APPEAL NO. 011706
FILED SEPTEMBER 4, 2001

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 July 6, 2001. With respect to the issues before her, the hearing officer determined that the appellant's (claimant) impairment rating (IR) is 13%, as certified by the first designated doctor selected by the Texas Workers' Compensation Commission (Commission) and that the Commission abused its discretion in appointing a second designated doctor. In his appeal, the claimant asserts error in each of those determinations and requests that we reverse the determination that his IR is 13% and render a new determination that his IR is 17% in accordance with the report of the second designated doctor. In its response to the claimant's appeal, the respondent (carrier) urges affirmance.

DECISION

Affirmed.

The parties stipulated that the claimant sustained a compensable injury to his low back and right ankle on _____, and that he reached maximum medical improvement (MMI) by operation of Section 401.011(30)(B) on July 2, 1999. On May 25, 1999, Dr. B examined the claimant at the request of the carrier and certified that the claimant reached MMI as of that date with a 12% IR, which was comprised of 10% for specific disorders of the lumbar spine under 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 2% for neurological impairment. Dr. B did not assign a rating for loss of range of motion (ROM). The claimant disputed Dr. B's certification and Dr. R was selected by the Commission to serve as the designated doctor. Dr. R examined the claimant on July 29, 1999, 27 days after the claimant reached statutory MMI, and assigned a 13% IR. Dr. R assessed an 11% rating under Table 49 and 2% for loss of lumbar ROM. Dr. R did not assign a rating for neurological deficits.

On November 11, 1999, Dr. M wrote a letter to the carrier stating that the claimant had not yet reached MMI and recommending a discectomy and fusion at L5-S1. On December 7, 1999, six months after the claimant reached statutory MMI, a request for a second spinal surgery was approved by the Commission because the carrier did not request a second opinion. On January 11, 2000, Dr. M wrote a letter to the Commission again stating that the claimant had not yet reached MMI because he is a surgical candidate. In a January 17, 2000, progress note, Dr. A stated that he also was "recommending surgery as per [Dr. M]" and that the claimant had not reached MMI.

On September 28, 2000, a Commission benefit review officer (BRO) sent a letter of clarification to Dr. R suggesting that he may not have been furnished all medical records and forwarding some unspecified medical records to Dr. R. The only reports specifically identified by the BRO in the letter are the January 11, 2000, letter of Dr. M and the January

17, 2000, report of Dr. A. In his response to the BRO's letter, Dr. R acknowledged that he did not have the records from Dr. M and Dr. A. Dr. R stated that "[d]ue to these new medical records I may reconsider the patient's [IR]. However, I need to see and examine the patient in my office before making the final decision." The claimant never had the proposed second spinal surgery and the approval has expired because the surgery was not performed within a year of the notification of approval from the Commission.

The carrier objected to the claimant's being reexamined by the designated doctor, stating that a reexamination was not appropriate because the claimant's surgery was not approved until six months after statutory MMI and because the records from Dr. M and Dr. A that precipitated the designated doctor's request for reexamination were not created until January 2000, well after the July 2, 1999, statutory MMI date and the July 29, 1999, designated doctor examination. The BRO decided to send the claimant to the designated doctor despite the carrier's opposition. In addition, the BRO decided to appoint a second designated doctor because the claimant had moved out of state. Thus, the BRO appointed Dr. S, who is located in the city and state where the claimant now resides, as the second designated doctor. On December 18, 2000, Dr. S certified a 17% IR, which is comprised of 11% under Table 49, 4% for loss of lumbar ROM, and 2% for neurological deficits.

The hearing officer did not err in giving presumptive weight to the first designated doctor's report and determining that the claimant's IR is 13%. The hearing officer made a specific finding that the second surgery was both proposed and approved after the claimant reached statutory MMI. In addition, she found that the medical records forwarded to Dr. R in the letter of clarification were not in existence at the time Dr. R examined the claimant. Based upon those findings and her discussion, it is apparent that the hearing officer determined that it was inappropriate to send the claimant back to the designated doctor for a reexamination. We have long held that surgery that was not under active consideration at the time of statutory MMI is not a basis for amending an IR. Texas Workers' Compensation Commission Appeal No. 992951, decided February 14, 2000; Texas Workers' Compensation Commission Appeal No. 991081, decided July 8, 1999; and Texas Workers' Compensation Commission Appeal No. 990833, decided June 7, 1999. Thus, the hearing officer did not err in determining that a sound basis did not exist for the Commission to send the letter of clarification and additional information to the designated doctor, which prompted his request to reexamine the claimant. As such, she also did not err in determining that a reexamination of the claimant was not indicated in this case.

Given our affirmance of the determination that it was inappropriate to send the claimant back to the designated doctor for a reexamination based upon information that came into existence after statutory MMI, we likewise affirm the determination that the Commission abused its discretion in appointing a second designated doctor in this case. Since it would have been inappropriate to send the claimant back to the initial designated doctor in the absence of a proper reason for doing so, it necessarily follows that it was an abuse of discretion to appoint a second designated doctor to perform the reexamination.

Finally, we briefly consider if Dr. R's report is entitled to presumptive weight under the 1989 Act. As noted above, the difference between the ratings of Dr. R and Dr. B are attributable to differences of opinion as to what rating to assign for specific disorders of the lumbar spine, neurological deficits, and ROM. By giving presumptive weight to the designated doctor under Sections 408.122 and 408.125, the 1989 Act has established a system whereby the designated doctor's resolution of such differences is to be accepted, unless the great weight of the other medical evidence is to the contrary. The hearing officer determined that the reports of Dr. B did not rise to the level of the great weight of other medical evidence contrary to Dr. R's certification and her determination in that regard is not so against the great weight of the evidence as to compel its reversal on appeal. Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986); Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986). Thus, the hearing officer did not err in giving presumptive weight to Dr. R's certification and determining that the claimant's IR is 13%.

The hearing officer's decision and order are affirmed.

The true corporate name of the insurance carrier is **THE INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA** and the name and address of its registered agent for service of process is:

CORPORATION SERVICE COMPANY
800 BRAZOS, SUITE 750
AUSTIN, TEXAS 78701.

Elaine M. Chaney
Appeals Judge

CONCUR:

Gary L. Kilgore
Appeals Judge

Thomas A. Knapp
Appeals Judge