APPEAL NO. 94366

This appeal arises under the Texas Workers' Compensation Act of 1989, TEX. LAB CODE ANN. § 401.001 *et seq*., (1989 Act). On October 12, 1993, a contested case hearing was held in (city), Texas, with (hearing officer). presiding. He determined that respondent (claimant) reached maximum medical improvement (MMI) on April 11, 1993, with 18% impairment, that claimant had disability through the date of hearing so he was entitled to temporary income benefits (TIBS) through April 11, 1993, and that appellant (carrier) is not entitled to contribution. Carrier appeals the disability determination, as against the great weight and preponderance of the evidence; MMI, stating first that (Dr. C) was the agreed designated doctor and also because Dr. C found MMI earlier than did the appointed designated doctor; impairment rating (IR), because Dr. C's rating should be given presumptive weight or adopted and because (Dr. B), named as a designated doctor, did not properly apply the Guides for the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides); and contribution, because claimant had a prior compensable injury resulting in back surgery and the IR is based in part on "operative level." Claimant replies that the hearing officer should be affirmed.

DECISION

We affirm.

Claimant worked for (employer). He had worked for employer for 20 years (currently as a line foreman) when he was injured on (date of injury). Injury to his back occurred when claimant was moving some sheetrock with others and fell backwards. In 1975, claimant testified that he had a prior back injury with the same employer for which he received benefits, including surgery. Claimant testified, and provided two statements in support thereof, that his earlier injury had resolved and he did all his work for 15 years without limitation. At the time of the hearing, claimant testified that his condition in regard to the (year) injury was getting worse.

No records of the surgery in 1975 or any medical records or medical opinions regarding such injury or surgery prepared at the time were offered into evidence. One doctor's record ((Dr. H), dated July 9, (year), indicates that "[h]is past medical history is significant for a L5 vertebral bone spur removal in 1975, performed by [Dr. H]." The only other references to a specific area of the back are made in regard to MRI tests which are said to indicate enhancement which "could represent post-op scarring in this region," when referring to the L5-S1 area and the report of Dr. C, infra. One record that contains this reference to possible scarring is that of (Dr. S) who otherwise states that the claimant refers to his "lower back surgery," and does not say he reviewed any medical record pertaining to the surgery or the injury. Nevertheless, without specifying what the surgery in 1975 was for, and acknowledging that there now is "a herniated disc at L5-S1 on the left," Dr. S opines that claimant's injury of (year) will not result in any permanent impairment, but the pre-existing condition does result in "some partial permanent impairment." Dr. S's report was made after he examined claimant on behalf of the carrier on October 22, (year).

Thereafter, Dr. C examined claimant on April 23, 1992. He noted in regard to claimant, "[l]aminectomy and diskectomy in 1975." Dr. C refers to radiculopathies at L4-5 and S1, and also mentions tissue in the L5-S1 level that could be scar tissue "from previous surgeries." Dr. C did not return claimant to work. Dr. C, in April 1992, had also said in his report that claimant was confused because of the report of Dr. S as to impairment being caused only by the prior condition. Dr. C then states, "I believe that this is probably why the patient is being sent here for a second opinion." Dr. C did prepare a Report of Medical Evaluation (TWCC-69) dated August 18, 1992, which stated that MMI had been reached on August 4, 1992, with five percent impairment. At the hearing, claimant testified that he went to Dr. C after a benefit review officer (BRO) called Dr. C to make that appointment "for a reevaluation." Claimant could not recall that Dr. C was agreed by the parties to be the designated doctor, but claimant also acknowledged that he has problems with his memory. On behalf of the carrier, RS testified that the parties agreed at the benefit review conference (BRC) to have Dr. C resolve the case. Nothing was reduced to writing, and the BRO called Dr. C's office to make the appointment for claimant to be seen.

Next, by letter dated October 5, 1992, the Texas Workers' Compensation Commission (Commission) directed the claimant to see (Dr. B), who it referred to as "designated doctor" to determine MMI and IR. Dr. B first reported that claimant had not reached MMI. The Commission wrote to Dr. B in January 1993, forwarding additional medical records and referring to Dr. B's statement, when he had found that MMI was not reached, that more testing was needed. Then on February 23, 1993, a Benefit Review Conference Agreement (TWCC-24) stated that carrier and claimant, each with representation, stated that the issue was whether claimant had reached MMI and whether there was any disability. The agreement said the issue was resolved by certain payment of temporary income benefits (TIBS) "pending new report from designated doctor, " (Dr. B). On April 21, 1993, Dr. B issued another TWCC-69 which stated that MMI was reached on April 19, 1993, "by 104 weeks rule" with an IR of 19%. Thereafter, on July 13, 1993, claimant requested that the Commission approve Dr. B as his treating doctor; the Commission approved.

On December 19, 1993, the hearing officer wrote to Dr. B inquiring whether his April report which specified 19% IR had been obtained after using the Combined Value Chart of the AMA Guides. This letter also asked Dr. B about a matter that is not raised on appeal, listing of objective documentation of impairment. Dr. B replied on January 4, 1994, that the IR was 18%, per application of the Combined Value Chart.

Carrier attacks the finding that claimant has disability, but both Dr. C and Dr. B, the latter in a document dated August 4, 1993, said that claimant could not work. In addition, claimant was emphatic in testifying that he could not work, that he could not walk the distance or do the light janitorial activities of a security guard which PI employer had offered him. The finding of disability is sufficiently supported by the evidence.

The carrier's main arguments regarding MMI were that claimant was found to be at MMI by Dr. C, said to be an agreed designated doctor, and that claimant did not improve

after Dr. C found MMI in 1992. The evidence, including the Commission appointment of Dr. B, sufficiently supports the finding that Dr. B was appointed as the designated doctor. In addition, the carrier's evidence that Dr. C was an agreed designated doctor was not supported by either claimant, Dr. C, or any written instrument. As a result, the hearing officer did not err in finding that Dr. B was the designated doctor. It is argued that claimant did not improve after Dr. C found MMI had been reached. It is true that Tex W. C. Comm'n, 28 TEX. ADMIN. CODE § 130.4, when discussing a presumption used to invoke a procedure to determine MMI, uses language of a historical nature, "lack of medical improvement." We find nothing in the 1989 Act to indicate that because a claimant is getting worse, he must have reached MMI because he is not improving. *Compare* to Texas Workers' Compensation Commission Appeal No. 92628, decided January 4, 1993, in which MMI was reached when a medical report indicated the course of a claimant's future condition by saying, "clinical condition is not likely to improve with further active medical treatment or surgical intervention." In this case, the designated doctor found MMI only at the statutory time limit after earlier evaluating claimant and reporting that MMI had not been reached. The determination that claimant reached MMI in April 1993 is sufficiently supported by the evidence. (We note that the hearing officer set the date of MMI as April 11th, contrary to the date of April 19, 1993, stated by Dr. B.)

The carrier also questions the IR of Dr. B, but at the hearing did not contend that Dr. B improperly applied the Guides in determining that Table 49, Section II, allowed eight percent based on subsection C and F. At the hearing, carrier contended that IR should be reduced by seven percent for a surgically treated disc based on the 1975 surgery. It also contended that Dr. B should have specified objective tests that support impairment, which point it does not assert on appeal. It also calls to our attention the fact that after July 1993, Dr. B was the treating doctor of claimant.

We observe that Dr. B's only comment after becoming treating doctor, was to lower the IR from 19% to 18% based on the combined value chart. We do not recognize that Dr. B's change of status influenced his reply to the hearing officer in which he lowered claimant's IR. We will not disturb the 18% IR when the attack as to improper application of a subsection of Table 49 by the designated doctor is raised for the first time on appeal.

At the hearing, carrier argued that Dr. S found no impairment stemming from the (year) injury. Carrier also stated that numerous doctors were unable to determine whether the problem was from the prior surgery or from "some new bulge." While Dr. S attributed the impairment to a prior condition, he did not attribute it to the past surgery and did not mention having reviewed any medical records that described what that surgery was. *See* Section 408.084 which allows contribution "in a proportion equal to the proportion of a documented impairment that resulted from earlier compensable injuries." As a result, Dr. S's opinion only provides support for a contention that the (year) injury caused no impairment. In the other direction, Dr. B is partially looking at an area of the lower back, L4-5, that is not mentioned in any of the general references to what claimant's prior surgery may have been. (All references that relate to an area other than "lower back," refer to L5-S1 as the site of surgery.) *Compare* to Texas Workers' Compensation Commission Appeal

No. 93246, decided May 10, 1993, in which no impairment from the injury in question was found. The hearing officer was also correct in stating that the burden of proof was on the carrier to show the amount of contribution that should be applied. *See* Texas Workers' Compensation Commission Appeal No. 92610, decided December 30, 1992. There was no evidence, only argument, provided that Table 49 should be used to carve out a percentage allowed for a past surgery as the proportion to be allowed for contribution. The evidence sufficiently supported the determination that no contribution should be applied.

Finding that the decision and order are not against the great weight and preponderance of the evidence, we affirm the hearing officer's decision and order. *See* In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

Joe Sebesta
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Philip F. O'Neill
Appeals Judge