

APPEAL NO. 991556

On June 24, 1999, a contested case hearing (CCH) was held. The CCH was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). The issue at the CCH was the impairment rating (IR) of respondent (claimant). The appellant (carrier) requests that the hearing officer's decision that the claimant's IR cannot be determined until another designated doctor is selected be reversed and that a decision be rendered that claimant has a zero percent IR as determined by the designated doctor chosen by the Texas Worker's Compensation Commission (Commission). No response was received from claimant.

DECISION

Reversed and remanded.

Claimant testified that prior to her back injury of Injury 2, she had sustained a slight lumbar strain in injury 1 while working for a previous employer, that she was treated by a doctor in injury 1 for that strain, that that doctor released her from treatment in injury 1, and that she had not again had treatment for her back or had any other back problems until her injury of Injury 2. Claimant testified that on Injury 2, she was lifting a large bag of coins and a box of coins from a floor-level filing cabinet when she felt a twinge and pop in her back. She said the bag had 100 rolls of pennies in it. The parties stipulated that on Injury 2, claimant sustained a compensable low back injury. The IR dispute involves the Injury 2, compensable injury. Claimant said that since her injury, she has had 30 epidural steroid injections and that her treating doctor, Dr. J, has told her that she may need surgery and recently sent her for a surgical consultation with another doctor, who is referring her to another doctor. She said she has not improved with the injections, that she continues to have back pain radiating into her right leg, and that she takes pain medication prescribed by Dr. J every day. Claimant has been off work since her injury and Dr. J has reported that claimant should not work.

Claimant had a lumbar MRI done on December 30, 1996, and the radiologist reported that at L3-4 there is mild degenerative disc desiccation and a mild disc bulge, without significant thecal sac compression or definite evidence of nerve root impingement; that at L4-5 there is mild spondylosis, mild degenerative facet arthrosis, degenerative disc desiccation, and a left lateral disc protrusion, without thecal sac compression or evidence of nerve root impingement, but with an abnormality suggesting inflammation associated with a radial annular tear; and that at L5-S1 there is mild spondylosis, mild degenerative disc desiccation, a mild to moderate disc bulge lateralizing to the right, and mild narrowing of the right lateral recess and neural foramen, abutting, but not definitely impinging upon, the right L5 nerve root. Dr. J has reported on numerous occasions since the December 1996 injury that claimant has complaints of lumbar pain radiating to her hips and legs. In February 1997, Dr. J diagnosed claimant as having a herniated nucleus pulposus (HNP) at L4-5 and L5-S1, bilateral sacroiliitis, facet arthropathy, and severe myofascial pain syndrome. Dr. J reported in February 1997 that EMG and nerve conduction studies she performed on

claimant showed evidence of right L5 nerve root irritation and she added a diagnosis of right L5-S1 radiculopathy.

Dr. L examined claimant at carrier's request on May 14, 1997, and he reported in a Report of Medical Evaluation (TWCC-69) dated May 19, 1997, that claimant reached maximum medical improvement (MMI) on May 14, 1997, with a zero percent IR. Dr. L noted that surgery had not been recommended, that he reviewed the MRI films, that those films showed degenerative disc desiccation at L4-5 and L5-S1, that there is no significant disc herniation or bulging present at any level, that there is only minimal desiccation and minimal bulging present at L4-5 and L5-S1, and that there is no nerve root entrapment at any level. Dr. L noted that clinical examination of claimant was highly reflective of symptom magnification, functional overlay, or frank malingering; that claimant does not appear to have any objective evidence of a serious back injury; that claimant has no sign of a surgical problem; that claimant does not require further medical treatment; and that no permanent impairment appears present due to the injury.

The Commission chose Dr. G as the designated doctor for the purpose of examining claimant for MMI and IR. In a TWCC-69 dated July 28, 1997, Dr. G reported that claimant reached MMI on July 28, 1997, with a zero percent IR. The parties stipulated that claimant reached MMI on July 28, 1997, per Dr. G's report. Dr. G recorded the history of claimant's 1996 work injury and the injury 1 strain. He reported that he examined claimant on July 28, 1997; that he reviewed the x-rays, MRI, and EMG; that the x-rays showed mild degenerative changes; that the MRI showed a mild disc herniation at L4-5, with some slight narrowing of the neural foramen at L5-S1 and some degenerative changes; and that claimant has had back pain radiating down her right leg. Dr. G noted an impression of lumbar strain and lumbar spondylosis. Dr. G wrote that he did not find any objective evidence of impairment on examining claimant "physically, neurologically, and in performing lumbar range of motion [ROM] evaluation" and he assigned her a zero percent IR for her work injury of Injury 2. Dr. G also wrote that in his opinion "the findings on the x-ray and MRI scan are not necessarily related to her Worker's Compensation injury or certainly not provably related to it, therefore, I would not assign her any impairments due to specific disorders of the spine." He also wrote that the EMG findings were of a nonspecific abnormality and not related to her work injury.

On August 7, 1997, Dr. J responded to Dr. G's TWCC-69, stating that the evaluation was not done according to the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), that claimant had well-documented pain and muscle spasm for more than six months, that the MRI was positive for a ruptured disc at L4-5 and a mild to moderate disc bulge at L5-S1, that Dr. G had stated in his report that claimant had some mild disc herniation at L4-5 with slight narrowing of the neural foramen at L5-S1, that that qualifies claimant for 13% impairment for a specific disorder of the spine under Table 49 IIB and IIC of the AMA Guides, and that ROM deficits show a combined disorder of the spine.

On November 25, 1997, a Commission disability determination officer sent Dr. J's response to Dr. G and asked if it remains his opinion that claimant reached MMI on July 28, 1997, with a zero percent IR, and also asked if he thought a reexamination of claimant is necessary. In his response dated January 8, 1998, Dr. G repeated statements he made in his TWCC-69 and added that "I fully agree with the official findings of the patient's imaging studies, however, I feel that these findings are not related to the present Workers' Compensation injury and are not provably pain generators in this patient. Therefore, I have not assigned any [IR] to this patient based upon Specific Disorders of the Spine as indicated on Table 49, on page 73 of the [AMA Guides]."

Dr. J reported that another EMG and nerve conduction study she performed on claimant on January 19, 1998, showed evidence of a L5 radiculopathy. In this EMG report, Dr. J stated that the December 1996 MRI showed "some bulged disc at L4-L5 and L5-S1 levels" and that "there is probably a pain generator in this patient." Dr. J added that she does not have an MRI prior to claimant's injury, that claimant was working full time and doing fine before her injury, and that she is not able to say that the MRI and EMG findings are "premorbid prior to injury." In a March 1998 report, Dr. J stated that she was requesting that claimant undergo a neurosurgical consultation to determine if claimant is a surgical candidate and gave diagnoses of L5-S1 HNP, sacroiliitis, and facet syndrome. In an April 1998 report, Dr. J recommended a CT myelogram.

In a letter to Dr. G dated May 5, 1998, a benefit review officer (BRO) wrote that she was asked to request clarification, that "case law has held that an asymptomatic pre-existing condition which is aggravated or accelerated by a compensable injury is part of the injury," that based on that would he continue to exclude a rating for a specific disorder of the lumbar spine and "please explain," that lumbar ROM was invalidated due to failure to meet consistency requirements, and that if retesting was not done, would it be appropriate to retest ROM.

In a letter dated May 28, 1998, Dr. G responded to the BRO's inquiry, stating that, in his opinion, "there is no evidence that the abnormality on the patient's x-ray and MRI scan were either caused by the present injury or the cause of the patient's symptoms. They are most likely pre-existing abnormalities which were not aggravated by her Workers' Compensation injury. Therefore, they are not eligible for any rating for specific disorders of the lumbar spine." Dr. G added that he would retest claimant for ROM.

Dr. J referred claimant to Dr. A, apparently for a surgical consultation, and Dr. A examined claimant on June 10, 1998. Dr. A wrote that the MRI showed a small protrusion at L5-S1, without evidence of nerve root compression, and mild degeneration at L4-5, without evidence of nerve root compression. Dr. A stated that, in his opinion, claimant does not have any problems with compression of the nerve roots and has nothing that indicates that surgery is necessary. He also stated that claimant was at MMI and does not require any significant treatment. However, Dr. A also stated that, if there is any doubt about any other pathology, a myelogram and CT scan would be indicated. He said that as far as he could see, claimant has no neurological abnormalities.

Dr. G reexamined claimant on August 5, 1998, and in a TWCC-69 dated August 5, 1998, he again reported that claimant reached MMI on July 28, 1997, with a zero percent IR. Dr. G noted that when he originally examined claimant in July 1997, he found inconsistent findings in her lumbar ROM; that he reexamined her on August 5, 1998; that he reviewed all of her medical records from the time he originally saw her to the date of the reexamination, including, among other things, a lumbar MRI (according to a report of Dr. J, that MRI was done in February 1998) and an EMG done in the last few months; that that EMG showed findings of denervation in some of the lumbar paraspinal muscles and some other nonspecific findings; that the MRI showed some bulging at L3-4 and L4-5 and a tiny central disc herniation at L5-S1, with no spinal stenosis or compression of nerve roots; that physical examination was unchanged from his prior examination of claimant; that repeat ROM testing measurements were invalid; that there were no sensory findings; that claimant's diagnosis is lumbar strain and lumbar spondylosis; and that "again, I did not find any objective evidence of impairment on examining this patient physically, neurologically, and with performing lumbar [ROM]."

Dr. G added that claimant has relatively minor findings on her lumbar MRI; that those findings would not be unusual in a woman of claimant's age, 43; that those findings are not necessarily pain generators or the cause of symptoms; that the MRI has no evidence of lumbar radiculopathy or nerve root compression; that there is no evidence of that clinically; and that the EMG findings are nonspecific and not related to claimant's work injury. Dr. G also stated that there is a strong nonorganic overlay in claimant, that her examination showed what appeared to be an inconsistent and exaggerated limitation of back motion; and that he cannot assign her any impairment for ROM, neurological abnormality, or specific disorders. Dr. G wrote that claimant told him that she is being considered for a myelogram, CT scan, and surgery; that if claimant underwent surgery she would have to be reevaluated; that it is his opinion as a neurologist that the claimant is not a candidate for surgery; and that he doubts that any type of lesion would be found, which, if surgically approached, would result in improvement or would be considered responsible for her symptoms.

Claimant underwent a myelogram and CT scan on September 16, 1998. Dr. LE reported that the myelogram showed "ventral dural defect consistent with posterior disc bulge at the L3-4, L4-5, and L5-S1 levels with significant compression of the L5 nerve root sleeve bilaterally." Dr. LE reported that the post myelogram CT scan showed "1. Broad posterior L3-4 disc bulge compresses the anterior thecal sac and creates central spinal stenosis. 2. Very broad based posterior L4-5 disc bulge extends to the neural foraminal region bilaterally and creates moderate narrowing of the neural foramen on each side in addition to compression of the thecal sac centrally. 3. Right posterolateral L5-S1 disc bulge presses on the right anterolateral thecal sac and creates some impression upon the right S1 nerve roots." In correlating the CT scan findings with the myelogram findings, Dr. LE wrote that there is a disc bulge at L3-4 pressing against the thecal sac, that there is a disc bulge at L4-5 causing significant compression of the thecal sac, and that there is a right posterolateral disc bulge at L5-S1, which presses against the thecal sac and creates some

impingement upon the right S1 nerve root. It does not appear that the myelogram and CT scan reports were ever sent to Dr. G.

Dr. J reviewed the myelogram and CT scan findings and wrote in October 1998 that a zero percent IR was unacceptable because claimant suffers pain, the EMG shows lumbar radiculopathy, and the February 1998 MRI shows a disc herniation at L5-S1 and degenerative stenosis at L4-5. In a TWCC-69 dated November 13, 1998, Dr. J reported that claimant reached MMI on November 13, 1998, with a 24% IR. Dr. J assigned impairment of seven percent for a specific disorder of the lumbar spine and 18% for abnormal ROM. Dr. J reviewed the diagnostic testing. She stated that claimant sustained injuries to her lumbar spine on Injury 2, when lifting the bag and box of coins. Dr. J wrote in February 1999 that claimant was hesitant about surgery and would like to continue conservative care.

A third MRI was done on April 21, 1999, and Dr. B reported that it showed a minimal L3-4 disc protrusion; a moderate L4-5 disc protrusion, possibly with a small extruded portion; and a moderate L5-S1 disc protrusion with annular tear. It does not appear that this MRI report was ever sent to Dr. G.

Section 408.125(e) provides that, if the designated doctor is chosen by the Commission, the report of the designated doctor shall have presumptive weight, and the Commission shall base the IR on that report unless the great weight of the other medical evidence is to the contrary, and that, if the great weight of the medical evidence contradicts the IR contained in the report of the designated doctor chosen by the Commission, the Commission shall adopt the IR of one of the other doctors. Section 401.011(23) defines impairment as "any anatomic or functional abnormality or loss existing after [MMI] that results from a compensable injury and is reasonably presumed to be permanent." Section 401.011(24) defines IR as "the percentage of permanent impairment of the whole body resulting from a compensable injury."

The hearing officer found that Dr. G is "unwilling" to evaluate claimant's impairment and that his report is not entitled to presumptive weight because it is against the great weight of the other medical evidence and because of his "apparent refusal to rate the claimant's injury." The hearing officer concluded that "claimant's IR cannot be determined administratively until another designated doctor is selected to resolve this dispute since the current designated doctor is unwilling to fully evaluate the claimant's lumbosacral injury for an IR." Carrier appeals the hearing officer's decision and order and requests that we find that claimant's IR is zero percent. In Texas Workers' Compensation Commission Appeal No. 941729, decided February 10, 1995, the Appeals Panel stated:

We have stated that the appointment of a second designated doctor does not appear to be contemplated by the [1989] Act, and should be done only in extraordinary circumstances. Texas Workers' Compensation Commission Appeal No. 93045, decided March 3, 1993; Texas Workers' Compensation Commission Appeal No. 94042, decided February 22, 1994. Noting that

appointment of a second designated doctor is rarely appropriate, we have restricted such to circumstances such as the unavailability of the first designated doctor, or his refusal to cooperate. See Texas Workers' Compensation Commission Appeal No. 94966, decided September 6, 1994. It should go without saying that dissatisfaction with the percentage found by a designated doctor should not, in and of itself, lead to the appointment of another designated doctor.

The record does not demonstrate that Dr. G was unavailable or that he failed to cooperate; in fact, he responded on several occasions to inquiries of the Commission. He has given his opinion on claimant's IR and his reasons for his opinion. If a second designated doctor were to be appointed, that doctor would have the benefit of reviewing the reports of the September 16, 1998, myelogram and CT scan and the report of the April 21, 1999, MRI. Dr. G has not had the benefit of reviewing those reports. We reverse the hearing officer's decision and order and remand the case to the hearing officer for further consideration and development of the evidence. In particular, the hearing officer should send the reports of the September 16, 1998, myelogram and CT scan and the report of the April 21, 1999, MRI to Dr. G for his review and for his opinion as to what effect, if any, those reports have on his IR evaluation.

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 Commission's Division of Hearings, pursuant to Section 410.202. See Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Robert W. Potts
Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

Tommy W. Lueders
Appeals Judge