APPEAL NO. 94042
FILED FEBRUARY 22, 1994

On December 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 issues at the hearing were: (1) whether the respondent (claimant) timely disputed the findings of (Dr. H) relating to maximum medical improvement (MMI) and impairment rating; (2) whether the claimant has reached MMI; and (3) the impairment rating. The hearing officer determined that the claimant timely disputed Dr. H's findings; that the claimant has not reached MMI; and that the claimant's impairment rating cannot be determined because he has not reached MMI. The appellant (carrier) disagrees with certain findings of fact and conclusions of law and requests that we reverse the hearing officer's decision and render a decision in its favor. No response was filed by the claimant.

DECISION

The decision of the hearing officer that the claimant has not reached MMI and that an impairment rating cannot be determined is reversed, and a decision is rendered that the claimant reached MMI on September 10, 1993, with a six percent impairment rating as reported by (Dr. O), the second designated doctor chosen by the Texas Workers' Compensation Commission (Commission).

The claimant testified that on (date of injury), he was working as a floor hand on an oil rig for the employer, (Employer), when he was involved in a series of accidents which resulted in pain in his right hand, right arm, and neck. He was seen by several doctors, and then chose Dr. H as his treating doctor. According to a radiology report, an MRI scan of the claimant's cervical spine done on July 23, 1992, demonstrated "minimal central fullness of the C6-7 disc" with no lateral recess, foraminal abnormality, or cord compression. Other features of the MRI were noted to be normal for the claimant's age group.

In December 1992, Dr. H reported that the MRI scan of the cervical spine showed a "disc herniation at C6-7" and that a discography also showed an "abnormal disc" at the C6-7 level. Dr. H said that facet blocks at C4-5 and C5-6 seemed to relieve some of the claimant's symptoms, and recommended a facet block at C6-7. Dr. H said he didn't know whether the claimant had multi-level disease or just a single herniated disc and did not know whether surgery would be required. At Dr. H's recommendation, the claimant undertook a four-week program at a pain center and was discharged from the center on February 12, 1993. The discharge report stated that the claimant wanted to avoid surgery. The claimant has not had surgery.

In a Report of Medical Evaluation (TWCC-69) dated April 15, 1993, Dr. H certified that the claimant reached MMI on April 13, 1993, with an eight percent whole body impairment rating. The impairment rating was given for permanent impairment of the

cervical area. Dr. H reported that he had discussed "options" with the claimant. The claimant testified that Dr. H told him he would need surgery in two to 10 years. Dr. H was the first doctor to assign the claimant an impairment rating. The hearing officer's finding that the claimant timely disputed Dr. H's certification of MMI and impairment rating under Tex. W.C. Comm'n, TEX. ADMIN. CODE § 130.5(e) has not been appealed. The parties were unable to agree on a designated doctor so the Commission chose (Dr. C) as the designated doctor to determine whether the claimant had reached MMI, and if so, to assign an impairment rating.

On August 5, 1993, the Commission approved the claimant's request to change treating doctors to (Dr. G). Dr. G reported that he examined the claimant on August 25, 1993, and found that the claimant's symptoms were consistent with nerve root irritation. Dr. G ordered a "CT myelogram" to check for evidence of neural compression. He also noted that previous diagnostic tests had shown a "disc problem" at C6-7 and that the claimant had had a reasonable trial of conservative management and apparently had no significant improvement.

In a narrative report dated August 30, 1993, Dr. C, the first designated doctor selected by the Commission, reported that he had examined the claimant and diagnosed a disc herniation at C6-7 with right-sided C7 radiculopathy and "postural/myofascial dysfunction with resultant neck and right shoulder pain." In a TWCC-69 attached to the narrative report, Dr. C reported that the claimant had not reached MMI and gave an estimated date of MMI of November 12, 1993. In his narrative report, Dr. C stated:

> I do not believe that this patient is not ["not" is the word used in the narrative report] at maximal medical improvement. It is my opinion that he [claimant] should complete his workup as scheduled by [Dr. G] including CT/ myelography scheduled for today. Although the patient had positive facet blocks at C4-5 and C5-6, he has definite evidence by history and physical and radiographic studies of a C7 radiculopathy on the basis of C6-7 disc disease. I would recommend selective nerve root blockade at the C7 level on the right.

In another narrative report also dated August 30, 1993, Dr. C stated everything that he stated in the narrative report attached to the TWCC-69, except that the first line of the foregoing paragraph is changed to read: "I do not believe that this patient is yet at maximal medical improvement" and the following two sentences are added at the end of the foregoing paragraph:

> This would be useful both diagnostically and possibly therapeutically. Should the patient have a significant reduction in pain with this procedure, then consideration should be given for anterior cervical diskectomy and fusion.

No explanation was given at the hearing for the differences in Dr. C's narrative reports which appear to be copies of the same report except for the different language

noted above. It may be that Dr. C discovered the double negative used in the report attached to the TWCC-69 and issued a corrected report with some added language. The claimant said he had never seen Dr. C before the examination of August 30, 1993.

In a report dated September 10, 1993, Dr. G, the claimant's second treating doctor, reported that the CT myelogram, which was done on August 30, 1993, did not reveal any significant neural compression and that the only abnormality found was a "mild disc protrusion" at C6-7 with no evidence of neural compression. Dr. G further reported that when he examined the claimant on September 9th, the claimant continued to complain of neck pain and intermittent paresthesias in both arms. Dr G stated:

> The severity of his [claimant's] symptoms does not correspond to the abnormality noted at C6-7 and since there are no neurological deficits and since there is no evidence of neural compression on the CT myelogram, I don't think that it is a good idea to have any surgical procedure performed at this time. If he develops progressive neurological deficits such as progressive radiculopathy or myelopathy then this would be a different condition and this may require operative intervention.
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> I explained to him that since his symptoms have been with him for some period of time, I think that he has reached maximum medical improvement and that he might want to think of returning to work in some capacity that is tolerated by him. It is also recommended that he sees [Dr. C] for continued care and treatment medically. I explained to the patient that I am unable to help him and that I do not recommend any surgery at this point. Referral to a pain clinic would be the next step and then a functional capacity assessment with impairment rating.

On September 24, 1993, the Commission approved the claimant's request to change treating doctors to Dr. C, who had previously rendered an opinion in his status as a designated doctor that the claimant had not reached MMI. At the hearing, the claimant testified that he has been treating with Dr. C since his request was approved and that he last saw Dr. C on November 24, 1993, when Dr. C gave him an injection at the C6-7 level which the claimant described as a nerve block. The claimant said that since the injection he has not had pain in his right arm, and also said that Dr. C plans to give him three more injections. The claimant further testified that he continues to have pain in his neck and under his right shoulder blade.

The parties agreed that a benefit review conference (BRC) was held on October 12, 1993, to consider the issues of MMI and impairment rating. The carrier said that the 90-day dispute provision in Rule 130.5(e) was also considered in regard to Dr. H's TWCC-69 which reported an MMI date of April 13, 1993, with an eight percent impairment rating. The parties also agreed that the benefit review officer (BRO) selected (Dr. O) to be the second designated doctor. No testimony was given concerning why the BRO chose a second designated doctor nor was there any testimony as to whether the selection was made at

the BRC or at a later time.

According to statements made by the hearing officer at the hearing, no BRC report was ever completed for the BRC. No explanation appears of record as to why a BRC report was not completed. The hearing officer stated that on his instruction a BRC report was made the day of the hearing. The report, which contains the usual information concerning date of injury, type of injury, etc., was admitted into evidence. However, the two disputed issues forms attached to the report only recite that one issue was MMI and the other issue was impairment rating. Nothing is written on the disputed issue forms concerning the claimant's position, the carrier's position, documents considered, witness statements, medical reports, or the BRO's recommendations, and the BRC report and disputed issue forms contain the typed name of the BRO but the report and forms are not signed. In other words, the BRC report in evidence sheds no light on why the BRO selected a second designated doctor.

By letter dated October 18, 1993, a Commission disability determination officer notified the parties that pursuant to Rule 130.6 (Designated Doctor: General Provisions) the claimant was being ordered to attend a medical examination with Dr. O on November 1, 1993, for the purpose of determining MMI and impairment rating. The claimant testified that he did see Dr. O but did not give a date. In a TWCC-69 dated November 10, 1993, Dr. O certified that the claimant reached MMI on September 10, 1993 (as previously noted, in a report dated September 10, 1993, Dr. G had stated that the claimant had reached MMI) with a six percent impairment rating. In an attached narrative report addressed to the BRO, Dr. O stated that he agreed with Dr. G's "MMI date of 10/9/93 (sic)," but at the end of the report stated "I would agree with the MMI date of 9/10/93. Documentable findings show a 6% impairment rating."

In its appeal, the carrier disagrees with the following findings of fact and conclusions of law:

FINDINGS OF FACT

9. It was not necessary or proper to select a second designated doctor, based on the facts in this case, and the findings of the second designated doctor are not entitled to presumptive weight.

10. The report of the original designated doctor, [Dr. C], is entitled to presumptive weight. In order to disregard the findings of the designated doctor the "great weight of the other medical evidence" must be to the contrary.

11. The findings by [Drs. H, G, and O] are insufficient to overcome the presumptive weight afforded to the findings of [Dr. C].

12. The claimant's impairment rating may not be determined until he has reached [MMI].

CONCLUSIONS OF LAW

3. The claimant has not reached [MMI].

4. The claimant's impairment rating cannot be determined at this time since he had not reached [MMI].

5. The "great weight of the other medical evidence" is not sufficient to overcome the presumptive weight afforded to the original designated doctor's opinion.

The carrier argues that Dr. O was a properly appointed second designated doctor and that his findings on MMI and impairment rating should have been given presumptive weight. While the carrier acknowledges that there is no evidence in the record as to why the BRO appointed a second designated doctor, it contends that it is fair to presume that the BRO was confronted with new medical evidence in the form of the September 10, 1993, report of Dr. G and that the BRO wanted that evidence reviewed by the designated doctor. The carrier points out that when Dr. C found that the claimant was not at MMI on August 30, 1993, Dr. C recommended that the claimant undergo the CT myelogram scheduled that day by Dr. G. The carrier further points out that according to the September 10, 1993, report of Dr. G, the CT myelogram revealed no significant neural compression with only a mild disc protrusion at C6-7, that Dr. G reported that the claimant's symptoms did not correspond to the findings of the CT myelogram, and that Dr. G, who was the claimant's second treating doctor, stated that the claimant had reached MMI. Since by time of the BRC, Dr. C had become the claimant's third treating doctor, the carrier contends that the BRO had to appoint another designated doctor in order to have the new medical evidence reviewed by a designated doctor. In the alternative, the carrier contends that the great weight of the medical evidence is contrary to Dr. C finding of no MMI. The hearing officer stated in the Statement of the Evidence portion of his decision that at the conclusion of the BRC, the BRO felt that a second designated doctor must be appointed since the original designated doctor had started treating the claimant. The hearing officer then found that, based on the facts of the case, it was not necessary or proper to select a second designated doctor and that the findings of the second designated doctor are not entitled to presumptive weight.

The 1989 Act provides that where a designated doctor is chosen by the Commission, the report of that doctor shall have presumptive weight and the Commission shall base the determination of MMI and the determination of impairment rating on that report unless the great weight of the medical evidence is to the contrary. Sections 408.122(b) and 408.125(e). No other doctor's report, including that of a treating doctor, is entitled to the presumptive weight accorded the report of the designated doctor. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. To overcome the presumptive weight accorded to the report of the designated doctor requires more than a preponderance of the medical evidence; it requires the great weight of the

other medical evidence to be contrary to the report. Appeal No. 92412, *supra*.

No one has contended at any point in these proceedings that Dr. C, the initial designated doctor, was not properly appointed by the Commission to serve as the designated doctor to determine MMI and impairment rating. In Texas Workers' Compensation Commission Appeal No. 92240, decided July 20, 1992, we stated that we were not aware of any provision in the 1989 Act which would prohibit a designated doctor from continuing to provide treatment to an employee. And, in Texas Workers' Compensation Commission Appeal No. 931047, decided December 28, 1993, we affirmed a hearing officer's decision which gave presumptive weight to the report of a designated doctor who determined that the employee had not reached MMI, and who later on became the claimant's third treating doctor. Thus we conclude that Dr. C's opinion of August 30, 1993, that the claimant had not reached MMI (as reported in the TWCC-69) is entitled to presumptive weight unless his opinion is contrary to the great weight of the other medical evidence.

We hold that Dr. C's opinion that the claimant had not reached MMI is contrary to the great weight of the other medical evidence. That part of the definition of MMI which applies to the facts of this case is "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated." Section 401.011(30). Dr. H, the claimant's first treating doctor reported that the claimant had reached MMI on April 13, 1993. Dr. G, the claimant's second treating doctor, reported on September 10, 1993, that the claimant had reached MMI, that the severity of the claimant's symptoms did not correspond to the findings of the CT myelogram, and that there was no evidence of significant neural compression. And finally, Dr. O opined that the claimant had reached MMI on September 10, 1993, and that further treatment would not be effective. Against the opinions of these three doctors is the opinion of Dr. C who noted that the claimant had continuing complaints of pain and prescribed nerve root blocks.

We note that when Dr. C certified that the claimant had reached MMI on April 13, 1993, he reported that the claimant had had facet blocks and that the claimant had continuing complaints of pain. We have observed in prior decisions that MMI does not mean there will not be a need for some further or future medical treatment and that the need for additional or future medical treatment does not mean that MMI was not reached at the time it was certified. Likewise, we have held that pain is not, in and of itself, an indication that MMI has not been reached and that a person assessed with a permanent impairment may continue to experience some pain as a result of an injury. *See* Texas Workers Compensation Commission Appeal No. 93489, decided July 29, 1993. Having reviewed the record, we conclude that the great weight of the medical evidence is contrary to Dr. C's opinion that the claimant had not reached MMI. We wish to make it abundantly clear that simply because an injured employee has reached MMI does not mean that the employee is not entitled to additional medical benefits. Under Section 408.021(a), an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.

The next question is what to do with the report of Dr. O, whom the Commission appointed as the second designated doctor. In Texas Workers' Compensation Commission Appeal No. 93045, decided March 3, 1993, we stated that the "need or desirability for the Commission to select a second designated doctor should be very limited and restricted to a situation such as, for example, where an initially appointed doctor cannot or refuses to comply with the requirements of the 1989 Act." The use of a designated doctor is intended under the 1989 Act to assign an impartial doctor to resolve disputes over MMI and impairment rating. Texas Workers' Compensation Commission Appeal No. 92650, decided January 20, 1993. As we stated in Texas Workers' Compensation Commission Appeal No. 92495, decided October 28, 1992, "it is imperative that . . . full confidence is maintained in the position of the designated doctor." Finally, we observe that in Texas Workers' Compensation Commission Appeal No. 92570, decided December 14, 1992, we reversed the determination of a hearing officer which invalidated the designated doctor's impairment rating and adopted the impairment rating of the treating doctor. We remanded the case for further consideration and development of the evidence, including affording the designated doctor an opportunity to consider the results of an EMG study which had been conducted after he had done his examination, and affording the designated doctor the opportunity to amend his impairment rating. In Appeal No. 92570, *supra*, we stated:

> Resolution of questions of MMI and impairment should not be indefinitely deferred to an open-ended series of testing. *See* Texas Workers' Compensation Commission Appeal No. 92275, decided August 11, 1992. Recognizing this, we nevertheless remand to allow the designated doctor the opportunity to consider the impact, if any, of the EMG test report on his impairment rating. The Commission should assure such is done expeditiously.

In the instant case, Dr. C, the initial designated doctor, reported that the claimant had not reached MMI, but recommended that the claimant go forward with the CT myelogram. Dr. G, the claimant's second treating doctor, then had the CT myelogram performed and found that the claimant's symptoms were not consistent with the findings of that diagnostic test and reported that the claimant had reached MMI. By the time of the BRC, Dr. C had become the claimant's treating doctor. There is no evidence of whether or when Dr. C was furnished a copy of the results of the CT myelogram or a copy of Dr. G's report which was written after Dr. C made his report. Under our decision in Appeal No. 92570, it would have been appropriate for the BRO to send Dr. C the results of the CT myelogram and Dr. G's letter so that Dr. G would have an opportunity at the earliest possible time in the dispute resolution process to review them and reconsider his opinion on MMI in light of them. However, at the time of the BRC, Dr. C was the claimant's treating doctor. We think it clear that a doctor cannot function as a designated doctor and as a treating doctor <u>at the same time</u> and maintain the status of an impartial designated doctor.

Confronted with the fact that the initial designated doctor was now a treating doctor

so that his opinion on MMI after he became a treating doctor would not be that of an impartial designated doctor, together with the fact that diagnostic testing had been done after the initial designated doctor had rendered his opinion and the fact that the second treating doctor had opined that the claimant had reached MMI based in part on that test, we conclude that it was appropriate for the BRO to appoint a second designated doctor. We observe that Dr. O, the second designated doctor, specifically refers to Dr. G's MMI date of September 10, 1993, so that it can reasonably be inferred that Dr. O was sent Dr. G's letter of September 10, 1993, which reviewed the results of the CT myelogram.

In this case, it would have been appropriate for the Commission to ask the initial designated doctor to review the new, material medical evidence which the initial designated doctor may not have previously had an opportunity to review. However, the initial designated doctor had become the treating doctor, thereby stymieing the dispute resolution process. We think it clear that simply because the designated doctor becomes the claimant's treating doctor should not prevent the Commission from going forward with its responsibility to have disputes resolved in a timely, impartial, and fair manner and in accordance with the provisions of the 1989 Act and rules of the Commission.

Having reviewed the record, we further conclude that the great weight of the other medical evidence is not contrary to Dr. O's report that the claimant reached MMI on September 10, 1993, with a six percent impairment rating. Both the first and second treating doctors agreed that the claimant had reached MMI. The only other impairment rating was the eight percent assigned by Dr. H. We observe that the second designated doctor found MMI had been reached at a date subsequent to the date of the no MMI opinion of the first designated doctor.

The hearing officer's decision that the claimant has not reached MMI and cannot be assigned an impairment rating is reversed, and a decision is rendered that the claimant reached MMI on September 10, 1993, with a six percent impairment rating as reported by Dr. O, the second designated doctor chosen by the Commission.

Robert W. Potts
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Thomas A. Knapp
Appeals Judge