

APPEAL NO. 93336

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 March 24, 1993, in (city), Texas, before hearing officer (hearing officer). The issues before the hearing officer were whether the claimant currently has disability due to an injury on or about (date of injury); whether the claimant has reached maximum medical improvement (MMI); and, if so what is claimant's proper impairment rating for the (date of injury). The appellant, hereinafter claimant, appeals the hearing officer's determination that he reached MMI on August 24, 1992, with an impairment rating of 7%, as found by the designated doctor's report. The claimant further contends the hearing officer erred in finding good cause for the respondent's, hereinafter carrier, failure to timely exchange certain documents offered into evidence.

The claimant also requests that this case be remanded to the hearing officer to consider new evidence, namely a communication from the designated doctor, which claimant says arose after the close of the hearing. The carrier contends in its reply that the hearing officer properly admitted into evidence carrier's exhibits, that he properly affirmed the designated doctor's findings, and that claimant's medical evidence was not sufficient to overcome the presumptive weight of the designated doctor's report. The carrier also contends that the claimant's "elective surgery despite recommendations of the designated doctor and the carrier appointed physician has no bearing on the claimant's date of [MMI] and his impairment rating," and it asks that this panel consider only the evidence presented at the contested case hearing.

DECISION

The decision and order of the hearing officer is reversed and remanded for further consideration and development of evidence.

It was not disputed that the claimant, who was employed by. (employer), suffered a compensable back injury on (date of injury). He had undergone physical therapy and had received pain medication and injections which had temporarily relieved his pain, but he said he had been told by an orthopedic surgeon, (Dr.H), to whom he had been referred by his treating doctor (and who, apparently, became his second choice treating doctor), that surgery would relieve his pain. The claimant testified at the hearing that his surgery was scheduled for April 14, 1993.

Claimant apparently began treating at the (medical) in 1991, and records in evidence show that he was referred out for various procedures (including an MRI, myelogram, CT scans, EMG, discogram, and somatosensory evoked potentials lower extremities) between June and September of 1991. The first doctor who found claimant to have reached MMI

was carrier's doctor,(Dr. Bo). In a letter dated November 18, 1991, Dr. Bo noted he had originally seen claimant in May of 1991, at which time he had mild pain and had returned to light duty work. Dr. Bo summarized claimant's studies, including the MRI showing disc protrusion at L4-5; stated his impression as "normal lumbar spine and disc changes for age" and stated no surgery was indicated; and found claimant to have reached MMI on November 18th with a 5% impairment. (Dr. Br), a doctor from the (medical clinic), also certified MMI as of February 3, 1992, with a 22% impairment rating; however, although the Form TWCC-69 completed by Dr. Br references an attached report, no such report was in the record. A March 13, 1992 letter from Dr. Henderson at the (medical clinic), which claimant's attorney said was written in response to carrier's dispute of the impairment rating, says that "[i]n light of the conditions of this patient, a terminal exam and an impairment rating were performed which demonstrated an approximate 22% impairment as a result of direct injury to the disc according to AMA guidelines" The letter also says that "[b]ecause of the [carrier's] refusal to pay, we have counselled with the patient and told him that we can no longer continue treating him even though it would have been to his best interest to continue conservative care. We have referred him to [Dr. H] for surgical opinion. The

impairment rating that was performed would be changed very little and will be increased to a higher level if the surgery is performed."

Medical records in evidence showed claimant had been treating with Dr. H at least since February 11, 1992, and that Dr. H had been discussing the possibility of surgery with claimant since that time. Dr. H's reports noted continuing complaints of pain, and on September 22nd he reported that claimant had decided to go ahead with surgery and that a Form TWCC-63 (Required Medical Report: Spinal Surgery Recommendations) would be submitted. Dr. H also referred the claimant to (Dr. Bu) for an "unofficial" second opinion. On June 25th Dr. Bu examined claimant, reviewed prior studies, and diagnosed herniated discs at L4,5 and L3. He stated his recommendation that claimant would benefit from a "360" because of the nature of the work he did, construction.

Thereafter, (Dr. Y) was appointed by the Texas Workers' Compensation Commission (Commission) as the designated doctor. Dr. Y examined claimant, stated his impression of degenerative disc disease at L4-5, and found him to have reached MMI on August 24, 1992, with a 7% impairment rating.

On October 19, 1992, Dr. Y also issued what was apparently a second opinion on spinal surgery which stated his recommendation as follows: "I do not believe the [claimant] is a candidate for surgery nor does he have a surgical lesion, considering the fact that he did not have pain at L4-5 upon injection on the discogram. Moreover his lumbar myelogram was completely normal, as well as his EMG studies."

On January 29, 1993, (Dr. P), who was a third opinion doctor on spinal surgery, stated that after reviewing claimant's chart he believed a surgical procedure would be indicated. He said that although claimant had a normal EMG, myelogram, and CT scan, his discogram was positive for pain and he had an annular tear at L3-4 and an annular fissure at L4-5. However, Dr. P recommended that claimant be admitted to a pain clinic prior to any surgical intervention.

On February 5, 1993, the Commission's medical review division ordered carrier to pay reasonable and necessary costs related to claimant's proposed surgery. The decision made the following findings: Dr. H had recommended spinal surgery; carrier elected to have a second opinion regarding the proposed surgery by Dr. Y, who did not concur with the need for surgery; pursuant to Commission order the claimant attended a required medical examination with Dr. P on December 22, 1992, to obtain a third opinion; Dr. P recommended that additional testing be performed to better determine the claimant's pain response; the testing was performed and forwarded to Dr. P, who, although he expressed reservations, concurred with the need for surgery.

The claimant challenges the hearing officer's conclusions of law stating that claimant

reached MMI on August 24, 1992, with an impairment rating of 7%, and that claimant's other medical evidence is not sufficiently great to overcome the statutory presumptive weight given to the designated doctor's report. Claimant notes that his treating doctor indicates that surgery is required to relieve claimant's pain, and that Dr. Bu and Dr. P both concur that surgery is necessary due to claimant's "abnormal architecture of the discs at L3-4 and L4-5." Therefore, he argues, these findings are contrary to the designated doctor's report and to the definition of "maximum medical improvement," which is defined in pertinent part as "the point after which further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated, based on reasonable medical probability." Article 8308-1.03(32). Claimant also argues that the hearing officer abused his discretion in finding good cause for the carrier's failure to timely exchange documents it offered into evidence. We will address the latter point first.

The record shows that at the hearing claimant's counsel objected to admission of all of carrier's documentary evidence because it had not been timely exchanged as required by Article 8308-6.33(e). That provision states that a party who fails to disclose information known to that party or documents which are in existence and in the possession, custody, or control of that party at the time when disclosure is required, may not introduce such evidence at any subsequent proceeding before the commission or in court on the claim unless good cause is shown for not having disclosed such information or documents. Commission rule, Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE §§142.13(c) provides (with one exception not relevant here) that parties are to exchange documentary evidence, including all medical reports and records, no later than 15 days after the benefit review conference; thereafter, parties are required to exchange additional documentary evidence as it becomes available.

The benefit review conference in this case was held on February 4, 1993, and claimant's counsel stated she received the documents on March 18. Claimant's counsel also stated at the hearing that it was "very likely" carrier received the documents through an earlier exchange between claimant and carrier.

The Appeals Panel has previously ruled that such reverse exchange of documents is not required by the statute or rule. As the panel wrote in Texas Workers' Compensation Commission Appeal No. 91088, decided January 15, 1992:

Rule 142.13 . . . must be read reasonably insofar as it mandates the means by which disclosure is made. The rule was not intended to require a reverse exchange of documents obtained as part of the opposing party's 'disclosure.' (If it were, Section 142.13(d), which requires exchange of additional documentary evidence as it becomes available, would trigger a perpetual shuttle of documents between the parties.)

Turning to the claimant's second point of error, the Appeals Panel has recently held

that where the claimant was a candidate for surgery and testified that he intended to have surgery pending another doctor's recommendation; the designated doctor did not offer any opinion as to whether such surgery would result in further material recovery from or lasting improvement to the claimant's injury; and there was an absence of any medical evidence that the claimant did not need surgery, a remand was necessary for the development of further evidence with regard to the designated doctor's opinion regarding surgery. Texas Workers' Compensation Commission Appeal No. 93293, decided June 1, 1993. By contrast, this panel has affirmed a hearing officer's determination of MMI and impairment based upon the report of the designated doctor, where such doctor specifically found surgery would not be effective, despite recommendations from other doctors. Texas Workers' Compensation Commission Appeal No. 93290, decided June 1, 1993. See also Texas Workers' Compensation Commission Appeal No. 93311, decided June 7, 1993, where the 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."

In Appeal No. 93290, we additionally noted that there was nothing in that record to indicate that surgery had been scheduled. That is precisely the opposite of the situation in the instant case; it was uncontroverted at the hearing that claimant's back surgery had been scheduled for a date less than one month from the contested case hearing. Moreover, in this case the claimant's decision to have surgery had proceeded beyond mere speculation, but had progressed to the point that a statutory second opinion had been rendered and a medical review order had been issued requiring that the carrier pay for surgery. While, as we stated in Appeal No. 93293, *supra*, the lack of an order under Article 8308-4.67 does not form a basis for determining that the great weight of the medical evidence is not contrary to the designated doctor's opinion, the existence of such an order coupled with the actual scheduling of the surgery itself, makes it prudent to determine whether (and, if so, to what degree) the designated doctor's opinion on MMI

and impairment may have changed because of the surgery. We therefore remand this case to the hearing officer so that further evidence may be developed on this point.¹

At the same time, we wish to distinguish the facts of this case to make clear, as we did in Appeal No. 93293, *supra*, that we are not retreating from earlier holdings acknowledging the special consideration accorded to a designated doctor's opinion. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. The record in this case indicates the claimant initially was placed on a course of conservative treatment; that the surgeon to whom he was later referred, Dr. H, discussed the possibility of surgery with him for approximately seven months, at which time claimant acceded and steps were expeditiously taken to secure a second surgical opinion; that the issue of surgery progressed through two additional opinions (a second and a third), and was finally resolved by order of the Commission's medical review division during a time period that ran parallel to that of the dispute resolution process, which was considering the issue of whether the claimant had reached MMI. Additionally, and similar to the fact situation in Appeal No. 93293, *supra*, the record shows that Dr. Y, in rendering his opinion as designated doctor, did not address the issue of surgery as raised by the medical reports of Drs. H and Bu, although as a second surgical opinion doctor he recommended against it. (While the potentially significant issue of appointing the same doctor to serve these two distinctly different functions was not raised at the hearing or on appeal, we agree with the parties' stipulation at the hearing that Dr. Y's surgical opinion was not entitled to presumptive weight under the statute, Article 8308-4.25(b) and 4.26(g).) Finally, the record appears to indicate that the question of surgery was not being raised by the claimant for purposes of delay or to prolong and prevent resolution of an issue which the Act provides should be finally resolved by an impartial designated doctor.

For the foregoing reasons, the decision of the hearing officer is reversed and the case remanded for further consideration of evidence on the issues of claimant's MMI and impairment in light of claimant's surgery. A final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is

¹Upon remand, the claimant may wish to offer into evidence the document it attached to its request for review which purports to contain a notation by the designated doctor on the issue of post surgical MMI and impairment. We do not base our decision to reverse and remand on this document, however; we believe such information should be elicited from the designated doctor by the hearing officer subject, of course, to both parties' opportunity to review and respond to such new information. See Texas Workers' Compensation Commission Appeal No. 93323, decided June 9, 1993. While we have declined to prohibit any party from communicating directly with a designated doctor, we have held that communication from a hearing officer will discourage unilateral contacts which could serve to undermine the perception that the designated doctor is impartial. Texas Workers' Compensation Commission Appeal No. 92595, decided December 21, 1992.

received from the Texas Worker's Compensation Commission's division of hearings, pursuant to Article 8308-6.41. See Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Robert W. Potts
Appeals Judge