APPEAL NO. 93856

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act) (formerly V.A.C.S. Article 8308-1.01 *et seq*.). On September 2, 1993, a contested case hearing (CCH) was held in (city), Texas, with (hearing officer) presiding as hearing officer. The single issue to be determined was: what is the correct impairment rating? The hearing officer determined that the appellant, claimant herein, had a two percent impairment rating as assessed by the designated doctor and that the great weight of medical evidence was not contrary to the finding of the designated doctor.

Claimant contends that the hearing officer erred in not considering Texas Workers' Compensation Commission- (Commission) approved surgery subsequent to the designated doctor's impairment rating, and requests that we reverse the hearing officer's decision and render a decision in his favor. Respondent, carrier herein, responds that the decision is supported by the evidence and requests that we affirm the decision.

DECISION

The decision of the hearing officer is reversed and the case is remanded for further evaluation regarding claimant's postsurgery impairment.

The claimant agreed to a telephonic hearing and testified by telephone from (state). Claimant testified he was injured on (date of injury), when he "rolled an 18-wheeler (truck)" while in the course and scope of his employment. Claimant testified he sustained a herniated or ruptured disc at the L5-S1 level. Claimant testified that within a week he saw (Dr. R) on April 4, 1991, and had follow-up visits with Dr. R on April 26, 1991, and May 10, 1991. The record reflects that Dr. R, by Report of Medical Evaluation (TWCC-69) and narrative dated August 14, 1991, certified maximum medical improvement (MMI) on August 14, 1991, with zero percent impairment.

We would note there is a relative dearth of medical reports and records in evidence from which we could have reconstructed claimant's course of treatment. Claimant testified that he currently resides in (state) and that carrier has not made medical reports and records available to him. The next report in evidence is a report by (Dr. RH) which we take to be carrier's examining doctor. Dr. RH in a report dated February 22, 1993, recites claimant's history involving his accident, that claimant apparently sustained three fractured ribs in the accident, was in physiotherapy for six months and attempted to go back to work in early 1992. Dr. RH reports that in October 1992 claimant was examined by (Dr. G), who claimant said first found his ruptured disc. Apparently a lumbar MRI was done on October 6, 1992. Dr. RH, in a report dated April 9, 1993, interprets the October 1992 MRI as follows:

> There is decreased signal intensity and some narrowing of the disc at L5-S1 with associated central bulging projecting slightly to the left and minimally indenting the thecal sac. There is no apparent involvement of the emerging nerve root on either side.

Dr. RH, in his February 1993 report, goes on to state that claimant was seen by (Dr. D), an orthopedist, on November 24, 1992, and that Dr. D did a discogram and recommended lumbar disc surgery with fusion. Dr. RH goes on to recite claimant's then back complaints, the doctor's examination and concluded that claimant ". .. has suffered from a musculo-ligamentous strain of the lower back." Dr. RH saw ". . . no indication to recommend surgical intervention."

The parties agreed that MMI has been reached in that statutory MMI was attained on or about March 25, 1993. At some point, (Dr. DH) was apparently appointed as a Commission-selected designated doctor. Dr. DH, in an undated TWCC-69, stated:

> Patient injured back and went to company doctor.. (sic) Patient was treated by [Dr. G]. Was worked up and then was also seen by [Dr. D] and [Dr. H]. There was a question of need for surgery. Patient is now at statutory MMI.

Dr. DH cited as objective evidence of impairment "Lumbar strain, MRI on 10-6-92 negative, Decreased spine range of motion" and assessed a two percent whole body impairment rating.

The only medical evidence submitted by claimant at the CCH was Dr. D's report dated June 2, 1993. Dr. D, in this report, refers to an impairment rating of 22% on February 22, 1993. The circumstances of that rating are not clear. Dr. D's report in virtual entirety is as follows:

> As per the insurance's request, [claimant] underwent an impairment rating on February 22, 1993. It was subsequently submitted to the insurance company as well as TWCC on March 9, 1993. The results were that the patient would have reached MMI on March 25, 1993 with an impairment rating of 22 percent. The patient at this time was awaiting a dispute resolution appointment to consider surgery which was subsequently scheduled for May 13, 1993. The procedure was to be one level PLIF with posterolateral fusion at the L5-S1 level.
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> In the interim, the patient notified this office that he had been notified that he had another impairment rating appointment to be done at the Impairment Ratings Facts at 4203 Gardendale and it was to be done by [Dr. H] on April 29, 1993. It is my understanding that [Dr. H] gave the patient an impairment rating of 2 percent. I find that impairment rating unacceptable as the patient had not undergone surgery at that time and obviously it was not taken into consideration.
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> The patient initially had an impairment rating of 22 percent preoperatively, but postoperatively, he did obtain relief from the problems he was having pain wise. So at this time, I would give him a 10 to 12 percent impairment rating

and along with a 9 to 10 month temporarily totally disabled status from the date of surgery.

Claimant testified, and it is undisputed, that in accordance with a Commission Medical Review Division Order, which found "extenuating circumstances" and ordered payments for reasonable and necessary costs related to the spinal surgery, claimant had spinal surgery on May 13, 1993. Claimant also testified he would likely be required to undergo another operation because of a recently discovered spur or bone splinter which is impinging on his spinal column. Carrier, in argument at the CCH, conceded that "obviously claimant is going to have impairment after surgery . . ." but somehow states this is a condition caused by the surgery rather than the initial injury. Claimant's argument is that he has had Commission-approved spinal surgery after the designated doctor's evaluation, and that fact rebuts the designated doctor report's presumptive weight.

The hearing officer accepted the designated doctor's rating and in essence appears to disregard the Commission-approved spinal surgery. Claimant appealed and submitted an additional report from Dr. D, dated November 24, 1992; a report from (Dr. GD), who claimant characterizes as a "TWCC referred . . . tie breaker," dated April 28, 1993; an undated report of (Dr. C), a psychiatrist who is co-director of the University of Texas Health Science Center at (city), Eating Disorder Program, and who examined claimant on March 22, 1993; and the Findings and Decision of the Commission Medical Review Division Spinal Surgery Dispute Resolution, dated May 4, 1993.

The medical reports and Commission order approving surgery submitted by claimant with his appeal cannot be considered. We have previously held that our review is limited to the record developed at the hearing (Section 410.203(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* 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 in his appeal as to why the reports were not submitted at the hearing. We do note that the reports were all dated some months before the CCH; however, claimant testified he had not been provided copies of the reports which appear to have been sent to carrier and, at least in Dr. D's report, to claimant's (city) address. There was testimony regarding the Commission order for spinal surgery and that the surgery was performed shortly thereafter.

This case shares some similarities with Texas Workers' Compensation Commission Appeal No. 93336, decided June 16, 1993. In that case the claimant was a candidate for surgery and testified that he intended to have surgery pending another doctor's recommendation. In the instant case, Dr. D, in the only report in the record from Dr. D, notes that on March 25, 1993 (the date the parties agreed was the date of statutory MMI), "[t]he patient at this time was awaiting a dispute resolution appointment to consider surgery which was subsequently scheduled for May 13, 1993." The designated doctor in an

undated TWCC-69 (apparently completed sometime before the Commission order approving surgery) notes "[t]here was a question of need for surgery" but assesses an impairment rating of two percent. Clearly a dispute regarding the necessity of surgery was in the process of being resolved by the Commission on the date of statutory MMI. The Commission approved surgery in early May 1993, and the surgery was performed on May 13, 1993. All of this information, including testimony that the designated doctor had made his impairment evaluation prior to surgery and thus had not considered surgery, was available to the hearing officer at the CCH. The hearing officer disregarded the fact that the Commission Medical Review Division had approved spinal surgery and stated "[a]ll doctors but [Dr. D] felt surgery was not indicated. . . ." Obviously, the Commission in approving surgery considered at least two doctors who recommended surgery. The hearing officer's findings and conclusions totally omit any mention of the fact that Commission-approved surgery had been performed. In Appeal No. 93336, surgery had not yet been performed but "had proceeded beyond mere speculation . . . and a medical review order had been issued requiring the carrier pay for surgery" as was the circumstance in the instant case. We held in Appeal No. 93336 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 . . . impairment may have changed because of the surgery." On the same ground we remand this case for the further development of the evidence to determine whether (and, if so, to what degree) the designated doctor's rating may have changed because of the surgery. We would observe that it would have been within the hearing officer's authority to have had the claimant reevaluated by the designated doctor after the surgery. We also note that claimant's postsurgical lesion would have constituted medical evidence contrary to the designated doctor's opinion. For example, the Guide to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association, at Table 49, provides for seven percent impairment for a surgically treated lumbar disc lesion with no residual symptoms.

We would also emphasize that the record appears to indicate that the question of surgery was not being raised by claimant for purposes of delay or to prolong or prevent resolution of the issue of impairment. In fact, as the hearing officer comments, claimant suggested that the Commission had not been as diligent as it should have been in the prosecution of his case. Claimant seems to indicate that the question of surgery had been raised in latter 1992 and was an ongoing issue at the time of statutory MMI. According to the claimant's unrefuted testimony, the Commission order approving spinal surgery was issued some six weeks after statutory MMI and claimant suggests it would be incongruous to now say because the Commission has delayed obtaining a third opinion and approving surgery until after the statutory MMI date that claimant is precluded from requesting that the impairment rating include the results of the Commission-approved surgery. Finally, as we said in Appeal 93336, nothing in this decision should be viewed as a retreat or change from earlier holdings acknowledging the special consideration accorded to 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 issue of impairment in light of claimant's Commission-approved 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 Texas Workers' Compensation Commission's division of hearings, pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Thomas A. Knapp
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Gary L. Kilgore
Appeals Judge