APPEAL NO. 93518

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq*. (Vernon Supp. 1993) (1989 Act). At a contested case hearing (CCH) held in (city), Texas, on June 1, 1993, the hearing officer, (hearing officer), finding that the designated doctor's certification of maximum medical improvement (MMI) and assignment of an impairment rating was not overcome by the great weight of contrary medical evidence, determined that claimant reached MMI on January 7, 1993, with a five percent whole body impairment rating. In his request for review, appellant (claimant) contends that the great weight of the other medical evidence was contrary to the designated doctor's report because his treating doctor and another doctor both recommended the spinal surgery performed by his treating doctor on June 9, 1993, after obtaining the approval of the Texas Workers' Compensation Commission (Commission). In its response, the respondent (carrier) objects to consideration of certain documents forwarded with claimant's appeal and cites the medical evidence supportive of the designated doctor's report in seeking our affirmance.

DECISION

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

Claimant, the sole witness, testified that he had been employed approximately five days when he hurt his back at work on(date of injury). According to the medical records, claimant related a history of having fallen several feet onto a pipe striking his lower back area. He said he first saw a company doctor and was returned to work. Claimant stated that an attorney who once represented him sent him to the (Clinic) for examination and that sometime later he began treating with (Dr. B).

According to the June 25, 1992, report of (Dr. C) of the Clinic, who examined claimant on that date for the purpose of an impairment rating, claimant reported having fallen an estimated three feet onto a metal pipe and striking the pipe on his left buttocks. The report stated that after some chiropractic treatments failed to alleviate his pain claimant was seen by (Dr. G) who provided medication, a series of physiotherapy treatments, and released claimant to return to full work on May 19th. Neither the records of the chiropractor nor of Dr. G were introduced. Dr. C's report mentioned that claimant's pain in his buttocks area had apparently diminished but that he said he began developing numbness in his left arm and left leg and that he could not walk before limbering up his leg on the occasions the numbness occurred. Claimant complained to Dr. C of constant pain in his low back and of intermittent periods of numbness in the left leg down to his toes. Dr. C stated that although there were no objective positive findings for a herniated disc or other musculoskeletal abnormalities, he intended to order x-rays and an MRI of the lumbar spine. An MRI report of June 28, 1992, noted diminished signal strength consistent with disc degeneration at L5-S1 and a posterior central disc herniation at L5-S1, but no abnormality at other lumbar spine levels.

In evidence was a Report of Medical Evaluation (TWCC-69), signed by (Dr. S) of the Clinic, which stated that claimant had reached MMI on June 25, 1992, with a zero percent impairment rating and which referenced her attached narrative report dated July 8, 1992. This report referred to the normal findings of the physical exam performed by Dr. C. Claimant stated he had never seen Dr. S. Dr. S's report stated that claimant had reached MMI with a zero percent impairment rating according to the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides) and that claimant had one positive finding, "that being a posterior central disk herniation as per the MRI." Dr. S's report referenced and attached range of motion (ROM) studies, apparently done at the Clinic, stating that the lumbar ROM tests were invalid, that the physical exam by Dr. C was normal, that no strength or sensory abnormalities were noted, and that claimant's reflexes were normal. Dr. S's report stated that according to the AMA Guides an unoperated disc with residual signs or symptoms receives a zero percent impairment rating. This report also stated that claimant "proved to be a very unreliable patient and failed miserably in his validity indicators."

Claimant testified that after seeing Dr. C, he was next examined by (Dr. K), a Commission selected designated doctor. Doctor K's TWCC-69 indicated his impression that claimant had a lumbosacral strain and contusion of the pelvis. Dr. K stated that claimant reached MMI on October 1, 1992, with a 10% impairment rating. Claimant testified that after Dr. K's examination, a benefit review conference (BRC) was held at which time a BRC Agreement was entered into by the parties resulting in the Commission's selection of another designated doctor, namely, (Dr. T). According to the BRC Agreement of November 16, 1992, a portion of the parties' resolution of the disputed issue was the selection of Dr. T as a designated doctor given that Dr. K's TWCC-69 failed to mention claimant's herniated nucleus pulposus and had no accompanying narrative report.

Claimant stated he was seen twice by Dr. T with the first visit relating to Dr. T's determinations on MMI and the impairment rating and the second relating to an opinion on the necessity for spinal surgery. Dr. T's report of January 7, 1993, stated that claimant was examined by him on that date and that he was continuing with treatment from Dr. B which included heat, a brace, and stretching activities. The earliest records of Dr. B introduced into evidence were February 1, 1993, discogram and CT scan reports with findings compatible with a herniated disc at the L5-S1 level. Dr. T stated he had reviewed the MRI report from the Clinic showing a disc herniation at L5-S1 and performed ROM measurements with an inclinometer. He reported that "[m]otor, reflex, and sensory examination is full, symmetric, and without anatomic abnormality." His diagnostic impression included a history of work-related lower back injury with residual low back pain, the MRI evidence of degenerative disc disease with a disc herniation at L5-S1, and "no evidence of radiculopathy or neural compression." Dr. T stated his opinion that claimant had reached MMI on January 7, 1993, and was "unlikely to benefit from further active surgical, medical, or physical therapeutic intervention." (Emphasis supplied.) Dr. T

assigned claimant a five percent impairment rating for his disc disease and stated that claimant's ROM measurements "do not meet validity criteria in accordance with the AMA Guides and therefore cannot be used for his rating."

Dr. B's letter to the carrier of February 8, 1993, stated that a discogram was compatible with a herniated disc at L5-S1, that he "explained all the options for his treatment," and that claimant "chose to have percutaneous diskectomy with laser." Claimant testified that Dr. B gave him a choice of three operations and let him pick one and he selected the laser surgery because he did not want to be cut open. Dr. B's letter of February 25th stated that claimant was waiting for a second opinion on the disc operation and that he had not reached MMI.

Claimant saw Dr. T on March 5th for a second opinion regarding spinal surgery. Dr. T's March 9th report referred to his earlier examination and determinations respecting MMI and impairment rating and stated that claimant's history on March 5th was "identical and totally consistent with what it was previously," that the examination was "inconsistent with someone who has a significant neural impingement from herniated nucleus pulposus," that he reviewed the additional discogram and postdiscogram CT scan at the L5-S1 level evidencing a central posterior bulge which "does not significantly encroach upon the nerve roots or have evidence of a free fragment." In recommending against spinal surgery, Dr. T stated the following:

> This patient has been recommended for a percutaneous laser diskectomy at the L5-S1 level by [Dr. B.] It is my experience and in training, that lumbar spinal discogenic surgery fails to produce reproducible consistent relief of lower back pain.
>
> If surgery would be undertaken, I would advise the patient that the back pain could not be expected to be appreciably helped. Since there is minimal complaint of leg pain, that the overall improvement expected from this is minimal.

Dr. B's letter of March 15th stated that claimant "was denied surgery by the second opinion" and that he, Dr. B, was requesting a third opinion since he and claimant disagreed with the second opinion. A report of May 24th by (Dr. CC) stated his impression as lumbar disc disease, and says that he thinks claimant "certainly is a good candidate for a percutaneous diskectomy done laser or other method," and that "spinal surgery is medically appropriate for treatment of this work related injury." Claimant advised the hearing officer in his closing statement that he was scheduled for the laser surgery on June 9, 1993.

Article 8308-1.03(32) defines MMI, in 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; . . . " Articles 8308-4.25(b) and Article 8308-

4.26(g) provide that the report of the designated doctor selected by the Commission will be given presumptive weight and that the Commission shall base its determinations respecting MMI and the impairment rating, respectively, on such report unless the great weight of the other medical evidence is to the contrary. The ultimate determination of the attainment of MMI and of the extent of impairment, if any, must be made upon medical and not lay evidence. Texas Workers' Compensation Commission Appeal No. 92394, decided September 17, 1992. The Appeals Panel has frequently noted
the important and unique position occupied by the designated doctor under the 1989 Act (*see e.g*. Texas Workers' Compensation Commission Appeal No. 92412, decided December 2, 1992) and has stated that a "great weight" determination amounts to more than a mere balancing or preponderance of the medical evidence (Appeal No. 92412, *supra*).

In his request for review claimant contends that the designated doctor's report determining that he reached MMI on January 7, 1993, with a five percent impairment rating is against the great weight of the other medical evidence because both Drs. B and CC recommended the surgery which he underwent on June 9th after the hearing, and because the Commission authorized the surgery. Attached to claimant's request for review were Dr. B's records sent to claimant's attorney on June 23, 1993. Those records included not only the February 1993 discogram and postdiscogram CT scan reports and the three letter reports in evidence, but also another essentially cumulative report pertaining to the discogram and Dr. B's letter reports dated December 16, 1992, January 14, 1993, March 15, and April 14, 1993; reports concerning a facet block on April 26th; reports concerning the June 9th percutaneous discectomy with laser; and Dr. B's correspondence of June 23rd to the effect that claimant had the June 9th percutaneous discectomy and was at that time in the recovery period and unable to work. Also attached to claimant's appeal was a Commission medical review division order of May 27, 1993, accompanied by related documents including the pertinent reports of Drs. T and CC, ordering the carrier to pay the reasonable costs related to the proposed surgery pursuant to the provisions of Article 8308-4.67.

We have previously stated that our review is limited to the record developed at the hearing (Article 8308-6.42(a)) and that we will not consider evidence first offered on appeal if it could have been timely obtained for presentation at the hearing with the exercise of due diligence, if it is cumulative of evidence already offered, or if it would probably not have produced a different result upon a remand and new hearing. *See e.g.* Texas Workers' Compensation Commission Appeal No. 92444, decided October 5, 1992, and Texas Workers' Compensation Commission Appeal No. 92459, decided October 12, 1992. Claimant offered no explanation whatsoever for not having previously obtained those documents which antedated the June 1st hearing, particularly the other records of Dr. B. In our view those records would not probably result in a different outcome if considered on remand. However, the same cannot be said respecting the Commission's May 27th order

for payment of the surgery and Dr. B's surgical records and postsurgery reports. The May 27th Commission order may well not have been available to claimant before the June 1st hearing, even with the exercise of due diligence, and the surgical report and postsurgery reports of Dr. B were not then in existence. *See* Texas Workers' Compensation Commission Appeal No. 93119, decided March 29, 1993.

In Texas Workers' Compensation Commission Appeal No. 93336, decided June 16, 1993, the scenario was quite similar to that of the instant case. There the claimant's surgeon had discussed spinal surgery with the claimant over a period of time; the claimant reported continuing pain and eventually decided to proceed with surgery; the designated doctor, who had previously found claimant to have reached MMI, issued a later opinion on the proposed spinal surgery that the claimant was not a candidate for surgery and did not have a surgical lesion; still later, a third opinion was obtained which stated that a surgical procedure would be indicated but which also first recommended admission to a pain clinic prior to surgery; and the Commission's medical review division later ordered the carrier to pay the costs of the proposed surgery. At the time of the hearing, the claimant in that case had surgery scheduled less than a month later. The Appeals Panel remanded that case stating that ". . . 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." For the same reasons, we remand this case for the further development of the evidence on this point, referring particularly to the recovery period following such surgery. As we said in Appeal No. 93336, we are not retreating from our prior holdings acknowledging the special consideration accorded a designated doctor's opinion.

For the foregoing reasons, the decision of the hearing officer is reversed and the case is remanded, as was Appeal No. 93336, "for further consideration of evidence on the issues of claimant's MMI and impairment in light of claimant's surgery."

Pending resolution of the remand, 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 received from the Commission's division of hearings, pursuant to Article 8308-5.41. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Philip F. O'Neill
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Lynda H. Nesenholtz
Appeals Judge