APPEAL NO. 93714

On July 2, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). The issue at the hearing was whether the certification of maximum medical improvement (MMI) and the assignment of a five percent impairment rating by (Dr. C) were timely disputed. The hearing officer determined that Dr. C "decertified" MMI and hence his certification of MMI never became final, and that the five percent impairment rating assigned by Dr. C was invalid since Dr. C did not use the second printing, dated February 1989, of the Guides to the Evaluation of Permanent Impairment, third edition, published by the American Medical Association in determining impairment rating. Based on these determinations, the hearing officer decided that the claimant's failure to dispute Dr. C's certification of MMI and assignment of impairment rating within 90 days was "not fatal" because the MMI certification and impairment rating never became final. The appellant (carrier) disputes the hearing officer's decision on several grounds and requests that we reverse the decision and render a decision that the claimant reached MMI on May 16, 1992, with a five percent impairment rating.

DECISION

The decision of the hearing officer is affirmed.

The parties stipulated that the claimant sustained compensable chest and back injuries while in the course and scope of his employment with his employer, (employer), on (date of injury). The claimant testified that he retained (Attorney G) as his attorney about one week after his injury at work.

On the day of the injury the claimant was taken to a hospital emergency room and was told to stay off work for about eight weeks. On (date), the claimant went to (the Clinic) where he was examined by (Dr. B) who diagnosed a ventral hernia and a lumbar strain and kept the claimant off work. On August 19, 1991, Dr. B reported to the carrier that an MRI showed a "small central disc at L5-S1" and recommended a CAT scan of the lumbar spine. Dr. B also recommended an upper GI evaluation. An August 26, 1991, report to the carrier showed that Dr. B kept the claimant off work.

The claimant testified that he was next treated by Dr. C who is associated with the Clinic. In a report to the carrier dated September 30, 1991, Dr. C diagnosed lumbar sprain and strain and stated that an MRI showed central disc protrusion at L5-S1, and that a CAT scan showed a small bulged disc at L4-5 and a central bulged disc at L5-S1 with possible herniation at L5-S1. Dr. C ordered a discogram.

The claimant said he was also treated by (Dr. W) who is associated with the Clinic. In a report to the carrier dated November 1, 1991, Dr. W diagnosed L4-5 and L5-S1 discopathy. In a report to the carrier dated November 20, 1992, Dr. W diagnosed lumbar sprain, L5-S1 discopathy, and an L4-5 bulging disc. Dr. W stated that the claimant "is a

surgical candidate for two level hemilaminectomy, discectomy, fusion and internal fixation." However, Dr. W also stated that the claimant would continue his "nonoperative care." Dr. W noted that (Dr. R) had been evaluating the claimant for "stomach problems" and that the claimant had "done well with this." On December 13, 1991, Dr. W wrote to the carrier stating that the claimant would continue with "nonoperative care" and that he, Dr. W, was trying to get the claimant back to gainful employment. On December 20, 1991, the claimant had a discogram performed which revealed normal findings except at the L5-S1 level which showed "interdisc disruption, posterior leakage and a positive provocative test." Dr. W stated that the claimant would continue on nonoperative care. On January 10, 1992, Dr. W reported to the carrier that the claimant was a candidate for surgery at the L5-S1 level, if nonoperative care failed.

On March 17, 1992, Dr. C reported to the carrier that the claimant was still symptomatic in his low back. On April 3, 1992, Dr. C reported to the carrier that the claimant was continuing pain management therapy but had completed physical and exercise therapy. Dr. C stated that he was putting the claimant in "our" work conditioning program and that he would recommend "a disability rating subsequent to that to prepare him for some form of gainful employment." On April 16, 1992, Dr. C reported to the carrier that "once he [the claimant] has finished his work conditioning program and has an impairment rating, he can return to his former type of employment without difficulty." In a letter to the carrier dated May 1, 1992, Dr. C stated that "He [claimant] has reached maximum medical improvement. We will get an impairment rating on his next office visit, prior to discharge." In a letter to the carrier dated May 15, 1992, Dr. C stated "I am referring him [claimant] for an impairment rating, as he has reached maximum medical improvement." Dr. C also stated in this letter that he was discharging the claimant today and returning him to "duty" to be seen on an as needed basis only. As with all prior correspondence from the Clinic to the carrier, the letters of May 1st and May 15th indicate that copies were sent to Attorney G.

In an undated Report of Medical Evaluation (TWCC-69), Dr. C certified that the claimant reached MMI on May 16, 1992, with a five percent whole body impairment rating. In the TWCC-69 Dr. C noted that the claimant had returned to work for one day but was "unable to continue," and that Dr. W felt that the claimant was a "future surgical candidate due to continued pain." In a report attached to the TWCC-69, Dr. C stated that "the following data are provided in accordance with the AMA's Guide to Permanent Impairment, Revised 3rd Edition, 1990." The TWCC-69 and attached report indicate that they were filed with the "I.A.B." (predecessor to the Commission), but there is no indication on the TWCC-69 or attached report that either were sent to the claimant or to Attorney G. The claimant said that he did not know that Dr. C certified MMI. However, later in his testimony the claimant indicated that he became aware that Dr. C certified MMI when his checks ended in September 1992. Still later, the claimant indicated that he doesn't understand the difference between MMI and a doctor's release to return to work.

In a Payment of Compensation or Notice of Refused/Disputed Claim (TWCC-21) dated May 21, 1992, which indicates that it was sent to the "claimant's representative" on May 21, 1992, the carrier indicated that it was terminating temporary income benefits (TIBS)

and gave as the reason for termination "per treating doctor claimant has reached MMI." The claimant testified that he didn't recall Attorney G telling him that Dr. C had certified MMI. The claimant also testified that he did not have a copy of any letter from Attorney G to the Commission disputing Dr. C's certification of MMI.

In a letter to the carrier dated June 2, 1992, which indicates that a copy was sent to Attorney G, Dr. C stated that the claimant was "discharged from our care and returned to regular duty with an impairment rating of five percent." Dr. C further reported that the claimant stated that he was unable to continue working after going back to work for one day. Dr. C stated that he was referring the claimant to Dr. W for an orthopedic consultation due to the claimant's apparent nonresponse to treatment.

In a letter to the carrier dated June 12, 1992, with a copy to Attorney G, Dr. W noted that the claimant was last seen by Dr. C on June 2, 1992, that Dr. C had "followed" the claimant over the last several visits, and that the claimant is "symptomatic and is a candidate of decompressive surgery at L5-S1." Dr. W further stated that "He [claimant] is a surgical candidate as stated above as nonoperative therapy has apparently failed." Dr. W further noted that the claimant had a bulging disc at L4-5 but that no surgery was planned for that problem "at this time."

In a TWCC-21 dated June 18, 1992, which indicates that a copy was sent to the "claimant's representative" on June 18, 1992, the carrier reported that they had paid the claimant four weeks of impairment income benefits (IIBS) on June 18, 1992.

In a Continuing Disability Benefit form to (Life Insurance Company), Dr. C reported on June 18, 1992, that the claimant was off work and is a candidate for surgery.

The carrier wrote to Dr. W on June 23, 1992, acknowledging receipt of his report dated June 12, 1992, in which he indicated that the claimant is a surgical candidate. The carrier said that it was enclosing Dr. C's reports and asked Dr. W if he disagreed with Dr. C's assessment of MMI "back in May 1992, and whole body impairment rating of 5%?" In a letter to the carrier dated July 22, 1992, Dr. W stated that the claimant was unable to work because of low back pain and that the claimant has a ruptured disc at L5-S1 and that all risks and complications of surgical and nonsurgical techniques had been explained to the claimant "today." Dr. W further stated that "no promises have been made, stated or implied that any form of surgical or nonsurgical techniques will help this patient." Other than mentioning that an impairment rating had been "performed," Dr. W did not mention MMI or impairment rating in response to the carrier's letter of June 23, 1992.

In a TWCC-21 dated September 4, 1992, which indicates that a copy was sent to the claimant on September 4, 1992, the carrier reported that it had paid 15 weeks of IIBS and that "total IIBS paid out." The claimant testified that he stopped receiving checks from the carrier sometime in September 1992 and that he did not know why his checks stopped. He said he terminated Attorney G at that time. The claimant testified that Attorney G had not written the Commission "protesting" the suspension of his checks.

In a letter to the carrier dated September 18, 1992, Dr. W diagnosed the claimant as having a partial ruptured disc in the lumbar spine and lumbar spondylosis. Dr. W said "He [claimant] had an impairment rating and I am trying to get him back to work." In a letter to the carrier dated September 23, 1992, Dr. W reported that the claimant had returned to work but the employer told the claimant there was no work available. Dr. W said the claimant was still symptomatic but that "he weighs too much for surgery." Dr. W said nonoperative care would be continued.

On October 9, 1992, Attorney G wrote to the Commission stating that the claimant had terminated his services as of that date.

On October 14, 1992, Dr. W wrote to the carrier stating that the claimant's prior discogram was normal other than at the L5-S1 level, that the claimant was about to have another discogram performed to assess his pathology, and that the claimant "will be a candidate for surgery in that area if this is still the case." Dr. W also noted that the L4-5 level had been "suggested to be problematic, which is why we want a more recent examination." Dr. W concluded his letter by stating that the claimant may be a candidate for L5-S1 surgery.

In a letter to the Commission dated October 19, 1992, with a copy to the carrier, (Attorney E) advised the Commission that he represented the claimant in connection with the claimant's workers' compensation claim. On November 5, 1992, Attorney E's legal assistant wrote to the carrier stating that the claimant had not received "compensation checks" since the beginning of September, that light duty work was unavailable for the claimant, and requesting resumption of TIBS.

In a letter to the carrier dated January 6, 1993, Dr. W reported that the claimant is a candidate for "chemonucleolysis and/or back surgery at L5-S1," that nonoperative care would be continued, and that the December 1991 discogram would be repeated to "update his candidacy for surgery." On January 7, 1993, the claimant had another discogram performed which, according to Dr. W, revealed normal findings at L2-3, L3-4, and L4-5. However, Dr. W reported that at the L5-S1 level the discogram showed intradiscal disruption, bilateral lateral rupture and leakage, anterior rupture and leakage, and posterior rupture and leakage with no provocative test. Dr. W stated that the claimant has a degenerative disc and mild instability at L5-S1, and that the claimant "will need a hemilaminectomy and discectomy and decompression posteriorly as well as possible fusion from L5 to the fusion if non-operative care fails."

An undated Required Medical Report: Spinal Surgery Recommendation form (TWCC-63) lists Dr. B as the claimant's treating doctor and recommends that the claimant have a laminectomy at L5-S1 and that Dr. W perform the surgery. The carrier received the TWCC-63 on February 17, 1993. In response to the spinal surgery recommendation, the carrier requested a second opinion examination by (Dr. M). In a letter to the carrier dated March 5, 1993, Dr. W wrote that the claimant had been scheduled for a laminectomy at L5-

S1. In a letter to the carrier dated May 3, 1993, Dr. M wrote that he had examined the claimant and "I cannot substantiate the presence of a herniated intervertebral disc, nerve root compression nor instability of the back and cannot agree with the indications for surgery."

A Benefit Review Conference (BRC) was held on May 7, 1993, to resolve the issue of whether the certification of MMI and the assessment of a five percent impairment rating by Dr. C were timely disputed. In the BRC disputed issue form dated May 18, 1993, the benefit review officer stated that the first time the dispute was raised was May 7, 1993, the date of the BRC, well past the 90 day time limit.

In a letter to the carrier dated May 19, 1993, Dr. W stated that he disagreed with Dr. M's conclusions and that "we need to now order a somatosensory evoked potential to see if we can further clarify the nerve involvement." In a TWCC-69 dated May 26, 1993, Dr. W reported that the claimant had not reached MMI and stated that the estimated date of MMI was "undetermined." On May 26, 1993, (Dr. WK), who is also associated with the Clinic, wrote to the carrier stating that the claimant has a diagnosis of herniated nucleus pulposus and that "he may well be a candidate for surgery." Dr. WK added that the claimant had been instructed to lose weight but that "he is basically clinically status quo. . . ." Dr. WK suggested that another MRI scan be performed to clear up any confusion on the part of Dr. M. Dr. WK concluded his letter by stating that the claimant would be continued on a weight loss program and other conservative management and that "hopefully, we will be able to avoid surgery." The claimant testified that he has not had back surgery as of the date of the hearing.

As previously noted, the issue at the hearing was whether the claimant timely disputed Dr. C's certification of MMI and assignment of impairment rating. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) provides that "[t]he first impairment rating assigned to an employee is considered final if the rating is not disputed within 90 days after the rating is assigned." We have held that "an impairment rating cannot be assigned, and made final, absent a certification of MMI." Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993. In interpreting this rule, we have stated that: "It would be inconsistent to interpret the rule to bind a claimant or carrier to the percentage of impairment, but allow an `end run' around this finality through an open-ended possibility of attack on the MMI. Such an interpretation would read the rule out of existence." Appeal No. 92670, *supra*. February 1, 1993. As concerns the time period for disputing the first impairment rating, we stated in Texas Workers' Compensation Commission Appeal No. 93423, decided July 12, 1993, as follows:

> We have observed that, notwithstanding the language in Rule 130.5(e), the 90 day time period in which to dispute the first impairment rating assigned to an employee does not necessarily run from the date the rating is actually assigned by the doctor. Texas Workers' Compensation Commission Appeal No. 92542, decided November 30, 1992, and Texas Workers' Compensation Commission Appeal No. 92693, decided February 8, 1993. The rationale, as

explained in Appeal 92542, *supra*, is "that it would require some stretch of the imagination to find that claimant could dispute a doctor's report before he was aware that it was rendered." Consequently, it is when the claimant has actual knowledge of the MMI certification or impairment rating that becomes the more critical matter, rather than when the rating is assigned.

Neither party has appealed that portion of the hearing officer's decision wherein the hearing officer determined that the claimant did not notify the Commission of "his dispute concerning Dr. C's certification of MMI and assigned impairment rating within 90 days after he (through his attorney) received notice thereof. . . ."

In its appeal, the carrier does dispute the following conclusions of law:

CONCLUSIONS OF LAW

4.[Dr. C] and [Dr. W] were concurrently the claimant's treating doctors for purposes of treatment for the claimant's compensable injuries for at least the period from November 1, 1991, through June 18, 1992.

5.[Dr. C's] certification of MMI on May 16, 1992 was decertified by: 1) [Dr. W's] report of June 12, 1992 stating that the claimant was a candidate for back surgery, and 2) [Dr. C's] statement on an insurance form dated June 18, 1992 to the effect that the claimant needed surgery on his lumbar spine.

6.Since [Dr. C's] certification of MMI was decertified, such certification never became final, and the claimant did not have to dispute such certification.

7.As a result of the decertification of MMI, the 5% impairment rating assigned to the claimant by [Dr. C] was no longer in effect.

In one portion of her decision the hearing officer decided that Dr. C's certification that the claimant reached MMI on May 16, 1992, was decertified both by Dr. W's report of June 12, 1992, and Dr. C's statement of June 18, 1992, that the claimant needed surgery. The hearing officer decided: "Therefore, the 5% impairment rating assigned by Dr. C was a nullity."

The first point the carrier raises on appeal is that the hearing officer erred in concluding that Drs. C and W were "concurrent treating doctors" because such a concept is not authorized under the Act. We agree with the carrier's contention. Section 401.011(42) provides that "treating doctor" means the doctor who is primarily responsible for the employee's health care for an injury. Prior to January 1, 1993, Article 8308-4.62 was the statutory provision relating to an employee's right to select a doctor. As of January 1, 1993, Article 8308-4.63 (now Sections 408.022 and 408.023 of the Texas Labor Code) became

the statutory provision for an employee's selection of doctor. Both Articles 8308-4.62 and 8308-4.63 provide for an employee's "initial choice of a doctor" and then provide the method by which an employee may, under Article 8308-4.62, "change doctors" and under Article 8308-4-63, "request authority to see an alternate doctor." Rule 133.3 sets forth the responsibilities of the treating doctor and provides, among other things, that the treating doctor is primarily responsible for coordinating the employee's health care for an injury; that except in the case of an emergency, the treating doctor approves or recommends all health care rendered to the employee, including referrals to consultants; and that the treating doctor is responsible for maintaining efficient utilization of health care. It is our opinion that the 1989 Act and Commission Rules contemplate that an injured employee will have one treating doctor at a time who is primarily responsible for the employee's health care. Having more than one treating doctor at any given point in time would make no one doctor primarily responsible for the employee's health care and the mechanism for approval and recommendation of health care would fall into disarray. However, although we hold that the hearing officer erred in concluding that Drs. C and W were concurrent treating doctors, we do not find such error, in and of itself, to be reversible error in this case. For one thing, there was no issue at the hearing concerning who the claimant's treating doctor was or is.

The carrier next contends that the hearing officer erred in concluding that a medical opinion of the necessity of surgery constitutes a withdrawal of certification of MMI. We address the carrier's contention only in the context of the facts of this case; a different fact situation may produce a different result. We have held that under appropriate circumstances a doctor can amend or correct a previously issued TWCC-69 form. *See* Texas Workers' Compensation Commission Appeal No. 92503, decided October 29, 1992; Texas Workers Compensation Commission Appeal No. 92441, decided October 8, 1992. In the instant case, Dr. C did not amend or otherwise purport to correct his TWCC-69 form wherein he certified MMI and assigned an impairment rating. In addition, since Dr. C noted in the TWCC-69 form that the claimant was a future candidate for surgery when he certified MMI, no inference can be made that Dr. C changed his opinion with regard to MMI when he subsequently noted on the life insurance disability form that the claimant is a candidate for surgery. There is simply no evidence that Dr. C withdrew his opinion that the claimant reached MMI on May 16, 1992, with a five percent whole body impairment rating. Consequently, we hold that the hearing officer erred in concluding that Dr. C "decertified" his certification of MMI. We also conclude that the hearing officer erred in concluding that Dr. C's certification of MMI was "decertified" by Dr. W. Although Dr. W has rendered an opinion that the claimant has not reached MMI, there is no basis in law or fact to allow the opinion of one doctor to operate to withdraw or amend the opinion of another doctor. The evidence before the hearing officer simply reveals that Dr. C believes the claimant has reached MMI notwithstanding that the claimant is a candidate for surgery, and Dr. W believes that the claimant has not reached MMI because the claimant is a candidate for surgery. We note that no doctor has expressed a direct opinion that surgery will, in reasonable medical probability, result in further material recovery from or lasting improvement to the claimant's injury.

The carrier next contends that the hearing officer erred in concluding that the

certification of MMI and impairment rating were ineffective because decertification of MMI is not authorized by the 1989 Act. We disagree with the carrier's contention to the extent that we have previously held that under appropriate circumstances a doctor may amend or otherwise correct a previously issued TWCC-69 form. *See* Texas Workers' Compensation Commission Appeal No. 93391, decided July 5, 1993; and Texas Workers' Compensation Commission Appeal No. 93428, decided July 5, 1993. The carrier fails to cite any authority for the proposition that an expert requires statutory authority to correct errors. *See* Texas Workers' Compensation Commission Appeal No. 92639, decided January 14, 1993. However, for the reasons previously stated, we agree that Dr. C did not amend or correct his TWCC-69 form and that Dr. W's letter of June 12, 1992, nor his subsequently issued TWCC-69 forms did not operate to amend or change Dr. C's certification of MMI.

Although we hold that the hearing officer erred in deciding that Dr. C's certification of MMI was "decertified" by Dr. W's report of June 12, 1992, and by Dr. C's statement of June 18, 1992, that the claimant is a candidate for surgery, we have no basis not to affirm the hearing officer's decision that Dr. C's certification of MMI and assignment of impairment rating never became final based on the hearing officer's Finding of Fact No. 6 that Dr. C used the "AMA's Guide to Permanent Impairment, Revised 3rd Edition, 1990" in determining the claimant's impairment rating, and her Conclusion of Law No. 8 that the five percent impairment rating assigned to the claimant by Dr. C on May 16, 1992, was invalid since Dr. C did not make such determination by using the second printing, dated February 1989, of the Guides to the Evaluation of Permanent Impairment, third edition, published by the American Medical Association. The carrier has not appealed Finding of Fact No. 6 nor Conclusion of Law No. 8. Nor has the carrier disputed that portion of the hearing officer's decision which states "[s]uch impairment rating was invalid, in any event because Dr. C did not use the statutorily required edition and printing of the AMA Guides." For example, the carrier has not contended that the claimant is foreclosed from presenting evidence showing that an incorrect version of the AMA Guides was used in assessing the first impairment rating if the first impairment rating is not disputed within 90 days. The carrier's issues on appeal pertain solely to the matter of concurrent treating doctors, withdrawal of certification of MMI, and "decertification" of MMI.

Pursuant to Section 408.124, impairment must be based on the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the AMA. Pursuant to Section 408.123, the certifying doctor shall assign an impairment rating using the impairment rating guidelines described by Section 408.124. Although the claimant did not assert at the hearing that the impairment rating was invalid on the basis that Dr. C used an incorrect version of the AMA Guides to determine impairment, the claimant did present evidence in the form of Dr. C's "Disability Impairment Rating" report which was attached to Dr. C's TWCC-69 that Dr. C did in fact use the 1990 version of the AMA Guides in determining impairment as opposed to the version of the AMA Guides mandated by Section 408.124. In Texas Workers' Compensation Commission Appeal No. 92393, decided September 17, 1992, we held that "In the absence of an issue on impairment rating that is based on the failure of a doctor to use the AMA Guides [previously defined in the opinion as the second printing, dated February 1989, of the Guides to the Evaluation of

Permanent Impairment, third edition, published by the AMA] in determining impairment, or in the absence of evidence adduced at the hearing that the doctor assigning an impairment rating did not use the AMA Guides, the hearing officer should not require a party to present evidence that the AMA Guides were used when the doctor's assigned impairment rating is reported on a Commission prescribed TWCC-69 form." In the instant case, evidence was adduced at the hearing that Dr. C did not use the proper version of the AMA Guides in determining impairment. We have previously held that "only the February 1989 second printing of the third edition of the AMA Guides may be used in assessing an impairment rating." Texas Workers' Compensation Commission Appeal No. 92335, decided August 28, 1992; and Texas Workers' Compensation Commission Appeal No. 92074, decided April 8, 1992.

Section 410.202(c) provides that a party appealing the decision of the hearing officer must clearly and concisely rebut the hearing officer "on each issue on which review is sought." Section 410.204 provides that the Appeals Panel shall issue a decision that determines each issue on which review was requested. We have previously refrained from deciding the correctness of unchallenged legal conclusions. *See* Texas Workers' Compensation Commission Appeal No. 91048, decided December 2, 1991; and Texas Workers' Compensation Commission Appeal No. 92268, decided August 6, 1992. Thus we need not decide whether the hearing officer erred in concluding that the impairment rating assigned by Dr. C was invalid, under the circumstances present here, because he used an incorrect version of the AMA Guides nor whether she erred in deciding that Dr. C's impairment rating was invalid based on her conclusion. But, as we stated in Appeal No. 92268, *supra*, "[o]ur abstention from deciding the correctness of a matter not made an appealed issue does not imply our agreement, however." Since the hearing officer decided that Dr. C's impairment rating never became final based in part on her conclusion that Dr. C's impairment rating was invalid because he used the wrong version of the AMA Guides, which conclusion has not been appealed, there is no basis for determining that the underlying certification of MMI became final under Rule 130.5(e). *See*, e.g., Texas Workers' Compensation Commission Appeal No. 93377, decided July 1, 1993.

The decision of the hearing officer is affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Gary L. Kilgore
Appeals Judge