APPEAL NO. 92064

On January 9, 1992, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. (hearing officer) determined that the claimant, (claimant), the respondent in this appeal, continued to have disability, as that term is defined in the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.03(16) (Vernon's Supp. 1992) (1989 Act), for purposes of payment of temporary income and medical benefits. The parties stipulated at the hearing that an injury occurred within the course and scope of respondent's employment with (employer), on (date of injury).

The appellant raises three major points of error, relating to a challenge on the sufficiency of the evidence, the admissibility of a doctor's report, and the determination as to who was respondent's treating doctor.

DECISION

We affirm the decision of the hearing officer to the extent that she has determined that respondent's disability continued, and find that this conclusion is not so against the great weight of the evidence so as to be manifestly unjust. However, we note that the hearing officer has erred in two respects: 1) finding that the treating doctor for respondent was not the doctor approved by the carrier and the commission in the agreement reached at the benefit review conference, and 2) finding that respondent had not achieved maximum medical improvement, when this matter was not properly an issue to be resolved by the contested case hearing officer. However, because neither of these findings affects the determination on the issue of disability, we conclude that, in this decision, such errors are harmless.

I.

At the outset, we note that the record indicates that both parties were confused about the distinctions in the 1989 Act between disability, maximum medical improvement, impairment, and the concept of return to work as it bears on these determinations. In addition to an issue over the occurrence of an injury in the course and scope of employment, the major issue left unresolved at the end of the benefit review conference related to the continued existence of "disability" of the claimant. At the beginning of the hearing, there appeared to be no meeting of the minds of the parties as to what the disability issue involved. Appellant clearly equated an end to disability with the achievement of maximum medical improvement. Respondent's attorney argued that his client should be permitted to have work hardening therapy and that any "award" relating to disability be deferred until therapy was completed. Both parties, as well as the benefit review officer, indicated that return to work would constitute the ending of disability. It is therefore necessary for us, once again, to separate these concepts.

A carrier is liable for compensation for injury of an employee who is subject to the Act if the injury arises out of the course and scope of employment. Art. 8308-3.01. Such an

injury is, by definition, a "compensable injury" Art. 8308-1.03 (10).

Temporary income benefits accrue on the eighth day of "disability" following a compensable injury, and are paid to a person who has disability, and in addition has not attained maximum medical improvement. Art. 8308-4.22; 4.23(a). "Disability" means the "inability to obtain and retain employment at wages equivalent to the preinjury wage because of a compensable injury." Art. 8308-1.03 (16). In other words, a claimant must be able to show a causal connection between his diminished wage and the compensable injury. It is possible for a claimant to return to work and still be disabled, if the lower wages are caused by the compensable injury. The classic example would be a return to half-time light duty work, at half the preinjury wage. Temporary income benefits would still be due to make up part of the difference. *See* Art. 8308-4.23(c).

Disability is not the same as impairment. "Impairment," as defined in Art. 8308-1.03 (24), means "any anatomical or functional abnormality or loss existing after maximum medical improvement ("MMI") that results from a compensable injury and is reasonably presumed to be permanent." The assessment of impairment is done according to Art. 8308-4.26 when the claimant achieves MMI, as defined in Art. 8308-1.03(32). It is possible for an injured employee to be back at work at preinjury wage and not be "disabled," but still in a state of recovery from an injury such that achievement of MMI is yet in the future.

At the point that MMI is achieved, the payment of temporary income benefits ends, and entitlement to impairment income benefits begins. Art. 8308-4.26(c). The state of MMI may be certified by the treating doctor or another doctor who must then submit his report to the treating doctor for agreement or disagreement. Art. 8308-4.26(d). However, if the achievement of MMI or the impairment rating is disputed, then dispute resolution through an agreed or commission-appointed designated doctor occurs according to the provisions set forth in Art. 8308-4.25 and 4.26. The report of a designated doctor on the issue of MMI has presumptive weight, and the commission shall base its MMI determination on this report unless the great weight of the other medical evidence is to the contrary. Art. 8308-4.25(b). The findings and conclusions of the designated doctor on the degree or existence of impairment can be binding even on the court or jury in judicial appeal of such cases. *See* Art. 8308-6.62(d), (e) & (f).

For further discussion, we note Appeals Panel Decision No. 91014 (Docket No. FW-00008-91-CC-3) decided September 20, 1991, as well as Appeals Panel Decision No. 91060 (Docket No. DA-00022-91-CC-1) decided December 12, 1991.

Finally, medical benefits do not depend upon disability. Art. 8308-4.61. Disputes over particular medical treatment or billings are resolved through the procedures set forth in Art. 8308-4.68 and 8.62, as well as applicable rules, and not through the benefit review conference/contested case hearing procedure set forth in Chapter 6 of the 1989 Act.

II.

Briefly, the facts and relevant procedural history of this claim are as follows. Respondent suffered a compensable back injury lifting propane bottles for his employer, on (date of injury). After ascertaining that there was no "company doctor," respondent sought treatment from ("Dr. G") who was suggested by a coworker. A letter written by Dr. G recapping his examination states that respondent had a slight amount of muscle spasm, and he diagnosed lumbar sprain and minor strain to the right Pasas Muscle. Dr. G noted that "patient complained of considerably more pain than the physical findings would indicate." Dr. G's letter indicates that he told respondent he would not accept his treatment as a workers' compensation case, and "I feel there is no serious injury present." Thereafter, respondent was referred to ("Dr. S") by the insurance carrier around the first of March, 1991. Dr. S ordered an MRI and examined and talked to respondent for about an hour; however, there is no report of this in the record, although it was referred to by the parties during the hearing. Respondent went next to ("Dr. SW") who had treated his father. A document from Dr. SW dated March 27, 1991, says that respondent's MRI indicates a minimal bulge at l-5 without any disc herniation or formaminal encroachment. Dr. SW recommended that respondent stay off work 2-3 weeks "since he felt he was physically unable to work." Although Dr. SW indicates that he would see respondent again after this time, his record shows that respondent did not show up on April 17 and April 25, 1991. Respondent reports that he also came for appointments when the doctor was not available because of emergency surgery. Respondent testified he saw Dr. SW a second time, and a disagreement ensued because of Dr. SW's inaccessibility on previous occasions. He stated that Dr. SW "wouldn't" tell him what his condition was. He did not return to Dr. SW.

Respondent filed a claim for unemployment benefits on July 28, 1991. He acknowledged that he signed a statement with the Texas Employment Commission that he was available and willing to work, and that he in fact looked for jobs during the pendency of his unemployment benefits. He indicated, however, that he did not in fact feel that he was able to work then, and that he felt basically the same the date of the hearing as he had at the time he applied for unemployment benefits.

Respondent sought and received approval from the commission on August 7, 1991 to change his treating doctor to ("Dr. F"). A copy of this approval was also mailed to the carrier. When respondent went to his office, he stated that he was directed to ("Dr. DS"), who practiced in the same office with Dr. F. Respondent asserted at the benefit review conference, and at the hearing, that Dr. DS was his current treating doctor. According to the record, respondent has seen Dr. DS once, on August 26, 1991. Dr. DS's report noted (as had the others before him) that respondent had a congenital spine problem, and repeats the reading of the MRI as noted in Dr. SW's report. Dr. DS's diagnosis is recorded as "chronic lumbar strain" and "questionable spondylolysis and spondylolisthesis, possibly of chronic nature." Dr. DS notes that respondent has been off work for six months; he then states "whether or not he can get back to his previous level of work is questionable. Certainly after six months very few patients, statistically either in the literature or my personal opinion, get back to their previous level of performance or function. Should he return to his previous

level he would be at some risk of reinjury to his back either to the muscle or possibly to the area of the small bulging disc. There is no way to predict the chance of him reinjuring his back. The patient truly has the pain that he is having." Dr. DS goes on to state that if light duty work was available that would not require bending or stooping, he might be able to perform this. The doctor suggests that respondent go to work-hardening therapy or a back clinic. Respondent testified that he was not currently seeking work because Dr. DS said he could reinjure his back.

A benefit review conference was held on November 19, 1991. The two issues left unresolved at the end of the hearing were whether an injury occurred in the course and scope of employment, and "whether or not the claimant's disability continues or is able to return to work with no disability." Although the benefit review officer notes that the respondent had not reached maximum medical improvement, this is not recorded as a dispute as there was, at that time, no assessment of MMI to be disputed. Dr. DS was described in the report as respondent's treating physician. At this time, the parties also entered into a written agreement, which provided that the respondent would attend a second examination by Dr. S as scheduled by the carrier at the carrier's expense and that the carrier would reauthorize reasonable and necessary treatment by Dr. DS or under his recommendation until the contested case hearing. The agreement was signed by both parties and the benefit review officer.

On December 16, 1991, respondent saw Dr. S, for about an hour. On that day Dr. S filed a comprehensive three page letter report, in which he among other things, certified that the respondent had reached MMI and assessed a 5% impairment rating using the AMA Impairment Guides. On January 3, 1992, the same report was filed attached to the proper TWCC form. The December 16, 1991 letter was mailed to the respondent, his attorney, Dr. DS, and the insurance carrier. Dr. S's diagnosis on this report states: "1. spondylolysis, L5 preexisting and, in my opinion, not related to this patient's on-the-job injury on 2-13-91; 2. Low back strain." Dr. S states further that he sees no good contraindications for the respondent to return to work. He found no evidence of muscle spasm during his examination, and noted that both hips moved fully. He noted that there was some paralumbar muscular tightness on dynamic examination.

III

There are three major points of appeal. The appellant contends that 1) it was error for the hearing officer to determine that Dr. F was the treating doctor, because he did not actually treat the respondent or assume primary responsibility for the health care, within the definition of "treating doctor" under Art. 8308-1.03(46); 2) that Dr. DS wasn't the treating doctor either, and his hearsay medical report should not have been admitted or considered by the hearing officer; and, 3) that there was insufficient evidence to support a finding of continued disability of the respondent (although this contention is connected to an assertion that Dr. S's December report was also a proper certification of MMI and should have been considered as such).

Findings of Fact relating to matters not stipulated are as follows:

"4.Pursuant to Art. 8308-4.62(b) of the Act, the claimant's treating physician was [Dr. F].

5.Claimant's treating doctor has not certified that claimant has reached maximum medical improvement and has not released claimant to return to work.

6.[Dr. S] did not submit his certification and evaluation to claimant's treating doctor pursuant to commission rules and the Act."

Conclusions of Law relating to matters not stipulated are as follows:

"4.Claimant has not reached maximum medical improvement as defined in article 83-8 (sic)-4.25 and 28 T.A.C. Section 130.1- 130.4.

5.Claimant is entitled to receive temporary income benefits and medical benefits pursuant to Article 8308-4.61 from January 9, 1992 until he has reached maximum medical improvement or until he no longer has a disability."

The hearing officer erred in concluding that Dr. F was the treating doctor, because, under the particular facts of this case, it is clear that Dr. DS became a carrier and commission approved selection by virtue of the benefit review conference agreement. Approval is all that is required by statute to sanction a change of doctor by a claimant. *See* Art. 8308-4.62(b). The benefit review conference agreement expressly directs the appellant to approve treatment by Dr. DS. Although Tex. W.C. Commission Rules, 28 Tex. Admin. Code § 126.7 prescribes procedures that should be undertaken when an injured employee wishes to change doctors, no rule can utterly exhaust all situations that may arise within the scope of the statute that the rule administers. Clearly, when all parties enter into agreement at a benefit review conference, there is no need for the mailing of a written request and written response as detailed in Rule 126.7. Under these particular facts, we believe the hearing officer erred by giving effect to the earlier commission approval of Dr. F over the subsequent written agreement to approve treatment by Dr. DS.

Although our holding on appellant's first point of error renders his second point of error moot, we would point out that the remedy for failure to comply with procedures for changing doctors is spelled out in Art. 8308-4.65, and it does not include exclusion of medical evidence. Although the fact that a doctor is not a treating doctor may affect the weight given to a medical report, it does not affect its admissibility. A medical report shall be received into evidence by the hearing officer even if it is hearsay. Art. 8308-6.34(e).

In considering whether the hearing officer committed harmful and reversible error by

concluding that Dr. F was the treating doctor, we consider whether the error was reasonably calculated to cause and probably did cause the rendition of an improper decision. *See* Hernandez v. Hernandez, 611 S.W.2d 732 (Tex. Civ. App.-San Antonio 1981, no writ).

This determination was tied in to her decision about the effect given to the report of Dr. S as a certification of maximum medical improvement. However, the issue of MMI was not ripe for decision by the hearing officer, because it was not an issue that came up until after the benefit review conference. The attorney for the respondent objected to hearing even the disability issue, so he can hardly be said to have agreed to resolution of MMI. The hearing officer notes that the procedure set out in Texas Workers' Compensation Rules, 28 Tex. Admin. Code Section 130.1-130.4, had not transpired (although she based this determination in large part upon failure to exchange the report with Dr. F). However, in our opinion, the more important impediment to resolving MMI is that there was no indication that the mechanism for resolution of disputes over MMI as required by Art. 8308-4.25 were invoked prior to the contested case hearing. Consequently, appellant's argument that Dr. S's medical report should have been accepted as a certification of MMI must be rejected. Of course, the hearing officer's conclusion of law that claimant had not reached maximum medical improvement is erroneous as a gratuitous finding on an issue not before her, but it is harmless error because the absence of MMI cannot equate to a finding that disability continues. Her finding was therefore not necessary to resolution of the ultimate issue of disability.

The fact that Dr. S's report in this case cannot be considered as a certification of MMI does not mean that it cannot be evaluated as evidence on the issue of disability. There is no express finding of fact or conclusion of law finding disability. But the conclusion is present by implication in Conclusion of Law No. 5 ("until he no longer has disability"), as well as the hearing officer's discussion acknowledging that there was "conflicting" evidence on the issue of disability. This discussion indicates that the medical evidence in the record, including Dr. S's report, was considered and weighed on the issue of disability.

We recognize that the evidence presented here could lead to the inference that respondent's disability had ceased. For example, the most recent and comprehensive physician's report from Dr. S (who had also seen respondent on a prior occasion) essentially finds no connection between respondent's injury on (date of injury) and his lack of wage. Dr. G and Dr. SW, who were chosen by respondent, take issue with the seriousness of his injury. Further, the agreement entered into at the benefit review conference clearly authorized treatment recommended by Dr. DS (and he recommended work-hardening therapy), but this was apparently not undertaken by respondent during the nearly two months between the benefit review conference and the contested case hearing. Nevertheless, the hearing officer is the sole judge of the weight, credibility, relevance, and materiality of the evidence. Art. 8308-6.34(e). Her decision should not be set aside because different inferences and conclusions may be drawn on review, even though the record contains evidence of inconsistent inferences. Garza v. Commercial Insurance Co. of Newark, N. J., 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). The finder of fact

has the right to judge the credibility of the claimant, and the weight to be given to his testimony, in light of other evidence in the record. Burelsmith v. Liberty Mutual Insurance Co., 568 S.W.2d 695 (Tex. Civ. App.-Amarillo 1978, no writ). Under prior law, the fact that an applicant for unemployment compensation benefits certifies a willingness to seek work did not preclude a finding of incapacity for purposes of workers' compensation. Aetna Casualty & Surety Co. v. Moore, 386 S.W.2d 639 (Tex. Civ. App.-Beaumont 1964, writ ref'd n.r.e.). We are likewise of the opinion that it cannot be unequivocally stated that offering to search for work is contradictory to a claim of disability, as that term is defined in the 1989 Act.

The erroneous determination that Dr. F was the treating doctor does not appear to have affected the determination that disability continued, because, as the hearing officer notes, such evidence can be presented by the claimant himself. Her finding on MMI does not constitute *res judicata* in a future dispute resolution proceeding undertaken in accordance with Art. 8308-4.25 and applicable rules of the commission, given that the matter was not fully ripe for a determination by her.

For these reasons, and finding that there is sufficient probative evidence to sustain the hearing officer on her implied conclusion that respondent was disabled, we affirm that portion of her decision. The findings that Dr. F was the treating doctor, rather than Dr. DS, and that respondent had not achieved maximum medical improvement, are erroneous, but do not constitute reversible error. As to Conclusion of Law No. 5, we would note that medical benefits do not cease upon an end to disability or upon achievement of MMI, but in other respects sustain this conclusion.

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Susan M. Kelley
Appeals Judge

CONCUR:

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Robert W. Potts
Appeals Judge

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Joe Sebesta
Appeals Judge