

APPEAL NO. 990027

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on December 14, 1998. He (hearing officer) determined that the appellant (claimant) reached maximum medical improvement (MMI) on November 17, 1997, with an impairment rating (IR) of zero percent. Claimant appeals, contending that the hearing officer erred in failing to add an issue regarding extent of injury, and in determining that claimant had a zero percent IR even though he underwent spinal surgery in August 1998. Respondent (carrier) replies that the Appeals Panel should affirm the hearing officer's decision and order.

DECISION

We reverse and remand.

Claimant contends the hearing officer erred in determining that he reached MMI on November 17, 1997, with an IR of zero percent. Claimant asserts that the designated doctor, Dr. R, ignored medical reports that he had a spinal endplate fracture and "post traumatic lumbar discopathy."

It was undisputed that claimant sustained a compensable injury on \_\_\_\_\_. The Texas Workers' Compensation Commission (Commission)-selected designated doctor was Dr. R. Medical records indicate that claimant was injured when his tractor lurched, causing, among other things, a groin and back injury. Claimant testified and said that he did not have leg pain from his injury, but that he had a lot of continuing back pain.

A September 1997 lumbar CTS scan report stated that there was no herniation and no evidence of recent bony injury, and that claimant has minor degenerative disc disease and prominent degenerative and hypertrophic changes involving the facets at L5-S1. An October 1997 MRI report signed by Dr. T stated, in pertinent part, that there was an abnormal signal on the fat suppression images and that the findings are compatible with either an abnormal replacement of marrow signal or the presence of hemorrhage within the bone. Dr. T went on to state:

I suppose a long-standing degenerative or posttraumatic process in this region might also present in this fashion such as might occur with marrow signal attenuated and altered by surrounding spur formation.

A February 23, 1998, radiological report states that claimant's disc spaces are well-maintained and that he has small spurs at L5-S1. In the October 1997 MRI report, Dr. T recommended a bone scan. An April 1998 bone scan report stated, "minimal increased asymmetric uptake L4 vertebral body anterosuperiorly to the left of midline as might be seen with mild degenerative reaction." The report also said, "[t]here is no evidence to suggest facet joint activity." A February 23, 1998, medical report indicates that claimant complained of back pain, weakness in his back and legs, and that he sometimes falls. A

March 25, 1998, report from Dr. P stated that testing indicated that claimant has discogenic back pain, that a bone scan is needed to see whether there is any significant increased uptake from one or the other of the lower lumbar facets, and that the original zero percent IR may be inaccurate. In an April 1998 record, Dr. P stated that, in his opinion, "there is a noticeable area of increased uptake in the left superior/anterior aspect of the L4 vertebral body." Dr. P said claimant may have fractured an endplate or "herniated some nuclear material into the bone," and that a discogram is recommended. In a May 14, 1998, letter, Dr. P noted the statements from claimant's bone scan and MRI report and stated that "there is a reasonable likelihood that a much more significant diagnosis exists underlying the patient's situation than [back strain.]" In a May 20, 1998, report, Dr. P stated that:

[claimant's] discograms reveal an apparently asymptomatic end plate injury at L3-4. They also show positive pain concordance with an apparently normal disc at L4-5 and a positive pain concordance with what appears to be possibly a deep intra-annular injection at L5-S1.

Dr. P stated that the "real issue" regarding the L4-5 level was whether "we have a painful disc even if it 'looks normal.'" Dr. P noted that the discogram was not "intradiscal" and that an intra-annular discogram is not a true discogram. In a June 1998 letter, Dr. P stated that he is reluctant to consider a surgical recommendation "for positive pain concordance with an apparently normal discogram in appearance." An April 16, 1998, report from Dr. M stated that claimant complained of severe back pain after activity and said, "I think this gentleman suffers from lumbar facet arthralgias from his accident." In a May 11, 1998, report, Dr. M included under "impression," "herniated nucleus pulposus" and noted that another doctor would like to proceed with discography. A May 18, 1998, discogram report signed by Dr. M stated under "post-operative diagnosis" "L3-4 inferior end-plate fracture with pressure sensation upon provocation," "L4-5 normal appearing disc, however cord pain upon provocation," and "L5-S1 possible normal disc concordant lumbalgia upon provocation." However, regarding the L3-4 level, the body of the report stated:

The disc had an inferior end-plate extrusion of dye that *appeared it could possibly be a fracture*, however, he initially stated he had pain, but further questioning elucidates the fact that he has a pressure sensation in his back that is not like his normal pain. [Emphasis added.]

A July 1998 report from Dr. S, who saw claimant for a second opinion regarding spinal surgery, stated that: (1) claimant was found to suffer from discogenic pain although "the disc is essentially normal on MRI"; (2) there is no evidence of herniation at any level; (3) MRI reports show hypertrophic changes involving the facets at L5-S1; (4) claimant has been through conservative care and continues to have chronic pain that has prevented him from returning to work; (5) claimant rated his pain very high but he does not have radicular symptoms; (6) claimant has normal motor strength and normal sensation; (7) claimant can forward flex and touch the tops of his socks, but his lateral rotations are moderately limited; and that (8) he concurs in the surgery recommendation, noting that a solid anterior fusion might eliminate some of the posterior pain.

An August 1998 operative report states that: (1) the post-operative diagnosis is "post traumatic lumbar discopathy at L4-5 and L5-S1"; and (2) claimant underwent a discectomy and fusion at those two levels. There is no Report of Medical Evaluation (TWCC-69) dated after claimant's discectomy and fusion at levels L4-5 and L5-S1 in August 1998. Claimant's treating doctor had certified that he had a zero percent IR in October 1997, before the claimant had surgery.

In a November 17, 1997, report, the designated doctor stated that: (1) claimant was thrown from a tractor, hurting his ribs and back and causing pain in his testicles; (2) claimant has recovered except for his back, which continues to hurt; (3) claimant is in "no acute distress"; (4) claimant moves about the room normally but complains of his central lumbar area; (5) there is no muscle wasting and no area of tenderness; (6) claimant's spine has "a free full range of motion [ROM]"; (7) claimant's neurological examination was grossly normal; (8) claimant's diagnosis is "back strain," and no further treatment is recommended; and (9) claimant's IR is zero percent. In the report, the designated doctor said, "Table 49 [of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides)] offers no award for back strain. His complete range of spinal motion does not indicate impairment." In June 1998, a Commission benefit review officer (BRO) wrote to the designated doctor and asked him to review some additional medical records. The designated doctor replied that no medical report indicates that claimant needs discography or surgery and that his original certification remains unchanged. The BRO wrote to the designated doctor again in July 1998 and sent additional reports, including the discogram report. The designated doctor replied that it would be wise not to carry out surgery and that his certification of MMI and IR did not change. In October 1998, the BRO wrote to the designated doctor and sent the operative report concerning claimant's August 28, 1998, spinal surgery. The designated doctor replied:

It is my understanding that subsequent surgery is not enough reason to alter an [IR]. . . . I have examined the documents you sent me. [Dr. S] reported that on July 8, 1998, his examination of [claimant] was essentially normal. MRI and CT examinations found no abnormalities. There is no recorded change of condition. There are no grounds to change [my certification].

The report of a Commission-selected designated doctor is given presumptive weight with regard to MMI status and IR. Sections 408.122(b) and 408.125(e). The amount of evidence needed to overcome the presumption is the "great weight" of the other medical evidence. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92166, decided June 8, 1992.

"Maximum medical improvement" is defined, as pertinent to this case, as "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)(A). The presence of pain is not, in and of itself, an indication that an

employee has not reached MMI. A person who is found to be at MMI and who is assessed to have lasting impairment may indeed continue to experience pain as a result of an injury. MMI does not, in every case, amount to a pain-free recovery. Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1993.

The 1989 Act provides that the hearing officer is the sole judge of the weight and credibility of the evidence. Section 410.165(a). Where there are conflicts in the evidence, the hearing officer resolves the conflicts and determines what facts the evidence has established. As an appeals body, we will not substitute our judgment for that of the hearing officer when the determination is not so against the great weight and preponderance of the evidence as to be clearly or manifestly unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Texas Workers' Compensation Commission Appeal No. 950456, decided May 9, 1995.

Whether a claimant has any impairment under Table 49 is a matter of medical judgment and the proper application of the AMA Guides. In reviewing the record in this case, we have reviewed the medical evidence, including the operative report. Because of the extreme complexity of the diagnosis and the unique circumstances of this case, in that spinal surgery was found to be reasonable and necessary and was approved by the Commission and performed, we conclude that it is essential in this case to select a designated doctor with special knowledge and training in the unique nature of the injury involved such as that possessed by an orthopedic surgeon. The unusual facts of this case call for a surgeon's analysis of the appropriate specific disorder rating, if any, indicated by the claimant's medical record and the doctor's examination. Further, remand for remeasuring of the claimant's ROM after his fusion surgery was necessary in this case. Under the specific facts of this case, we conclude that the hearing officer erred in according presumptive weight to the designated doctor's report and in determining that claimant reached MMI on November 17, 1997, with an IR of zero percent. Therefore, we remand for the appointment of a second designated doctor who is an orthopedic surgeon. In remanding this case, we do not hold or imply that a claimant who undergoes surgery following the designated doctor's certification then must be examined by a designated doctor who is a surgeon. We do so here only because of the extreme difficulty encountered in the diagnosis of the injury, the course of treatment culminating in the approval of the particular spinal surgery, and the lack of an examination and certification by a doctor possessing the expertise to fully evaluate the condition.

We reverse the hearing officer's decision and order and remand this case for proceedings consistent with this decision. 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.

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Judy Stephens  
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.  
Chief Appeals Judge

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Elaine M. Chaney  
Appeals Judge