APPEALS PANEL NO. 94025
FILED FEBRUARY 16, 1994

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § *et seq*. (1989 Act). On December 13, 1993, a contested case hearing was held in (City), Texas, with _____ presiding. The issues presented for resolution were:

1. Whether the Claimant has reached maximum medical improvement from his compensable injury of (Date of Injury), and if so, when?

2. What is the Claimant's correct impairment rating?

The hearing officer determined that the appellant, claimant herein, reached statutory maximum medical improvement (MMI) on January 7, 1993, and that the designated doctor's impairment rating (IR) of 11% was entitled to presumptive weight and was not contrary to the great weight of other medical evidence.

Claimant contends that the designated doctor's report and IR are "invalid as a matter of law," that the IR assessed by the designated doctor was defective and contrary to the great weight of medical evidence. Claimant requests that we reverse the hearing officer's decision and render a decision that claimant "be awarded 100% permanent impairment." (Respondent), a self-insured governmental entity, (City) herein, responded that the decision is supported by the evidence and requests that we affirm the decision.

DECISION

The decision of the hearing officer is affirmed.

The circumstances of the claimant's injury are not particularly relevant in that there is no dispute as to a compensable injury. Claimant injured his back, apparently working with a 55 gallon "trash can." Claimant testified that he saw (Dr. E) the same day and was treated for a lumbosacral strain. Claimant was subsequently referred to (Dr. B) a neurosurgeon who opined that back surgery was not necessary at that time and released claimant to work. Claimant testified he was unable to work because of pain and saw (Dr. S) for a second opinion regarding back surgery. Claimant said Dr. S prescribed physical therapy. Claimant then saw (Dr. O), who became claimant's treating doctor. Dr. O recommended back surgery and claimant subsequently saw (Dr. H), apparently for another opinion on spinal surgery. Dr. H felt spinal surgery was not warranted and claimant was sent to (Dr. Se) as the Texas Workers' Compensation Commission (Commission) selected designated doctor. Claimant was also seen by (Dr. Bl) a City Medical Examination Order (MEO) doctor.

Dr. O, claimant's treating doctor in a report dated February 11, 1992, recited claimant's history, and noted "the x-rays are normal and the MRI does show a little bulging at the 4-5 disc space. I do not think there is anything significant to the L3-4 changes." Dr. O's impression, at that time was "[c]entral disc protrusion, L4-5." Dr. O commented "I

would have no qualms about doing a simple discectomy . . . a fusion might be considered but at this point I would be inclined to pass on that the first time around." A subsequent progress note dated 2-18-92 reported no significant change from the February 11, report. A progress note of 3-17-92 states, "central disc protrusion and degeneration at L3-4 and to a lesser extent some internal disruption of the L4-5 disc . . . . I do not think we should get into a fusion at this point . . . simple discectomies at 3-4 and possible 4-5 will do the trick." A note dated 4-8-92 indicated claimant was seeing Dr. S who wrote "a very excellent and long and thorough dissenting opinion about [claimant's] surgery . . . ." A note of 4-21-91 refers to Dr. B. Dr. O by Report of Medical Evaluation (TWCC-69) and note dated 9-8-92 certified that MMI is "undetermined," assesses a 100% IR, and states "[p]atient cannot return to work, cannot get the treatment he needs therefore, his impairment rating is 100%." Dr. O's note states "[a]s usual . . . was not available and my efforts to communicate with anyone else yielded nothing but perfunctory excuses in yet another senseless diatribe about what the law was. This poor devil [claimant] has now been jacked around by the system for over six months since I rendered a perfectly good and valid opinion of what should be done."

Dr. B, the neurosurgeon, in a May 2, 1991, report recommended "an EMG" and stated "the appropriate operation would be an anterior interbody discectomy and fusion of L3-4 and L4-5, which is a major, big-time, back operation, that I am not sure his symptoms justify." In Dr. B's records is a letter from Dr. O, dated April 21, 1992, where Dr. O urges "I do not think he needs a fusion . . . but a simple discectomy at 3-4 and 4-5." Dr. B writes to Dr. O, by letter dated 30 April 1992, "I totally agree with you that there is certainly surgical indication for a discectomy at L3-4 as well as L4-5."

Dr. H, by report dated September 22, 1992, rendered an opinion "regarding the admissibility of elective lumbar spine surgery." Dr. H indicated he had available the notes of Dr. O, Dr. B and a second surgical opinion from Dr. S. Dr. H reviewed myelograms, CT, discograms, post discogram CT and two MRIs. Dr. H stated claimant "may well need a fusion at L3-4. I realize this would be a floating fusion and may not be all that effective from the posterior and this may even be a rare case where anterior lumbar fusion is indicated." Dr. H states he does not believe operating on claimant's "discs from the right side at L3-4 and L4-5 are apt to be of any lasting benefit." Dr. H recommended "some sort of lesser form of work . . . ."

Dr. Bl, the City's MEO doctor by TWCC-69 dated March 12, 1993, certified MMI on 2-1-93 with a 16% IR with a detailed report how he arrived at the IR. Dr. Bl's assessment is "[p]ost-traumatic lumbosacral spine pain radiating to the right posterior lower extremity down to the knee level . . . degenerative disc at L3-4, L4-5 . . . ."

Dr. Se was appointed as a Commission selected designated doctor by letter dated May 27, 1993, to determine "[p]ercentage of impairment only." Dr. Se by TWCC-69 and narrative report dated June 16, 1993, assessed an 11% IR. In a four page narrative report, Dr. Se recited claimant's medical history, Dr. Se's examination results, recited that he (Dr. Se) has reviewed claimant's medical records, including MRIs, and recited that he used the

"1989 AMA Guidelines, Third Edition, Second Printing" using enumerated charts and tables. Dr. Se concludes claimant "has a disc at L3-4 and L4-5. I too, recommend that he undergo surgical intervention in terms of laminectomy, diskectomy, and a spinal fusion." Nonetheless Dr. Se assessed an "11% whole body impairment to the lumbar spine."

The hearing officer determined that there was no showing Dr. Se failed to use the "AMA's Guides to the Evaluation of Permanent Impairment, Third Edition (Second Printing, 1989)" (AMA Guides) or that there was any defect in Dr. Se's report. The hearing officer determined claimant reached statutory MMI on January 7, 1993, with an 11% IR, accorded Dr. Se's opinion presumptive weight, finding the great weight of other medical evidence was not contrary to that of the designated doctor's opinion.

Claimant contends that the designated doctor's report "is invalid as a matter of law" pointing to the claimant's testimony that he cannot "bend, lift or stoop and that he is in constant pain which reduces his ability to be gainfully employed." Claimant emphasizes Dr. O's opinion and report which states that since claimant "cannot return to work, cannot get the treatment he needs, therefore his impairment rating is 100%." First of all we note that Dr. O, apparently in a sense of frustration, assigned an impairment rating based on claimant's ability to return to work rather than the AMA Guides. Section 408.124 provides:

> (a) An award of an impairment income benefit, whether by the commission or a court, shall be made on an impairment rating determined using the impairment rating guidelines described in this section.
>
> (b) The commission shall use for determining the existence and degree of an employee's impairment"Guides to the Evaluation of Permanent Impairment," third edition, second printing, dated February 1989, published by the American Medical Association. [Citation omitted.]

There is no evidence that Dr. O used the AMA Guides in arriving at his IR, and, in fact, the language of his reports would indicate the rating was made in frustration based on claimant's inability to return to work. Certainly Dr. O's 100% IR does not outweigh the opinion of Dr. Se who recited and specified that he used the AMA Guides. Claimant further recites the opinions of Dr. B and Dr. H as supporting the 100% IR, however, we note neither Dr. B nor Dr. H assigned an IR based on the AMA Guides. Dr. B's and Dr. H's opinions dealt with whether claimant should have spinal surgery, which was not an issue which the hearing officer was authorized to resolve. Consequently those opinions, which may or may not have been considered by the hearing officer, certainly do not constitute the great weight of the other medical evidence contrary to the designated doctor's opinion. In that they gave no IR the reports may even be in agreement with the opinion of the designated doctor.

Claimant further urges that he was unable to subpoena the designated doctor, that Dr. Se does not specify what tests were used to determine range of motion, and that the report fails to state a date of MMI "whether statutory or actual." We disagree with

claimant's contention that the designated doctor's rating does not comply with the AMA Guides. Dr. Se specifically stated he used the correct version of the AMA Guides and specified the tables and charts used to compute his rating. Dr. Se was appointed to determine "[p]ercentage of impairment only" as statutory MMI had already occurred. We find no error that, under these circumstances, the designated doctor did not volunteer an MMI date when he was not asked for one. Nor do we find error that the designated doctor did not specify to the claimant's satisfaction the exact type of tests that he used. Finally on this point, regarding the fact that the hearing officer failed to subpoena Dr. Se, Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE §142.13(f) (Rule 142.13(f)) provides that a hearing officer may grant a party permission to conduct discovery beyond that described upon a showing of good cause. Claimant had been afforded the opportunity to depose Dr. Se by written questions but apparently chose not to do so on economic grounds. Both a prior hearing officer on a request to subpoena Dr. Se and the hearing officer at the CCH concluded that claimant failed to establish that the information claimant sought could not be obtained through a deposition by written questions or that there was other good cause. A determination of good cause is within the sound discretion of the hearing officer and should be set aside only if the discretion is abused. Morrow v. H.E.B., 714 S.W.2d 297 (Tex. 1986). To determined whether there has been an abuse of discretion, the reviewing court must look to see if the judge below acted without reference to any guiding rules and principles. Texas Workers' Compensation Commission Appeal No. 93810, decided October 26, 1993. We find the hearing officer did not abuse his discretion, under these circumstances in refusing to issue a subpoena for the designated doctor.

Lastly the claimant argues that the IR of the designated doctor is contrary to the great weight of medical evidence and clinical objective findings, citing Dr. O's "clear and convincing medical proof that the appropriate [IR] to be given the claimant is 100% . . . ." Again we note there is no indication that Dr. O used the AMA Guides nor any other objective clinical findings. We do note, as does the City, that Dr. O in his TWCC-69 did not complete block 17 which requires that if the impairment rating is 5% or greater, "list specific body part/system and rating." Section 408.125(e) provides that the report of a designated doctor, selected by the Commission "shall have presumptive weight . . . unless the great weight of the other medical evidence is to the contrary." (Emphasis added.) Further we have on more than one occasion noted the unique position that the designated doctor's report occupies under the Texas Workers' Compensation system. Texas Workers' Compensation Commission Appeal No. 92255, decided July 27, 1992; Texas Workers' Compensation Commission Appeal No. 92275, decided August 11, 1992; Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Similarly, we have observed that no other doctor's report, including a report of a treating doctor, is accorded this special presumptive status. Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992; Appeal No. 92412, *supra*. To overcome the presumptive weight requires more than a mere balancing of the evidence or even a preponderance of the medical evidence. Appeal No. 92412, *supra*. We find no error in the hearing officer's determination according Dr. Se's report presumptive weight and finding that the designated doctor's IR is not contrary to the great weight of other medical evidence.

Having reviewed the record, we find no reversible error and sufficient evidence to support the hearing officer's factual determinations. In considering all the evidence in the record, we find that the decision of the hearing officer is not so against the great weight and preponderance of the evidence as to be manifestly wrong and unjust. In re King's Estate, 244 S.W.2d 660 (Tex. 1951).

The decision and order of the hearing officer are affirmed.

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Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Stark O. Sanders, Jr.
Chief Appeals Judge

_____
Alan C. Ernst
Appeals Judge