APPEAL NO. 93753

This appeal is brought pursuant to the Texas Workers' Compensation Act of 1989, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on July 23, 1993, in (city), Texas, (hearing officer) presiding as hearing officer. The issues at the CCH were: 1. Whether the respondent's (claimant's) back problems were related to an earlier knee injury. 2. Whether the employer m ade a bona fide offer of employment. 3. Whether claimant was entitled to a change of doctor. 4. Whether claimant has reached maximum medical improvement (MMI). 5. What is claimant's impairment rating.

The hearing officer found for the claimant on issues one through three. As to issues four and five, the hearing officer found that questions of MMI and IR were premature since a designated doctor has not been appointed to resolve them. The appellant's (carrier's) position on these issues is addressed in the discussion below.

DECISION

The decision of the hearing officer is affirmed.

The claimant worked in the meat department of a supermarket. There is no dispute that on (date of injury), she tripped and fell in the course and scope of her employment injuring her right knee. She reported the injury to her supervisor the same day, but did not visit a doctor until the following week because she thought her condition would improve on its own. On April 20, 1992, she went to a (clinic) where she described her injury as leg pain. (Dr. S) at the clinic diagnosed a knee contusion and sprain. On April 22, 1992, Dr. S placed her on light duty. Her last visit to the clinic was June 24, 1992, when the diagnosis was leg and foot pain. Because she wanted to consult a specialist, clinic doctors suggested the claimant see (Dr. M) who treated her from April 28, 1992 until August 12, 1992. X-Rays showed no fracture of the right knee, and Dr. M. concluded that the claimant "primarilly (sic) sustained a contusion to the knee, which should improve with some additional rest." She remained off work from April 22 until June 2, 1992. He again took her off work on June 30, 1992, "since the work is what appears to be aggravating her condition" of pain in the right ankle and calf. An entry in Dr. M's treatment records for August 11, 1992, indicates the pain was radiating to the lower back. An August 12, 1992, entry reads:

> [Claimant] was initially diagnosed as having a contusion but since that time has had other complaints that are inconsistent with her injury. Today, she states that the pain in her lower leg and knee is now radiating to her lower back. She denies improvement. She has been off work since the injury and physical examination has been unremarkable. I think that [claimant] has received maximum benefit from medical treatment. I think she can return to work and has no permanent impairment from the injury. She is being dismissed from our care.

Apparently dissatisfied with Dr. M, the claimant next saw (Dr. N) on August 14, 1992. He

reports that claimant complained of right leg and right hip pain "in spite of normal x-rays, anti-inflammatory medicine, and physical therapy." He diagnosed low back and limb pain and recommended she remain off work. On January 7, 1993, Dr. N authorized her return to work without restriction. On January 26, 1993, Dr. N approved a recommendation from consulting physical therapists that she be returned to limited duty with the primary limitation that she not lift more than 35 pounds. She last saw Dr. N on February 12, 1993.

The claimant testified that sometime shortly after Dr. N's release to go back to work, she discussed another change of doctors with (KC), the carrier's agent and thought she had approval for a change from Dr. N. She returned to work sometime in January, 1993, performing the same duties as before the accident. She continued to work until February 25, 1993, when because of the pain she returned home. She testified that her employer told her that, because of her pain, she would have to first resolve with a doctor what she could or could not do at work before returning. The claimant admitted that she never sought permission to change treating physicians from Dr. M to Dr. N. She testified that KC told her that she would need to complete some paperwork only if she wished to change from Dr. N to another treating physician. After Dr. N told claimant he could do no more for her, claimant again talked to KC about a change in doctors. KC told her she would have to request permission from the Texas Workers' Compensation Commission (Commission). On March 2, 1993, the claimant submitted an Employee's Request to Change Treating Doctors, (TWCC-53) to the Commission. The request was approved on the same day and a copy was sent to the carrier. The carrier was not consulted prior to this approval of a change in treating physicians.

On March 25, 1993, the claimant referred herself to (Dr. K), who diagnosed "chronic lumbosacral strain" and placed her on light duty with a ten pound lifting restriction and changing positions every one to two hours. In a letter of April 5, 1993, Dr. K advised KC that due to difficulty in walking because of claimant's knee injury, the claimant "did develop low back pain and a chronic lumbosacral strain. In all medical probability, it is related." The claimant is presently not working and her supervisor indicated that no job was available to her until she could lift up to 50 pounds.

The issues raised on appeal will be treated in the order presented by the carrier.

WHETHER CLAIMANT WAS ENTITLED TO HER CHANGES OF TREATING DOCTORS

The hearing officer's findings of fact and conclusions of law pertinent to this issue are:

FINDINGS OF FACT

13.The doctors at [the clinic] were not CLAIMANT's choice of doctors.

14.EMPLOYER at least implied that CLAIMANT should seek initial treatment from [the clinic].

15.CLAIMANT consulted [Dr. M], who was her first choice of a treating doctor, on 04-28-92.

16.With CARRIER's knowledge and approval, CLAIMANT changed to her second treating doctor, [Dr. N], on 08-14-92, but nothing concerning the change was filed with the Commission.

17.[Dr. N] released CLAIMANT on 08-14-92 (sic). She completed a Request to Change Treating Doctors on 02-23-93 and the Commission approved CLAIMANT's change to [Dr. K] on 03-02-93.

CONCLUSIONS OF LAW

4.CLAIMANT was entitled to her changes of treating doctors.

Pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. (formerly TEX. REV. CIV. STAT. ANN. Article 8308-4.62 (Vernon Supp. 1992), which by it terms expired December 31, 1992), an injured employee was entitled to an initial choice of doctor. The employee was permitted to change doctors once after the initial choice provided the employee notified the Commission within three days of the visit to the second doctor. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 126.7 (Rule 126.7). An initial choice made by an employer did not constitute the employee's choice, unless the doctor continued to treat the employee for a period of 60 days. Rule 126.7(f). A third or subsequent doctor selected by the employee was subject to the approval of the insurance carrier or the Commission.

The carrier contended at the CCH and on appeal that Dr. S was the claimant's initial choice of treating doctor. *See* Rule 126.7(c). The carrier presented the testimony of (CC), the claimant's supervisor, and (JC), the department manager, as well as an affidavit of (MJ), the store manager at the time, that it was the employer's policy that injured employees could choose whatever doctor they wanted for treatment; that the clinic had no connection with the employer; and that no one in a position of authority directed the claimant to this clinic but the claimant testified that JC told her that if she wanted to go to a doctor, she "could" go to the clinic. The claimant admitted that no one told her she had to go to the clinic or that she could not go anywhere else. Nonetheless, the claimant believed that was where all injured employees went and a coworker, (MS), testified that when she was injured she got sent to the clinic and thought all employees got sent there though there was no written policy on this. JC testified that many employees do go to this clinic presumably because of its convenience.

On appeal, the carrier contends that there is "no evidence that [employer] chose or selected [Dr. S] . . . to treat the Claimant." The Appeals Panel has previously stated that in reviewing a "no evidence" challenge, we consider only the evidence and reasonable inferences drawn therefrom which, when viewed in the most favorable light, support the hearing officer's determinations. All evidence and inferences to the contrary are

disregarded by the appeals panel. Texas Workers' Compensation Commission Appeal No. 92069, decided on April 1, 1992. We therefore consider only the claimant's and MS's testimony on this point. Each believed that injured employees were sent as a matter of course to the clinic. Advice to the claimant from JC that she "could" also go there could have reasonably been construed by her to be an indication that the employer would only pay for her visit there, and, in the context of other employees' experience, was what the employer wanted her to do. Given this evidence and disregarding all contrary evidence and contrary inferences from the evidence, we are unwilling to conclude that the hearing officer erred in his Finding of Fact No. 14, above, that the employer, not the claimant, by implication chose Dr. S.[1]

Given our decision affirming the hearing officer's conclusion that Dr. S was not the claimant's first choice of treating doctor, we need not decide whether the change from Dr. S to Dr. M was done in accordance with Rule 126.7(g).

With regard to the change from Dr. M to Dr. N, the hearing officer found this was done with the carrier's knowledge and approval, but with no notice to the Commission. Under Rule 126.7, as then in effect, proper procedure would have been for the claimant to advise the Commission within three days of the visit to the new doctor. In turn, the Commission was to advise the carrier of the change within ten days. In her testimony, the claimant stated that she discussed a change from Dr. M to Dr. N with KC and assumed that KC approved the changed. In her deposition, KC states only that neither the claimant nor the Commission ever advised her (KC) in writing of her reasons for the change and the Commission's approval of the change. It is important to note that Rule 126.7 did not require prior approval of the change. It is a notice provision only when a claimant seeks to change from a first to a second treating physician. The hearing officer found that the carrier did have knowledge of the change by virtue of the claimant's conversation with KC. There is evidence to support this finding and we will not disturb it on appeal. Given this finding and the absence of any statutory or regulatory requirement for pre-approval of the change, we cannot find that Dr. N did not become a treating doctor. As to the continuing liability of the carrier to pay for Dr. N's services to the claimant, carrier contends that failure to comply with the notice provisions in Rule 126.7 "relieves the Carrier from payment for the medical treatment of the doctor." Nothing in this rule provides for this result. Section 408.024 of the 1989 Act states that "after notice and an opportunity for hearing, the Commission may relieve an insurance carrier of liability for health care that is furnished by a health care provider . . . in a manner inconsistent with the (selection) requirements of this chapter." Nothing in the statute makes relief automatic or mandatory. Because, as we note above, the lack of an after-the-fact notice of change to a second doctor does not render that change ineffective, we do not conclude that Dr N's selection was inconsistent with the 1989 Act.

The change from Dr. N to Dr. K occurred after January 1, 1993, when Article

[1]Because the carrier did not raise the issue of whether Dr. S became the claimant's initial treating physician by virtue of her continuing treatment with Dr. S for 60 days pursuant to Rule 126.7(f) we need not address it on appeal.

8308-4.62 was no longer in effect.[2] All parties agree that the claimant submitted to the Commission an Employee's Request to Change Treating Doctors (TWCC-53) and the Commission approved this request on March 2, 1993, prior to her first visit with Dr. K. It is also agreed that, without fault of the claimant, the Commission did not comply with Rule 126.7(i) in that it approved the change to Dr. K without prior approval of the change from the carrier. Carrier contends that such failure by the Commission to follow its rules relieves it of liability for the cost of medical care rendered by Dr. K and makes her appointment as a treating physician invalid. We address this issue because on all the relevant dates in 1993 concerning the selection of Dr. K, Rule 126.7 was still in effect. As stated above, Section 408.024 is not an automatic release of liability for the cost of medical care. It is a form of relief available to the carrier upon request and the presentation of evidence that Dr. K's selection was "inconsistent" with the 1989 Act. The carrier at the CCH presented only evidence of a procedural irregularity without identifying how this approval was inconsistent with the criteria contained in Section 408.022(c) or with any other requirements of the statute. Under these circumstances we do not conclude that this approval of Dr. K as a treating doctor was invalid; or that he did not acquire the status of a treating doctor; or that the carrier is relieved of liability for payment of Dr. K fees.[3]

WHETHER CLAIMANT REACHED MMI

The carrier contends on appeal that the statement of Dr. M quoted above and introduced as claimant's exhibit 1 at the CCH constituted a certification of MMI. In urging this position, carrier cites Texas Workers' Compensation Commission Appeal No. 92384, decided on September 14, 1992, for the proposition that certification of MMI "can be made only on a TWCC Form 69" and urges its reversal as "arbitrary and capricious." Contrary to the carrier's characterization of this case, we believe the Appeals Panel has never held that certification of MMI must be by means of a properly completed TWCC-69. The Appeals Panel in Appeal No. 92384, *supra*, went to great lengths to discuss what was meant by certification and what was critical to an effective certification of MMI. The Appeals Panel concluded by saying:

> We emphasize with this ruling that we are not attempting to elevate form over substance so as to thwart, rather than implement, the dispute resolution

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[2]The repeal of Rule 126.7 was not effective until July 1, 1993. Interim instructions for choosing doctors were approved by the Commission and made effective January 1, 1993. Neither Section 408.022 which superseded Article 8308-4.62 nor the interim instructions require prior approval of a third and subsequent choice of doctors by the carrier. The interim instructions also replaced the TWCC-50 with the TWCC-53.

[3]We question the concept in the hearing officer's Conclusion of Law 4 that the claimant was "entitled" to her change of doctors at least with regard to the fourth change. To the extent that this conclusion is tantamount to a conclusion that the selection of Dr. K was not invalid as a matter of law, we will not disturb it on appeal.

> process. The fact that a certification of MMI or a finding of impairment is not on the Commission's form does not, in and of itself, go to its substance as an expert opinion.

It went on to caution about the risks associated with not using the prescribed form.

Rule 130.1(c) sets out the minimum requirements for a legally sufficient report of certification of MMI. The only ones clearly not contained in Dr. M's medical treatment record of August 12, 1992, are the worker's compensation claim number and his professional license number. In addition it does not state that the claimant has reached MMI; rather it states: "I think that [claimant] has received maximum benefit from medical treatment." Rule 130.2(b)(2) provides, in addition to the above, that when MMI is certified by a treating doctor, that doctor shall send the completed report within seven days to the Commission, the employee and the carrier. While we believe the statement of Dr. M may contain the bare minimum requirements essential to a finding of MMI, we believe it is fatally defective in one regard: it is not a proper certification. Rule 130.1 defines certification as a formal assertion of medical facts or expert opinion. We are unwilling to conclude that this statement in and of itself was intended to be anything more than an entry of on-going treatment in a progress note . It taxes credulity to believe that Dr. M when he signed this log thought he was declaring or intended to declare that he was formally asserting MMI for purposes of determining the claimant's benefits under the 1989 Act. His failure (at least there is no evidence on this point) to furnish copies of this statement to the Commission and carrier (there is no evidence on how and when the claimant received a copy) within seven days together with the informal nature of the document itself (including numerous dates, cursive writing of more than one individual) convince us that Dr. M did not intend to certify or "formally assert" MMI by means of this document. Further indication that this document was not intended and did not serve to certify MMI or determine an impairment rating is garnered from the carrier's last minute efforts to secure a TWCC-69 indicating an MMI date of August 11, 1992, with 0% impairment rating, signed by Dr. M on July 20, 1993, only three days before the CCH.[4] Also because of the centrality of MMI to the benefit compensation scheme under the 1989 Act, certification if adequate, must reasonably alert the parties to the precise date of its existence. This statement did not do this.

WHETHER CLAIMANT HAD ZERO PERCENT IMPAIRMENT RATING

The carrier contends that Dr. M's medical log entry also constitutes a zero percent impairment rating. For the reasons stated above, including that MMI had not been certified, we conclude that this statement does not constitute a valid certification of IR. In so doing, we note that the use of the words "permanent impairment" instead of "impairment rating" raises serious questions about whether Dr. M was using this statement to formally assert an impairment rating. More importantly, we question its effectiveness as a certification of

[4]Because we resolve this issue on the basis of a lack of certification, we need not address the several dates on the statement to determine when MMI occurred other than to say this further reflects on the informal nature of the document.

impairment rating of zero percent because in her deposition, MK, the carrier's agent, said she told the claimant on January 22, 1993, that she received an impairment rating of four percent and MK also referenced an eight percent on a transmittal letter to the Commission. Under these circumstances, we consider it disingenuous for the carrier to assert on appeal that zero percent was the proper IR when its agent had been using higher ratings in conversations with the claimant. Because we hold that Dr. M's statement was not a valid certification of MMI or impairment rating, we need not address carrier's other contention that this rating became final by virtue of the claimant's failure to object to it within 90 days of notice other than to comment that there is no evidence of when the claimant knew of this alleged rating. *See* Rule 130.5(e) and Texas Workers' Compensation Commission Appeal No. 93724, decided in September 28, 1993.

WHETHER THE EMPLOYER MADE A BONA FIDE OFFER OF EMPLOYMENT

The relevant determinations of the hearing officer on this issue are:

FINDINGS OF FACT

12.EMPLOYER has never given CLAIMANT a written offer of employment since the date of her original injury on (date of injury).

CONCLUSIONS OF LAW

3.CARRIER failed to prove by clear and convincing evidence that it made a bona fide offer of employment to CLAIMANT.

There is no dispute that any offer of employment was oral. The claimant testified that she was released for light duty work on January 26, 1993, with a 35 pound lift limit. She worked until February 25, 1993, when she said her legs gave out. At that time she had no doctor's excuse so CC, her supervisor, told her that she could return for light duty if she had a doctor's statement. When claimant returned after her consultation with Dr. K on March 25, 1993, with a 10 pound weight lifting restriction, she was advised that there was no work available with this limitation.

The carrier asserts that the only valid work releases were those of Dr. M on August 12, 1992, and of Dr. N on January 7, 1993, each unrestricted as to duties or maximum weight limitations. Carrier insists that in the face of these unrestricted releases and an open commitment from the employer to the claimant for an unrestricted position, the claimant took herself off work and refuses to return. The carrier further argues on appeal that Dr. K's restricted release should not be considered because her status as a personal treating physician is invalid; that Section 408.103(e) does not place the burden of proof on the carrier to establish that the employer made a bona offer of employment; and that the Commission has no authority to promulgate Rule 129.5(b) which provides: "If the offer of employment was not made in writing, the insurance carrier shall be required to provide clear and convincing evidence that a bona fide offer was made." We disagree with the carrier.

Conceding for the sake of argument that Dr. K's appointment was invalid because not pre-approved by the carrier, we are not then compelled to fashion some sort of administrative "exclusionary rule" to prohibit consideration of her medical opinions by a hearing officer.

As to the question of the burden of proof, we consider the bona fide offer of employment to be in the nature of an affirmative defense subject to proof by the party asserting it to their benefit. And, although the 1989 Act does not expressly place this burden on one party or the other, the logic of its use as an affirmative defense makes it appropriate that to prevail, the carrier affirmatively prove facts and circumstances rather than the claimant prove a negative. *See* Hayes Consolidated Independent School District v. Valero Transmission Company, 645 S.W. 542, 546 (Tex. App. - Austin 1982, writ ref'd n.r.e.)

Section 402.061 of the 1989 Act gives broad rule making power to the Commission; "A rule's provisions should be in harmony with the general objectives of the Act." Texas Workers' Compensation Commission Appeal No. 91073, decided December 20, 1991. "An agency rule is presumed valid," Texas Workers' Compensation Commission Appeal No. 92119, decided on May 4,1992, and the burden is upon the person attacking the rule to prove otherwise. Lunsford v. Board of Nurse Examiners, 648 S.W.2d 391 (Tex. App.-Austin 1983, no writ). We have confirmed that the purpose of the 1989 Act, like that of its predecessor, was to provide fast and fair relief to an injured employee. Appeal No. 92119, *supra*. Given the vagaries of oral offers in general and their susceptibility to misinterpretation and disputes as to terms, we conclude that this requirement for clear and convincing evidence to establish such an offer is consistent with the purpose of the 1989 Act.

The carrier urges that, in any event, it met its burden of proof and established by clear and convincing evidence that the employer did make a bona fide offer of employment. On appeal, the carrier contends that the limited work release signed by Dr. N (which was contrary to an unlimited release signed earlier by Dr. N) was inadmissible hearsay and admitted without a proper predicate. Hearsay can be admitted in a CCH. As to lack of a proper predicate, the carrier contends that as part of its subpoena of all of Dr. N's records of claimant, Dr. N's records custodian stated by affidavit that she provided all the records of Dr. N and that those records did not contain this purported release. The release appeared on its face to be valid. It was not alleged to be a forgery. It was not rendered inadmissible solely because the custodian had no copy. We believe that it was properly before the hearing officer and given the weight the hearing officer deemed appropriate. Under these circumstances, we believe there was sufficient evidence to support the hearing officer's findings and conclusions on the lack of a bona fide offer of employment and have no sound basis to disturb it on appeal.

WHETHER THE CLAIMANT'S BACK INJURIES ARE RELATED
TO THE KNEE INJURY

Dr. K in a letter of April 5, 1993, to the carrier stated that "in all medical probability" the claimant's knee injury caused her lumbosacral strain. The carrier urges that this

diagnosis and opinion be held not admissible because Dr. K was not a validly approved treating doctor and because the evidence is hearsay. We have already disposed of these contentions and mention them again only to reiterate that the hearing officer is the sole judge of the relevance and materiality of the evidence and of its weight and credibility and the inferences to be drawn therefrom. Section 410.165. The hearing officer resolves conflicts and inconsistencies in the medical evidence and judges the weight to be given to expert medical testimony. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). To this end, the hearing officer as fact finder may believe all, part or none of the testimony of any witness. The testimony of a claimant as an interested party raises only an issue of fact for the hearing officer to resolve. Campos, *supra*; Burelsmith v. Liberty Mutual Insurance Company, 568 S.W.2d 695 (Tex. Civ. App.-Amarillo 1978, no writ). An appeals level body is not a fact finder, and does not normally pass upon the credibility of witnesses or substitute its own judgement for that of the trier of fact, even if the evidence would support a different result. National Union Fire Insurance Company of Pittsburgh, Pennsylvania v. Soto, 819 S.W.2d 619, 620 (Tex. App.-El Paso 1991, writ denied). When reviewing a hearing officer's decision we will reverse such decision only if it is so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Pool v. Ford Motor Company, 715 S.W.2d 629, 630 (Tex. 1986). Injury may be proven by the testimony of the claimant alone and objective medical evidence is not required to establish that particular conduct resulted in the claimed injury, except in those cases where the subject is so technical in nature that a fact finder lacks the ability from common knowledge to find a causal basis. *See* Texas Workers' Compensation Commission Appeal No. 92083, decided on April 16, 1992. The claimant complained of back injury as early as August, 1992, in seeking treatment from Dr. M. She has consistently since then complained of back pain in connection with her knee injury. Her testimony and the accumulated medical evidence provide ample support for the hearing officer's finding that her back pain was a compensable injury connected to her knee injury.

Finally, we point out that the hearing officer in his Conclusion of Law No. 5 indicates a belief that questions of MMI and IR were "premature for consideration at this contested case hearing because a designated doctor has not been appointed by the Commission to resolve those disputes." To the extent that this is taken to mean that MMI and IR can only be established by a Commission appointed designated doctor, we disagree. For example, such determinations can be made final by agreement of the parties or by failure to timely contest them. We also construe the hearing officer's Finding of Fact No. 18, that "CLAIMANT apparently[5] has been certified as reaching MMI and assigned an impairment rating by a physical therapist and a doctor" to refer to the TWCC-69 signed by Dr. M on July 20, 1993, and admitted as Carriers Exhibit 9. Since, as stated by the claimant at the CCH, this was the first time she was aware of this document and that she did not agree with a zero percent IR, we consider her objection to this certification a timely dispute under Rule

[5]The use of the word "apparently" in a finding of fact is ill-advised because it suggests tentativeness inconsistent with the notion of a "finding." In this case we regard it as mere surplusage of no significance.

130.5(e) and the order of the hearing officer to attempt resolution of this dispute proper.

For the above reasons, the decision of the hearing officer is affirmed.

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Stark O. Sanders, Jr.
Chief Appeals Judge

CONCUR:

_____
Joe Sebesta
Appeals Judge

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Gary L. Kilgore
Appeals Judge