APPEAL NO. 93432

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 May 3, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. She determined that respondent (claimant) had not reached maximum medical improvement (MMI). Appellant (carrier) asserts that the designated doctor's opinion finding MMI should have been used by the hearing officer because the great weight of other medical evidence was not contrary to it. Claimant did not reply.

DECISION

Finding that the hearing officer erred in determining that the great weight of other medical evidence was contrary to the designated doctor's report, we reverse and render.

Claimant worked as a security guard for ABM Security. The parties stipulated, according to the record, that claimant sustained injuries on May 24, 1991, in the course of employment, to the ankle, hand, knee, head, and back. Claimant testified that she fell on some stairs. She first saw Dr. W), referred to her by the employer. After Dr. W, she saw several doctors for treatment, and offered the medical records of (Dr. S), her current doctor. Among the doctors she saw, other than the designated doctor and doctors who performed tests, were Drs. F and L, but no records from either were introduced by either party.

Other than the designated doctor's report of Dr. L (Dr. L), the records of Dr. S, and a brief report by Dr. S (Dr. So), only test reports (by claimant) and rehabilitation forms (by carrier) were introduced. Dr. So, approximately one year after the accident on May 11, 1992, saw the claimant. He ordered an MRI and obtained that report, dated May 18, 1992, before preparing his report, dated May 28, 1992. Dr. So discussed claimant's history of a laminectomy in 1965. He reported as follows:

> I think the possibility of returning this lady to some form of gainful employment is highly improbable. I think she should certainly lose weight, should get her blood pressure under control, and treat her many other medical problems. I do not find anything on my physical examination that would prevent her from returning to the type of employment that she was performing at the time of the injury in question.

Dr. S's records reflect that on February 2, 1993, he first took claimant's history of falling. On physical examination he found tenderness of the lumbar area and noted that her range of motion is limited by pain. He refers to "conservative" treatment by Dr. F (Dr. F) but never states what that is. (The detail of Dr. S's records shown hereafter illustrates that Dr. S obtained certain testing on claimant and noted pain; more significant is the absence of any indication as to whether Dr. S thinks "further material recovery from or lasting improvement to an injury"--standards in determining MMI which are "based on reasonable medical probability"--can be achieved regarding claimant.) On February 3, 1992, a bone scan was done; the results appear to address claimant's feet. Thereafter, Dr. S on February 9, 1993,

reports the bone scan as negative in the lumbar area, notes complaints of pain, and calls for an MRI of the lumbar area. On February 16, 1993, Dr. S again notes complaints of pain. On February 23, 1993, Dr. S states that the MRI shows HNP (herniated nucleous pulposus) at L4-L5 on the right; he gave her "an infiltration with Depo Medrol and Marcaine" and kept her on "conservative" treatment. On March 3, 1993, Dr. S again notes claimant's complaint of pain and again says that the MRI shows a herniated disc at L4-5. He calls for a myelogram and CT scan. On March 16, 1993, Dr. S again notes claimant's complaint of pain and notes that he will try to get a myelogram and CT scan approved. On March 30, 1993, Dr. S again notes claimant's complaint of pain and again notes his lack of approval for the two tests. On April 2, 1993, a note indicates that the two tests were approved by the carrier. On April 6, 1993, a note repeats claimant's complaint of pain and says the tests will soon be done. On April 8, 1993, a handwritten note appears to indicate that claimant was admitted for the two tests. Thereafter, Dr. S's records, claimant's exhibit 3, show only the reports of the tests, both dated April 10, 1993; the myelogram shows "possible recurrent herniation of the disc on the left side," and the CT scan shows "recurrent herniation of the nucleous pulposus at L4-L5 on the left." There is no statement in the hearing record by Dr. S as to MMI or to whether Dr. S thinks any further treatment is necessary, one way or the other (much less whether claimant is a candidate for surgery); claimant did testify at one time that Dr. S "suggested" surgery and at another that he said she would have to have surgery to get rid of her pain.

Claimant also introduced two reports of MRI; one is dated May 18, 1992 (the same MRI ordered by Dr. So, referred to previously). It shows spondylosis at L4-5 "with an extremely shallow broad-based central herniation which only minimally indents the thecal sac." The second MRI is dated February 18, 1993 and says, in part, "right paracentral subligamentous disc protrusion/herniation is identified (at L4-5) with mild compromise of the right side of the thecal sac but no evidence of significant neural foraminal compromise." Looking at these reports may give a layman the impression of consistency between the two, but there is nothing written on either, or in the medical records in evidence, that provides any medical evidence whether one is significantly different from the other; nor does either report provide any opinion that material recovery or lasting improvement is anticipated (or how the doctor plans to achieve either) in regard to "extremely shallow broad-based central herniation which only minimally indents" or "mild compromise," respectively. Similarly, neither the myelogram dated April 10, 1993, nor the CT scan also dated April 10, 1993, states any medical opinion as to what their respective "impressions" mean either in regard to possible treatment of, or improvement in, the claimant. No record in evidence or medical testimony indicates that the MRI dated February 18, 1993 or the two tests dated April 10, 1993, show anything significantly different than the MRI report dated May 18, 1992. *(See* Texas Workers' Compensation Commission Appeal No. 92275, dated August 11, 1992, which said that there was no evidence to show pending tests would have controlled or changed any physician's opinion.)

Contrary to the "Statement of Evidence" contained in the hearing officer's decision which said that Dr. L did not have "MRI test results showing a disc herniation in May, 1992," Dr. L's narrative of December 22, 1992, indicates that he did have the May 18, 1992 "lumbar MRI report" when he evaluated the claimant, found that MMI had been reached, but did not

indicate that the May 18, 1992 MRI report necessitated any surgery. As stated previously, that MRI report of May 1992 showed "extremely shallow broad-based central herniation which only minimally indents the thecal sac," and there is no medical evidence that any subsequent report would change the conclusion the designated doctor reached from that MRI as to recovery or further improvement.

Dr. L not only listed the May 18, 1992 lumbar MRI report at the beginning of his narrative that accompanied the TWCC form 69, but also mentioned it within his "history" by saying, "[s]he had an MRI which revealed spondylitic changes and post operative changes from her 1965 surgery without other apparent findings." His evaluation on December 22, 1992, included range of motion testing and he commented, "the patient reports central back pain at the extremes of motion in all directions tested." Dr. L may appear to be in conflict with the stipulation of the parties that said claimant's injuries on May 24, 1991 included injury to the back; Dr. L says there is no "apparent" back injury associated with the May 24, 1991 incident. He points out the lack of back symptoms until November 1991. He concludes that claimant reached MMI on September 1, 1991.

Dr. L's report as to MMI is to have presumptive weight unless the great weight of other medical evidence is to the contrary. *See* Article 4.25(b) of the 1989 Act. The other medical evidence in the record includes that of Dr. So which says on May 11, 1992 (one year after the accident) that there is nothing shown on physical examination that should keep claimant from returning to work; Dr. So had the MRI showing the "extremely shallow" herniation. Dr. So's opinion has a different thrust compared to Dr. L's, but does not appear to be "contrary" to it. The hearing officer's Finding of Fact No. 8 indicates she did not consider Dr. So's opinion to be part of the other medical evidence that showed MMI had not been reached. That finding reads:

FINDING OF FACT

> 8.As a whole, [Dr. S's] records, coupled with the results of claimant's diagnostic studies, show that, as of May 3, 1993, <u>in reasonable medical probability</u>, the claimant had not yet attained the point after which further material recovery from or lasting improvement to her back can no longer reasonably be anticipated. (emphasis added)

This finding states that it is based only on Dr. S's records and diagnostic studies--it does not indicate consideration of claimant's testimony about what Dr. S advised her as contributing to the "reasonable medical probability." The finding appears to have little support in either Dr. S's records or diagnostic studies, which, as stated previously, provided no indication as to recovery or improvement in regard to claimant's back. Article 8308-1.03(32) does require that standards for whether MMI has been reached must be "based on reasonable medical probability," with the exception of MMI being reached by passage of time. Even if a finding could be upheld that in reasonable medical probability MMI had not been reached, such finding would be based only on a preponderance of the evidence. Issues generally considered in prior workers' compensation law were decided under a standard of "preponderance of the evidence." *See* <u>Martinez v. Travelers Insurance Co.</u>, 543 S.W.2d

911 (Tex. Civ. App.-Waco 1976, no writ). Since the 1989 Act did not set a standard of proof different from that in prior law, the general test (except when specified as different in a certain area) continues to be "preponderance of the evidence." *See* Texas Workers' Compensation Commission Appeal No. 92167, dated June 11, 1992. The 1989 Act in Article 8308-4.25(b) and 4.26(g) does not call merely for a "preponderance of the evidence," but specifies that the standard to overcome the designated doctor is "great weight." The latter clearly requires a higher standard than does "preponderance of the evidence." (*Also see* Texas Workers' Compensation Commission Appeal No. 92412, dated September 28, 1992, which said that questions under the "great weight" standards require more than balancing the evidence.) The issue in this case requires a finding that addresses the great weight of other medical evidence. There is no finding of fact that the great weight of other medical evidence is contrary to the designated doctor's opinion. There is a conclusion of law that says:

The great weight of the medical evidence other than the designated doctor's report is contrary thereto.

Another finding of fact which the hearing officer may have provided to support this conclusion of law is Finding of Fact No. 6, in which it is said that Dr. L did not review the "MRI films and several other existing medical records" ("records" are not listed as being in evidence by the hearing officer and are not identified as being significant in addition to the numerous reports and studies listed as considered by Dr. L). Texas Workers' Compensation Commission Appeal Nos. 93095, and 93381, dated March 19, 1993, and July 1, 1993, respectively, provide that a designated doctor's opinion is not invalidated by the fact that he did not personally interpret a study in question, whether film or a specimen, such as blood or stool. Certainly a hearing officer could weigh the quality of the report as greater in an appropriate instance if the designated doctor interpreted a test herself when the report of that test was being disputed. In the case before us on appeal, there is no contention by the claimant that the May 18, 1992, MRI report, in evidence as claimant's exhibit 2, was incorrect in showing herniation so that the designated doctor might choose to interpret the film himself or send it out for a consulting interpretation.

Finding of Fact No. 7 is noted as stating that reports, including "myelogram," show disc herniation at L4-5. The myelogram states only that herniation is "possible."

While not essential to the determination of this appeal, Finding of Fact No. 5 states that Dr. LA) certified MMI as reached on October 16, 1992 with ten percent impairment. There is no record, report, or testimony by Dr. LA, or stipulation of the parties in the record of hearing, on which to base a finding that he certified MMI, although claimant testified about Dr. LA's treatment of her. If this finding were given any weight, it too would not be contrary to the designated doctor's opinion that MMI had been reached, although it would specify a different date.

The hearing officer's conclusion of law that "the great weight of the medical evidence other than the designated doctor's report is contrary thereto" is against the great weight of the evidence. The designated doctor's report was not shown to have been based on

insufficient information. (The hearing officer had correctly informed the claimant that since she was disputing the designated doctor, she had the burden to prove that the great weight of other medical evidence was contrary to his opinion of MMI and impairment.) Dr. So's report was not contrary to that of the designated doctor; the diagnostic studies, in themselves, contain no medical evidence as to what they indicate in regard to the claimant's treatment or recovery; Dr. S had several pages of records in evidence, but none included any reference to future treatment that was needed, if any, for the conditions shown in the diagnostic studies; Dr. S never addressed "MMI." Dr. S's reference to claimant's pain and ordering of diagnostic studies that generally showed some herniation of a disk, without some medical evidence indicating that treatment is expected to provide material recovery or lasting improvement, cannot constitute the great weight of medical evidence as being contrary to the designated doctor's opinion that MMI has been reached. *Compare* to the conclusions and recommendations proffered by doctors as to future treatment, set forth in Texas Workers' Compensation Commission Appeal No. 93427, dated July 14, 1993. *Also see* Texas Workers' Compensation Commission Appeal No. 93300, dated June 3, 1993, which said that MMI may be reached even when the claimant still has pain.

The decision and order of the hearing officer are reversed and a new decision rendered that the designated doctor's opinion as to MMI and impairment is entitled to presumptive weight provided by Article 9308-4.25(b) and 4.26(g) of the 1989 Act, resulting in MMI being reached on September 1, 1991, with an impairment rating of zero percent.

Joe Sebesta
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Lynda H. Nesenholtz
Appeals Judge