APPEAL NO. 92176

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV STAT. arts. 8308-1.01 *et seq*. (Vernon Supp. 1992) (1989 Act). On April 6, 1992, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as hearing officer. The hearing officer determined that appellant was not entitled to stop the payment of Temporary Income Benefits (TIBS) to respondent because there was no evidence that appellant's doctor's certification of respondent's having reached Maximum Medical Improvement (MMI) had been forwarded to respondent's treating doctor and because respondent's treating doctor has not certified that respondent has reached MMI. Appellant challenges this determination on the grounds that since respondent had agreed to be examined by appellant's doctor, the latter's opinion was entitled to some weight; that there was no evidence that its doctor's Report of Medical Evaluation (TWCC-69) had not been forwarded to respondent's treating doctor; and, that there is no treating doctor's report that respondent has not yet reached MMI. Appellant asks us to reverse the hearing officer and render a decision that appellant is entitled to suspend the payment of TIBS.

DECISION

Finding no error and further finding the evidence factually sufficient to support the hearing officer's findings of fact and conclusions of law, we affirm.

On (date of injury), respondent sustained a back injury stacking heavy bags of sand while employed by (Employer). He testified he has since been unable to work and has constant pain in the back at the waist area. His job duties require him to lift more than 25 pounds which he cannot do without experiencing pain. Respondent said he hasn't been able to return to his job since his injury because the doctor told him not to lift more than 35 pounds and hasn't told him he can return to work. He doesn't really know if he could work because he hasn't attempted to do so. The first doctor respondent saw after his injury was (Dr. G) to whom he was sent by Employer. No records of (Dr. G) were introduced. After visiting (Dr. G), respondent, on his own initiative, began to be treated at the (Clinic) where he has seen three different doctors and where he still receives therapy three times a week. A CT scan of respondent's lumbar spine performed on June 19, 1991, was normal and continued conservative therapy was recommended by the radiology consultant. An MRI evaluation of his lumbar spine on August 7, 1991, was also normal.

On August 19, 1991, an examination of respondent was undertaken by (Dr. Y), M.D., an orthopedic surgeon. (Dr. Y's) examination was not ordered by the Texas Workers' Compensation Commission but rather was arranged for by appellant with respondent's consent. According to (Dr. Y's) report of August 19, 1991, his diagnostic impression was: "1. Lumbosacral Syndrome, Chronic; 2. Rule out herniated nucleus pulposus." He recommended that respondent be placed on a rehabilitation program if MRI and CAT scans were within normal limits. In a subsequent letter report of October 23, 1991, (Dr. Y) stated he had reviewed CT scan and MRI reports and found them within normal limits. He recommended respondent be started on a physical rehabilitation program for four weeks

and then be returned to work at his regular duties. In a Report of Medical Evaluation (TWCC-69), received by appellant on November 13, 1991, (Dr. Y) stated that respondent had reached MMI on "9/1/91" with a 0% whole body impairment rating.

Respondent testified that the (Clinic) referred him to (Dr. N), M.D., who examined him on October 28, 1991. According to the Initial Medical Report (TWCC-61) prepared by (Dr. N) on November 5, 1991, respondent was diagnosed with cervical, thoracic, and lumbosacral spine pain. The TWCC-61 stated the anticipated date that respondent would achieve MMI as "2/15/92." (Dr. N's) treatment plan was for respondent to be off work for 6-8 weeks, to continue a full course of chiropractic therapy, and to begin biofeedback therapy. Respondent testified he underwent a discogram procedure on November 13, 1991. A post-discogram CT scan performed for (Dr. N) on November 13, 1991, revealed some posterior fissuring present at the L4-L5 level. Respondent saw (Dr. N) three times but doesn't recall the date of his last visit. The record didn't indicate whether (Dr. N) became respondent's treating doctor.

Respondent introduced a report from (Dr. V), M.D., an orthopedic surgeon, dated March 19, 1992, which stated he had examined respondent and his records. (Dr. V's) report stated that the November 1991 lumbar discogram showed a disk disruption at L4-5 and that the MRI and CT scans were normal. He recommended an EMG and nerve conduction studies and a repeat lumbar discogram stating "I am very suspicious that the L4-5 level is causing his symptoms." A report on the lumbar discogram and post-discogram CT scan done for (Dr. V) on March 31, 1991, stated the impression: "Posterior midline annular disruption L4-5 with concordant pain produced. Free flow of epidural contrast is present cephalad to the lesion." The record didn't indicate whether (Dr. V) became respondent's treating doctor.

Appellant averred to the hearing officer that a letter introduced from (Dr. Y), dated April 2, 1992, was in response to his having reviewed (Dr. V's) report of March 19, 1991. According to that letter (Dr. Y's) opinion "still stands as patient reached MMI on 9/1/91 and has a 0% impairment rating." Appellant also advised the hearing officer that, so far as was known, (Dr. Y's) report concerning MMI had not been sent to (Dr. N), respondent's treating doctor.

According to the Benefit Review Conference (BRC) Report in evidence, respondent had been receiving TIBS for 40 weeks as of the date of the BRC (February 20, 1992). Appellant took the position at the BRC that it should be allowed to stop paying TIBS based on (Dr. Y's) certification of MMI received November 13, 1991, while respondent contended he had not reached MMI and was still disabled. The sole disputed issue at the hearing was whether appellant had the right to suspend TIBS based on (Dr. Y's) assessment that respondent has reached MMI with a 0% impairment rating. The hearing officer's findings and conclusions pertinent to our decision follow:

FINDINGS OF FACT

3.(Dr. Y) was not Claimant's treating doctor at any time with respect to a back injury Claimant suffered on (date of injury).

4.There was no evidence that (Dr. Y) was a designated doctor as that term is defined under Commission Rule 130.6.

5.There was no evidence that (Dr. Y's) certification of maximum medical improvement was forwarded to the treating doctor as required by Rule 130.3.

6.There was no evidence that Claimant's treating doctor has either certified that Claimant has reached maximum medical improvement or that he no longer has disability.

CONCLUSIONS OF LAW

2.(Dr. Y's) status in this case is as a doctor, other than a treating doctor, who certified the employee has reached maximum medical improvement and not as a designated doctor.

3.Since (Dr. Y) is not a designated doctor in this case his medical opinion is not entitled to presumptive weight.

4.Carrier is not entitled to stop payment of temporary income benefits in this case based on (Dr. Y's) certification that maximum medical improvement has been reached with a zero impairment rating because there was no evidence that (Dr. Y's) report was forwarded to the treating doctor as required by Rule 130.3 and because Claimant's treating doctor has not certified Claimant has reached maximum medical improvement or that he no longer has disability.

Article 8308-4.23 provides that an employee who has disability and who has not attained MMI is entitled to TIBS and that payment of such benefits continues until the employee has reached MMI. The 1989 Act defines MMI as meaning the earlier of "(A) the point after which further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated, based on reasonable medical probability; or (B) the expiration of 104 weeks from the date income benefits begin to accrue." Article 8308-1.03(32).

Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.1(a) (Rule 130.1(a)) requires a doctor who determines during the course of treatment that an employee has reached MMI to complete and file the medical evaluation report required by that rule. Rule 130.2(a)

requires a treating doctor to examine the employee and certify that an employee has reached MMI and assign an impairment rating, if any, "as soon as the doctor anticipates that the employee will have no further material recovery from or lasting improvement to work-related injury or illness, based on reasonable medical probability." Appellant does not challenge the hearing officer's determination that respondent's treating doctor has not certified that respondent has attained MMI and has no disability. As previously observed we cannot tell from the record whether either (Dr. N) or (Dr. V) became respondent's treating doctor.

Article 8308-4.16 authorizes the Commission to require an employee to submit to a medical examination at the request of the insurance carrier to resolve any question about the attainment of MMI but provides that the Commission shall do so only after the insurance carrier has attempted and failed to receive the employee's permission and concurrence. Rule 126.5(d) further provides that the "commission or carrier may request an injured employee to submit to a medical examination to evaluate whether [MMI] has been reached." Article 8308-4.25(b) provides that if a dispute exists as to whether the employee has reached MMI, the Commission shall direct the employee to be examined by a "designated doctor" selected by mutual agreement of the parties, and, absent such an agreement, the Commission shall select the designated doctor, whose report shall have presumptive weight. *See also* Rule 130.6. Appellant does not challenge the hearing officer's conclusions that (Dr. Y) was not a "treating doctor" nor a "designated doctor" whose determination of MMI was entitled to presumptive weight.

Rule 130.3(a) requires a doctor (other than a treating or designated doctor) who certifies that an injured employee has reached MMI to complete a medical evaluation report, as required by Rule 130.1, and to send a copy to the treating doctor no later than seven days after the examination. Rule 130.3(b) requires the treating doctor receiving such a report to send to the Commission within seven days either a statement indicating agreement with the certifying doctor's certification of MMI and impairment rating or the Rule 130.1 report if the treating doctor disagrees with either the MMI certification or the impairment rating. It seems self-evident that if (Dr. Y's) medical evaluation report was not sent to respondent's treating doctor, the latter would be in no position to either agree with (Dr. Y) that respondent reached MMI on "9/1/91" or to disagree and submit a medical evaluation report as Rule 130.3(b) requires. Appellant urges that "(Dr. Y's) report should not be ignored simply because there is no proof that the doctor complied with Rule 130.3 in making a timely exchange of his report with the treating doctor." Appellant further posits that nothing in Rule 130.3 manifests an intent that a certifying doctor's report "be totally ignored if the doctor who is to complete the report does not strictly comply with the rule." Appellant goes on to argue that "[a]lthough it is a valid policy that all medical reports be timely exchanged, to allow the parties to take appropriate action without delay, neither carriers nor claimants should be at the mercy of deadlines over which they have no control." This argument begs the issue. Appellant's problem here is not merely the failure of (Dr. Y) to forward his Rule 130.1 report to the treating physician no later than seven days after his examination, but rather the utter lack of evidence that his report was ever sent to the treating doctor for a response pursuant

to Rule 130.3(b). Under the circumstances of this case, including the fact that the designated doctor procedures were not invoked, the issue of whether or not respondent reached MMI on "9/1/91" was just not ripe for determination.

We find the evidence sufficient to support the hearing officer's findings and conclusions in this matter. We stated in an earlier decision that the Rule 130.1 report of a certifying doctor mutually agreed to by the parties must be sent to the treating doctor who must then either state agreement or prepare a Rule 130.1 report. We also observed in that decision that such a procedure parallels and is not mutually exclusive of the designated doctor mechanism provided for in Article 8308-4.25 and Rule 130.6 for the resolution of a dispute over MMI. Texas Workers' Compensation Commission Appeal No. 92077 (Docket No. HO-00122-91-CC-1) decided April 13, 1992. We cannot agree with appellant's assertion that respondent had some burden of proving (Dr. Y's) report had not been sent to his treating doctor, and, that he hadn't yet attained MMI. Respondent's burden of proof extended to his showing he sustained a compensable injury under the 1989 Act. Washington v. Aetna Casualty and Surety Company, 521 S.W.2d 313 (Tex. Civ. App.-Fort Worth 1975, no writ); Reed v. Aetna Cas. & Sur. Company, 535 S.W.2d 377 (Tex. Civ. App.-Beaumont 1976, writ ref'd n.r.e.). We may not and will not here substitute our judgment for that of the hearing officer where the findings are supported by sufficient evidence and are not against the great weight and preponderance of the evidence. Texas Employers Insurance Association v. Alcantara, 764 SW.2d 865, 868 (Tex. App.-Texarkana 1989, no writ).

The hearing officer's decision and order are affirmed.

_____
Philip F. O'Neill
Appeals Judge

CONCUR:

_____
Stark O. Sanders, Jr.
Chief Appeals Judge

_____
Joe Sebesta
Appeals Judge