APPEAL NO. 980154
FILED MARCH 12, 1998

Following a contested case hearing (CCH) held in (City), Texas, on December 2, 1997, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. ' 401.001 *et seq.* (1989 Act), the hearing officer resolved the disputed issues by concluding that the respondent's (claimant) impairment rating (IR) is 25% (based on the amended report of the designated doctor), that claimant is "excused" from attempting to find work because he had no ability to perform any work, and that claimant is entitled to supplemental income benefits (SIBS) for the first compensable quarter. The appellant (carrier) appeals these conclusions and two associated findings of fact on evidentiary insufficiency grounds and asks that we render a decision that claimant's IR is 10%, the first IR determined by the designated doctor, and that claimant is not entitled to SIBS. Claimant has responded, asserting that the evidence is sufficient to support the hearing officer's determinations and rebutting various assertions made in the carrier's brief.

DECISION

Affirmed.

Claimant testified through a Spanish language translator that he was injured on _____, while employed as a dishwasher at a club, that in January 1993, he underwent shoulder surgery, that he has not returned to work following his injury, that in May 1995, he underwent the first of two operations on his lumbar spine, and that his shoulder surgery and spinal surgery were delayed by the necessity of resolving a liver problem. Claimant further testified that during the filing period for the first compensable quarter, represented to be from June 14 to September 13, 1994, he did not work because the doctor had told him not to work, because he could not work, and because he was awaiting the resolution of his liver problem, undergoing various tests, and awaiting spinal surgery.

The medical records reflect that claimant was first treated by his family physician, (Dr. O); that Dr. O referred claimant to (Dr. R), an orthopedic surgeon who performed claimant's shoulder surgery in January 1993 and spinal cord stimulator surgery in February 1997; and that Dr. R practiced with (Dr. H), also an orthopedic surgeon, who performed claimant's lumbar laminectomy on May 31, 1995. Dr. R, on August 21, 1991, reported the history of claimant's slipping and falling on a wet kitchen floor and diagnosed musculoskeletal low back pain and right rotator cuff tendinitis. Dr. R reported on September 4, 1991, that claimant's TENS unit was helping his low back pain. On November 1, 1991, Dr. R diagnosed right rotator cuff tendinitis and "rule out progressive L5 radiculopathy."

On April 2, 1992, (Dr. B) provided a second opinion to the carrier on the recommendation for right shoulder surgery and non-concurred. Concerning claimant's lumbar spine, Dr. B stated that claimant gave a history of slipping and falling backwards,

striking the back of his right shoulder and his entire back on the floor; that Dr. O, on _____, found tenderness from L3 to L5 and in the right shoulder and took claimant off work, anticipating he would be off six months; that on _____, Dr. O diagnosed shoulder strain and lumbosacral strain; and that on June 28, 1991, Dr O diagnosed lumbar herniated disc and indicated that an MRI revealed an L4-5 herniated disc and that a shoulder MRI revealed tendinitis and degenerative joint disease. In evidence is an _____, MRI report of the lumbosacral spine obtained by Dr. O concluding there was a suggestion of a small midline herniated disc at L4-5. Dr. B also stated that claimant was referred for examination by neurologist, (Dr. E); that Dr. E on June 11, 1991, included in his impression, "rule out lumbosacral radiculopathy of the right lower extremity"; and that on November 9, 1991, Dr. E found sensory diminution in the right leg. Dr. B also stated that Dr. E reported that claimant was fitted with a TENS unit. The records of Dr. O and Dr. E were not in evidence.

Dr. R, on June 24, 1992, reported that claimant returned for an evaluation of back pain and shoulder pain after a seven month absence; that in November (presumably 1991) he had recommended arthroscopic surgery on the shoulder; that he disagreed with Dr. B that claimant had normal shoulder arthritis; that he injected claimant's trigger point at L4-5; that claimant definitely needs an arthroscopy; and that he will see how claimant's back does with injection. Dr. R stated on July 15, 1992, that the back injection helped claimant for about a week and the pain returned; that the back pain is going to be chronic and he will have to learn to live with it; and that if the carrier denies the shoulder, claimant will have to come up with the money himself or learn to live with a stiff shoulder. On August 12, 1992, Dr. R wrote that there had been no further progress on obtaining a third opinion for the shoulder, that he again injected claimant at L4-5, and that he will see claimant "whenever he can get things cleared with the workman's comp people." On September 9, 1992, Dr. R said he reviewed the MRI, that claimant would benefit from surgery, and that he would "attempt to set this up."

Dr. R wrote on September 18, 1992, that claimant came in for a preoperative history and physical, that claimant has some problem with his liver, has been seeing a doctor at (hospital) and takes medication, and that surgery will be postponed pending evaluation of his liver function. Dr. R wrote on October 9, 1992, that he met with claimant's rehab nurse, who advised him that claimant "is apparently falling through the cracks and nobody knows what is going on with him"; that he reviewed with the nurse the entire problem including claimant's having an abnormal liver function, that claimant needed to see his doctor at the hospital and provide that doctor's records before he is set up for surgery, and that claimant will follow up with Dr. R once he gets clearance for surgery. On November 20, 1992, Dr. R wrote that claimant had been going to a neighborhood clinic and they agreed he has symptoms of hepatitis and have provided him with medication, that his back is getting worse, and that Dr. R will try claimant with a TENS unit and see him once he gets clearance from the clinic. On December 11, 1992, Dr. R reported that claimant advised he was cleared by the hospital, that claimant's shoulder has severely restricted motion and his back pain is getting worse and radiating down his right leg, that he is going to reschedule shoulder surgery, and that he doubts very seriously that claimant "will ever be a productive

member of society again regardless of the outcome of his shoulder surgery, because of his back pain."

On January 4, 1993, Dr. R wrote that Dr. O did claimant ‘s preoperative history and physical and that surgery is scheduled for Wednesday and, on January 13, 1993, that claimant was one week postsurgery and he seriously doubted that claimant would ever regain full shoulder motion.

The parties stipulated that the statutory maximum medical improvement (MMI) date is April 6, 1993.

On April 12, 1993, Dr. R wrote to the carrier that claimant was very distressed because "Workmen’s Comp has cut off his benefits" and that claimant reported being told that Dr. R waited too long to do the surgery. Dr. R then stated that, first, surgery was denied for over a year and, second, once surgery was approved, it was scheduled expeditiously; that claimant had chronic hepatitis and elevated liver functions; that he was cleared medically in December and had surgery in January; that there was only a three-month delay from the date that surgery was approved until it was performed; and that the delay was reasonable considering the need to get claimant on medication for hepatitis. Dr. R further stated that claimant continued to complain of low back pain radiating into his thigh; that he said that another doctor told him he had a ruptured disc and needed surgery; that the 1991 MRI shows a small bulging disc at L4-5 and the 1991 EMG showed normal nerves; that "because of this discrepancy in Workmen’s Comp>s strong desire to close this case," he felt that a CT and myelogram should be obtained and that if they are positive, that claimant be referred for consideration of spinal surgery and a possible repeat EMG. Dr. R also stated that claimant had not reached MMI and would not for another two months, that he is going to ensure that claimant gets a complete work -up for his back, and that if it turns out to be normal, claimant will be assigned an IR for his back at the time his shoulder is rated which would be sometime in June. Dr. R concluded by commenting that claimant’s benefits should be continued and that the reason for their discontinuance, Dr. R’s delay in operating on claimant, "is certainly not valid."

An April 26, 1993, lumbar myelogram obtained by Dr. R revealed a herniated disc at L5-S1 and disc bulge at L4-5 and a CT scan of that date revealed a small herniated disc at L5-S1.

Dr. R reported on May 3, 1993, that claimant’s myelogram and CT scan revealed a herniated disc at L5-S1 which did not correlate with his MRI showing a ruptured disc at L4-5 and only a small bulge at L5-S1. Dr. R said he would order another EMG and if it is abnormal would refer claimant to Dr. H for consideration for back surgery. Dr. R wrote on May 17, 1993, that claimant would be scheduled for a discogram and that he had discussed claimant’s case with Dr. H. A request for authorization of a discogram to finally confirm a herniated disc at L5-S1 was dated July 13, 1993.

On July 26, 1993, Dr. R wrote that claimant was currently unable to engage in any type of employment because he is not able to stand or sit for any length of time and must change positions frequently.

An August 12, 1993, CT scan obtained by Dr. H revealed a herniated disc at L5-S1. On August 13, 1993, Dr. R wrote that claimant's discogram was markedly positive at L5-S1, that a CT scan revealed a free fragment of disc in the canal, that an EMG showed mild denervation at the L5-S1 level, that his MRI was normal but that the myelogram and CT scan showed a right-sided bulge at L5-S1, and that claimant would see Dr H and be set up for a laminectomy.

In evidence is a Required Medical Report: Spinal Surgery Recommendation (TWCC-63) signed by the carrier on "8/19/93" which listed the proposed surgery as a lumbar laminectomy and which scheduled claimant for an examination by the carrier's second opinion doctor, (Dr. M) on September 28, 1993. Dr. M's report of that date stated that claimant "has had a long drawn-out problem with his lower back and right leg and now it appears that he has a lower lumbar disc problem with a pinched nerve problem, and surgery has been recommended." After reviewing a lumbar MRI scan of _____, lumbar myelogram and post myelogram CT scan reports, and a discogram, Dr. M concurred with Dr. R that a lumbar laminectomy was reasonable and indicated.

Dr. R wrote on December 20, 1993, that "everyone agrees" that claimant needs spinal surgery but that he nas not yet received the liver function clearances from Dr. O, the hospital, and (Dr. S). Dr. R wrote on January 5, 1994, that claimant had not yet been cleared for surgery, and on March 29, 1994, that claimant still had a lot of back pain and still had not obtained clearance for surgery and that he had nothing further to offer claimant until he was cleared for surgery.

In evidence is a Report of Medical Evaluation (TWCC-69) signed by Dr. R on "6/16/94" stating that claimant had reached MMI "by statute" and that his IR was 20%. Dr. R further reported that the IR included components for claimant's herniated lumbar disc and for his shoulder and that claimant still needs surgery for his back but that his liver enzymes have prevented surgery. A Payment of Compensation or Notice of Refused or Disputed Claim Interim (TWCC-21) dated "6/3/94" stated that the carrier received a TWCC-69 reflecting MMI on "4 -2- 93" with an IR of 20% and that the carrier made a reasonable assessment of 14% which has been paid. The author of the TWCC-69 was not identified.

Dr. R reported on September 30, 1994, that claimant said his right leg pain and numbness were getting worse; that in May, Dr. O told claimant his liver functions were improving; that he, Dr. R, suggested that claimant return to Dr. O and, when cleared for surgery, he would have claimant see Dr. H for back surgery; that claimant stated that the carrier had changed the IR from the 20% he had given claimant to 14%; that he, Dr. R, stood by the 20% IR he assigned as claimant was measured by a physical therapist; and that he advised claimant to appeal the IR. Dr. R reported on December 2, 1994, that

claimant stated that Dr. O felt his liver enzymes were almost back to normal and that he, Dr. R, had set claimant up to see Dr. H in a month.

On December 27, 1994, (Dr. N), the designated doctor, certified on a TWCC-69 that claimant reached MMI on "12/13/94" with an IR of 10%. In his accompanying narrative report, Dr. N stated that on April 2, 1991, claimant reported slipping in grease, falling onto his back and then over onto his right arm, and injuring his right shoulder, right arm, low back and right hip, and that he has been off work since that date and has not been released by his doctor to return to work. Dr. N's review of the medical records reflected that claimant was first treated by Dr. O; that Dr. O on _____, diagnosed lumbosacral strain and right shoulder strain; that an MRI of _____, revealed a small herniated disc at L4-5; that on June 27, 1991, Dr. O diagnosed lumbar herniated disc, right shoulder tendinitis, and right shoulder degenerative joint disease; that x-rays on August 21, 1991, revealed advanced degeneration of the lumbar spine; that Dr. O in October 1991 referred claimant to Dr. R who recommended work hardening; that claimant saw Dr. H on November 15, 1991, and was diagnosed with right shoulder instability and chronic right lumbar strain; that on January 6, 1993, Dr. R performed right shoulder surgery; that a lumbar myelogram on April 26, 1993, revealed a herniated disc at L5-S1 and a bulging disc at L4-5; that a CT scan of the same date revealed a small herniated disc at L5-S1; that an EMG on May 5, 1993 revealed evidence of mild nerve root injury at L5-S1 on the right; and that a discogram on August 12, 1993, revealed a herniated disc at L5-S1, and that claimant said that Dr. R, his treating doctor, informed him that he needs back surgery.

Dr. N further reported that claimant complained of low back, right shoulder, and right hip pain with the low back pain radiating into the right lower extremity. Dr. N's diagnosis included old degenerative arthropathy of the right shoulder preexisting the accident and degenerative intervertebral disc disease of the lumbar spine, advanced, at L3-4 and L4-5, old and preexisting the accident, and resolved lumbar strain. Dr. N further stated that claimant may return to work with restrictions in reaching overhead for three months and then to regular duty without restrictions and that there were preexisting degenerative changes in the right shoulder and lumbar spine that may be aggravating the present condition. Dr. N stated that the percentage of whole person impairment is 10% and that impairment for loss of range of motion (ROM) in the right shoulder is 16%. He referred to Table 3 in Chapter 3 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) which reflects that a 16% upper extremity impairment converts to a 10% whole person impairment. Dr. N further stated that there is no permanent physical impairment for the lumbar spine or right hip, and that claimant sustained a soft tissue injury which has resolved, apparently referring to the lumbar spine. Dr. N did not comment on whether claimant had any impairment from the aggravation he mentioned.

Dr. O wrote Dr. H on February 22, 1995, stating that claimant's most recent liver functions indicate sufficient improvement so as "to proceed with the surgical procedure that your office had recommended. (10-25-93)."

Dr. R wrote on March 17, 1995, that claimant is going to need a total shoulder replacement in the near future, that he has been finally cleared by Dr. O for surgery, and that he is going to have to obtain a second opinion for the surgery. The Texas Workers' Compensation Commission (Commission) notified the parties on April 3, 1995, that the carrier had waived its right to a second opinion regarding claimant's spinal surgery and was liable for the costs of the surgery. Dr. H wrote on May 5, 1995, that claimant has been rescheduled for May 31st and his operative report of May 31, 1995, reflected the spinal surgery on that date and the diagnosis of right S1 nerve root irritation. Dr. R wrote on July 28, 1995, that claimant still had a lot of shoulder pain and the same numbness and tingling in his leg and that "there was such a long period of time that lapsed between the determination of need for surgery and the actual surgery, he may have sustained damage to the nerve that will take a long period of time to resolve." Dr. H wrote on October 4, 1995, that an MRI showed epidural fibrosis at the area of the previous surgery. Dr. R wrote on December 5, 1995, that injections did not help claimant's back for more than four or five days, that he is "at the end of the line with his back," and that he is having increasing shoulder pain.

On January 2, 1996, Dr. R wrote that claimant has severe shoulder pain, is unable to work, and will require surgery on his right shoulder. Dr. H wrote on February 6, 1996, that he did not feel claimant would ever be gainfully employed and that he is going to continue to have epidural steroid injections. Dr. R wrote on April 30, 1996, that he disagreed with Dr. N's 10% IR, that subsequent to Dr. N's evaluation, claimant underwent spinal surgery, and that Dr. N had not assigned any impairment for claimant's lumbar spine. A May 8, 1996, MRI obtained by Dr. H revealed moderate diffuse epidural fibrosis surrounding the thecal sac at the L5-S1 level. Dr. R's TWCC-69 dated June 11,1996, stated that claimant reached MMI on that date with an IR of 48%. In the accompanying narrative report, Dr. R stated that the 48% IR had components for loss of shoulder ROM, for loss of back ROM, and for a surgically treated lumbar spine disc. He also referred to the "Third Edition, Revised" of the AMA Guides.

On September 24, 1996, a Commission benefit review officer (BRO) wrote Dr. N stating that claimant underwent back surgery on May 31, 1995, and enclosed the records of Dr. H and Dr. R for Dr. N's review. The BRO asked whether Dr. N needed to reexamine claimant and whether it remained his opinion that claimant's IR was 10%.

Dr. R reported on January 3, 1997, that claimant had been his patient for five years; that he sustained injuries to his back and shoulder on the job on _____; that since that time he has been unable to work and is going to try a spinal cord stimulator; that claimant needs a total shoulder replacement which has been denied because of preexisting arthritis; that until claimant receives a total shoulder replacement and gets his chronic back pain under control, he is not able to do any type of productive work, even the most sedentary work; and that even though claimant should have surgery and retraining, at best he could get back to a part-time, sedentary job.

Dr. R's operative report of February 26, 1997, stated that claimant underwent the implantation of a spinal cord stimulator and that his diagnosis was chronic back pain. Several of Dr. R's reports indicate that he proposed a total shoulder replacement, that claimant advised that the carrier was refusing authorization, and that claimant was going to retain an attorney for assistance.

Dr. N's TWCC-69 dated "4-21-97" certified that claimant reached MMI on April 10, 1997, with an IR of 25%. In his accompanying narrative report, Dr. N stated that he evaluated claimant on April 10, 1997; that when he saw claimant in December 1994, he felt claimant had old, advanced degenerative changes in both the right shoulder and lumbar spine and had reached MMI; that no further treatment was necessary; that claimant could return to light duty for three months; and that "[h]e was given an [IR] of 16%.[sic]" Dr. N further stated that since that time, claimant has received physical therapy, has had injections in the low back, and has undergone low back surgery in May 1995 (decompressive laminectomy) and in February 1997 (spinal cord stimulator); that claimant has received psychiatric care and psychotropic and pain medications; that in his opinion, claimant has not benefitted from the surgery and further surgery is totally contraindicated; and that the spinal cord stimulator has inhibited claimant's ROM at least 50%. Based on the AMA Guides, Dr. N assigned 10% impairment for the surgery, 10% for claimant's low back ROM, and 13% (eight percent whole body) for the shoulder which combined to an IR of 25%. Dr. N commented that "[t]he problem here is that the examinee has undergone numerous procedures since his last examination which generates more impairment according to the `Guides,' but that, nevertheless, claimant's IR is 25% "based on his examination today."

In addition to the aforementioned legal conclusions, the carrier has appealed factual findings that Dr. N's 25% IR is not contrary to the great weight of the medical evidence and that during the filing period for the first compensable quarter, claimant did not return to work because he was unable to perform any work as a direct result of his impairment.

Regarding the IR issue, the carrier correctly notes that the hearing officer did not address whether claimant's reevaluation by the designated doctor on April 21, 1997, more than four years after the statutory MMI date and two and one-half years after the designated doctor's initial report, was accomplished for a proper reason and within a reasonable period of time, citing various Appeals Panel decisions stating those two factors as criteria. *See e.g.,* Texas Workers' Compensation Commission Appeal No. 94492, decided June 8, 1994; Texas Workers' Compensation Commission Appeal No. 941243, decided October 26, 1994. Concerning the "proper reason" criterion, the carrier maintains that at the time of statutory MMI, while claimant's treating doctor had recommended further lumbar spine diagnostic tests and had stated that depending on the results, spinal surgery may be recommended, spinal surgery was not then "actively in process" because it had not yet been recommended, it was speculative as to whether, if ever, claimant would be medically cleared from his liver condition, and claimant would still have to go through the Commission's spinal surgery procedure. Concerning the "reasonable period of time" criterion, the carrier states that while claimant "more than likely" had the surgery within a

reasonable time after the designated doctor's examination, he did not within a reasonable time attempt to get the IR amended and thus put the carrier in the position of having to defend a claim for SIBS more than three years after the expiration of the filing period. The carrier further notes that while claimant argued at the hearing that the designated doctor's first report should not be given presumptive weight because it did not include the entire injury, Dr. N opined that claimant just had a soft tissue back injury which resolved and that even if claimant's preexisting condition was aggravated by the accident, Dr. N did not have to assign impairment if the aggravation had also resolved. The carrier also states that Dr. N did not assign impairment for loss of lumbar ROM in his first report because he felt that the studies were invalidated by voluntary restriction. The carrier further asserts that even if the hearing officer had found that the Dr. N's first IR did not include the entire injury, such finding would not *per se* invalidate the report and the hearing officer would still have to determine whether claimant had requested the amendment of the report within a reasonable time.

Claimant contends that his surgery was contemplated before the statutory MMI date but delayed because of the necessity of receiving a surgical clearance for his liver condition and that much of the delay in seeking an amended IR is attributable to the designated doctor, pointing out that the Commission wrote Dr. N in September 1996, and he did not respond until April 1997.

Regarding the SIBS issue, the carrier contends that during the filing period, claimant's shoulder was healed from the surgery and that although his treating doctor had in 1993 recommended lumbar spine surgery, claimant was not actively receiving treatment for his shoulder or his back and thus the medical evidence fails to establish a total inability to work during the filing period.

In Appeal No. 94492, *supra*, the employee sustained a back injury in _____, reached statutory MMI in February 1993, received a 12% IR from the designated doctor in May 1993, underwent back surgery in August 1993, and was reevaluated by the designated doctor at the direction of the Commission who in December 1993 amended the IR to 16% but stated he could not measure ROM due to the recency of the surgery. The carrier contended that since MMI was reached by operation of law (Section 401.011(30)(B)), the IR should be a "snapshot" of the employee's impairment on the date of MMI. The Appeals Panel noted its previous holdings that a doctor may amend or correct an MMI and IR determination for proper reason in limited but appropriate circumstances, that subsequent surgery can be a valid basis for a designated doctor to amend his opinion as to MMI, and that just because a claimant may be a candidate for surgery does not mean in every instance that MMI or IR may not be found. Discussing the need for orderly, expeditious resolution of claims, the Appeals Panel nonetheless observed 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," and that "a properly revised IR (premised on a clinical or laboratory finding, Section 408.122) should not be sacrificed solely for the expediency of finality." The opinion also noted the provision of Section 410.307 and stated that it did "not

seem reasonable to conclude that a substantial change of condition, such as occasioned by required surgery subsequent to an initial IR determination following statutory MMI must be ignored by the Commission thereby forcing the parties into court."

On the other hand, the Appeals Panel has also stated that "resolution of IR cannot be indefinitely deferred to await the result of a potential lifetime course of medical treatment." Texas Workers' Compensation Commission Appeal No. 950615, decided June 5, 1995.

In Texas Workers' Compensation Commission Appeal No. 94978, decided September 8, 1994, the claimant was injured in July 1991, his treating doctor determined that he would not benefit from spinal surgery and that he reached MMI in April 1993 with a nine percent IR, and the claimant disagreed. The claimant reached statutory MMI on August 4, 1993, and was assigned an IR of seven percent by the designated doctor on August 25, 1993. He saw another doctor in October 1993 who ordered a discogram and determined that spinal surgery was necessary, the treating doctor concurred, and the claimant had the surgery in March 1994. In remanding for further consideration of the IR by the designated doctor, the author judge stated: "We are hesitant to determine that the fact that medical confirmation of an ongoing back problem which necessitated surgery came after the date of statutory MMI means that the Commission, in the name of expediency, must turn a blind eye to the reality of the circumstances surrounding claimant's injury and his treatment for that injury in considering claimant's IR. Rather, we believe that the more prudent course of action is to permit the designated doctor to consider whether, and if so, to what extent, his IR may have changed in light of claimant's surgery." The concurring opinion noted that remand will bypass some steps in the dispute resolution process suggested in 1 JOHN T. MONTFORD, *ET AL.*, A GUIDE TO TEXAS WORKERS' COMP REFORM ' 4B.26, pp.4.103- 4.115 (1991), but that the end result will likely be the same.

In Texas Workers' Compensation Commission Appeal No. 950861, decided July 12, 1995, the Appeals Panel noted that the simple fact of post-statutory MMI surgery will not in every case provide a basis for adopting the amendment of a designated doctor's report. In Texas Workers' Compensation Commission Appeal No. 970653, decided May 28, 1997, the Appeals Panel, citing various decisions, stated that generally, if an IR was assigned by a designated doctor at the time the claimant reached MMI by operation of law, the designated doctor may amend the report if surgery was being contemplated at the time the claimant reached MMI or if a substantial change of medical condition occurred after the claimant reached MMI; that the fact that surgery was performed after MMI alone does not require that the IR in an amended report be adopted; and that under certain circumstances, a designated doctor may issue a report with an IR a considerable time after the claimant has reached MMI and the report of the designated doctor is not invalid solely based on the time when the report was rendered.

In Texas Workers' Compensation Commission Appeal No. 971385, decided August 25, 1997, the Appeals Panel stated the following:

> The determination as to whether a designated doctor's certification based on an intervening surgery should be afforded presumptive weight is to be made based on 1) An analysis of whether the surgery which was eventually performed was "under active consideration" at the time of the initial designated doctor evaluation and if the surgery was not under active consideration, it is inappropriate to amend the certification based upon it. [Citations omitted.]; 2) Whether the employee experienced material recovery or lasting improvement from the surgery. *Id*.; and 3) Whether the employee had the surgery in a reasonable amount of time after the initial designated doctor's report.

The carrier appeals the finding that the 25% IR assigned by Dr. N is not contrary to the great weight of the other medical evidence. The evidence shows that claimant was diagnosed with and treated for a lumbar spine injury from the outset; that he was given medications and a TENS unit in 1991; that he was started on epidural steroid injections in 1992; that on September 9, 1992, Dr. R reported that claimant would benefit from spinal surgery and that he would attempt to set it up; that claimant's shoulder surgery was delayed by the necessity of obtaining clearance from Dr. O and the hospital for claimant's liver problem; that six days after reaching statutory MMI, Dr. R wanted a new CT scan and myelogram and said he would refer claimant for surgery if they were positive; that these tests (April 26, 1993) revealed a herniated disc at L5-S1 which did not correlate with a previous MMI and that in May 1993, Dr. R ordered a new MMI and a discogram and discussed the case with Dr. H; that the August 1993 discogram and CT scan were positive and Dr. R scheduled claimant to see Dr. H for the laminectomy; that Dr. M concurred with the necessity of spinal surgery in September1993; that as of December 1993, claimant had not received a liver functions clearance; that in February 1995, Dr. O advised Dr. R that the liver functions were all right for the surgery which had been proposed in October 1993; that the lumbar laminectomy was performed on May 31, 1995; that following the surgery claimant continued to have back pain and right leg numbness, that epidural fibrosis in the area of the surgery was seen in October 1995, and claimant received injections in 1995 and 1996; that the Commission sent the records of Dr. R and Dr. H to the designated doctor in September 1996 and inquired about a reexamination; and that the designated doctor reexamined claimant on April 21, 1997, and amended his IR to 25% to include the back injury. We also note that the record in this case does not suggest that claimant procrastinated (to the contrary, the system procrastinated) on undergoing spinal surgery or raised the issue of spinal surgery for purposes of delay or to prolong or prevent the resolution of the impairment issue. The factors peculiar to this case may be reasonably interpreted as denying claimant the opportunity to have his lumbar surgery reach the "active consideration" level at the time of statutory MMI. Under the particular and absolutely unique circumstances of this case, we are satisfied the finding is not so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986).

As for claimant's entitlement to SIBS for the first quarter, the carrier appeals the finding that during the filing period, claimant did not return to work because he was unable to perform any work as a direct result of his impairment and the conclusion that he was "excused" from attempting to find work because he had no ability to perform any work. The Appeals Panel has repeatedly said that a claimant is never "excused" from meeting the statutory requirements for SIBS. *See e.g.*, Texas Workers' Compensation Commission Appeal No. 972635 (Unpublished), decided February 5, 1998; Texas Workers' Compensation Commission Appeal No. 972260 (Unpublished), decided December 19, 1997; and Texas Workers' Compensation Commission Appeal No. 72295 (Unpublished), decided December 22, 1997. In her sparse discussion of the evidence, the hearing officer states that during the filing period claimant was pending spinal surgery and was unable to work, and that he has been unable to work since the injury.

The Appeals Panel has held in Texas Workers' Compensation Commission Appeal No. 931147, decided February 3, 1994, that if an employee established that he or she has no ability to work at all, then seeking employment in good faith commensurate with this inability to work "would be not to seek work at all." Under these circumstances, a good faith job search is "equivalent to no job search at all." Texas Workers' Compensation Commission Appeal No. 950581, decided May 30, 1995. The burden of establishing no ability to work at all is "firmly on the claimant," Texas Workers' Compensation Commission Appeal No. 941382, decided November 28, 1994, and a finding of no ability to work must be based on medical evidence or "be so obvious as to be irrefutable." Texas Workers' Compensation Commission Appeal No. 950173, decided March 17, 1995. *See also* Texas Workers' Compensation Commission Appeal No. 941332, decided November 17, 1994. A claimed inability to work is to be "judged against employment generally, not just the previous job where the injury occurred." Texas Workers' Compensation Commission Appeal No. 941334, decided November 18, 1994. The absence of a doctor's release to return to work does not in itself relieve the injured worker of the good faith requirement to look for employment, but may be subject to varying inferences. Appeal No. 941382, *supra*. Whether a claimant has no ability to work at all is essentially a question of fact for the hearing officer to decide. Texas Workers' Compensation Commission Appeal No. 941154, decided October 10, 1994.

We find sufficient medical evidence to support the challenged finding and conclusions. Dr. R reported on July 26, 1993, that claimant could not engage in any type of employment; Dr. H reported on February 6, 1996, that he did not feel that claimant would ever be gainfully employed; and on January 3, 1997, Dr. R reported that claimant has been unable to work for the past five years and cannot even perform sedentary work. Dr. R reported on July 26, 1993, that claimant could not engage in any type of employment; Dr. H reported on February 6, 1996, that he did not feel that claimant would ever be gainfully employed; and on January 3, 1997, Dr. R reported that claimant has been unable to work for the past five years and cannot even perform sedentary work.

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Joe Sebesta
Appeals Judge