APPEAL NO. 950232

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq*. On January 30, 1995, a contested case hearing was convened in (city), Texas, with (hearing officer) presiding. The issues in dispute were whether the appellant (claimant), who is the claimant, had reached maximum medical improvement (MMI); if so, what was his impairment rating (IR); and whether the Texas Workers' Compensation Commission (Commission) had abused its discretion by approving requests for changes in claimant's treating doctor.

The hearing officer found that claimant had reached MMI on January 11, 1994, with a 14% IR, in accordance with the report of the designated doctor appointed by the Commission.

The claimant has appealed, arguing that the designated doctor's report should not have been given presumptive weight because it did not consider and include claimant's lumbar spine injury. The claimant asks that the decision of the hearing officer be reversed and that claimant be re-examined by the designated doctor to assign an IR for the lumbar spine. The carrier responds to this that the lumbar spine was clearly considered by the designated doctor, who did not find a permanent impairment. The carrier argues that the lumbar injury was "included" in the sense that it was considered and examined by the designated doctor, and that IR is not required for injuries that do not result in impairment. The carrier files a cross-appeal, stating that the determination of the hearing officer that the Commission did not abuse its discretion in approving changes of treating doctors was erroneous and not in accordance with the law and rules of the Commission. The carrier discusses why each and every change of treating doctor requested by the claimant was against the statutory intent of the laws restricting the ability to make a change. The carrier points out that there was no demonstrable reason for the Commission to keep approving such requests, given a lack of evidence that the doctors were not appropriately treating claimant's injury. The carrier points out that the hearing officer's finding of fact that the reason for the changes was to get medical care that would lead to recovery is not supported by the record.

DECISION

We affirm.

Claimant contended that he injured his lower back and neck on (date of injury), while employed by (employer). Claimant testified he had had back surgery in January 1987.

On July 30, 1994, claimant was involved in a non-work related automobile accident. He maintained that he injured only his neck, and not his lower back. He stated he had hired an attorney to pursue any claim for this.

The evidence indicated that claimant's first treating doctor (although claimant did not subjectively consider him to be his first choice) was (Dr. M). Claimant said Dr. M was referred by a hospital emergency room where claimant was treated. As of December 17, 1992, Dr. M noted that claimant had significant non-physiological factors underlying his extreme and persistent complaints. Dr. M noted that a CT scan of the neck showed diffuse degenerative changes but no evidence of neurological compromise. Claimant stated that he was sent to (Dr. H), a neurosurgeon, for a second opinion. Dr. H's letter of February 25, 1993, notes that claimant appears to be in excellent overall condition, that he complained of severe neck and lower back pain, that an MRI showed no recurrent disc, and that most of claimant's complaints were functional.

Claimant said he requested a change from Dr. M because Dr. M's treatment had not relieved his pain or symptoms. A Request to Change Treating Doctors (TWCC-53) was filed on February 18, 1993, by the claimant. The reason for change stated on this is to the effect that claimant had increasing pain and discomfort after physical therapy but Dr. M continued him on the program anyway. A change to (Dr. C) was approved by the Commission on March 4, 1993. There was no evidence that the carrier disputed this approval at the time.

Claimant testified that after Dr. M, however, he was treated by (Dr. CL), who referred him to (Dr. CW) for a second opinion on surgery, and that Dr. CW felt it was not needed. A report from Dr. CL in evidence for an examination on October 22, 1993, reported that claimant had exhibited pain magnification behaviors, and that blocks to relieve pain might be considered depending upon current MRI information. Dr. CL reported on April 7, 1994, that Dr. CW did not believe claimant had a problem amenable to surgery.

Claimant indicated that Dr. C referred him to the PRIDE rehabilitation program that he stated he was unable to physically complete. However, in a letter to Dr. C, dated August 3, 1993, (Dr. M) noted that claimant had completed the PRIDE therapy and was released to work with a 50 pound lifting limit on August 9, 1993. He also noted that claimant had reached MMI on that date. Dr. C, after reviewing Dr. M's records, determined that claimant had a 14% IR.

On April 13, 1994, the claimant filed a TWCC-53 to change from Dr. C to (Dr. W). The reasons given for the change (the back of the form that continues the narrative was not included in the record) involve the fact that Dr. C once got up rudely during an appointment with claimant, and that claimant was dissatisfied with a referral to Dr. CL. The request was approved by the Commission on April 19, 1994. There was no evidence that the carrier disputed this approval at the time. Claimant testified, however, that Dr. W only performed a myelogram and did not treat him, and that he thereafter changed to (Dr. TB). A copy of this TWCC-53 is not in evidence. Claimant said that Dr. TB treated him primarily for his automobile accident, and that because Dr. TB primarily did "auto accidents", he changed from Dr. TB to (Dr. CH). However, claimant's change of doctor form to change to Dr. CH, filed on October 7, 1994, recites that claimant is still in pain and Dr. TB's treatment has not

helped him, that Dr. CH could refer him to excellent physical therapy, and that he would recover under Dr. CH's care.

Claimant was examined by (Dr. O), on behalf of the carrier, on September 15, 1993. Dr. O certified MMI on August 9, 1993, with a six percent IR. Dr. C indicated his disagreement with this rating.

The designated doctor appointed by the Commission, (Dr. JM), examined claimant and certified that he had reached MMI on January 11, 1994, with a 14% IR. The narrative report makes clear that Dr. JM examined and studied diagnostic tests involving claimant's lumbar and cervical spine. He noted that an EMG performed by Dr. CL showed radiculopathy. To briefly summarize a comprehensive report, Dr. JM assigned a four percent IR for the specific condition, nine percent IR for loss of range of motion, and one percent IR for sensory loss, for a total of 14% IR. (All IRs noted are whole body). On January 25, 1994, in apparent response to inquiry from the Commission, Dr. JM stated that he did not believe that an impairment was attributable to the lumbar region. On August 25, 1994, the Commission contacted Dr. JM for further clarification of his rating and forwarded additional records, which apparently confirmed there was no cervical disc herniation., Dr. JM commented that claimant's lumbar conditions were attributable to his earlier surgery. A lumbar myelogram performed on June 15, 1994, indeed stated that all of claimant's observed lumbar condition may relate to epidural fibrosis from previous surgery. A post-myelogram CT scan on the same date found laminectomy defect at L5-S1 but was normal at other levels.

On September 9, 1994, another MRI of the lumbar spine was conducted at the request of Dr. TB and no evidence of recurrent disc herniation was found, and the detected protrusion was L5-S1 and was read as scar tissue. MRIs on the cervical and thoracic spines at the same time were read as normal. Dr. TB's conclusion in October 1994, prior to releasing him effective October 12th, was that claimant essentially had a spinal strain and related radiculopathy.

Regarding his requests for changes in doctor, the claimant denied that he changed when a return to work was recommended. He testified, however, that he did not request any change because of doubts about the professional reputation of the doctors or medical inappropriateness of any treatment (although he stated that he could not judge the latter because he was not a doctor).

"Impairment" is defined in the 1989 Act as "any anatomic or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." TEX. LAB. CODE ANN. § 401.011(23). Further, impairment must be based upon "an objective clinical or laboratory finding." TEX. LAB. CODE ANN. § 408.122(a). We note that there was no issue over extent of the injury, and the parties differ as to whether claimant has an "impairment" as a result of the current compensable lumbar injury.

The report of a Commission-appointed designated doctor is given presumptive weight. TEX. LAB. CODE ANN. § 408.122(b) 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. 92166, decided June 8, 1992. The designated doctor has determined that no ratable injury is attributable to claimant's lumbar spine. While we believe there is evidence that claimant reached MMI well before the date chosen by the designated doctor, we cannot say that contrary evidence amounts to such weight as to render the hearing officer's determination incorrect.

The matter of the great number of changes in treating doctors that were approved in this case is a matter we find troublesome. Unfortunately, neither the carrier nor the hearing officer appear to have given detailed consideration to each and every change requested and granted. The issue was presented in a broad fashion going back to, presumably, all changes over the previous two years. We would note that reasons that would justify an earlier change may not comprise further justification for subsequent changes. Of course, referrals are not considered changes in treating doctor, pursuant to Section 408.022(e).

The Commission is bound by the law and its own rules in approving such changes. We do not believe it overstates the import of Section 408.022 to characterize it as a major cost-controlling provision of the 1989 Act. As stated in 1 MONTFORD, BARBER & DUNCAN, A GUIDE TO TEXAS WORKERS' COMP. REFORM (1991), p. 4-167, "This new provision was enacted as a means to implement greater regulatory control over utilization and costs of medical benefits." The Commission is directed in Section 408.022(c) to establish criteria to be used to grant approval for changing doctors when a claimant is dissatisfied with his initial choice. The criteria may include:

(1)whether treatment by the current doctor is medically inappropriate;

(2)the professional reputation of the doctor;

(3)whether the employee is receiving appropriate medical care to reach maximum medical improvement; and

(4)whether a conflict exists between the employee and the doctor to the extent that the doctor-patient relationship is jeopardized or impaired.

The Commission, through Tex. W.C. Comm'n. 28 TEX. ADMIN. CODE § 126.9 (Rule 126.9), effective July 1, 1993, incorporated these criteria. The operative portion of the Rule is subsection (e):

Reasons for approving a change in treating doctor include but are not limited to:

(1)the reasons listed in [Labor Code Section cited above]; and

(2)the selected doctor chooses not to be responsible for coordinating the injured employee's health care. . . .

The Commission, in Rule 126.9(f), is directed to act on this request by approval or denial within ten days; either party must dispute this action, for good cause, within ten days after receipt of the order. The short time frame for dispute is likely because the sole remedy at the disposal of the Commission is to relieve the carrier of liability for payment of the health care provider's bills should it be determined that the employee failed to comply with Commission rules for change; there is no provision under this section to order a refund. Section 408.024; Rule 126.9(h) and (i).

We would agree that the use of the term "include but are not limited to" cannot be used to justify simple approval of all requests made, as this would subvert the legislative mandate to establish "criteria." The articulated reason of the hearing officer, that the changes were requested by the claimant to "in an effort to get medical care that would lead to recovery from his injuries," is a weak rationale. However, based on the limited record before us, the conclusion that the Commission did not abuse its discretion in approving requests is affirmable. Briefly reviewing the requests for changes made in this case, we cannot agree that there was an abuse of discretion in the approvals from Dr. M to Dr. C and Dr. C to Dr. W, as there were at least colorable reasons involving the appropriateness of the treatment or the doctor-patient relationship articulated in the requests. The request for change from Dr. W to Dr. TB is not in evidence, so there is essentially no evidence that discretion was abused. With regard to the request for change from Dr. TB to Dr. CH, we note that another finder of fact could have reached an opposite conclusion; however, we will not substitute our judgment for that of the hearing officer in this case. However, the record in this case would seem to require that strict scrutiny under the statutory criteria must be exercised by the Commission for any further requests for change.

The decision of the hearing officer will be set aside only if the evidence supporting the hearing officer's determination is so weak or against the overwhelming weight of the evidence as to be clearly wrong or manifestly unjust. Atlantic Mutual Insurance Co. v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.). The record in this case does not lead us to the conclusion that the hearing officer's determination has been clearly wrong, and the decision and order of the hearing officer are accordingly affirmed.

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Susan M. Kelley
Appeals Judge

CONCUR:

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Alan C. Ernst
Appeals Judge

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Tommy W. Lueders
Appeals Judge