APPEAL NO. 001281

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 March 29, 2000, and May 2, 2000. With regard to the issues before her, the hearing officer determined that the appellant (claimant) reached maximum medical improvement (MMI) on August 3, 1995, with a 12% impairment rating (IR); and that the claimant had disability from August 4, 1995, through September 20, 1995. The claimant appealed, contending that the decision is against the great weight of the evidence, giving a detailed recitation of various treatment, contending (apparently) that there is no time limit in which to "request clarification" of (i.e., challenge) a designated doctor's opinion, and that she had been "misdiagnosed" in 1995. The claimant requests that we reverse the hearing officer's decision and that we order all records and subsequent reports be sent to the designated doctor for review and comment or we find the designated doctor's report invalid. The respondent (carrier) responds to the points raised and urges affirmance.

DECISION

Affirmed.

The file contains voluminous medical reports which are summarized is some detail by the hearing officer and which we will only briefly reference. The claimant was employed as a registered nurse (RN) and sustained a low back injury moving an operating room bed on _____. The claimant began treating with Dr. P, who prescribed conservative treatment. In January 1995, during a functional capacity evaluation for the back injury, the claimant felt a pop and sustained a cervical injury. The carrier has accepted a cervical injury as part of the compensable back injury of _____. At issue in this case is the cervical injury. Dr. P first mentions the cervical injury in a report of a February 14, 1995, visit, commenting that the claimant had "evidence of preexisting degenerative changes of C6-7 as evidence of C7 radiculitis in her right upper extremity." An MRI was performed on February 24, 1995, which showed "canal and foraminal stenosis, C6-7 and to a lesser extent, C5-6." The claimant was continued on a course of pain medication and physical therapy. The claimant testified that she continued to have neck and right arm pain and numbness in varying degrees for the next five years, but that Dr. P told her that she "would just have to deal with it."

The claimant was examined by Dr. Dr. JB, a carrier independent medical examination doctor, who, in a report dated May 2, 1995, assessed a 15% IR, which included a 6% impairment from Section II C, Table 49 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association and 1% for cervical loss of range of motion (ROM) (the rest of the rating was for lumbar conditions not at issue here). Dr. JB's impression was cervical degenerative disc disease with foraminal narrowing of C5-6, C6-7 with right radiculitis at C6-7. That IR was disputed and the parties stipulated that Dr. H was the Texas Workers' Compensation Commission-appointed designated doctor. Dr. H, in a

Report of Medical Evaluation (TWCC-69) and narrative dated October 12, 1995, noted that the claimant had been requested to return on two separate occasions for ROM measurements, referenced the MRI and Dr. P's x-rays, and certified MMI on August 3, 1995, with a 12% IR (of which 6% was due to cervical impairment from Table 49, Section II C, and 1% for cervical flexion ROM). Other cervical ROM was invalidated because it was not "reproducible."

What occurred after the fall of 1995 is not clear. Apparently, the claimant moved and admitted that she worked for about 12 weeks in January/March 1996 at a dialysis center but had to stop because of neck pain. The claimant testified that she moved back to Texas in October 1996. The claimant also testified that she sought treatment from various chiropractors and massage therapists offering canceled checks and receipts for payment of those visits in 1998. The claimant also worked as a home health nurse from January to March 16, 1997, but she said she had to quit because of the travel requirements. Apparently, at the end of March 1997, the claimant worked in a nursing home "for about a year" but stopped working there because she "had a fuss with the boss." The claimant apparently moved again and began work as an operating room nurse at a hospital in (city) in 1999 where she met Dr. N.

According to the claimant, one day in 1999 she was not feeling well, Dr. N asked her what was wrong, and she told him about what Dr. P had said, that she had been told she had some bulging discs and that Dr. N said "those disks aren't bulging, they're herniated" (this was apparently in a casual conversation without an examination). The claimant testified that at first she did not believe Dr. N, but that he "kept pounding me, [saying] I can help you." In any event, the claimant testified that she began treating with Dr. N, that Dr. N ordered an MRI, that Dr. N told her that she had "two huge herniated disks," and that Dr. N recommended surgery in the form of an "anterior cervical discectomy with intervertebral body fusion."

An MRI was performed on September 10, 1999, with the impression being:

> 1. Moderate degenerative spondylosis at the C6-7 level with mild central spinal stenosis and mild spinal cord flattening which lateralized slightly toward the left and with neuroforminal stenoses which are moderately severe on the left and moderate on the right.
>
> 2. Moderate degenerative spondylosis and chronic diffuse posterior bulge/ protrusion at the C5-6 level with mild central spinal stenosis, mild spinal cord flattening, and neuroforminal stenoses which are moderately severe on the left and moderate on the right.

The claimant contends that the 1999 MRI shows disc herniations while the 1992 MRI does not. The carrier contends that both MRIs are essentially similar. Dr. N commenced the second opinion spinal surgery process. Dr. JH, the carrier's second-opinion doctor, compared the two MRIs, was of the opinion that the 1995 MRI did not show a disc

herniation, recommended a cervical myelogram, and was of the opinion that the cervical disc surgery would not help the claimant. The claimant's second-opinion doctor, Dr. S, was of the opinion that the claimant had a herniated nucleus pulposus at C5-6 and C6-7 and agreed with Dr. N's proposed surgery. Cervical surgery was performed on November 22, 1999. Both the preoperative and postoperative diagnosis was "disk disease at C5-6 and C6-7 with right C-67 and C-7 radiculopathy, intractable pain and neurologic deficits." The carrier points out that there is no mention of a herniated disc in the operative report.

The claimant now seeks to send the 1999 MRI, diagnostic tests, second-opinion reports, and operative report to Dr. H "for clarification." Dr. H had certified MMI as of August 3, 1995; the parties agreed that statutory MMI (Section 401.011(30)(B)) was reached on August 11, 1996, and that surgery was not being considered and had not been recommended on either of the MMI dates. Surgery apparently had first been considered in August or September 1999. The hearing officer, in the Statement of the Evidence, commented:

> The report of [Dr. H] dated November 10, 1995 is given presumptive weight. The great weight of the other medical evidence is not contrary to this report. Claimant has progressive cervical spondylosis which was noted by [Dr. H] in his report of 1995. Although a designated doctor may for a proper purpose and within a reasonable period of time amend his report no clarification letter will be sent to [Dr. H] at this late date. Any response would not have been requested or received within a reasonable period of time after his first certification or for a proper purpose.

The claimant contends that Dr. H's report is "invalid" (no reason is given) and is not entitled to presumptive weight, that MMI should be the "statutory date" (which the claimant incorrectly states is August 11, 1997) and that the 1999 records, etc., should be sent to Dr. H. The claimant contends that "no authority exists that sets an outside time limit on requests for clarification," dismisses Appeals Panel decisions that the carrier cites (that an amendment of a designated doctor's report must be for a proper purpose and within a reasonable time) as not being applicable because Dr. H has not (yet) amended his report, and then cites Appeals Panel decisions which the claimant believes support her position which also involve amendment to a designated doctor's report.

In this case, the evidence appears to be in conflict with Drs. JB, H, P, and JH, and Dr. B, a referral doctor from Dr. P, who were all of the opinion that the claimant has some bulging discs at C5-6 and C6-7 with osteophytes (bone spurs) and degenerative arthritis, all of which were considered in the 1995 IR; while Dr. N, Dr. S, and Dr. T, a doctor to whom the claimant was referred by Dr. N for an IR (Dr. T's report was excluded as not having been timely exchanged), believed that surgery was necessary and that the claimant had herniated discs.

In Texas Workers' Compensation Commission Appeal No. 980999, decided June 29, 1998, we discussed the amendment of a designated doctor's report and the "proper reason" within a "reasonable time" standard, stating:

> In Texas Workers' Compensation Commission Appeal No. 94492, decided June 8, 1994, although rejecting the "snapshot" theory, that is that an indelible IR must be assessed at the time of MMI, either certified or statutory, we stated that the clear scheme of the 1989 Act is to move a case along to resolution in an orderly and expeditious manner and that it would be only the rare, exceptional case, such as the necessity of subsequent surgery, that an amendment might be proper. An IR should be assigned with reference to achieving MMI. Texas Workers' Compensation Commission Appeal No. 950615, decided June 5, 1995. In that case, citing the Texas Supreme Court case on the constitutionality of the 1989 Act (Texas Workers' Compensation Commission, *et al.* v. Garcia, 893 S.W.2d 504 (Tex. 1995)), the Appeals Panel noted that resolution of an IR cannot be indefinitely deferred to await the results of a potential lifetime course of medical treatment. We believe that is more clearly the case where there are numerous diagnostic tests and an amendment is predicated upon yet another diagnostic test performed some 19 months after an initial designated doctor's report.

Further, in Texas Workers' Compensation Commission Appeal No. 971770, decided October 23, 1997, a case cited by the carrier, the Appeals Panel set out at some length, with numerous case citations, the principles to be applied in determining whether a designated doctor's amendment of a prior report was effective, particularly in the context of what constituted a reasonable time to amend the report. Important to the analysis is the date of statutory MMI and the date when surgery came under active consideration. Texas Workers' Compensation Commission Appeal No. 990058, decided February 24, 1999. We have also held that a reasonable time may vary according to the facts of a particular case. Texas Workers' Compensation Commission Appeal No. 941168, decided October 14, 1994, and Appeal No. 971770, *supra*. Very clearly, surgery was not contemplated either when the designated doctor rendered his opinion in November 1995 or on August 11, 1996, the date of statutory MMI. In this case, Dr. H was the designated doctor, there is no evidence that Dr. H's report was invalid at the time, and the hearing officer accorded presumptive weight to Dr. H's report and that decision is supported by the evidence.

The claimant believes that the 1999 reports and documentation should have been sent to Dr. H to consider the fact that the claimant had surgery in November 1999, four years after Dr. H had rendered his report and more than three years after statutory MMI. The requested letter would have been to solicit an amended report from Dr. H which would have brought into play the proper reason/within a reasonable time analysis. We do not believe the hearing officer erred in failing to do so under these circumstances.

On the issue of disability, the hearing officer found disability, as defined in Section 401.011(16), was from August 4, 1995, to September 20, 1995, which is the last date the

claimant saw Dr. P prior to returning to work in January 1996. The carrier has apparently paid some temporary income benefits (TIBs), but it is not clear to what date. In any event, we are affirming the designated doctor's MMI date of August 3, 1995, and although that does not necessarily end disability, it does preclude the further payment of TIBs after August 3. *See* Section 408.102(a). The claimant's testimony regarding disability after January 1996 is unclear. The claimant testified that she worked from January through March 1996 (no mention was made as to what wage in comparison to the preinjury wage), worked January to March 1997, and then worked "about a year" from the end of March 1997. The claimant then worked again at the hospital where she met Dr. N in 1999. It is the claimant's burden to establish the specific dates of disability and she has failed to do so other than in broad terms.

Upon review of the record submitted, we find no reversible error. We will not disturb the hearing officer's determinations unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). We do not so find and, consequently, the decision and order of the hearing officer are affirmed.

Thomas A. Knapp
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Judy L. Stephens
Appeals Judge