APPEAL NO. 94201

At a contested case hearing held in (city), Texas, on January 20, 1994, the hearing officer, (hearing officer), took evidence on the two disputed issues, to wit: 1. Has the appellant (claimant) reached maximum medical improvement (MMI) and, if so, when; 2. If the claimant has reached MMI, what is the impairment rating (IR). Finding that claimant reached statutory MMI on February 9, 1993, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act), that the designated doctor appointed by the Texas Workers' Compensation Commission (Commission) properly certified that claimant's IR is 10%, and that the designated doctor's opinion was not overcome by the other medical evidence, the hearing officer concluded that claimant reached MMI on February 9, 1993, by operation of law, and that his whole body impairment is 10%. Claimant appeals only the IR determination. He asserts error in the designated doctor's having been provided with the report of another doctor which critiqued the designated doctor's report and led the designated doctor to revise his IR from 16% to 10%. The carrier cited several Appeals Panel decisions approving designated doctors' amendments of their reports under certain circumstances, stated that this was not a case of the carrier's engaging in "unilateral contact" with the designated doctor, and urged that the evidence was sufficient to support the hearing officer's IR determination.

DECISION

Affirmed.

Claimant testified that he was injured on (date of injury). There was no dispute concerning the compensability of his injury which the medical records indicated was a back injury sustained in a motor vehicle accident at work. The carrier called no witnesses but represented to the hearing officer that after the Commission-selected designated doctor,(Dr. H), issued his report in July 1993 assigning claimant an IR of 16% for a surgically treated disc (L3-4) and a disc herniation (L4-5), the carrier had the report reviewed by its doctor, (Dr. O), who opined that Dr. H had not correctly used the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). Carrier's letter to Dr. O of October 18, 1993, asked Dr. O to advise whether Dr. H properly utilized "Table 45" (sic) in the AMA Guides. Section 408.124 requires the Commission to use the third edition, second printing, February 1989 version of the AMA Guides to determine IRs. Claimant insisted that Dr. H told him he had used the "1990 edition" of the AMA Guides because the other edition was out of print. The hearing officer then telephoned Dr. H during the hearing and Dr. H stated he had used the third edition, second printing, dated February 1989.

Claimant took the position that he was never examined by Dr. O, that he had never seen Dr. O's report, and that the hearing officer erred in sending Dr. O's report to Dr. H for the latter's consideration since it led to Dr. H's changing claimant's IR from 16% to 10%. Claimant conceded he had signed the "green card" sending him Dr. O's report by certified mail but said he did not look at the correspondence. Apparently, the hearing was originally set for November 24,1993. The hearing officer stated that he continued the hearing, with

the parties' concurrence, to send Dr. H the report of Dr. O and obtain clarification from Dr. H concerning his report and the manner in which he used the AMA Guides. Claimant further testified that he should have Dr. H's first IR of 16%, with which he agreed, because he had sustained a "reherniated disc" for which he needed a second operation which the carrier denied, and because he has pain every day and is unable to return to his same job. Claimant conceded he had no medical training.

Dr H's Report of Medical Evaluation (TWCC-69), dated "07-19-93," indicated that claimant injured his lower back at work on (date of injury), and underwent "a lumbar decompression and hemilaminotomy at L3-4" by (Dr. Q) on March 12, 1991. Dr. H also stated that Dr. Q's surgery revealed "an L4 and L5 herniated nucleus pulposus as well."

Dr. Q's "Report of Operation" stated claimant's pre-operative diagnosis as "spinal stenosis L3 and L4, rule out herniated disk." Dr. Q's postoperative diagnosis was: "1. Spinal stenosis L3. 2. Herniated lumbar disk at L4. 3. Hypertrophied ligamentum flavum L3 and L4." Dr. Q reported that on "3/11/91" he performed surgery described as "lumbar hemilaminotomy at L3 and L4 with decompression of the L3 level on the left and excision of herniated lumbar disk at L4 only on the left." According to his report, Dr. Q decompressed the nerve root at the L3 level but did not excise the disc. He did excise the disc at the L4 level.

Dr. H's report stated that claimant reached MMI on "07/19/93" with an IR of 16% consisting of 10% for the "L3-4 disc surgery one level with residuals" and seven percent for the "L4-5 disc herniation." Dr. H assigned no impairment for abnormal range of motion (ROM) or for sensory deficit. Dr. H's letter of September 13, 1993, to the Commission stated that claimant had two herniated discs attributable to his (date of injury), injury; that the herniated disc at L3-4 was surgically treated and, pursuant to Page 73 II E of the AMA Guides, was assigned a 10% impairment; and that claimant's herniated disc at L4-5, which was not surgically treated but which was persistent and not a bulge, was assigned a seven percent impairment under the same provision.

The hearing officer wrote Dr. H on November 30, 1993, enclosing an "operative report" which, he said, "indicates surgery at two levels." The hearing officer also enclosed Dr. O's October 22, 1993, letter which, he said, suggested that Dr. H may not have properly used the required AMA Guides. The hearing officer asked Dr. H to "address these two matters, and indicate whether or not this changes your assessment of whole body impairment."

Dr. O's October 22, 1993, letter to the carrier stated that he reviewed Dr. H's report and disagreed with Dr. H; that claimant "may have had two disc injuries and if this is correct, 10% can be given for an operated level. The other level was not operated on, therefore, nothing can be given for that level." Dr. O went on to state: "Please look at Table 49 and note that the only way to give an impairment for more than one level is if it has been operated on. For example, if you had three bulging discs, unoperated and had facet arthropathy at all three levels, it would come under Heading 2-C and would get 7%. However, seven

percent cannot be given for each level. The only other time you can render more than one rating is when there is a surgical level." Dr. O went on to state that this situation was "debated extensively and was corrected in The Third Edition Revised Guides, so that if you had this particular case, you would give 10% for the surgical level and 1% for a second level that is unoperated. However, you would not give the full 7%." Dr. O concluded that the mandated version of the Guides "doesn't allow you to give any other level other than surgical levels" and noted that "this was corrected in The Third Edition Revised Guides."

Dr. H's January 17, 1994, letter to the hearing officer stated as follows: "[Dr. O] is correct on this rule. An additional 7% impairment for the non-operated herniated disc cannot be awarded when impairment is given for a surgically operated disc. As a result, an amended TWCC-69 form is attached." Dr. H's amended TWCC-69 stated that claimant's IR was 10% for "L3-4 disc surgery one level with residuals."

The 1989 Act, section 410.165(a) provides that the hearing officer is the sole judge of the weight and credibility to be given the evidence. It is for the hearing officer as the fact finder to resolve the conflicts and inconsistencies in the evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ).

We do not find error in the designated doctor's having amended his report under the particular circumstances of this case. We note with approval that, consistent with Appeal Panel decisions, the carrier's contact with the designated doctor was through the Commission and not unilateral. *Compare* Texas Workers' Compensation Commission Appeal No. 94237, decided March 31, 1994. The Appeals Panel has approved the amendment by a designated doctor of his or her report under proper and appropriate circumstances. *See e.g.* Texas Workers' Compensation Commission Appeal No. 93207, decided May 3, 1993; Texas Workers' Compensation Commission Appeal No. 93448, decided July 21, 1993.

We are satisfied that the hearing officer's determination that Dr. H's amended report was entitled to presumptive weight under Sections 408.122(b) and 408.125(e) was sufficiently supported by the evidence. Both Dr. H and Dr. O opined that claimant's IR was 10% under the statutory mandated version of the AMA Guides and there was no other medical evidence regarding claimant's IR. We will not disturb the hearing officer's findings unless they are so against the great weight and preponderance of the evidence as to be manifestly unjust and we do not find them to be so in this case. Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986); In re King's Estate, 244 S.W.2d 660 (Tex. 1951).

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Lynda H. Nesenholtz
Appeals Judge

Thomas A. Knapp
Appeals Judge