APPEAL NO. 93612

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. LAB. CODE ANN. § 401.001, *et seq*. On January 6, 1993, a contested case hearing was convened in (city), Texas, with (hearing officer) presiding, to determine only two issues: the claimant's correct impairment rating, and whether the effects of a work-related injury (a contusion to his hand sustained on (date of injury)) also included a drug dependency. The hearing officer recessed the hearing on her own motion in order to provide the designated doctor with additional medical records of claimant and to clarify questions relating to that designated doctor's examination. The hearing was reconvened on February 24, 1993. At this hearing, for the first time, the claimant argued that the appointment of the designated doctor was "premature", but the hearing officer declined to add this issue. On March 2, 1993, the record was reopened on motion by the claimant to accept evidence on the assertion of the "premature" appointment of the designated doctor. The record was reopened again after this and closed on June 15, 1993.

The hearing officer did not determine the issue of impairment. Rather, she determined (as a conclusion of law) that the designated doctor had been prematurely appointed because claimant had not in fact abandoned medical treatment, and also because there was no dispute concerning maximum medical improvement (MMI) or impairment. The hearing officer then effectively invalidated the designated doctor's appointment as such and did not give his report presumptive weight. The hearing officer then found that claimant reached MMI on November 11, 1992, (the date certified by his current treating doctor) but stated that the impairment issue was not ripe for decision, pending the appointment of another designated doctor. On the issue of drug dependency, the hearing officer determined that claimant became addicted to Tylenol #4 as a result of use of the painkiller to treat his compensable injury and sought methadone treatment for this addiction, and that carrier was therefore liable for this medical treatment. The hearing officer directed that a second designated doctor should include claimant's drug dependence into his impairment rating.

The carrier has appealed this decision noting that any issue of the validity of the designated doctor's appointment was not properly before the contested case hearing officer, having been raised for the first time seven months after the doctor's examination, and that the great weight of contrary medical evidence was not against the doctor's report. The carrier further argues a lack of evidence that established a causal connection between the injury and the contended addiction, and argues that it should not be liable for claimant's methadone treatment. The claimant has not responded.

DECISION

After reviewing the record of the case, we reverse the hearing officer's conclusion that the appointment of the designated doctor, valid on its face, was premature. We note that the designated doctor was properly appointed in accordance with Texas W.C. Comm'n, 28 TEX. ADMIN. CODE §130.4 (Rule 130.4) and applicable statutes, that claimant did not

timely raise an issue as to the doctor's appointment, that the designated doctor's opinion is entitled to presumptive weight, and that the great weight of medical evidence is not to the contrary of that doctor's report. We render a decision that claimant reached MMI on August 4, 1992, in accordance with the designated doctor's report (as amended) with a four percent impairment, which we find is entitled to presumptive weight and is not overcome by the great weight of other medical evidence.

We further reverse the determination of the hearing officer that claimant became addicted to Tylenol #4 as a result of medical treatment for his compensable injury, necessitating drug dependency treatment, and we conclude that claimant failed to prove, as a matter of law, that his alleged addiction and subsequent treatment is within the scope of his compensable injury such that the carrier is liable.

FACTS

The claimant stated that a cable struck the back of his right hand[1] on (date of injury), when he was employed by (employer). Medical records in the case indicate that claimant went to the emergency room of his local hospital a few times in the week immediately following the incident. An x-ray report taken December 25, 1991, indicated no fracture or dislocation, although soft tissue swelling was present.

On or about January 13, 1992, claimant went to (Dr. H), a hand specialist in (city). A statement that date signed by Dr. H indicated that he released claimant to light duty work effective January 14, 1992, saying that he was restricted only by the cast on his right arm. Dr. H also noted in his report dated that same day that he had aspirated a hematoma. His Initial Medical Report filed with the Texas Workers' Compensation Commission (Commission) noted that claimant "should be fine in 4-6 weeks." A report from Dr. H dated February 6, 1992, noted that x-rays indicated a flake from a bone in the back of claimant's hand. Dr. H prescribed Naprosyn[2] and physical therapy, which was arranged in claimant's town.

A physical therapy report dated April 9, 1992, recaps claimant's treatment. Claimant was treated eleven times from February 28 through March 26, 1992. The physical therapist noted that claimant did not show up for five scheduled appointments and cancelled one. The therapist noted that passive range of motion was within normal limits, active range of motion was limited secondary to pain. Minimal to no swelling was present. Physical therapy was discontinued at this point by the therapist.

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[1] The hearing officer's findings that claimant injured his left hand are, we believe, typographical errors.

[2] According to the Physician's Desk Reference 1991, this is an anti-inflammatory drug.

On March 24, 1992, Dr. H reported that he performed injections, and noted that claimant was obtaining Tylenol #3 from . "Dr. S" (Dr. S). On March 30, 1992, claimant filed a request to change his treating doctor. He listed Dr. H as his second treating doctor and Dr. S as his first treating doctor. Claimant said that Dr. H didn't care if he was hurting him and did not show compassion. Claimant sought a change to (Dr. W) which was approved, but he testified that Dr. W's office would not accept him when they found out it was a workers compensation claim in which claimant was represented by an attorney. On June 12, 1992, claimant filed a request to change his treating doctor from Dr. H to (Dr. B), which was approved.

In early May 1992, the carrier requested a medical examination order from the Commission. The carrier asked permission to have claimant examined by a doctor farther away than 75 miles, asserting that it could not find a doctor within that distance. The Commission refused to order this examination. Thereafter, on May 19, 1992, the carrier, contending that claimant had not shown up for some scheduled appointments with Dr. H, began to invoke the procedures set out under Rule 130.4.

In accordance with this Rule, a medical status request letter with a TWCC-69 Medical Evaluation Report form was sent by the Commission to Dr. H on June 3, 1992. Dr. H was asked to list all appointments which had been scheduled, but not attended. Dr. H responded that he could not complete the TWCC-69 form because claimant had not attended his last three regularly scheduled appointments in April and May 1992. The carrier, on June 24, 1992, requested a benefit review conference and asked that the Commission appoint a designated doctor. The carrier recited abandonment of medical treatment, noting the missed appointments and that claimant had not seen Dr. B. The Commission notified the parties that a designated doctor would be appointed if they could not agree on one.

The evidence indicates that, in April 1992, there was an active controversy over a purported *bona fide* job offer made by the employer. The claimant stated that he fired his attorney because of a mistake he felt his attorney made over the job issue. Claimant's attorney withdrew July 7th. On July 10th, the Commission appointed (Dr. C) as designated doctor because the parties had been unable to agree upon a designated doctor.

Dr. C issued a report finding that claimant had reached MMI on August 4, 1992, and had a two percent whole body impairment. The claimant did not dispute that Dr. C examined him. In the meantime, claimant had started seeing Dr. B on June 30, 1992. Dr. B noted that his examination revealed no gross abnormalities. There was no swelling. Pain and tenderness were noted. Range of motion was judged normal. Dr. B recommended a nerve conduction study to rule out carpal tunnel syndrome. Dr. B next saw the claimant on August 7, 1992, and noted that he was "essentially unchanged". The nerve conduction studies were essentially normal, with a questionable indication of possibly

minor carpal tunnel syndrome. Dr. B prescribed a hand splint.

On August 18, 1992, Dr. B noted that another doctor found that claimant reached maximum medical improvement with a three percent impairment rating. Dr. B stated that "based upon this information, we will discharge the patient from our care" and noted that if he or the carrier determined that further medical attention was necessary, he would be glad to continue seeing the claimant. On October 14, 1992, the claimant returned to Dr. B complaining of pain. Dr. B noted that claimant was going back to work, and that his present problem was complicated by his prior need for large quantities of pain medication. Dr. B indicated that claimant was at this time disputing his earlier impairment rating.

Dr. B sent the claimant to (center) for an impairment rating. On November 18, 1992, Dr. B noted that claimant was essentially unchanged. Dr. B agreed with the assessment by center and eventually completed a TWCC-69 stating that claimant reached MMI on November 18, 1992 with a five percent whole body impairment.[3]

The hearing officer continued the January hearing to allow the designated doctor to review additional medical evidence, but he did not change his assessment as a result.

On May 11, 1993, the hearing officer, acting on her own motion and citing a recent Appeals Panel decision, sought clarification from the designated doctor about the version of the Impairment Guides he had used. The hearing officer also indicated that she could not consider as valid a report signed by a Dr. S.

On May 19, 1993, in response to questions posed by the hearing officer, Dr. C reviewed his notes and records and amended his impairment rating to from two percent to four percent. His calculations are described in detail, and use range of motion figures generated by his findings noted in August 1992. The difference between his two ratings is that range of motion deficiencies for the index and ring fingers that appear to have been omitted from the two percent rating are factored into the four percent rating. The August 4, 1992, date of MMI remained unchanged. Both parties were given the opportunity to respond to this report, but the record does not reflect any responses, and the record finally closed on June 15, 1993.

[3] Dr. B corrected an inadvertent notational error which had originally copied an eight percent upper extremity rating into the whole body impairment rating block on the TWCC-69.

DESIGNATED DOCTOR ISSUE

Whether the designated doctor had been properly appointed was never disputed by the claimant until the February 24, 1992, reconvened contested case hearing. The carrier then objected to the late raising of the issue. The hearing officer stated that she would not permit the issue to be raised. The hearing officer did allow claimant to present some evidence on the designated doctor's appointment, announcing that it would be admitted for the sole purpose of preserving an appeal on the issue. After the hearing record had been closed, the claimant asked that the record be reopened to include documents leading up to the appointment of Dr. C. The hearing officer reopened the record to accept these documents, although the carrier once again objected to this action. The record does not indicate that the hearing officer reversed the ruling made at the contested case hearing not to allow the issue of Dr. C's appointment to be raised.

We reverse the hearing officer's determination that Dr. C was prematurely appointed as a designated doctor. It is crystal clear that Dr. C was validly appointed in accordance with Rule 130.4. The hearing officer's findings that Dr. C's appointment was premature because there was no dispute over MMI or impairment are wholly without foundation in the record. Moreover, the further finding that claimant had not abandoned medical treatment overlooks the fact that there are other bases for requesting a designated doctor under Rule 130.4.

That rule does not call for appointment of a designated doctor solely in the case of abandonment. The mere failure to attend appointments can trigger a request for a designated doctor, regardless of the underlying reason for nonattendance, as can an apparent lack of improvement in an injured employee's medical condition. When Dr. H failed to respond to the Medical Status Request by completing the TWCC-69, the carrier filed a request for benefit review conference and designated doctor in accordance with Rule 130.4(h) & (i). A valid Commission order was subsequently issued. Whether or not the carrier used "magic words" in its request for review of claimant's medical condition, it clearly invoked Rule 130.4 (which is entitled "Presumption that Maximum Medical Improvement has been Reached and Resolution When MMI has not been Certified").

We have before stated that a "dispute" does not require issuance of a report on MMI that is contested; a dispute can result from the doctor's failure to opine that MMI has been reached. *See* Texas Workers' Compensation Commission Appeal No. 93479, decided August 2, 1993. We noted that the 1989 Act, Art. 8308-4.25 (codified as TEX. LAB. CODE §408.122(b)) contemplated an appointment, not only upon a report of MMI, but to resolve "a dispute . . . as to whether the employee has reached" MMI. A dispute may be triggered when medical records indicate essentially an unchanged condition, but the treating doctor has failed (or refused) to certify MMI.

Thus, even without the fact that the designated doctor was duly appointed under Rule 130.4, it is impossible to review the several weeks of claims file correspondence that are included in this record, and not derive the clear impression that a dispute existed over MMI. Notwithstanding the hearing officer's observation that the carrier was "pressing for an order" to stop temporary income benefits, the records indicate that the carrier was pressing not for such an order but for a review of claimant's medical condition.

Just as the hearing officer's voiding of Dr. C's appointment is not factually supported by the record, it also fails procedurally. Plainly, the validity of Dr. C's appointment had not been raised as an issue that could be considered by the hearing officer, as required under the 1989 Act, Section 410.151(b) (formerly Art. 8038-6.31(a)), and the hearing officer affirmatively declined to include it. The hearing officer was thereafter not at liberty, under the hearings procedures set forth in the statutes and rules, to adjudicate the validity of Dr. C's appointment.

The report of a Commission-appointed designated doctor is given presumptive weight. Section 408.125(e) (formerly Art. 8308-4.26(g)). The amount of evidence needed to overcome the presumption, a "great weight," is more than a preponderance, which would be only greater than 50%. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992. "Maximum Medical Improvement" is defined, as pertinent to this case, as "the point after which further material recovery from or lasting improvement to an injury can no longer be reasonably anticipated, based on reasonable medical probability." Section 401.011 (30)(a) (formerly Art. 8308-1.03(32)(a)). We have stated many times that the presence of some pain is not, in and of itself, an indication that an employee has not reached MMI; a person who is assessed to have lasting impairment may indeed continue to experience some pain as a result of an injury. *See* Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1993.

In reviewing Dr. B's reports, we do not find that it would amount to a great weight of evidence against Dr. C's report (had the hearing officer so found). Dr. B notes that claimant was essentially unchanged from one examination to the next, two of which spanned the same period of time as Dr. C's examination. Although the hearing officer apparently felt that a rating should be assigned to claimant's drug dependency, it would not appear to us that this condition would meet the definition of "impairment" as set forth in Section 401.011 (23) (formerly Art. 1.03(24)).

Reviewing all of the medical evidence, including Dr. C's reports and Dr. H's earlier assessments, persuades us that remand would serve no purpose in this case and we therefore render a decision adopting the report of the designated doctor as to the date of

MMI and extent of claimant's impairment.

DRUG DEPENDENCY ISSUE

Testimony underlying the claimant's contention that he became addicted to drugs as a result of his injury was developed solely at the February 24, 1993, session of the hearing. The claimant contended that he required methadone treatment, which he entered May 19, 1992, as a result of addiction to Tylenol #4, which he testified contained codeine. He confirmed that neither of his treating doctors, Dr. H or Dr. B, prescribed this drug. Instead, it was prescribed by the emergency room doctor, Dr. S. Claimant testified that Dr. S was an obstetrician. He stated that he returned to her when Dr. H refused to prescribe Tylenol #3 or #4.

Claimant estimated that he saw Dr. S ten times. He further stated that Dr. S recommended that he go into a methadone treatment program for further pain relief and because both Dr. S and he felt he was taking too much Tylenol #4. He also stated that he went into methadone treatment also because the doctor was going to get into trouble and couldn't give him any more Tylenol #4.

When the hearing officer asked the claimant if a doctor had told him that he was more susceptible to being addicted to Tylenol #4 because of his prior history of addiction or because anyone with his injury would become addicted, the claimant indicated that the second was the statement made to him. Claimant agreed that he did not disclose to any doctor his prior history of drug use, which included addiction to heroin that he stated he abandoned in 1975.[4] Claimant said Dr. S told him that anyone in as much pain as he was would become addicted. Claimant stated at the hearing that he felt his past history of drug use was not relevant to the issue of his present addiction.

Although claimant's request to change from Dr. H to Dr. B as treating doctor was filed with the Commission on June 15, 1992, a letter from Dr. S dated August 11, 1992, states that Dr. S "is currently" under care secondary to a hand fracture suffered at work and that due to his severe pain, he became dependent upon Tylenol #4. The records from the methadone clinic., include a questionnaire completed by claimant in which he indicated he had used codeine #4, Tylenol #4 and Relafen 500 mg "since 1981." At the hearing, he stated that he intended to indicate by his answer that he had used these substances before, beginning in 1981; he stated that he used them back then for two years following an accident, but not since then until his injury.

[4] The record does not support the hearing officer's observation in the Statement of the Evidence that claimant was told by the emergency room doctor that he was more susceptible to Tylenol #4 addiction because of prior drug use.

The clinic records also include a questionnaire completed on May 19, 1992, by an interviewer, and a check mark is placed next to "new tracks," with a further notation "also old tracks inside elbow right and left in arms." Claimant testified that his "track marks" were from Vietnam. Other notes on the clinic records appear to read that "Pt. has long Hx of IV opioid use and is addicted; he satisfies criteria for MM program." Drug urine test results were submitted for dates both before and after the injury, the most recent being May 1, 1992. All were negative for the substances tested.

Claimant testified that at the time of the hearing he had resolved his dependency, no longer took Tylenol #4, and that he had completed his methadone detoxification approximately December 10, 1992. The carrier disputed payment for methadone treatment on the basis that it was not reasonable and necessary to treat claimant's injury of (date of injury).

The hearing officer found as fact that: "[b]ut for the compensable injury, the Claimant would not have become addicted to Tylenol #4 and would not have required methadone treatment to assist him in overcoming his addiction." However, we do not read the law to include, within the ambit of a compensable injury, every consequence that might arguably not have occurred "but for" the fact of an injury. We believe that the law supports compensation for a condition brought about by reasonable or necessary medical treatment for a work related injury. Liberty Mutual Insurance Co. v. Pool, 449 S.W.2d 121, 123 (Tex. Civ. App.- Texarkana 1969, writ ref'd n.r.e.); Home Insurance Co. v. Gillum, 680 S.W.2d 844 (Tex. App.- Corpus Christi 1984, writ ref'd n.r.e.).

There was no evidence of the prescribed dosage of the drug compared to his use of the drug. Claimant stated he and Dr. S formed the opinion that he was taking "too much" Tylenol #4. Claimant also testified that the injury caused him to "chew down" this substance. Such evidence, coupled with other facts brought forward, does little to buttress a claim that he incurred addiction as a result of reasonable and necessary prescribed medical treatment of his compensable injury, as opposed to noncompliant use of a painkiller that his treating physician did not prescribe. We therefore believe that the evidence does not support, as a matter of law, that claimant's methadone treatment is within the scope of compensable consequences from his work-related injury. *See analogous issue* in Texas Workers' Compensation Commission Appeal No. 93464, decided July 12, 1993.

For these reasons, we reverse the hearing officer's decisions on both issues, and render a decision finding that the carrier is not liable for methadone treatment, and adopting the report of the designated doctor that claimant reached MMI on August 4, 1992, with a four percent impairment. Benefits accrued, but not paid, should be paid in accordance with this decision, along with applicable interest.

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Susan M. Kelley
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.
Chief Appeals Judge

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Philip F. O'Neill
Appeals Judge