disc in my back. . . ." She also went to Dr. J, who did not treat her but referred her to Dr. S. Dr. S assessed lumbar sprain, cervical disc pathology and back pain. He placed her on Xanax, Robaxin, Fiorinal, and Vistaril. Dr. S reported that claimant had a myelogram and CT scan on May 16, 1991. He noted then that she dated the onset of her problem to (date of injury) "when she fell while at work." The CT scan was within normal limits in the lumbar areas but showed a bone spur anteriorly; it did show evidence of claimant's past cervical surgery. Claimant received physical therapy from April into July 1991. Dr. S, in August 1991 records

that claimant had seen (Dr. O) and added that she did not want surgery. In February 1992, Dr. S noted that an MRI of February 3, 1992 showed "some signal change in the inferior aspect of L5 and superior aspect of S1 which appears degenerative. . .mild spurring at this level which appears degenerative. . . ." He noted in March 1992 that he scheduled claimant to see (Dr. H) on April 9, 1992. Dr. S saw claimant at monthly intervals through July 1992. Dr. S's entry on July 22, 1992 shows his assessment as "lumbar radicular syndrome, lumbar degenerative disc disease, cervical disc pathology, back pain."

Claimant testified that as of March 9, 1992 (the hearing was on March 12, 1992), she did want to have surgery and wanted Dr. H to do it. She testified that Dr. S prescribed several drugs for her and Dr. H took her off those drugs. The following testimony also took place on direct examination.

Q[Dr. S] can no longer perform surgery; is that correct? He has lost his privileges or something that you're not really aware of, but he--he told you that for a surgical result you'd have to go to doctor--to some other doctor. Is that right?

AYes, that's true.

Records of Dr. H indicate that he first saw claimant on April 9, 1992. He stated her history of injury as stemming from a frame falling on her low back. His review of tests conducted indicated that x-ray showed a narrowing at L5 -S1; myelography indicated the right L5 nerve root was cutoff; CT scan showed "facet arthrosis L5 -S1 & stenosis L5 -S1;" an MRI showed desiccation L5 -S1. He diagnosed lumbar radiculopathy. He noted in May 1992 that a discogram "appears to be normal," but added that claimant had pain. Then on November 24th, in commenting on MMI having been found in regard to claimant, Dr. H said that MMI had not been reached and if it had, impairment would be more than 0%.

Dr. O was seen by the claimant in July 1991 and June 1992 at the request of the carrier. Contrary to the assertions of claimant that Dr. O changed his opinion from one advising surgery to one saying that MMI had been reached, Dr. O's two opinions are consistent and clearly stated. In July 1991, Dr. O reviewed claimant's tests available at that time and stated his impression as "degenerative lumbosacral disc protrusion with aggravation due to injury and persistent low back pain and right sciatica." He advised that she would "do pretty well" with a discectomy, but did not advise a fusion because she smoked. In June 1992, Dr. O commented that he had told her in 1991 that she needed surgery. In referring to a suspected degenerative disc and her symptoms he says, "I see nothing that is likely to change that very much except surgery at that lower disc level but she still does not want it. . .she has reached the maximum benefits of medical care a long time ago without surgery as far as I am concerned." He signed a TWCC form 69 indicating MMI on June 22, 1992 with 0% impairment.

(Dr. Bl) was selected as the designated doctor by the Commission to evaluate claimant. Dr. Bl examined claimant in September 1992 and stated on a TWCC form 69 that she reached MMI on June 22, 1992 with 0% impairment. His attached narrative indicates that claimant on (date of injury) was struck "over the superior lateral aspect of the right buttocks." He adds that claimant said a frame of a chair weighing 15 pounds fell six feet hitting her in the left flank and buttock area. Dr. Bl noted that claimant said Dr. O had advised her to have surgery. On physical examination Dr. Bl makes several observations concerning gait, standing and sitting; he then comments, "[p]alpation over the entire lumbar area demonstrates an exaggerated diffuse pain response." He found some range of motion limitation due to "voluntary gaurding" (sic). He related that he had records from the various doctors involved or their offices. While Dr. Bl does not say that he examined each test itself as opposed to considering the reports of those examinations, his report does indicate that he viewed the tests themselves, when it says, "(m)yelogram of the upper cervical spine was also reviewed which showed effusion at C4 -C5. . .[a]n MRI scan shows desiccation of the L5 -S1 indicating early degenerative disc disease or lack of signal." Dr. Bl then stated, "[o]n review of the hard copies of the x-rays, CAT scans, MRI scans, myelogram show preexistent degenerative processes. I find it very difficult to assign any of the radiographic changes noted to the blunt trauma which occurred with the arm piece falling from a height. . .I do not feel the surgical procedure would be effective in treating this patient's present symptomatic complaints." In referring to degenerative disc disease and degenerative osteoarthritis he said, "[t]his process was not caused by the falling arm chair rail." Dr. Bl's narrative that accompanied the TWCC form 69 was introduced by claimant as part of the 129 pages of medical records making up claimant's exhibit 1.

At the hearing claimant argued that surgery was needed so MMI should not be found. Both in opening and closing argument, claimant makes the point that two doctors say she needs surgery, Dr. O had said she needed it and then equivocated, and Dr. Bl said she does not need surgery. Claimant then argued that if MMI is found, the date assigned it should be later than June 22, 1992. No assertion is made as to what the impairment rating (other than 0%) should be. While claimant also states that Dr. Bl felt she "never had a problem in the low back region," that the evaluation by Dr. Bl was conducted in too short a time, that it did not go well, that Dr. Bl does not say he reviewed the tests themselves, and that "he did not do the EMG," the claimant did not object that Dr. Bl should not have identified certain of claimant's problems as not being caused by the (date of injury) incident. Had such an objection been raised at the hearing, the hearing officer could have (if he so chose) queried the designated doctor as to impairment rating in light of the hearing officer's determination of the injury--any question of injury is resolved by the hearing officer as finder of fact; the designated doctor's opinion is only entitled to a presumption, within the purview of Article 8308-4.25 and 4.26, in regard to MMI and impairment rating, not as to injury. *See* Texas Workers' Compensation Commission Appeal No. 92617, dated January 14, 1993. While an assertion of error directed at a designated doctor's opinion which addresses causation

may not result in reversal (*See* Texas Workers' Compensation Commission Appeal No. 93246, dated May 10, 1993), such assertion raised for the first time on appeal, as here, will not be the basis for reversal. *See* Texas Workers' Compensation Commission Appeal No. 91100, dated January 22, 1992.

The hearing officer did not err in assigning presumptive weight to the opinion of the designated doctor, Dr. Bl, as to MMI. Dr. O also believed that MMI had been reached on the same date. In addition Dr. W, at the inception of claimant's treatment, commented as to the limited extent of injury. Dr. Bl specifically stated that surgery would not be effective, and no significant tests were conducted subsequent to his opinion. MMI was found 16 months after the injury. Finding of Fact No. 5 that claimant's health care providers found a normal lumbar spine is supported by sufficient evidence as shown by the CT scan, myelogram and discogram. The MRI showed degenerative changes. In regard to the impairment rating, claimant did not propose a rating; the only other impairment rating, which the hearing officer could have selected once MMI was found, was set forth by Dr. O and he, too, said the impairment was 0%.

The findings of the hearing officer that addressed the designated doctor, his evaluation of the claimant, his determinations, and that such conclusions of MMI and impairment were not contrary to the great weight of other medical evidence were supported by sufficient evidence. The Findings of Fact and Conclusions of Law are sufficiently supported and support the Decision and Order. The Decision and Order are not against the great weight and preponderance of the evidence and are affirmed.

Joe Sebesta
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Thomas A. Knapp
Appeals Judge