APPEAL NO. 002237

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 August 24, 2000. The hearing officer determined that the appellant's (claimant) impairment rating (IR) was 5%. The claimant appealed the adverse determination contending that the determination was against the great weight and preponderance of the evidence, that the hearing officer used the wrong standard in determining that the amended reports were not performed within a reasonable time, and, that the hearing officer erred in selecting the first report from the designated doctor which, the claimant contended was not performed in compliance with the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association. The respondent (self-insured) responded that the hearing officer's decision was supported by sufficient evidence and should be affirmed.

DECISION

Reversed and remanded.

The essential facts of this case are largely undisputed. The claimant sustained a compensable back injury on _____, and, as agreed by the parties, reached statutory maximum medical improvement (MMI) on September 1, 1997. The claimant's treating doctor is Dr. G.

On May 28, 1996, Dr. N, a carrier-selected doctor, certified that the claimant reached MMI on May 25, 1996 with a 0% IR. The MMI and IR were disputed by the claimant, and Dr. M was appointed by the Texas Workers' Compensation Commission (Commission) as the designated doctor for purposes of assessing the IR and whether the claimant had reached MMI. Dr. M provided an initial IR of 5% which was subsequently amended to 11%, then to 16%. At the CCH, the claimant contended that 16% was entitled to presumptive weight and the self-insured contended that the 11% IR was entitled to presumptive weight. The hearing officer determined that the 5% IR was not entitled to presumptive weight, but that it constituted the great weight of the other medical evidence and was the correct IR.

The claimant sustained a compensable injury to his back on _____, and began treating with Dr. H. An MRI was performed on October 9, 1995, which revealed a radial annular tear at L5-S1. The claimant subsequently treated with Dr. P and then changed treating doctors to Dr. G, who initially examined the claimant on June 26, 1996, for complaints of severe back pain with radiculopathy. Conservative therapy was continued and EMG/nerve conduction studies were ordered. Dr. G on various occasions wrote that if the claimant's condition failed to improve, a CT discogram would be ordered to determine if the annular tear was the pain generator, and, if so, the claimant would become a candidate for surgery. A progress note of September 27, 1996, reflects that an MRI showed a radial tear at L5-S1 and that the EMG nerve conduction study was essentially

negative. The claimant was continued on therapy and Dr. G noted the discogram had been denied due to a lack of medical necessity. Dr. G continued to examine and treat the claimant but no surgery was pending or ordered.

Dr. M, as designated doctor, examined the claimant on October 17, 1996, and by a Report of Medical Evaluation (TWCC-69) of the same date, certified that the claimant reached MMI on October 17, 1996 with a 5% IR. In her report Dr. M indicated that she had limited medical records for review and that certain records had been received, including Dr. P's initial medical report, Dr. N's report certifying the claimant at MMI with a 0% IR, a clarification letter from Dr. N, a negative EMG report from Dr. Gu, a physical therapist's functional capacity evaluation indicating that the claimant had the ability to work at a medium work capacity, and Dr. G's report of September 26, 1996, stating that the claimant had a radial tear at L5-S1 and that a discogram had been denied by the self-insured. Dr. M noted that previous medical records from Dr. H (the first treating doctor), the initial report from Dr. G, the physical therapy notes, and the MRI results were not available for review. Dr. M assigned the claimant a 5% impairment due to specific disorder of the spine based on Table 49 (II)(B). No impairment for abnormal range of motion (ROM) was assessed due to Dr. M's belief that the claimant did not put forth maximum effort and had voluntarily restricted his movement. Dr. M released the claimant back to work with no restrictions.

The claimant continued to treat with Dr. G, who, by progress note dated August 29, 1997, indicated that the claimant was considering possible surgical intervention. However, Dr. G wrote, "at this time, [the claimant] is trying to live with his pain as is. He remains a candidate for discogram and post-discographic CT, as well as fusion in the future if he is unable to live with his pain. He will return in one month."

The claimant had the discogram on January 26, 1998, and Dr. G's progress note dated February 9, 1998, reflects that the discogram confirmed the presence of the radial tear and a herniated disc at L5-S1. Dr. G wrote, "at this time, the patient wants to think about having surgery in terms of global fusion. We will give him a repeat of his pain medications and see him in about 3 weeks. We will check his status and proceed from there." On March 13, 1998, Dr. G's records reflect that the claimant had decided to have a 360E fusion with hardware. The claimant had the surgery on June 15, 1998.

At the claimant's request a Commission benefit review officer, by cover letter dated September 2, 1998, sent the medical records of the claimant's surgery to Dr. M and asked whether the IR of 5% remained the same and whether the claimant should be reexamined.

The claimant was reexamined by Dr. M on September 24, 1998, who acknowledged receipt of records reflecting that the claimant had surgery in June 1998. Dr. M declined to award an impairment for abnormal ROM due to failed straight leg raise (SLR) validity criteria. In her opinion, subsequent testing would not be successful. Dr. M noted that the claimant had reached statutory MMI but felt that he had not yet stabilized enough to render an IR. Dr. M suggested the claimant be evaluated again around December 16, 1998.

The claimant returned to Dr. M on February 11, 1999. A 10% impairment due to specific disorder from Table 49 (II)(E) was assigned and a 1% neurological impairment was assigned for a combined whole body impairment of 11%. No impairment for abnormal ROM was given due to the claimant's failure to meet the SLR validity criteria. Dr. M recommended that "[the claimant's] medical be kept open in order for him to fully avail of medical and adjunct services to correct and/or relieve his continuing post-surgical problems. A repeat impairment testing is suggested whenever this outcome is attained so a more accurate or more representative impairment can be calculated."

The claimant continued to treat with Dr. G. On November 30, 1999, the claimant had surgery to remove the hardware in his back which had been installed during the June 15, 1998, surgery.

In response to a Commission letter of February 11, 2000 (initiated by the claimant's request letter dated December 20, 1999), Dr. M by letter dated March 2, 2000, responded that she had recommended repeat testing in her February 11, 1999, report because the lumbar ROM testing was declared invalid. She wrote that it was unfair to accept the 11% rating because it did not take into consideration the post-surgical ROM limitations and in her opinion the claimant was "by all means stable at this point" to have the testing done. At the Commission's request Dr. M reevaluated the claimant on April 20, 2000. She assigned the claimant a 16% IR. The IR was comprised of a 10% impairment for specific disorder and an additional 2% for the removal of hardware under Table 49. A 4% impairment was given for abnormal ROM in left and right lateral flexion. Dr. M wrote that "[the claimant's] flexion and extension ROM was deferred due to SLR validity."

The hearing officer found that at the time of Dr. M's first IR the claimant was not scheduled for spinal surgery and that the claimant as late as August 29, 1997, was still opting to live with the pain. Because the claimant was not scheduled for spinal surgery at the time of the first IR from Dr. M, the second (11%) and third (16%) IRs were not performed within a reasonable amount of time. The hearing officer found that the first (5%) IR was not entitled to presumptive weight because Dr. M did not review all the medical records before rendering her decision. However, she concluded that the 5% IR constituted the great weight of the other medical evidence and adopted it for purposes of deciding the claimant's IR.

Sections 408.122(c) and 408.125(e) provide in part, that the report of the designated doctor has presumptive weight and the Commission shall base its determination of MMI and IR on the report unless the great weight of the other medical evidence is to the contrary. The Appeals Panel has addressed cases where a designated doctor amends his or her IR report after statutory MMI and after the claimant has had surgery. We have held that a designated doctor may, with proper reason and in a reasonable amount of time, amend the original report of MMI and IR for various reasons which can include, but are not limited to, the need for surgery. *See* Texas Workers' Compensation Commission Appeal No. 941168, decided October 14, 1994. The report may be amended, for example, where there were incomplete or erroneous facts, when the first report was rendered, which are

subsequently taken into account in amending the report (Texas Workers' Compensation Commission Appeal No. 941600, decided January 12, 1995), or, that upon reexamination, the designated doctor finds a claimant in a worsened condition with more impairment. However, a designated doctor should not amend an IR just to be equitable or charitable. *See* Texas Workers' Compensation Commission Appeal No. 992849, decided February 3, 2000; and Texas Workers' Compensation Commission Appeal No. 992857, decided January 31, 2000. Whether a doctor has amended his or her report for a proper reason and within a reasonable amount of time is essentially a question of fact for the hearing officer. Texas Workers' Compensation Commission Appeal No. 960888, decided June 18, 1996.

In cases where a claimant has surgery after the designated doctor certifies an IR, the Appeals Panel considers whether the designated doctor's IR assignment took place before or after the date of statutory MMI. We have noted that a key, distinguishing factor is whether surgery is "under active consideration" at the time of statutory MMI. Texas Workers' Compensation Commission Appeal No. 950861, decided July 12, 1995; and Texas Workers' Compensation Commission Appeal No. 990833, decided June 7, 1999. In Appeal No. 950861, *supra,* the Appeals Panel, quoting Texas Workers' Compensation Commission Appeal No. 941265, decided November 1, 1994, stated:

> [W]hile there may be those rare, exceptional cases where "compelling circumstances," such as the need for further surgery, might affect the claimant's ultimate IR, "it is certainly not open-ended and even surgery undergone at some future time that was not actively considered at the time of statutory MMI and the rendering of an IR will not necessarily permit an amendment or revision of the IR."

It is apparent that the hearing officer used the wrong standard in determining whether Dr. M amended her report within a reasonable time and for a proper purpose. The hearing officer found that "[s]ince Claimant was not scheduled for Spinal Surgery at the time of [Dr. M's] first certification, the second and third certifications were not performed within a reasonable amount of time from the initial findings." The inquiry is not whether spinal surgery was being actively considered at the time of Dr. M's first report, but whether spinal surgery was being actively considered at the time statutory MMI occurred.

The hearing officer also stated that she would not give presumptive weight to Dr. M's initial report assessing a 5% IR because Dr. M did not review all medical records before rendering her decision. In Texas Workers' Compensation Commission Appeal No. 991702, decided September 24, 1999, we noted that Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6(j) (Rule 130.6(j)) does not require that a designated doctor review literally "all" records. Rather, we stated that in order to prevail on such a theory, it is incumbent upon the claimant to identify, with supporting medical evidence, what record was essential and not made available to the designated doctor. In this instance, the claimant asserted that the designated doctor did not have the results of the CT discogram when she tendered her initial IR report in 1996. The hearing officer does not specify what record was essential

in making her determination that Dr. M did not have all the records. It does appear that Dr. M was aware of the MRI results indicating a radial tear at L5-S1 because she did have Dr. G's September 27, 1996, report.

Accordingly, we reverse Findings of Fact Nos. 3 and 4 and remand the case back to the hearing officer to apply the correct standard in determining whether the designated doctor properly amended her report within a reasonable period of time and for a proper purpose and whether presumptive weight should be given to Dr. M's initial report of 5% dated October 17, 1996. The hearing officer may wish to refer this case back to the designated doctor for an IR as of September 1, 1997, the date of statutory MMI. 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.

Kathleen C. Decker
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Thomas A. Knapp
Appeals Judge