APPEAL NO. 93610

On June 21, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). The issues at the hearing were: 1) whether the appellant/cross-respondent (claimant) had reached maximum medical improvement (MMI), and, if so, what is the claimant's impairment rating; 2) whether the claimant has had disability at any time since September 21, 1992; and 3) whether the respondent/cross-appellant (carrier) may take a credit against future income benefits for temporary income benefits (TIBS) which were paid while claimant was working. The hearing officer determined that the claimant reached MMI on February 17, 1993, with a four percent impairment rating as reported by the designated doctor; that the claimant has not had disability at any time since September 21, 1992; and that she did not have jurisdiction to determine the third issue.

The claimant disputes certain findings of fact and conclusions of law and contends that the hearing officer misstated the evidence and erred in rulings on the admission of certain evidence. The claimant requests that we reverse the hearing officer's decision and render a decision that he has not reached MMI and that he has had disability subsequent to September 21, 1992. The carrier requests that we clarify the hearing officer's decision and order to reflect that TIBS paid to the claimant after his disability ceased on September 21, 1992, but before he reached MMI on February 17, 1993, are impairment income benefits (IIBS) and an offset against IIBS owed to the claimant.

DECISION

The decision of the hearing officer is affirmed.

The claimant began working for the employer, (employer), as a process design engineer in December 1989. He earned $4,000 per month. In June or July of 1991 he began tracing utility lines at the employer's plant. The claimant traced the lines in order to prepare a drawing of the layout of the plant. In order to trace the lines, which were 12 to 14 feet above ground, the claimant had to continuously look up as he followed the lines from their source to their ending point. He said there were 18 to 20 utility lines and each was more than a mile long. As a result of having to continuously look up, the claimant said he got a stiff neck, had neck pain, eventually was unable to look up above eye level, and was unable to turn his head from side to side without pain. Apparently, the question of injury in the course and scope of employment was never contested.

The claimant testified that he notified his supervisor that he had neck pain in August 1991 and that the last day he worked for his employer was October 17, 1991. However, the claimant said that he was not laid off by the employer until about April 2, 1992. The claimant was paid TIBS from October 24, 1991 until October 28, 1992.

On September 21, 1992, the claimant began working for (Employer B) in a

managerial job for $4500 per month. He testified that this job did not require him to do any line tracing. He said he got the job out of economic necessity. He was terminated by Employer B on or about November 20, 1992. The claimant said his termination was because he lacked the managerial skills required for the job and because he was taking "Somacompound" for his neck pain which made him drowsy and unable to complete his work on time. A termination report from Employer B indicates that the claimant was terminated because his project leadership and time management skills were poor, he lacked knowledge required for his job, he had problems meeting deadlines, and because of "overall work performance and knowledge demonstrated for a 10 year experienced process engineer." The claimant said he was unaware of any requirement to inform the carrier that he was employed while he was receiving TIBS and therefore did not inform the carrier of his employment with Employer B. The claimant was asked if there were chemical engineering jobs available which would not require him to look up. The claimant responded that "[d]epends, yes, if I go in managerial jobs or something, no it does not require to look up, but if you tell them you cannot, they will not hire you. . . ."

The claimant has seen several doctors for his neck condition. He said he first saw (Dr. Y), a chiropractor in September 1992. He then saw (Dr. K), M.D., in October 1992, who asked him to see a neurologist. The claimant talked to the carrier about seeing a neurologist and the carrier referred him to (Dr. C), M.D. The claimant then began treatment with (Dr. B), M.D., in March 1993. He was then evaluated by (Dr. H), M.D., the designated doctor selected by the Commission, and he subsequently began treatment with (Dr. V), M.D.

An x-ray of the claimant's cervical spine done on October 20, 1992 was normal as was a magnetic resonance imaging scan (MRI) done on October 21, 1992. In a Report of Medical Evaluation (TWCC-69) dated October 21, 1992, Dr. Y certified that the claimant reached MMI on September 16, 1992, but did not assign an impairment rating. In an attachment to the report, Dr. Y said that in his opinion the claimant doesn't have any "permanent injury or disability." Dr. Y also said that "[h]e [the claimant] may be 100% disable (sic) for above the head type of work. Otherwise he should be able to perform any job that he is qualified to perform." In a TWCC-69 dated May 20, 1993, Dr. Y indicated that the claimant had not reached MMI, but noted that the claimant was not under his care.

The only documentary evidence offered by the claimant concerning his treatment with Dr. K was a bill for services performed on October 5, 1992. The carrier's objection based on relevance was sustained and the document was not admitted into evidence.

The claimant said he was thoroughly examined by Dr. C on December 21, 1992, and was again seen by Dr. C on February 23, 1993. In a TWCC-69 dated February 17, 1993, Dr. C certified that the claimant reached MMI on February 17, 1993, with a zero percent impairment rating. Dr. C noted on the report that "[h]e [the claimant] did not do therapy as requested on last visit - so will declare MMI on 2/17/93." The claimant said he did not attend the physical therapy treatment recommended by Dr. C because his neck condition prevented him from driving from (city), Texas, where he lived, to (city), Texas, where the

therapist was located.

In January 1993 a second MRI of the cervical spine was done. It showed no evidence of focal "HNP" or significant disc bulge, a normal cervical cord, diffuse desiccative changes with some disc space narrowing at C4-5 and C5-6, and straightening of the cervical spine.

Dr. B reported in a letter to the carrier dated March 9, 1993, that he performed a neurological evaluation of the claimant and that "I gave [the claimant] two weeks of physical therapy and after these two weeks he will reach his maximum medical improvement. The rate of disability is 4% due to his neck pain."

In a report dated March 18, 1993, Dr. H, the designated doctor, certified that the claimant reached MMI on February 17, 1993, with a four percent impairment rating. The claimant testified that Dr. H was the designated doctor and that he saw Dr. H, but that Dr. H did not give him a physical examination. However, Dr. H indicates in his report that a physical examination was performed and that the examination revealed normal reflexes and no motor-sensory defects. Dr. H also compared the results of "our" examination with that performed by Dr. C and found the results of Dr. C's examination to have been unchanged.

In a report dated April 26, 1993, Dr. V recommended that the claimant continue physical therapy for four to six weeks. In a report dated May 10, 1993, Dr. B indicated that the claimant had not reached MMI and estimated that he would reach MMI on June 10, 1993. A report from a physical therapist dated June 4, 1993, indicated that the claimant was receiving physical therapy three times a week and that he was improving.

CLAIMANT'S APPEAL

The claimant disputes the following findings of fact and conclusions of law:

FINDINGS OF FACT

No. 6.Dr. H certified that claimant had reached MMI on February 17, 1993.

No. 9.Since September 21, 1992, the compensable neck injury which claimant sustained while employed at [employer] has not prevented claimant from obtaining and retaining employment at wages equivalent to the wage claimant earned prior to October of 1991.

CONCLUSIONS OF LAW

No. 3.Claimant reached MMI on February 17, 1993.

No. 5.Claimant has not had disability at any time since September 21, 1992.

Undisputed findings of fact are that Dr. H was the designated doctor appointed by the Texas Workers' Compensation Commission (Commission), and that Dr. H assigned the claimant a four percent impairment rating.

Pursuant to Sections 408.122(b) and 408.125(g), the report of the designated doctor selected by the Commission has presumptive weight and the Commission must base its determinations of MMI and impairment rating on the designated doctor's report unless the great weight of the medical evidence is to the contrary. In this case, the hearing officer based her determinations of MMI and impairment rating on the report of the designated doctor and found that the great weight of the medical evidence was not contrary to the report of the designated doctor. Having reviewed the record, we conclude that the hearing officer's findings and conclusions concerning the claimant's having reached MMI on February 17, 1993, with a four percent impairment rating are supported by sufficient evidence, are not contrary to the great weight of the medical evidence, and are in accordance with the applicable provisions of the 1989 Act. Dr. Y's reports are somewhat ambiguous when read together; however, the findings of Drs. C and B tend to support the designated doctor's findings and only that of Dr. V is to the contrary.

Concerning the claimant's assertion that Dr. H did not give him a physical examination, we have previously stated that while a designated doctor may rely on tests performed by others in arriving at his or her final evaluation, the designated doctor must also examine the injured employee and not simply review records and rely on examinations by other persons. *See* Texas Workers' Compensation Commission Appeal No. 93095, decided March 19, 1993. In this case, the designated doctor's report clearly indicates that a physical examination was performed, sets forth findings on physical examination, and compares the designated doctor's examination to the examination performed by Dr. C. The designated doctor even states that "our exam is unchanged from the one done by [Dr. C]." We also note that when the claimant was asked whether Dr. H asked him to move his head, the claimant did not respond with a simple "no," but instead said "I don't think he did" and "I'm pretty much (sic) he did not." With the evidence in this posture, we do not believe that the hearing officer, who is the judge of the credibility of the witnesses, was compelled to give credence to that portion of the claimant's testimony to the effect that he was not examined by Dr. H.

"Disability" means the inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage. Section 401.011(16). In this case there was compelling evidence that the claimant could obtain employment at wages equivalent to his preinjury wage on and after September 21, 1992. However, although acknowledging that he lacked the skills to work for Employer B, the claimant essentially urged that he was not able to retain employment with Employer B because of the side effects of medicine he was taking for his compensable injury and therefore had disability throughout his period of employment with Employer B and thereafter. As we have previously pointed out, the hearing officer is the judge of the credibility of the witnesses. The hearing officer was not required to believe all of the claimant's testimony concerning the reasons he could not perform work. The hearing officer also resolves conflicts and inconsistencies in the evidence. In this case, Employer B's termination report clearly reflected that the primary reason for the claimant's termination was that he did not have the knowledge and skills expected of one of his experience. This evidence, along with the claimant's testimony concerning the availability of work and Dr. Y's statement that the claimant is able to perform any job he is qualified to perform, sufficiently supports the hearing officer's Finding of Fact No. 9 and the conclusion that the claimant has not had disability since September 21, 1992. We conclude that the hearing officer's determination of no disability since September 21, 1992, is supported by the evidence and is not so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. In Re King's Estate, 150 Tex. 662, 224 S.W.2d 660 (1951).

The claimant appears to disagree with the hearing officer's admission into evidence of Employer B's termination report on the basis that it is hearsay. This same objection was raised by the claimant at the hearing. We find no error in the admission of the report, which is signed by the claimant's supervisor. Section 410.165(b) provides that the hearing officer may accept written statements signed by a witness. Moreover, Section 410.165(a) provides that conformity to legal rules of evidence is not necessary in a contested case hearing. We also conclude that error, if any, in the exclusion of Dr. K's bill for services would not present reversible error because exclusion of that document was not reasonably calculated to and probably did not cause the rendition of an improper decision in this case. *See* Hernandez v. Hernandez, 611 S.W.2d 732 (Tex. Civ. App.-San Antonio 1981, no writ).

The claimant contends that the 1989 Act is unconstitutional in that he has been unable to obtain an attorney to represent him in his claim. We decline to consider the claimant's challenge to the 1989 Act because administrative agencies have no power to determine the constitutionality of statutes. *See* Texas State Board of Pharmacy v. Walgreen Texas Co., 520 S.W.2d 845 (Tex. Civ. App.-Austin 1975, writ ref'd n.r.e.).

CARRIER'S APPEAL

I now turn to the carrier's request for clarification of the hearing officer's decision and order. One of the issues at the hearing was whether the carrier can take credit against future income benefits for TIBS paid while the claimant was working at Employer B. At the

outset of the hearing the carrier argued that between September 21, 1992, and October 28, 1992, the claimant was working making greater wages than his preinjury wages, that the claimant failed to inform the carrier that he had gone back to work, that the carrier continued to pay TIBS during that period of time, and that the claimant continued to accept the TIBS. The evidence showed that the carrier paid the claimant maximum TIBS from September 21, 1992 to October 28, 1992, which is a portion of the period in which the claimant worked for Employer B. The claimant acknowledged that he did not inform the carrier that he was working at Employer B. In the discussion of the evidence section of her decision, the hearing officer stated that:

> Since the matter of repayment of allegedly fraudulently obtained Temporary Income Benefits must be addressed in an APTRA Hearing, rather than a Contested Case Hearing, the Hearing Officer has no jurisdiction to consider this issue. Therefore, it is not decided herein.

The carrier does not challenge the hearing officer's determination that under the facts presented at the hearing the issue of whether or not the carrier may take a credit against future income benefits for TIBS paid the claimant while he was working involved a matter of allegedly fraudulently obtained TIBS or her determination that she had no jurisdiction to consider the issue. The portion of the hearing officer's decision and order that the carrier wants clarified reads:

> Carrier is ordered to pay claimant twelve weeks of Impairment Income Benefits, payable from February 18, 1993. A credit is allowed against this award in the amount of Impairment Income Benefits, if any, which previously have been paid to claimant.

The carrier contends that if the decision and order of the hearing officer are to be interpreted by the Commission as not allowing the carrier the opportunity to take a credit for all payments made as temporary income benefits after September 21, 1992 and prior to MMI on February 17, 1993, the carrier disagrees with and requests clarification of that portion of the order.

Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 129.4 (Rule 129.4) provides in subsections (a) and (d) as follows:

(a)The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured employee as necessary to match the fluctuations in the employee's weekly earnings after the injury.

(d)If the employee is no longer employed by the employer, the employee is responsible to provide information to the insurance carrier about the existence or amount of any earnings, or any offers of employment.

While the hearing officer did not reference a provision of the law relating to repayment of fraudulently obtained benefits, we note that Section 415.008 relates to fraudulently obtaining or denying benefits, and provides in subsections (a), (b), and (c) as follows:

(a)A person commits a violation if the person, to obtain or deny a payment of a workers' compensation benefit or the provision of a benefit for the person or another, knowingly or intentionally:

(1)makes a false or misleading statement;

(2)misrepresents or conceals a material fact:

(3)fabricates, alters, conceals, or destroys a document; or

(4)conspires to commit an act described by Subdivision (1), (2), or (3).

(b)A violation under this section is a Class B administrative violation.

(c)A person who has obtained excess payment in violation of this section is liable for full repayment plus interest computed at the rate prescribed by Section 401.023. If the person is an employee or person claiming death benefits, the repayment may be redeemed from future income or death benefits to which the person is otherwise entitled.

Section 415.031 provides for the initiation of administrative violation proceedings; Section 415.032 provides for the investigation of the violation and notice of the charge and right to request a hearing; and Section 415.034 provides that the hearing shall be conducted in the manner provided for a contested case under the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes; note effective September 1, 1993, the Administrative Procedure Act (APA) is codified in Chapter 2001 of the Government Code). The APA does not apply to benefit contested case hearings with the exception of the enforcement of subpoena provision. Section 410.153, Rule 142.1. Consequently, a benefit contested case hearing is not the proper forum to determine an administrative violation.

Since the carrier has not contested the hearing officer's determination that the issue of a credit against future income benefits for TIBS paid the claimant while the claimant was working involved allegedly fraudulently obtained TIBS, that determination is not reviewable on appeal. Section 410.204(a). As we have pointed out, fraudulently obtaining workers' compensation benefits is an administrative violation requiring notice of the violation charged and notice of the right to request a hearing conducted under the APA. As we observed in Texas Workers' Compensation Commission Appeal No. 92291, decided August 17, 1992, "[w]e do not see an obvious legislative intent that calls for an implication that recoupment is allowed in areas of the 1989 Act that do not address it when it is specified elsewhere." In this case, the hearing officer determined that the credit issue involved alleged fraud and that determination has not been appealed. Fraudulently obtaining workers' compensation benefits is addressed in Section 415.008, and subsection (c) of that section provides that excess payments obtained in violation of that section may be redeemed from future income benefits. Consequently, if the carrier desires to have excess TIBS payments redeemed from future income benefits in this case where the carrier failed to contest the hearing officer's determination that the credit issue involved alleged fraud, then the carrier's remedy is to initiate an administrative violation proceeding under Section 415.032. I think it is clear from the hearing officer's determination that she did not have jurisdiction to decide the credit issue that her order allowing a credit against the IIBS award for any IIBS previously paid to the claimant does not encompass a credit for the TIBS paid to the claimant while the claimant was working for Employer B.

The decision of the hearing officer is affirmed.

Robert W. Potts
Appeals Judge

CONCURRING OPINION:

I concur in the result reached by Judge Potts. The carrier tells us on appeal that it "has paid [claimant] all the [IIBS] owed him and has taken, what it believes, is a lawful offset pursuant to the hearing officer's decision and order." Having already interpreted the hearing officer's order and taken its action accordingly, the carrier now asks that we "clarify the order and decision of the hearing officer." In my view, such a request is in the nature of an advisory opinion which we should decline to render until the issue is properly developed and squarely before us. As for the authority of a hearing officer to apply a credit against IIBS for the overpayment of TIBS, it seems to me that because the hearing officer is expressly authorized to make an award of benefits (Section 410.168(a)(3)), the hearing officer has such implied powers as are necessary to effectuate that express authority including the power to apply a credit or offset in an appropriate case.

Philip F. O'Neill
Appeals Judge

DISSENTING OPINION IN PART:

I respectfully dissent from the majority opinion's determination not to decide the issue relating to credit. Clearly, we have been asked to review, within the scope of Section 410.202, the determination of the hearing officer insofar as she ordered impairment income benefits for a twelve week duration. We are compelled, under Section 410.204, to respond on each issue in which our "review" is requested. I don't think that the carrier in this case was further required to invoke "magic words" disagreeing with a hearing officer's recitation in a discussion of the evidence. This tribunal emphasized in past decisions that inclusions or omissions in the statement or discussion of evidence does not constitute error; it seems contradictory now to fault a carrier for not doing that which we have told claimants and carrier it is pointless to do. *See* Texas Workers' Compensation Commission Appeal No. 92185, decided June 18, 1992. Because the carrier has timely disputed the hearing officer's order to pay twelve weeks worth of impairment benefits, and argues further its position that only seven weeks worth are due, this matter has been appealed, and we are required to respond.

The hearing officer erred by not deciding the issue of credit, and I'd reverse and remand on this issue. The contested case hearing is the forum for determining, and indeed, awarding benefits that result from a hearing officer's decision. Section 410.168. The fact that there may be provisions in the administrative penalty sections of the law that govern the actions of the parties doesn't, in and of itself, prevent a hearing officer from deciding a benefits issue. For example, a hearing officer could not decline to award benefits if the record indicated that the carrier unreasonably terminated or reduced benefits in violation of Section 415.002(e).

While Section 415.008(e) indicates that a hearing officer must hold a final award of benefits in abeyance if there is a pending administrative violation proceeding on a fraud allegation, there is no evidence that there was, in this case, any such proceeding pending. Absent such express direction to withhold a final award, I think that when an issue relating to payment of, the amount of, or entitlement to benefits arises, including offsets or credits, the hearing officer clearly has "jurisdiction." *See* Rule 140.1, definition of "benefit dispute."

If the hearing officer had decided to apply a credit in this case, I would have affirmed that determination. Regardless of how it happened, it is undisputed that a payment of income benefits occurred during a period that the claimant was not entitled to them because his earnings exceeded his preinjury wages; benefits would not have been due during the time claimant worked for Employer B even if the hearing officer had agreed that he had disability for all periods of nonemployment up to a maximum medical improvement. See Sections 401.011(16) and 408.103.

In addition, the hearing officer expressly found that disability, as that term is defined in the 1989 Act, ceased on September 21, 1992. To grant a credit against amounts due as future income benefits (according to another part of her decision) would have been an implementation of her determination as to the disability issue. It was not necessary for her to determine whether there was an administrative violation. Equitable adjustments which prevent payment of benefits during a period of nonentitlement are, I believe, within the power of our hearing officers to determine. An offset here would have been consistent with the reasoning we've employed in Texas Workers' Compensation Commission Appeal No. 92556, decided December 2, 1992, where we noted that payment of the temporary income benefit can, in some cases, be viewed as payment of the impairment income benefit. [As that opinion discussed, overpayments during a period of entitlement which resulted from computational errors are a different issue.]

Susan M. Kelley
Appeals Judge