APPEAL NO. 991742

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on July 21, 1999. The issues at the CCH involved the impairment rating (IR) to be assigned to the respondent (claimant), for her compensable injury of _____, and the date she reached maximum medical improvement (MMI).

The hearing officer gave presumptive weight to the final report of the designated doctor that the claimant's IR was 28% and that she reached MMI on May 28, 1998, which was not against the great weight of contrary medical evidence.

The appellant (carrier) has appealed, arguing that presumptive weight is more properly accorded to a pre-surgical opinion of the designated doctor because surgery was not actively considered by the claimant at the time that report was done. There is no response from the claimant.

DECISION

Affirmed.

At inception, we would point out that whether surgery was under "active consideration" at the time a designated doctor's report is rendered relates to analysis of subsequent amendments (and surgeries) that take place after statutory MMI. Texas Workers' Compensation Commission Appeal No. 990833, decided June 7, 1999. The Appeals Panel has held that it is more reasonable to consider and accept amendments to an IR before statutory MMI has occurred. *See* Texas Workers' Compensation Commission Appeal No. 970653, decided May 28, 1997; Texas Workers' Compensation Commission Appeal No. 981587, decided August 28, 1998. The Legislature has, in essence, allowed a 104-week "window" for the effects of an injury and its treatment to transpire before moving the claimant to the next tier of benefits. In this case, the claimant's date of injury was _____, and her last day of work was August 5, 1996, making the date of statutory MMI roughly two years after that. The findings of fact of the hearing officer make clear that he considered the date that statutory MMI would have been reached in his decision.

The claimant injured her back on _____, while working as a brazer for (employer). She bent over, pushing on a box of parts to move it to her area on the line, when she pulled her back. She said that it was later in the day when she attempted to rise from sitting and could not, that she was aware of her pain, which was in the lower right back. Claimant saw a number of doctors prior to having back surgery on March 5, 1998, which was approved through the second opinion process.

An MRI from August 5, 1996, showed a disc protrusion in the lumbar spine at L5-S1 as well as degenerative disc disease. (The compensability of the injury, however, was not disputed.) The claimant's treatment was complicated somewhat by what were

characterized as pain magnification behaviors. She began treatment with Dr. P on February 12, 1997. On March 17, 1997, Dr. P, noting that claimant used a cane, found intrinsic disc pain and symptom exaggeration. He stated that he felt work hardening would be an unnecessary expense and suggested she return to her job while being monitored by him.

The claimant was referred to Dr. CR on March 20, 1997. Around this time claimant tried light duty for the employer for three to five days and was unable to continue due to pain. Dr. CR recommended re-imaging. On April 14, 1997, Dr. P examined the claimant, noted she was then in a wheelchair, and stated that she was at MMI. He stated that she was not a surgical candidate due to results of a preoperative evaluation, which considered psychological factors as well as physical.

While being treated, there was also a process of impairment evaluation being undergone. The record is not fully developed on the facts leading to the appointment of Dr. C, a chiropractor, as designated doctor, although claimant's testimony indicated that one of her treating doctors, Dr. G, gave her a 22% IR. Dr. C examined the claimant on February 19, 1997, and stated that she was not yet at MMI. She noted in her narrative that claimant had been somewhat rushed through the system toward MMI without allowing benefits of appropriate treatment to be realized. Dr. C noted that she felt claimant might be a candidate for surgery due to unrelenting pain. While not agreeing that claimant was at MMI, Dr. C noted that her testing and objective condition equated to a 29% IR.

Dr. C reexamined the claimant on July 11, 1997, and at that time noted that, despite indications of functional overlay and symptom magnification, the claimant nevertheless had a significant injury to her back. Dr. C felt her only chance for improvement was surgery, without which she was currently at MMI. Claimant's testimony indicated that she personally was not actively considering surgery. Dr. C's range of motion (ROM) figures demonstrate deficits at all planes of motion; the lateral lumbar aggregate ROM IRs were eight percent. It is unclear that the other ROM deficits were invalidated by the straight leg raising test, although it appears they might have been. However, Dr. C's reason for not including ROM figures is as follows:

> I must reiterate, however, that I do believe that [claimant] has significant injury and should be afforded the opportunity for improvement, should an acceptable option become available to her. For these reasons, I found it necessary to invalidate all [ROM] and grant impairment only for specific disorders.

A new MRI dated September 19, 1997, noted that there was the possibility of a small fissure in the left L4-5 neural foramen. An EMG done in October 1997 was normal. Dr. CR examined the claimant again and his October 20, 1997, letter indicates that he discussed surgery with her at that time.

After completion of the second opinion process in February 1998, the claimant had lumbar fusion surgery on March 5, 1998. Dr. CR performed the surgery. It appears that the Texas Workers' Compensation Commission (Commission) contacted Dr. C once more on October 12, 1998; she reevaluated the claimant (in an examination that claimant said lasted at least one and one-half hours) and certified MMI on May 28, 1998, with a 28% IR. Her lateral ROM deficits were present but less than her previous examination. The claimant was asked if she had waited until fall 1998 to "dispute" Dr. C's seven percent IR; she stated that she believed she had raised the matter earlier, but that the Commission's request to Dr. C had followed a benefit review conference (BRC). None of the documentation for this earlier BRC is in the record. There is in evidence a letter dated August 28, 1998, from Dr. G, asserting that the claimant has a 25% IR.

Dr. CR examined claimant on October 5, 1998, in a post-surgical follow up and found her improved somewhat but not completely. Dr. CR discussed with the claimant a morphine pump for pain relief.

The hearing officer found that Dr. C's October 1998 report, post-surgical, was done for a proper purpose and he accorded this presumptive weight. The carrier argues that the report entitled to such weight is the seven percent IR. However, it is clear that even if the hearing officer accorded presumptive weight to the second report (or were we to reverse his decision), the result would not be a seven percent IR. Dr. C's narrative states that she omitted valid ROM measurements from her IR for subjective reasons that are not, frankly, based on the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). Without accounting for the full range of measured ROM deficits, combination of the lateral ROM figures with the specific IR from Table 49 of the AMA Guides would result in at least a 15% IR.

However, we affirm the hearing officer's determination that the third report of Dr. C was done for a proper reason and within a reasonable period of time given all the facts here. Notwithstanding the carrier's arguments about symptom magnification, surgery was approved through the proper process. (The carrier's assertion in its appeal that this surgery was "ill advised" is raised rather late in the day, and the hearing officer was not at liberty to reconsider the desirability of surgery in this CCH.) The hearing officer could believe that surgery as an ultimate procedure was, in fact, actively considered before, during, and after the time of Dr. C's July 1997 examination, even if rejected at that point for psychological reasons. The claimant could not directly communicate with the designated doctor, and it appears that reexamination was done quickly after the Commission contacted Dr. C after surgery.

The report of a Commission-appointed designated doctor is given presumptive weight. Sections 408.122(c) and 408.125(e). The amount of evidence needed to overcome the presumption, a "great weight," is more than a preponderance, which would be only greater than 50%. *See* 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. 92164, decided June 5, 1992. However, presumptive weight does not mean a "rubber stamp" adoption of the designated doctor's report where the hearing officer weighs the evidence and determines that the great weight of other medical evidence proves that the claimant is not at MMI, or that the percentage of impairment is not accurate. *See* Texas Workers' Compensation Commission Appeal No. 94053, decided February 23, 1994.

The hearing officer found that the great weight of contrary medical evidence was not against the 28% IR of Dr. C. We find this determination supported by sufficient evidence, and accordingly affirm his decision and order.

Susan M. Kelley
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Gary L. Kilgore
Appeals Judge