APPEAL NO. 990311

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). On January 13, 1999, a hearing was held. The hearing officer determined that the appellant (claimant) reached maximum medical improvement (MMI) on December 8, 1995, with an impairment rating (IR) of five percent, and with disability continuing after December 8, 1995. Claimant asserts that the designated doctor's report was overcome by the great weight of other medical evidence citing that no rating was provided for a specific disorder under Table 49, Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). Claimant also states that the designated doctor did not apply his own professional judgment to his report, that the case should be returned to the designated doctor for added range of motion (ROM) testing, that the hearing officer should not consider an "intervening injury" without placing the burden of proof on respondent (carrier) to show sole cause, and, referring to a "tape measure" states that the hearing officer should correspond with the designated doctor to clarify whether he conducted his examination in conformity with the AMA Guides. Carrier replied that the decision should be upheld. Claimant then replied to the carrier's response but did not do so in the allowed time period. *See* Section 410.202.

DECISION

We affirm.

Claimant testified that he worked for (employer) on _____, when he injured his back pulling material up to a scaffold with rope. He saw his family doctor "the following Monday," (this was evidently Dr. N). He treated claimant into December 1994 and then referred him to Dr. T. MRIs were accomplished on the lumbar and thoracic spine on October 26, 1995. Dr. T said that claimant's x-rays show "significant disc disease . . . osteiophytes in the lower thoracic segments consistent with juvenile onset Sherman's disease." Claimant was referred to Dr. S, who appears to have begun treating claimant in January 1995. At that time the history indicated "past medical history of . . . spinal trauma" with a "more recent work-related injury which occurred on (most recent work-related injury)." Dr. S also noted that there was "prior spinal injury at the same level" with that level described as "T-7 to the iliac crest." Dr. S then stated that "after three years, the chances for excellent resolution are not good."

Dr. S referred claimant to various doctors. During July 1995 claimant was seen by Dr. A, a neurosurgeon. Dr. A noted that trigger point injections, epidural steroid injections, and nerve blocks had been done without significant relief, adding that claimant denied "any past history of injuries to his back or other problems relative to his back except for a repair of a small fascia hernia . . . ." Dr. A said that claimant's MRI showed "no evidence of disc herniation or mass"; he did note degenerative changes, however. Dr. A also noted "symptoms somewhat out of proportion . . . ." (Claimant had been referred to Dr. G for intercostal injections.) Dr. S also sent claimant back to Dr. N in May 1995 because

claimant was an "extremely high risk for heart attack." Claimant was also seen by Dr. Tu in September 1995, who examined him on behalf of the carrier; he referred to an MRI of the lumbar area as showing no evidence of a herniated disc and an MRI of the thoracic area was said to be "within normal limits." He referred to a 1992 history of surgery for a lumbar fascial hernia. He compared x-rays from "nearly a year" ago to present ones and said that there "appears to be a progression of the soft tissue ossifications, primarily about the lower thoracic level." He thought no surgery was called for. He recommended a bone scan to rule out "occult skeletal pathologies" which he said the mid to lower thoracic spine should be examined for. He thought MMI could be reached in two to three months.

Dr. S on December 8, 1995, provided a "maximum medical benefit report" but did not specify that MMI was reached on December 8, 1995, although he did state that the IR was zero percent. He did a physical examination on that day, noting that claimant found "light touch . . . excruciating" on his back, but noted also that while claimant "was distracted, I stroked my hand up and down his back, without any sign of discomfort," adding that this was witnessed by his nurse. He went on to discuss "functional overlay," noting that the area of pain is "not physiologic [emphasis added]" demonstrating no "specific dermatomal distribution," that imaging studies are negative, and said there was an absence of other vasomotor signs. Claimant disputed this IR.

A designated doctor, Dr. W, was provided. He evaluated claimant on January 27, 1996, and found MMI on December 8, 1995, with five percent IR, comprised of three percent for lumbar ROM, one percent for thoracic ROM, and one percent for ROM of his left shoulder. Dr. W noted the MRI results from October 26, 1994, showed no abnormalities except "mild degenerative changes," specifically stating there was "no evidence" of a herniated disc.

In April 1996 Dr. Wa stated that claimant returned (the record does not make it clear whether Dr. Wa was the treating doctor for a period of time--there is no indication that he was examining claimant on behalf of the carrier. He too stated that "all of claimant's examinations thus far have turned out negative, and I feel this is a myofascial strain." He noted a "considerable amount of spondylosis throughout the spine."

Another note from Dr. Wa appears in the record over one year later on July 14, 1997. He referred to physical therapy having been done, but noted that he had not seen claimant since August 1996. Dr. Wa referred to the 1994 MRI which showed no disc problem but added:

> But that does not mean he doesn't have a disc problem now. If he came to us now and all he had was a 3-year old MRI, we'd get a new one, because things change. [Emphasis added.]

In August 1996, Dr. Wa had noted a chronic muscle strain and "generalized deterioration of the spine." The parties at the hearing did not stipulate as to the date of statutory MMI, but claimant in his closing argument in proposing that MMI be found to be at statutory MMI,

stated that it occurred on October 14, 1996. Therefore, statutory MMI took place nine months before Dr. Wa's July 1997 note that said "things change."

Dr. Gh began treating claimant. He is listed on a series of tests (lumbar myelogram, CT scan, and discogram) that were done in July 1997. These studies referred to bulging and herniated discs throughout the lumbar area. Dr. Gh on July 11, 1997, said that he reviewed the "discogram" (the myelogram was done on July 3, 1997, while the discogram was done on July 28, 1997). He said it shows "bulging discs" throughout the lumbar area. On August 1, 1997, Dr. Gh stated that the discogram showed disc tears at L2-3 and L4-5. There is no indication in the record that any attempt was made to seek a review of these studies by the designated doctor in the remaining five months of 1997 or in the first six months of 1998.

On October 22, 1998, four years after the injury and two years after claimant stated statutory MMI was reached, Dr.Gh noted that claimant's back pain was "recently much worse." Several months earlier on July 6, 1998 (one year after the myelogram, CT scan, and discogram were done), the Texas Workers' Compensation Commission (Commission) wrote to Dr. W attaching these studies and asking him to review them and state whether his opinion was changed. No question was raised at that time about the manner in which Dr. W had performed the designated doctor evaluation in January 1996, approximately 29 months before. Dr. W replied on July 21, 1998, stating that he had reviewed the added notes and studies but commented, "multiple physicians have evaluated the MRI study of the lumbar region which was not felt to show significant evidence of disc herniations or neurologic impingement. The documents provided by your office does [sic] not change the previous [IR] or my opinion regarding it." (Emphasis added.)

Dr. Gh then provided a Report of Medical Evaluation (TWCC-69) in which he said that the date of MMI was September 8, 1998, with an IR of 21%.

The hearing officer is the sole judge of the weight and credibility of the evidence. *See* Section 410.165. When there is a designated doctor involved in a case, his opinion as to MMI and IR will be given presumptive weight and will be used to determine MMI and IR unless the great weight of other medical evidence is contrary to the designated doctor. *See* Sections 408.122 and 408.125.

Claimant first states that IR from Table 49 for a specific disorder should have been allowed. Texas Workers' Compensation Commission Appeal No. 960406, decided April 15, 1996, pointed out that Table 49 is a two-step process; a herniated disc must correlate to signs or symptoms. We note that Dr. S had observed that claimant's pain was not physiologic and does not fit any dermatomal distribution. In addition, there were no objective findings at the time of Dr. S' and Dr. W's reports of MMI and IR. Also, herniated discs that were not identified by the designated doctor may be present much later but do not necessarily mean that another injury occurred for which carrier had the burden of proof to show sole cause; as Dr. Wa said in July 1997, "things change." (He did not say that there had been a substantial change in claimant's condition, and the hearing officer did not find that another injury occurred.) In addition, Texas Workers' Compensation Commission

Appeal No. 94570, decided June 15, 1994, said that bulging discs do not necessarily require an IR, noting also that they had to correlate with objective clinical findings, and stating that to have an IR there must be pathology "caused by the compensable injury." Texas Workers' Compensation Commission Appeal No. 962293, decided December 20, 1996, affirmed no IR when the herniated disc involved was found not to have been aggravated by the injury. Perhaps as important, Texas Workers' Compensation Commission Appeal No. 950861, decided July 12, 1995, reversed an amended IR and rendered that the IR would not be changed after statutory MMI unless there was a substantial change of condition or treatment, such as surgery, in process at the time of statutory MMI. There was no argument made that claimant underwent a substantial change of condition; even if such an argument were made, a progression of degenerative disc disease to herniated discs three years after injury does not mandate that a substantial change of condition has occurred. *Compare to* Texas Workers' Compensation Commission Appeal No. 951273, decided September 18, 1995, which allowed a change in the IR after statutory MMI when the disease involved could not be diagnosed before that time. In the case under review, the designated doctor was not required to provide an IR from Table 49 based on the evidence developed at the time of evaluation and was not required to give more weight to tests performed approximately 29 months after injury than he did to other tests proximate in time to the injury.

The claimant also states that Dr. W did not personally review the MRI in concluding that there was no pathology to rate. Texas Workers' Compensation Commission Appeal No. 93381, decided July 1, 1993, stated that a designated doctor does not have to interpret tests himself but may rely on interpretations by others, noting that otherwise a designated doctor in certain occupational disease cases would have to microscopically interpret blood samples himself. The designated doctor decides when he can rely on another interpretation and when he needs to see the scan himself. Compare to the requirements for spinal surgery in which second opinion doctors must review the films. *See* Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 133.206(i)(2) which requires an opinion "based on . . . films forwarded by the surgeon." In addition, Dr. W in his 1998 reply said that the medical records sent did not change "[his] opinion." The hearing officer could conclude that the report of Dr. W was his own.

The remaining questions raised on appeal relate to the manner in which Dr. W performed the IR examination. First, we note, as stated, that when the Commission was asked to clarify the IR of Dr. W in July 1998 (approximately 20 months after statutory MMI and approximately 29 months after Dr. W provided his report), there is no indication that a question of the manner of evaluation was raised--the only question was as to a review of additional studies (already approximately one year old) performed in 1997. Claimant states that he should be re-examined because a "consistency" question was presented when, Dr. W said, "dicomfort did not allow me to do rotational testing of his thoracic spine," and a lack of consistency calls for a repeat of the test; a remand is requested so that re-examination may be done. However, the Appeals Panel in numerous cases, including Texas Workers' Compensation Commission Appeal No. 970954, decided July 7, 1997, has stated that a claimant may only be re-examined for a proper reason and in a reasonable time. Even if claimant's discomfort were equated to a consistency problem, which was then interpreted

to be a proper reason, over two years past statutory MMI, over 30 months after the designated doctor's opinion, and six months after claimant last queried the Commission about the designated doctor, without raising this point at that time, constitutes an unreasonable time in this case.

The other aspect of the designated doctor's manner of doing the evaluation raised by claimant involves the use of a tape measure at some point in the examination which is said by claimant to necessitate a letter of clarification. Such a letter could have been written at an earlier time within the discretion of the hearing officer or other official, but use of a tape measure does not require a conclusion that the AMA Guides were not followed. *See* Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993, which did not find a "substantial basis" for rejecting the designated doctor's report based on evidence that he used a "measuring tape, rather than an inclinometer."

The determination of the hearing officer that Dr. W's certification of MMI and IR has not been overcome by the great weight of contrary medical evidence is sufficiently supported by the evidence. The determinations that claimant's date of MMI is December 8, 1995, and his IR is 5% are sufficiently supported by the evidence. Finding that the decision and order are sufficiently supported by the evidence, we affirm. *See* In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

_____
Joe Sebesta
Appeals Judge

CONCUR:

_____
Stark O. Sanders, Jr.
Chief Appeals Judge

_____
Tommy W. Lueders
Appeals Judge