APPEAL NO. 93077

On December 22, 1992, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The issues heard were: 1) the date on which the claimant reached maximum medical improvement; 2) whether the carrier overpaid claimant's temporary income benefits; and 3) whether carrier can recoup any overpayment from impairment income benefits. The hearing officer determined that the claimant, who is the respondent in this case, had not attained maximum medical improvement (MMI), and that the report of Dr L was contrary to the great weight of other medical evidence. Although Dr. L was appointed by the Texas Workers' Compensation Commission as designated doctor, the hearing officer made no findings or conclusions that Dr. L served as such. Because of her decision, the issues of overpayment and recoupment were not addressed.

The carrier has appealed for several reasons, noting that it was error for the hearing officer to find that the great weight of medical evidence was against the designated doctor's report. The carrier notes that the medical evidence in the record is scant and does not constitute a great weight of evidence. The carrier objects to the hearing officer's finding that relates to the conclusions of the carrier's doctor, indicating that the doctor's statement was taken out of context. The carrier objects to the hearing officer's determination that the claimant has not reached MMI either on the date reported by the designated doctor right up to the date of the hearing. Finally, the carrier complains about the setting aside of an interlocutory order of the benefit review officer to pay impairment income benefits from March 9, 1992. The claimant agrees that the decision is correct because he continues to improve.

DECISION

After reviewing the record, we find errors and omissions of evidence critical to determination of the issues, and therefore reverse and remand the case for further consideration and development of the evidence.

I.

The claimant was injured when working as night manager and auditor for (employer), where he had worked for four years. Shortly after his shift began at 11:00 p.m. on (date of injury), he lifted a box from the hallway, he felt like someone hit him in the back and he couldn't rise. A coworker offered to assist him by walking on his back. Claimant testified that when the coworker did this, it was "completely impossible" for him to get up again. His treating doctor, (Dr. O) initially treated the condition as a strain, but when pain persisted, ordered an MRI examination which revealed degenerative disc disease with a herniated nucleus pulposus. The claimant agreed that he had about four months of therapy and that Dr. O told him in October 1991 that he could do light duty work.

The claimant indicated that he was examined by M.D. (Dr. H), in September 1991 at the request of the carrier. He had a second examination by Dr. H in November 1991, after

the carrier had written to Dr. H. In the only medical document in the record from Dr. H, a letter dated November 19, 1991, Dr. H indicates he cannot determine if the claimant reached MMI without another examination. It was the claimant's testimony that Dr. H did not find that he reached MMI.

The claimant said he was represented by an attorney at the time that a first benefit review conference was held on January 16, 1992. Both the carrier and the claimant characterized what they believed the issues were at that first conference, and the hearing officer has undertaken to discuss the issues from that first conference in her decision. However, the only document in issue from the first conference is a signed agreement that the claimant agreed that he read before he and his attorney signed it. It states that the disputed issue is "[a] dispute exists as to whether claimant can return to his work, and what level of work he can perform." Under the "resolution" portion of the agreement, it states:

> Parties agree that benefits will continue until the claimant is examined by a Commission approved designated doctor who will determine: 1) return to work, with any applicable restrictions; 2) disability; 3) MMI; 4) impairment rating; 5) need for present/future medical treatment.

The claimant did not ask that this agreement be set aside or contend it was fraudulent. Rather, he stated that MMI had not been in issue, although he testified that MMI was "put as part of what the designated doctor should inform them about."

The Commission thereafter appointed (Dr. L) as a designated doctor; who examined the claimant on March 9, 1992. His report indicates that he reviewed numerous medical records from the treating doctor and carrier doctor. Dr. L obtained additional x-rays. His recorded impression was "Degenerative disc disease at L4-L5 with mild mechanic symptoms, without clear radicular symptoms at the current time." He noted that claimant was anxious to avoid surgery and did not feel it was warranted. Dr. L indicated that "therefore, a final rating is given." In the narrative report, regarding MMI, Dr. L states: "has been achieved and was probably achieved in October of 1991." His TWCC-69 attached to the report states that MMI was reached "10-91", with a 5% impairment attributed to the lumbar region.

At the hearing, the carrier presented a deposition on written questions from Dr. L, in which Dr. L stated that the date of MMI was October 31, 1991. The claimant objected that he had not seen this before the hearing. Without hearing argument from the carrier, the hearing officer noted that the deposition was dated December 14, 1992 and that therefore she would find good cause for not having exchanged it before the hearing. Claimant was given a recess to review the previously undisclosed evidence.

The claimant stated that Dr. L told him during the examination that he would probably get benefits for another four months as a result of his report, and that after that he should be prepared to get on with his life. The claimant acknowledged throughout the hearing that Dr. O released him to light duty in October 1991, but that employer does not have such light duty and has already hired a replacement for him.

The claimant stated that he was surprised in late March 1992 to get a notice that his checks would stop based upon an MMI date of October 1991. A second benefit review conference ensued, and the claimant was not represented by an attorney at this conference. At that October 28, 1992, conference, under a reported issue of "on what date did the claimant reach maximum medical improvement?", the claimant's position is reported as "claimant argued that he had not reached [MMI] until he was examined by [Dr. L]., the Commission appointed Designated Doctor on 3/09/92." The carrier's position noted that it "would accept" an MMI date of October 31, 1991. The benefit review officer determined that MMI had not been properly certified for October, but that Dr. L's report did state MMI as of the date of his examination, and she issued an interlocutory order for payment of impairment income benefits based upon an MMI date of March 9, 1992.

Throughout the contested case hearing, the claimant argued that Dr. L had not even examined him in October, and that because Dr. O indicated back then that he was still improving, he had not reached MMI in October. He stated that he has discussed Dr. L's report with Dr. O, who agreed he did not reach MMI in October. During claimant's opening statement, he questioned the MMI finding "in October." During the claimant's closing argument, he urged the hearing officer to take note of the benefit review officer's recommendation that MMI was achieved on March 9, 1992. The benefit review conference report indicates that it was based upon an array of medical reports not all of which were put in evidence at the contested case hearing.

The claimant stated that beginning in October 1991, Dr. O treated him with analgesic creams and exercise. He could not recall if he saw Dr. O between December 1991 and August 4, 1992, but felt that he did see Dr. O between August 4, 1992 and December 1992. (The date of August 4, 1992 apparently related to an examination or report by Dr. O, which was not in the record). A letter from Dr. O dated December 2, 1992, says nothing one way or the other about "MMI", as such; it notes that claimant has progressively improved from October 4, 1991 to December 1992. Dr. O also states "a distinct possibility" that the tear in the nucleus "could" extend and necessitate surgery.

II.

THE HEARING OFFICER'S DECISION

Aside from findings of fact relating to coverage and employment, and conclusions of law regarding jurisdiction and venue, the hearing officer's findings and conclusions are:

FINDINGS OF FACT

4.[Dr. O], claimant's treating doctor, reported that claimant was still improving October 1991.

5.[Dr. H] stated on November 19, 1991 that he could not determine whether claimant had reached maximum medical improvement.

6.On March 9, 1992, [Dr. L] certified claimant as having reached maximum medical improvement in October 1991 with a 5 percent impairment rating. [Dr. L] is the only doctor who has certified claimant as having reached maximum medical improvement to the date of this decision.

7.Claimant's treating doctor, [Dr. O], has not certified claimant as having reached maximum medical improvement or been given the opportunity to agree or disagree with the reports of [Dr. L] to the date of this decision.

CONCLUSIONS OF LAW

3.[Dr. L]'s March 9, 1992 Report of Medical Evaluation supplemented by his December, 1992 written responses certifying that claimant reached maximum medical improvement on October 31, 1991 are contrary to and against the great weight of the other medical evidence.

4.Claimant did not reach maximum medical improvement on October 31, 1991, and has not reached maximum medical improvement to the date of this decision.

[NOTE: There is no Conclusion of Law No. 5]

6.The Interlocutory Order ordering payment of impairment income benefits is set aside.

In addition to this, the hearing officer's statement of the evidence notes that claimant denied that MMI was in issue when the designated doctor issued a report. Although the hearing officer makes no express determination that Dr. L was a designated doctor, we believe that this finding is implied by her application of a "great weight" standard in Conclusion of Law No. 3. This conclusion also indicates that, contrary to the concerns expressed by the carrier in its appeal, the hearing officer may have determined that claimant

was bound by his first benefit review conference agreement, and that the designated doctor was properly appointed by the Commission ancillary to resolution of a dispute over the existence of MMI.[1]

III.

RESPONSE TO POINTS OF APPEAL

The Appeals Panel has previously assigned error when a hearing officer who has rejected the presumptive weight of the designated doctor's report failed to detail the medical evidence that constitutes the "great weight" against the presumptive weight of a designated doctor's opinion, and to clearly state why and how such evidence outweighs the designated doctor. Texas Workers' Compensation Commission Appeal No. 92522, decided November 9, 1992. The decision here fails in that same respect. We would note that the fact found by the hearing officer that other doctors have not certified MMI does not, in and of itself, constitute medical evidence against achievement of MMI. More pertinent would be the medical reasons why a doctor may not have certified MMI. In summary, we cannot discern here what the hearing officer considered as outweighing the designated doctor's report insofar as she held that it was a certification of MMI effective October 31, 1991.

We remand this case not only for the required findings, but also because it is obvious that relevant and critical medical evidence that was discussed at the hearing, and relied upon by the designated doctor and the benefit review officer, was omitted from the record of this case. The criticality of missing reports by Dr. H, the carrier's doctor, concerning a second examination conducted of the claimant, is underscored by the hearing officer's characterization of the November 19, 1991 letter as, essentially, an opinion that MMI was not in existence. The carrier has asked us to review Finding of Fact No. 5, but to do so with the existing record would ask us to analyze error based upon the "tip of the iceberg" of medical evidence deemed critical by the hearing officer's decision in her decision to reject the designated doctor's report.

The dispute resolution process set forth in Texas Workers' Compensation Act, TEX. REV. STAT. ANN. arts. 9309-6.01 *et seq*. (Vernon Supp. 1993) (1989 Act), indicates the objective that a decision regarding benefits should be based upon complete facts of the case. The benefit review conference officer is specifically directed to ensure that all pertinent information, and specifically information relating to medical condition, is contained in the claim file used at the conference. Article 8308-6.13(a)(3). Prior to the contested

[1] At the end of the hearing, the hearing officer indicated concern about how a designated doctor could have been appointed without there being an "issue" on MMI. However, if the hearing officer had not agreed that Dr. L was a designated doctor, or that claimant was not bound by his benefit review conference agreement, such findings and conclusions would have to be clearly stated with reference to applicable standards for setting aside agreements set forth in Article 8308-6.15(c).

case hearing, parties must exchange "all medical reports", not just reports that are intended for use at the hearing. Article 8308-6.33(d)(2). The failure to get all information to the other side may be sanctioned by exclusion from evidence. Article 8308-6.33(e). The hearing officer is directed to "ensure. . .the full development of facts required for the determinations to be made." Article 8308-6.34(b).[2] Further, the hearing officer "shall" accept into the record all signed medical reports. Article 8308-6.34(e). Such provisions highlight the importance given to medical evidence. Given the further provisions in Article 8308-4.25(b) and 4.26(g) that the designated doctor can only be rebutted by a great weight of medical evidence, the importance of medical reports to determinations of MMI is pivotal.

We have stated before that the hearing officer, in cases regarding the substance of the report of a designated doctor, need not be passive, but should seek clarifying information from the designated doctor when the report is unclear. Texas Workers' Compensation Commission Appeal No. 92570, decided December 14, 1992. Notwithstanding Dr. L's answers to deposition on written questions tendered by the carrier, there is arguably still an ambiguity in that the designated doctor was unable to specify an October date at the time of his examination, but nine months later was able to specify the end of that month as MMI, based upon review of the same records.

We have also noted that when critical information is discussed at a hearing, which has a bearing on the substance of a designated doctor's report, it should be included in the record. *See* Texas Workers' Compensation Commission Appeal No. 92495, decided October 28, 1992. Both the claimant and the carrier (through cross-examination) brought out the occurrence of a second examination by Dr. H. The hearing officer evidently determined that Dr. H's evaluation, as a carrier doctor, was important to the "great weight" analysis, and reviewed a single letter from Dr. H, in isolation from other reports, a fact complained of by the carrier on appeal. The benefit review conference lists other reports from Dr. H not in the record of this case. Under these circumstances, we can not determine the appealed issues with such reports omitted from the record. Finally, to the extent that the January 16, 1992 first benefit review conference report was a factor to the hearing officer's decision, that report, and not just the agreement or testimony about the issues raised at the conference, should have been included in the record.

We are concerned that the hearing officer's finding that no doctor has certified MMI effective after October 31, 1991 ignores a position asserted by the claimant in closing argument, and which is further supported by Dr. L's report in this case: that Dr. L also stated in his narrative report, which is part of the certification, that claimant had reached MMI by

[2] It would seem advisable that a hearing officer should, in cases involving MMI and impairment rating, bring into the record all relevant medical reports considered by the benefit review officer which neither party tenders at the contested case hearing. While we cannot say that the failure to do so would be error in every case, as a matter of law, we would note that such actions will prevent expenditure of additional time on remands of cases where the omitted medical evidence is critical.

the date of his examination, which was March 9, 1992. The Appeals Panel has stated that the report of the designated doctor is not just a single TWCC-69 but may include narrative reports attached to that form, or subsequent reports. *See* Texas Workers Compensation Commission Appeal No. 92469, decided October 15, 1992. The report submitted here on March 9, 1992 is unequivocal about MMI on the date of that examination, even if it was not a valid certification of an October 1991 MMI. There is no medical evidence currently in the record, other than that of the designated doctor, directly refuting the achievement of MMI on March 9, 1992. While the hearing officer could have interpreted Dr. O's December 1992 letter stating that claimant has improved since October 1991 to indicate that some improvement went on after March 9th, this letter standing alone would not greatly weigh against MMI at Dr. L's March examination.

Finally, the hearing officer's Finding of Fact No. 7, that Dr. O was not given an opportunity to respond to Dr. L's report, may indicate application of an erroneous standard in evaluating the designated doctor's report. There is no requirement in the Commission Rules or the statute that the designated doctor's report be forwarded for comment to the treating doctor. Consequently, it appears that the substance of the designated doctor's report may have been discounted by viewing him as just the first certifying doctor (in spite of the ostensible application of a "great weight" standard). We are confident that this can be sorted out on remand of this case, and that the relevance of such an observation, if any, will not be left to speculation.

Because of the lack of necessary findings and conclusions by the hearing officer, the determination to reject the report of the designated doctor is erroneous. However, we are unable to completely evaluate the merits of all points of error or render a decision given the lack of potentially important medical information alluded to by the parties, and considered by the designated doctor and benefit review officer, which would bear on the hearing officer's conclusions about the effect of the carrier doctor's November 19, 1991 letter as well as the determination that the designated doctor's opinion was greatly outweighed. Depending upon the decision on remand, it may also be necessary for the hearing officer to determine whether or not an offset against any impairment income benefits obligation can be made. *See* Texas Workers' Compensation Commission Appeal No. 92556, decided December 2, 1992; *also* Texas Workers' Compensation Commission Appeal No. 92291, decided August 17, 1992.

Pending remand, a final decision is not issued in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party, including claimant, 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 Texas Workers' Compensation Commission's division of hearings, pursuant to Article 8308-6.41. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Susan M. Kelley
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Thomas A. Knapp
Appeals Judge