APPEAL NO. 93788

This appeal arises under the Texas Workers' Compensation Act of 1989 (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq*. (formerly V.A.C.S., Article 8308-1.01 *et seq*.) On February 5, 1993 and June 23, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. She held the record open until August 2, 1993, and thereafter determined that respondent (claimant) reached maximum medical improvement (MMI) on February 4, 1993, with 18% impairment; in addition, she found that an interlocutory order previously issued was supported by the evidence. Appellant (carrier) asserts that the date of MMI was incorrect, that the impairment rating of the designated doctor was overcome by the great weight of other medical evidence, and that the interlocutory order was issued without basis. Claimant did not respond.

DECISION

The decision is affirmed in part and reversed and remanded in part.

At the hearing, the parties agreed that the issues were whether claimant had reached MMI; if so, what is the correct impairment rating; and was the interlocutory order supported by the facts at the benefit review conference (BRC). (After the February 5, 1993 hearing, the designated doctor's opinion was received, and at the June 23, 1993 hearing, evidence and argument were allowed as to the correct use of The Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (Guides)).

Section 410.204(a) states that the Appeals Panel "shall issue a decision that determines each issue on which review was requested."

On appeal the carrier asserts that the hearing officer erroneously admitted a doctor's statement that had not been exchanged without inquiring into and ruling upon whether there was good cause for failure to timely exchange. In addition, the carrier asserted that MMI had been reached earlier than found by the hearing officer in that claimant had not improved for a period of time. Regarding the impairment rating, the carrier stated that the designated doctor, (Dr. M), included evidence of degeneration that was not a part of the compensable injury, erroneously interpreted table 49 of the Guides and erroneously added the impairment values instead of correctly using the combined values chart. Finally, carrier questioned the basis for the interlocutory order to continue to pay impairment income benefits (IIBS) after a doctor performing a required medical examination found MMI (with the apparent concurrence of the treating doctor) and an impairment rating specifying limited benefits that had been paid at the time of the BRC.

The Appeals Panel determines:

That the determination when MMI was reached was based on sufficient evidence and is affirmed.

That the issue of impairment rating is remanded to the hearing officer to indicate what, if any, evidence received after the June 23, 1993, hearing was considered in reaching the rating found by the hearing officer.

That upon remand, the hearing officer will determine whether the impairment rating she chooses as a basis for her decision is subject to the criteria of the combined values chart of the Guides.

That the interlocutory order was sufficiently supported by the evidence.

On (date of injury), claimant fell twice while working for the (employer). She described one fall as from a chair she was standing on while cleaning the top of a vending machine; the other accident was not described, although claimant stated that one hurt her neck area and the other her low back area. She had worked for employer for five years.

Claimant has been treated by (Dr. P), an orthopedic surgeon. On March 30, 1992, the claimant was evaluated in a required medical examination by (Dr. A), who found that claimant reached MMI on March 30, 1992, with 11% impairment. Dr. M was appointed as the designated doctor and evaluated claimant on February 4, 1993. He stated on a TWCC form 69 (medical evaluation report) that claimant reached MMI on February 4, 1993, with an 18% impairment. His report accompanying the TWCC form 69, introduced as carrier exhibit E, indicates that he assessed four percent for cervical spondylosis and seven percent "for each degenerative disc." He added that claimant's test for range of motion was invalid. After reviewing x-rays and MRI exams, Dr. M stated that claimant had cervical spondylosis without myelopathy and degenerative disc disease in two discs.

Carrier first argues that medical reports fail to establish any improvement in claimant after March 30, 1992, and since the designated doctor did not specify his basis for choosing February 4, 1993, as the date claimant reached MMI, then claimant should be found to have reached MMI on March 30, 1992. Section 401.011(30) provides, in part, that MMI means "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated;. . ." (emphasis added). This definition does not provide that if no improvement occurs for a period of time, then MMI has been reached. It is true that Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.4 (Rule 130.4) contains some language about suspending temporary income benefits (TIBS) in situations that include lack of improvement; Rule 130.4(n) may appear to indicate that lack of improvement is indicative of MMI having been reached, but does so within the context of a rule used to invoke procedure to see if MMI has been reached.

Section 408.122(d) provides that in a dispute as to MMI, a designated doctor is chosen. The Commission is to base its determination of whether MMI has been reached

on that doctor's report unless the "great weight of the other medical evidence is to the contrary." The "other medical evidence" consists of the evaluation by Dr. A and the records of Dr. P. Dr. P did indicate agreement with the evaluation of Dr. A shortly after Dr. A reported that claimant reached MMI. However, Dr. P then stated on February 2, 1993, that after reviewing claimant's records he felt that she had not reached MMI. This document is the exhibit to which the carrier objected when offered and now asserts error on appeal.

When offering the statement of Dr. P at the hearing on February 5, 1993, the claimant observed, "after talking to [Dr. P] on February the 2nd, he reviewed the files. And this -- this was the letter that I've given you. I'd like to introduce it into evidence as exhibit 2." After taking the objection that the letter was not exchanged, the hearing officer stated, "and I'm going to note your objection as to not having been previously exchanged. And I will also note the date on the letter. And I will admit claimant's number 2, as well." Texas Workers's Compensation Commission Appeal No. 93749, dated October 6, 1993, considered a question of admission of two documents not exchanged; it found no basis for a hearing officer to "note" an objection and admit a document not exchanged. However, that opinion continued by implying a determination of good cause to a part of offered evidence based on the fact that the claimant received the document within three days of the hearing and on the ruling by the hearing officer admitting it. The facts in this case as to claimant's exhibit 2 closely follow the reasoning of Appeal 93749, and carrier's assertion of error is rejected. The opinion of Dr. M that MMI was reached on February 4, 1993, is not contrary to the great weight of other medical evidence which shows Dr. A finding MMI on March 30, 1992, and Dr. P first finding MMI had been reached and then deciding that as of February 2, 1993, it had not been reached. The hearing officer's decision as to the date MMI was reached was supported by sufficient evidence of record.

Carrier first attacked the impairment rating by stating that the designated doctor assigned a rating for degenerative discs that should not have been considered. We note there was no issue as to the extent of the injury caused by the (date of injury), falls. In addition, carrier had the evaluation of its own evaluating doctor (Dr. A) which gave a seven percent rating for the lumbar area with Dr. A stating, "I believe changes shown by the MRI is (sic) more due to normal aging process." He then assigned four percent impairment for "cervical sprain" and seven percent for "lumbar sprain." Texas Workers' Compensation Commission Appeal No. 93246, dated May 10, 1993, reviewed a designated doctor's rating that did not consider possible injuries by stating that it is the hearing officer, as finder of fact, who decides whether an injury aggravated a prior condition. That appeal cited Texas Workers' Compensation Commission Appeal No. 92617, dated January 14, 1993, in which a hearing officer sent a designated doctor's report back to him with instructions to disregard a particular injury in preparing his report as to MMI and impairment rating. Neither Section 408.122(d) nor Section 408.125(e) provide that the great weight of other medical evidence must be contrary to the designated doctor in regard to his opinion as to what the

compensable injury was; these sections address "great weight of other medical evidence" as necessary only to overcome the designated doctor's opinion as to MMI and impairment rating.

In this case the treating doctor did not indicate that the effects of the falls on (date of injury), were transitory or had been corrected leaving only the underlying degenerative disease that had preceded that date. (*Compare to* Appeal No. 93246, *supra*). The hearing officer in accepting the impairment rating of the designated doctor made no finding that the injuries caused by the falls of (date of injury), did not include some effect on the degenerative disc condition of the claimant. The Statement of Evidence in the decision of the hearing officer indicates consideration of the assertion that any aggravation of a prior condition no longer continued and did not affect impairment; she states that carrier argued that the lumbar spine changes are "degenerative and not the result of her accident." The hearing officer's determination of impairment of 18% is sufficiently supported by the evidence in regard to the question of degenerative changes.

The record is not clear as to what evidence, including medical opinion as to the interpretation of the Guides, was available, and admitted, by the hearing officer when the record was closed on August 2, 1993. The decision says the record was kept open for clarification by the designated doctor. The carrier asserts that it submitted two medical opinions about the use of the Guides, but the hearing officer does not indicate whether she admitted and considered these. At the close of the hearing on June 23, 1993, the hearing officer said that if she made an inquiry of the designated doctor, each party would get a copy of his response and would have 10 days to reply. The decision (and record) is silent as to what was received after the hearing although the file containing the decision includes a July 6, 1993, letter from the designated doctor, Dr. M, that was neither rejected nor made part of the record. Since the Appeals Panel is restricted to the record, the appeal, and the response (*See* Section 410.203(a)), in reviewing any case, the extent of the record must be clear. On remand, the hearing officer should state whether a letter from the designated doctor was received after June 23, 1993, whether it was made part of the record, when it was provided to the parties, the date the parties were given to respond to it, and whether any material was received by the Commission from a party prior to the deadline given. If material was received from a party, it should be added to the record and considered, or the reason for rejecting it should be specified. (We note that one document referred to by the carrier as having been submitted is dated August 4, 1993, and the hearing officer's decision states the record was closed on August 2, 1993.)

The carrier also asserts that it was error for the BRC officer to require by interlocutory order that the carrier continue IIBS until the claimant was examined by the designated doctor. Section 410.032 imposes no restrictions on the extent of benefits that the benefit review officer (BRO) may order interlocutorily, and the subsequent injury fund will repay overpayments if the order is reversed or modified. In addition Rule 141.6 provides no

restriction on the extent of the benefits that the BRO may order. Rule 130.4(n) provides an example of express direction to a BRO in regard to payment of benefits, but it addresses only suspension of temporary income benefits; no limitation is imposed on the extent of IIBS. A review of these provisions indicates that neither the statute nor the rules has chosen to limit the extent of income benefits that can be the subject of an interlocutory order. In view of the hearing officer's decision as to impairment rating, there is no basis at this time for finding the evidence insufficient to support the interlocutory order.

The decision and order are reversed and remanded as to the impairment rating. The date MMI was reached is affirmed. The hearing officer should reconsider and develop the evidence with emphasis on showing which evidence was admitted and considered in the record. If the impairment rating provided by the designated doctor is used as a basis for an impairment rating, the hearing officer should indicate whether it complies with the Guides, including the Combined Values Chart. Reconsideration and development of the evidence, together with additional or different findings of facts and conclusions of law, may be appropriate as determined by the hearing officer in reaching a decision. Since reversal and remand necessitate issuing a new decision by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which the new decision is received, pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, dated January 20, 1992.

Joe Sebesta
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Philip F. O'Neill
Appeals Judge