APPEAL NO. 950496
FILED MAY 15, 1995

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held on November 29, 1994, to determine whether the respondent (claimant) had disability after January 29, 1992; when claimant reached maximum medical improvement (MMI); and what was claimant's correct impairment rating (IR). The hearing officer closed the record on March 2, 1995, and issued her decision concluding that claimant had disability (Section 401.011(16)) from January 30 to April 5, 1992, from April 17 through August 25, 1992, and from September 26, 1992 to the present; that claimant reached MMI on July 6, 1993, by operation of law (Section 401.011(30)(B)); and that claimant's whole body IR is 16% based on the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission). The appellant (carrier) asserts on appeal the insufficiency of the evidence to support these determinations. The carrier further asserts that the hearing officer erred in failing to make a factual finding that the designated doctor originally certified that claimant reached MMI on May 27, 1992, with an IR of four percent; that the hearing officer erred in returning claimant to the designated doctor for re-evaluation after he had cervical spine surgery approximately one and one-half years after reaching statutory MMI and approximately two years and five months after the designated doctor first certified that he had reached MMI with a four percent IR; and that the hearing officer further erred in accepting the designated doctor's revisions. The carrier also asserts, in the alternative, that the hearing officer erred in failing to seek clarification of the designated doctor's report concerning "back up data" on claimant's cervical range of motion (ROM) impairment and in failing to obtain the designated doctor's opinion on MMI and IR, were the surgery not considered. No response was filed by the claimant.

DECISION

Reversed and remanded for reconsideration, based on the evidence of record, of the finding and conclusion regarding the date of disability.

It was undisputed that claimant sustained a compensable injury on _____. He testified that while operating a jackhammer he slipped on some oil on the floor of the pumphouse where he was working, that his head struck a wall and he felt a "major sting." He said he reported his injury the next day; that his employer sent him to Dr. E; that his neck was swollen and Dr. E indicated he would need to see some other doctor; and that he was next seen by Dr. WH who, he said, "just doped me up." No records from those doctors were in evidence. Claimant said he then sought treatment from Dr. KE, a chiropractor. Dr. KE testified that his initial diagnosis was cervical strain/sprain, which he treated conservatively. In an undated Report of Medical Evaluation (TWCC-69), Dr. E certified that claimant had reached MMI on "1/19/92" with an IR of "3%" and he conceded on cross-examination that he did not later file "a rescission" of that report. Dr. KE further stated in that TWCC-69 that claimant initially entered his care with Kyphotic cervical curve and head, neck and arm pain; that claimant has full neck mobility, cervical lordosis without

segmental fixations, mild infrequent headaches (which should resolve) and left volar hand pain; and that he has been released to return to work but subjective hand pain continues. Claimant testified that he returned to work for his employer approximately ten months following his injury after being released by Dr. KE, doing less heavy work, but that he kept having headaches and "terrible neck pain" and had to stop working. Claimant did not testify to the dates he returned to work and later stopped working.

Dr. MH, the designated doctor, examined claimant on May 27, 1992, and certified that he reached MMI on that date with an IR of "4%." Dr. MH reported that a nerve conduction study showed carpal tunnel findings and that a CAT scan showed a small bulge at C5-6. Dr. MH's report does not indicate that he reviewed any diagnostic test showing a herniated disc at C6-7.

Claimant testified that he again tried to work for the employer but that he could not continue to do so and was again laid off due to his condition. Again, he did not testify to the dates. He also stated that he had not worked for any other employer since his injury and indicated that he could not work when on medications because of their effects and, further, that he could not work when not on medications because "it was too much of a load" and he could not handle the responsibilities. He agreed with the cross examiner that he had no medical report stating he could not work between January 1992 and July 1993.

Claimant stated that he returned to Dr. KE because of his worsening condition but that he obtained only temporary relief from Dr. KE's treatments. Dr. KE's report of September 8, 1994, recounted that when he began treating claimant on July 24, 1991, an MRI of July 22, 1991, ordered by Dr. WH, noted a "small subligamentous central bulging disc . . . at C5-6;" that claimant's subjective symptoms reduced through the course of treatment; and that claimant "had reached a plateau of improvement in January 1992" so Dr. KE evaluated claimant for MMI and released him from active care, although claimant still had hypesthesia of the left C6 and C8-T1 dermatomes with pin prick. Dr. KE also reported that in February 1993 claimant reentered his care with intermittent episodes of left-sided neck pain, headaches, dizziness and left wrist pain; that evaluation noted hypesthesia of the C5-6 and T1-2 dermatomes on the left, and that radiographic studies noted a reversal (kyphosis) of the normal cervical lordosis at C4-5, "presumably a delayed onset of ligamentous instability from the previous trauma;" that claimant was treated for three months and again released on April 2, 1993. Dr. KE further reported that claimant re-entered his care on July 20, 1994, with exacerbation of ulnar root irritation bilaterally, neck pain with occasional headaches, and diminished sensation of the left C-7 dermatome, and that radiographs showed C5-6 instability with possible canal stenosis with flexion. A follow up MRI of July 22, 1994, noted: "1. Reversal of normal cervical curvature. 2. Central disc bulge at C5-6. 3. Rather large right sided HNP at C6-7 with significant impingement on the right . . . " Dr. KE, at that point, referred claimant to Dr.CC for a surgical opinion. Dr. KE's report concluded:

> I strongly feel that [claimant's] symptoms all stem from his original injury in 1991. It is well documented that after an injury, a progressive cascade of degenerative changes will ensue, most notably ligamentous instability due to abnormal movement patterns of the surrounding vertebral segments, a slow breakdown of annular fibers of the discs above and below the original injured level, due to over-compensation and even hypertrophy of the posterior facet articulations.

Dr. KE testified when the claimant returned to his care again in July 1994 he, Dr. KE, decided his January 1992 certification of MMI with the three percent IR was incorrect, not because of his misdiagnosis but because of claimant's substantial change in condition. He said he would change the IR he assessed because of claimant's progressive degenerative changes in his neck and sensory problems with his arms. At the hearing, Dr. KE did not feel it would be appropriate to assign an IR until claimant heals from his surgery but noted he was recovering well.

Dr. CC, a neurosurgeon, reported on August 19, 1994, that his review of the recent MRI shows "an area that appears to be changed on the 6-7 region from his earlier MRI." An August 29, 1994, CT myelogram revealed a large focal disc protrusion-herniation at the C6-7 level on the right side. Dr. CC reported on September 15, 1994, that "[t]he patient has no prior history of neck injuries or neck problems that he relates to me. All his problems started after his accident of _____. It has just taken this amount of time apparently to have it diagnosed."

Dr. MRH, who apparently provided the second opinion for spinal surgery, recited in the history portion of his October 5, 1994, report that claimant was off work for about seven months after his injury, that he then went to work for one month and was again off a few more months, and that he stopped working altogether about two years ago and has been off work for more than three years. Dr. MRH described the 7/22/91 MRI as appearing normal and the 7/22/94 MRI as showing a slight bulging on the right side of C6, C7. Dr. MRH further stated that claimant had a small defect to explain his symptoms and that three years have passed and claimant was no better. He regarded claimant as a candidate for removal of the disc, and said he advised claimant that after such surgery it was unlikely he could ever go back to heavy work. Though the surgical records were not in evidence, claimant indicated that Dr. CC operated on his cervical spine in October 1994, about one month before the hearing.

Following the hearing, the hearing officer sent the medical records introduced at the hearing to Dr. MH, the designated doctor, advised him that claimant had undergone spinal surgery in October 1994, and asked Dr. MH "whether and in what manner" he believed he should revise his previous assessment of claimant's MMI date and IR. After seeing claimant on January 27, 1995, Dr. MH issued a TWCC-69 dated February 14, 1995, which stated that claimant had reached MMI on "01-27-95" with an IR of 16% consisting of nine

percent for a surgically treated disc, one percent for multiple operative levels, and the remainder for various abnormal cervical ROM. In the accompanying narrative report Dr. MH stated that claimant had not improved after his May 17, 1992, examination of claimant, that on October 24, 1994, claimant underwent a partial laminectomy of C-6 with bilateral removal of C6-7 disc with bilateral foramenotomies of the nerve root C-7, and that claimant "has now reached a plateau in his improvement." Dr. MH also set forth each of the abnormal cervical ROM measurements for which he assigned impairment ratings.

The carrier's response to Dr. MH's report, filed on March 1, 1995, requested "further clarification" in the nature of Dr. MH's "worksheets for calculating [ROM], figures 83 and 84 of the AMA Guides" and also requested that Dr. MH be asked what MMI date and IR he would assign if the surgery was not considered. The response also asked the hearing officer to find that claimant's 8th day of disability was "7/10/91" and that the calculation of the statutory MMI date be based on that date, pointing to support in the carrier's Payment of Compensation or Notice of Refused/Disputed Claim form (TWCC-21) in evidence showing the "date lost time began" as "7/3/91." In the alternative, the carrier asked the hearing officer to reopen the record for evidence on these issues. The carrier also urged that claimant's MMI date, if changed, could not be later than statutory MMI "which would be sometime in July 1993," and that the 16% IR should not be adopted because it was obviously based on the October 1994 surgery which was too far removed in time from the MMI date to be considered in assigning the IR.

With respect to the hearing officer's finding and conclusion on the dates of claimant's intermittent disability, we agree with the carrier's assertion that these dates are unsupported by the evidence and appear to have simply been extracted from the benefit review conference report which stated those dates as claimant's position at that proceeding. *See* note 1 in Texas Workers' Compensation Commission Appeal No. 93501, decided August 2, 1993. Further, those dates do not appear to correspond with the periods claimant indicated he was not working and with historical recitations in the medical records. Accordingly, Finding of Fact No. 5 and Conclusion of Law No. 3 are reversed and the case is remanded for the hearing officer to reconsider the disability issue and make such findings and conclusions on the periods of disability as are based on the evidence already in the record.

With respect to MMI, the carrier did not challenge Finding of Fact No.9 that claimant reached MMI by operation of law on July 6, 1993, 104 weeks after his temporary income benefits accrued on his eighth day of disability, July 10, 1991, and this is consistent with the carrier's position at the hearing. However, the carrier does challenge the conclusion that claimant reached MMI on July 6, 1993. In reading the appeal, however, the carrier's complaint seems to be with the hearing officer's moving off the May 27, 1992, MMI date first certified by the designated doctor rather than with the calculation of the statutory MMI date. Because, as will be seen below, we do not find error in claimant's having been reevaluated by the designated doctor following his post-statutory MMI surgery, we affirm

the challenged conclusion.

In Texas Workers' Compensation Commission Appeal No. 94492, decided June 8, 1994, the employee, who had had several operations on his injured back, was assigned a 12% IR by the designated doctor on May 12, 1993, after having reached statutory MMI on February 2, 1993. He apparently continued to have significant problems, underwent further surgery on August 19, 1993, and, at the direction of the Commission, was reevaluated by the designated doctor who, on December 8, 1993, revised his IR to 16% taking into account the recent surgery. (Remand was necessary to evaluate ROM.) The opinion did not indicate whether claimant's additional surgery was under active consideration at the time the designated doctor assigned the first IR. The opinion noted that the definition of MMI does not incorporate IR and thereby make an IR at the 104 week time frame "indelible;" that the Appeals Panel does not hold that an IR cannot be amended or revised "for proper reason" without automatically disturbing an MMI determination; and that "there will be those rare, exceptional cases where compelling circumstances, such as the need for further surgery, might reasonably be expected to, or necessarily will, affect the claimant's ultimate IR resulting from a compensable injury." In considering that case when it returned from the remand, the Appeals Panel observed that amendment or revision of an IR "is certainly not open-ended and even surgery undergone at some future time that was not actively considered at the time of statutory MMI and the rendering of an IR will not necessarily permit an amendment or revision of the IR," citing Texas Workers' Compensation Commission Appeal No. 941243, decided October 26, 1994.

In Appeal No. 941243, the employee injured his back on (date of injury for Appeal No. 941243), and apparently reached statutory MMI on July 23, 1993. The designated doctor's report of January 3, 1994, assigned an IR of 13%. At the August 9, 1994, hearing the employee disputed the designated doctor's IR because he could not work. He thereafter had surgery on or after September 14, 1994, and on appeal contended that his post-hearing surgery should increase the amount of his IR. However, the Appeals Panel affirmed the hearing officer's determination that his IR was 13% as found by the designated doctor. The designated doctor's report did not indicate that the medical records provided to her suggested that surgery was then pending or even being considered. The hearing officer's decision acknowledged that claimant was "being evaluated for surgery." The opinion in Appeal No. 941243 reviewed several cases involving surgery after an initial determination of an IR. It noted that while surgery performed after a designated doctor has found MMI and IR but before statutory MMI has been reached presents an issue as to whether the designated doctor's opinion is contrary to the great weight of the other medical evidence, "a different question arises when statutory MMI has passed without significant development of the surgical option before the Commission." The opinion then discusses post-statutory MMI IR revision in cases where surgery was under active consideration at the time that statutory MMI was reached and an initial IR assigned, as well as cases where the evidence established a substantial change of condition after statutory MMI.

In the case we consider, as in Appeal No. 941243, the evidence does not indicate that surgery was under active consideration for claimant either when the designated doctor first assigned an IR or when claimant reached statutory MMI. Accordingly, we regard that case as precedential in our finding that the mere fact that claimant had post-statutory MMI surgery did not require reconsideration of the initial IR assigned by the designated doctor. However, unlike the facts in Appeal No. 941243 where "[n]o substantial change of claimant's medical condition is shown by the evidence," the case we here consider had evidence that a repeat diagnostic test revealed a herniated disc at C6-7 which was not, apparently, disclosed in the earlier testing. Further, the evidence shows that both claimant's treating doctor and the surgeon viewed it as part of the original cervical injury. We thus believe that on this basis, this case is distinguishable from Appeal No. 941243 and is consistent with Appeal No. 94492. *And see* the concurring opinions in Texas Workers' Compensation Commission Appeal No. 94978, decided September 8, 1994, which would permit a post-statutory MMI revision of an IR based on a "significant change of medical condition." *See also* Texas Workers' Compensation Commission Appeal No. 941168, decided October 14, 1994, where post-statutory MMI surgery on a previously undiagnosed herniated disc resulted in a reevaluation by the designated doctor (who had initially assessed an IR of nine percent) who revised the IR to 22%. The hearing officer nevertheless found that the employee reached MMI on the earlier date first determined by the designated doctor with an IR of nine percent. The Appeals Panel reversed and rendered holding that the hearing officer erred in determining that the designated doctor did not have a proper reason for amending the original certification of the MMI date and the IR. Accordingly, we affirm the findings that Dr. MH certified claimant as having reached MMI in January 1995 with a 16% IR and that Dr. MH's certification of claimant's IR has not been overcome by the great weight of contrary medical evidence; and we affirm the corresponding conclusion that claimant has a 16% IR. We find no merit in the carriers remaining asserted errors.

For the reasons stated above, we reverse the decision of the hearing officer and remand for further consideration of the evidence of record and for such further findings and conclusions as may be appropriate on the issue of claimant's period(s) of disability.

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.

Philip F. O'Neill
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Thomas A. Knapp
Appeals Judge