APPEAL NO. 990540

Following a contested case hearing held on February 4, 1999, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer, resolved the sole disputed issue by determining that the impairment rating (IR) of the respondent (claimant) is 16% as certified by the designated doctor. The appellant (self-insured) has appealed this determination. The file does not contain a response from claimant.

DECISION

Reversed and a new decision rendered.

According to the August 27, 1998, report of the designated doctor, Dr. G, claimant was injured while working for the self-insured as a custodian on _____, when forced to use a malfunctioning buffer which turned back and twisted her around and reinjured her lower back. Claimant testified that she underwent spinal surgery on February 12, 1997; that following this surgery she developed a staph infection, "had to get [her] spine scraped," and underwent five more surgical procedures; that the self-insured's doctor, Dr. WB, determined that she reached maximum medical improvement (MMI) on July 23, 1998, and assigned an IR of 29%; that the self-insured disputed Dr. WB's IR; that Dr. G, the designated doctor, determined that she reached MMI on July 23, 1998, and assigned an IR of 16%; and that her treating doctor, Dr. CB, concurred in Dr. WB's 29% IR. She also said she was seen several times by Dr. B, an infectious disease consultant. Claimant urged that she was entitled to additional ratings for impairment from the procedures she underwent following her initial spinal surgery. She first asked the hearing officer to find that her IR was 29% as assigned by Dr. WB and concurred in by Dr. CB; in the alternative, she requested the 16% IR assigned by the designated doctor.

Ms. P testified that she is a claims supervisor for the self-insured's third party administrator and that she has reviewed claimant's record but does not have medical training. She stated that following claimant's initial spinal surgery, no further requests for spinal surgery were filed on behalf of claimant and that the self-insured feels that the five subsequent procedures claimant underwent do not qualify as additional spinal surgeries and thus do not qualify for additional ratings under the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides).

The February 12, 1997, operative report of Dr. FS reflects that claimant's diagnosis was "Disc L5 transitional"; that another doctor performed the laminectomy, diskectomy, facetectomy, and foraminotomy "L5 to transitional vertebra bilaterally"; and that Dr. FS performed "spinal fusion five transition to sacrum." Dr. FS's records reflect that on "02/27/97," claimant was taken to the operating room (OR) where she was given general anesthesia and her "back was opened up"; that pus was drained; that a possible cyst, superficial and not deep into the laminar area, was removed; that curettage was done; and

that the wound was irrigated and closed. Dr. FS's other records indicate that on "03/03/97," claimant was taken to the OR where she was given general anesthesia and necrotic tissue was again debrided; that on "03/06/96 [sic]," claimant was taken to the OR where she was given general anesthesia and purulent material and necrotic tissue was removed and debrided from the surgical wound which was then irrigated and dressed; that on "03/26/97," claimant was taken to the OR and "the back was debrided and irrigated"; and that on "04/15/97," claimant was taken to the OR where she was given general anesthesia and necrotic tissue was removed and the wound irrigated and closed. Dr. FS wrote on January 14, 1999, that claimant "was operated on initially for back surgery, that is surgery on her spine," and that "[s]he subsequently developed infection and had to have debridement of her back which means spine."

Also in evidence is an April 14, 1998, report by Dr. SS stating that since her spinal surgery claimant has had a persistent postoperative low back infection, that an MRI on April 8, 1998, demonstrated two postoperative fluid collections in the lower back on the right, and that the fluids were successfully aspirated. The MRI report stated that these fluid collections could be either sterile seromas or abscesses or both.

Dr. B's June 17, 1998, report states that he examined claimant on that day; that her white count was normal; that there is no further evidence of swelling or fluctuance along the back wound; that she has good range of motion (ROM) and excellent motor power in the lower extremities; and that he does not think she still has persistent infection in her back.

Dr. WB's Report of Medical Evaluation (TWCC-69), dated July 23, 1998, states that claimant reached MMI on that date with an IR of 29%. In his narrative report of the same date, Dr. WB states that claimant's IR was calculated according to the AMA Guides. Referring to Table 49 for impairment for specific spinal disorders, Dr. WB states that claimant "qualifies under Category II E Lumbar, granting her a 10% Whole Person Impairment," and that "she has also undergone approximately five documented surgery [sic], and as such under Category II G, is granted a 2% impairment for the first, and 1% impairment for the additional four, giving her a 6% Whole person Impairment" for a total of 16% based on specific disorders. Dr. WB further states that claimant qualifies for 13% for abnormal ROM and three percent for neurological impairment all of which combine for a total whole person IR of 29%.

Dr. G's TWCC-69, dated September 3, 1998, states that claimant reached MMI on "07/23/1998" with an IR of 16%. Dr. G's narrative report of August 27, 1998, reflects that claimant was then 59 years of age, that she exhibited positive Waddell signs, and that Dr. G's diagnosis was post surgical arachnoiditis, lumbar spine. Concerning the IR, Dr. G stated that claimant is assigned 10% under Table 49 II E for lumbar spine surgery with residual symptoms, two percent under Table 49 II G "for the second surgery on 2/27/98 [sic]," and "an additional 1% for each of the surgeries on 3/3/97, 3/6/97, 3/26/97, and 4/15/97 rendering a 4% whole person [IR]" for a total IR of 16% under Table 49. Dr. G further stated that claimant had no ROM impairment and that no sensory or strength impairments were identified.

In evidence is a September 28, 1998, "[IR] Review" report from Cascade Disability Management, Inc. which is signed by Ms. I and which reflects that in 1997 she completed the designated doctor training course in cooperation with the Texas Workers' Compensation Commission (Commission). Ms. I's report states that the designated doctor's report was reviewed; that claimant was correctly awarded a 10% IR from Table 49 II E; that claimant was also correctly awarded a two percent IR from Table 49 II G1; that claimant may have been incorrectly awarded an additional one percent for each of the surgeries of March 3,1997, March 6, 1997, March 26, 1997, and April 15, 1997, totaling four percent; that this may be an incorrect assignment of impairment as each of these surgeries were done to treat open wound infections and would not fall under Table 49 II G; and that claimant's Table 49 impairment is 12%.

Dr. CB wrote on November 5, 1998, that following her initial surgery, claimant developed a staphylococcal infection and underwent several weeks of intravenous antibiotic therapy and the procedures by Dr. FS; that she has healed from the surgery and complications but is left with less than optimal operative results; and that she has extensive scar tissue which limits her lumbar ROM and which is in addition to the restriction in ROM generally anticipated following lumbar spine fusion. Dr. CB felt that Dr. G did not take into consideration the extensive damage to the tissues involved in the original surgery and later complications and he agrees that a 29% IR is a more accurate reflection of her current condition. Dr. CB further wrote on January 25, 1999, that he understands there is a dispute regarding the multiple surgical procedures claimant had relating to her spinal injury; that following the original surgery, she developed wound infection involving the spine and had additional surgical procedures for incision and drainage of the wound; that all of the surgeries are related to her spinal condition; and that he feels the 29% IR more accurately reflects her current medical condition.

Table 49 of the AMA Guides, entitled "Impairment Due to Specific Disorders of the Spine," provides in Table 49 II E for a 10% rating for surgically treated disc lesions with residual symptoms. Table 49 II G 1 instructs to "add 2%" for a "second operation" and Table 49 II G2 instructs to "add 1%/operation" for "third or subsequent surgery." Part 3.3a of the AMA Guides at page 71 includes a paragraph entitled "Principles for Calculating Impairment." That paragraph's first sentence states: "Evaluation of impairment of the spine involves both diagnosis-related factors (i.e. structural abnormalities), and musculoskeletal/neurological factors that require physiologic measurements."

Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 133.206 (Rule 133.206) is entitled "Spinal Surgery Second Opinion Process." Rule 133. 206(a)(13) defines "concurrence" as follows:

> A second opinion doctor's agreement that the surgeon's proposed type of spinal surgery is needed. Need is assessed by determining if there are any pathologies in the area of the spine for which surgery is proposed (i.e. cervical, thoracic, lumbar, or adjacent levels of different areas of the spine)

> that are likely to improve as a result of the surgical intervention. Types of spinal surgery include but are not limited to: stabilizing procedures (e.g. fusions); decompressive procedures (e.g. laminectomy); exploration of fusion/removal of hardware procedures; and procedures related to spinal cord stimulators.

The hearing officer found that following the spinal surgery, claimant developed wound infection at the surgical site which required five additional surgical procedures which he identified as the procedures performed on February 27, March 3, March 18 (sic), March 26, and April 15, 1997; that Dr. WB's IR consisted of 16% for specific disorder impairments, 13% for ROM impairment, and three percent for lower extremity motor dysfunction; that the self-insured disputed Dr. WB's IR and Dr. G was appointed as the designated doctor; that Dr. G certified that claimant reached MMI on July 23, 1998, with a 16% IR; that Dr. G's IR was essentially the same as that of Dr. WB except that Dr. G did not assign any impairment for ROM or for the lower extremities; and that Dr. G's IR is not contrary to the great weight of the other medical evidence. The hearing officer concluded that claimant's IR is 16% as certified by the designated doctor.

The self-insured contends on appeal that "the designated doctor's [IR] is appropriate except for the 1% he added to the [IR] for each of the four additional procedures" and that claimant's correct IR is 12%. Since the self-insured accepts the additional two percent added for the February 27, 1997, procedure, which involved the removal of a possible cyst, we do not address that rating. The self-insured contests on appeal that the assignment by the designated doctor of the additional four percent under Table 49 II G2 for incision wound care procedures was error in that the AMA Guides do not contemplate that subsequent wound care procedures at the site of spinal surgery, even if they involve incision and/or debridement, qualify for additional ratings under Table 49 of the AMA Guides. The self-insured contends that the procedures following the initial spinal surgery are more correctly classified as post-surgery incision wound care and not spinal surgery. The self-insured noted that in Texas Workers' Compensation Commission Appeal No. 950472, decided May 8, 1995, the Appeals Panel stated that it was unclear in that case whether a later operation to repair an incisional hernia, following spinal surgery and after the employee had reached statutory MMI, was actually spinal surgery or merely the repair or debridement of scar tissue from the site of the incision from the original surgery and that with the record in that state, the Appeals Panel could not say as a matter of law that the employee was entitled to additional impairment for a second spinal surgery.

Section 408.125(e) provides in part that the report of the designated doctor selected by the Commission is entitled to presumptive weight and that the Commission shall base the IR on such report unless it is contrary to the great weight of the other medical evidence.

We agree with the self-insured that the last four procedures performed by Dr. FS on claimant's back following her spinal surgery were treatments for an infected incision wound and did not qualify for additional percentages of impairment under Table 49 II G2 of the AMA Guides, and that the additional four percent added for them by the designated doctor

was error. We do not find error in the remainder of the designated doctor's IR, namely, 10% under Table 49 II E and the two percent under Table 49 II G1, which are accepted by the self-insured; and, further, we, do not find that Dr. G's report is otherwise contrary to the great weight of the other medical evidence. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

Accordingly, we reverse Conclusion of Law No. 3 and so much of the hearing officer's decision as states that claimant's IR is 16% and we render a new decision that claimant's IR is 12% based on the designated doctor's report.

Philip F. O'Neill
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Judy L. Stephens
Appeals Judge