APPEAL NO. 93834

On August 10, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The issues determined at the contested case hearing were whether claimant had disability from an injury sustained (date of injury), in the course and scope of her employment with (employer), and whether it was proper for the Texas Workers' Compensation Commission (Commission) to approve claimant's request to change treating doctors from (Dr. K) to (Dr. S). The hearing officer determined that claimant had continuous disability from the date of injury and that the Commission properly approved her change of treating doctor. The hearing officer also ordered that the carrier pay for physical therapy prescribed by (Dr. T), although there was no express issue relating to such treatment.

The carrier has appealed, arguing that the determination of disability is against the preponderance of evidence, which includes at least two releases to work. The carrier further argues that the approval of the change of treating doctor was outside the standards set forth in the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act) (formerly V.A.C.S., Article 8303-1.01, *et seq.*). The carrier finally argues that the order to pay for physical therapy ordered by Dr. T was improper, because it deprives carrier of the right to contest a change to Dr. T, and because there was no issue relating to Dr. T's treatment. The claimant responds essentially by asking that the decision be affirmed.

DECISION

Finding no reversible error with respect to the issues on disability and change of treating doctor, we affirm the hearing officer's decision on those issues. However, we void that portion of the order regarding treatment ordered by Dr. T as going beyond the issues over which the hearing officer had jurisdiction.

The claimant stated that she injured her back when she was moving a dolly with two boxes of copy paper on (date of injury). She worked as an administrative assistant for the employer, and had planned to resign and move to (state) to take new employment with (Company), which was owned by a friend. Her resignation was to be effective (date), but because of her injury, she left work (date of injury).

Claimant first saw (Dr. W) because her personal physician did not take workers' compensation cases. Dr. W took her off work, and diagnosed her as having lower back strain. Claimant moved to (state), arriving there August 19, 1992, contacted her prospective employer to tell him she was on workers' compensation and could not take the position, and then sought treatment from (Dr. L). Dr. L recommended an MRI be performed and referred her to Dr. K, a back specialist. The MRI revealed a minimal bulge at L4-L5 with no impingement and no compression.

Claimant said she first saw Dr. K on November 17, 1992, and that he pushed her down from her neck as she was bending over, telling her she could do better than she was

doing. She testified that this caused pain, and she was so upset that she called the adjuster that day about seeking a change of doctor. Claimant stated she was told by the adjuster, (MK), that a change would be time consuming and a paperwork hassle. Claimant continued to treat with Dr. K through mid-January, 1993, and then one more time in February 1993 after intervention by MK acting for the carrier. She stated that Dr. K never told her that she was released to work. A letter from Dr. K to the carrier dated November 17, 1992, states that her MRI was "basically normal." He observed that she was "temporary (sic) and partially disabled" but that since office work would be performance of lighter duties than she performed at home, she could return to "her former occupation with no restriction at all."

A second letter from Dr. K dated January 12, 1993, recapped a diagnosis of lower back pain, etiology unknown. Dr. K found normal range of motion upon examination and noted that he considered the mechanism of injury as corresponding to a "pulled muscle," which would be expected to heal with or without treatment within three months. He again noted that while she should refrain from heavy work, she could return to the duties of her former secretarial occupation without restriction. Otherwise, he restricted her to no more than 25 lbs. lifting, pushing, or pulling. Claimant stated that the first she knew about the release was when told about it by the adjuster in February 1993.

The claimant sought Commission approval on February 26, 1993, for a change of doctors to Dr. S, and this was granted by the Commission in March 1993. In March, claimant was treated in the emergency room of KM. In summary, as of March 23, 1993, this doctor deemed her unable to work, complaining of back and leg pain. Claimant first saw Dr. S on April 1, 1993. Claimant testified that Dr. S indicated concern over the fact the claimant had filed a complaint against Dr. K with the (state) medical oversight authority. Dr. S took claimant off work from April 1 through April 14, 1993. Dr. S's evaluation to the carrier of his April 1st exam found a resolving lumbosacral strain, and observed that claimant "has very little motivation regarding resumption of her work." He prescribed physical therapy, but claimant testified that this was denied by the carrier, for the reason that it was prescribed more than eight weeks after the occurrence of the injury.[1] Although Dr. S noted that claimant was unable to keep an April 14, 1993, appointment due to car trouble, he nevertheless completed a TWCC-69 Report of Medical Evaluation stating that claimant reached maximum medical improvement (MMI) on April 14, 1993, was "N/A" impairment rating. Claimant stated that Dr. S refused to see her because he was not being paid by the carrier. The record includes an interlocutory order from the June 17, 1993, benefit review conference directing the carrier to pay medical benefits for treatment at the direction of Dr. S.

[1]According to the adjuster, authorization for such physical therapy was denied because there "was a dispute" regarding Dr. S. It appeared, however, that the carrier had at that point a duly executed approval of the change by the Commission. Whatever the carrier's rationale, we would observe that it appears rather self-defeating to deny treatment that could well assist an injured worker to return to work.

The claimant testified that both Dr. K and Dr. S gave her many pain killers, anti-inflammatory drugs, and steroids. She experienced a swelling reaction during her treatment with Dr. S (which is corroborated in at least two telephone messages directed to Dr. S and included in the record). She indicated that the swelling was so bad she could not put on her shoes. Claimant stated that the controversy over her injury has caused her to experience depression and to seek counselling at the direction of the new doctor she was seeing, (Dr. T).

The claimant stated that she had begun to treat with Dr. T, with whom she had a good relationship, and that he detected a tissue lump in her back (reference to this appears in his records). Dr. T told her that her medication had been masking the pain, and he had taken her off pain medication and recommended therapy. The record indicated that claimant sought Commission approval on June 28, 1993 for a change of doctor to Dr. T, because Dr. S refused to treat her further. As of the date of the hearing, claimant had not received a response from the Commission approving or denying her request.[2]

The carrier's adjuster, MK, testified that she agreed she received complaints from the offices of Dr. L, Dr. K, and Dr. S about claimant's refusal to cooperate with treatment, frequent phone calls, and generally difficult personality. She stated that Dr. K told her that if claimant did not cooperate he would release her. MK confirmed that claimant called her after the first visit with Dr. K to indicate dissatisfaction. She denied that she told claimant that the change would be a paperwork hassle, because there was no requirement for paperwork prior to January 1, 1993.[3] When asked if she actually referred claimant to the Commission when she called in November 1992 to voice dissatisfaction with Dr. K, MK's reply was non-responsive. Although MK stated that she never caused a denial of payment to claimant's doctors, she indicated that Dr. S's prescribed physical therapy was denied because there was a dispute over Dr. S.

WHETHER THE HEARING OFFICER ERRED IN FINDING THAT CLAIMANT HAD CONTINUOUS DISABILITY

The Act defines "disability" as the "inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage." Section 401.011. In other words, diminished wages or inability to work must relate to the compensable injury, and not be caused primarily by other factors or conditions not related to the compensable injury.

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[2]In her response to the appeal, claimant contends that she has now received Commission approval for the change to Dr. T.

[3]Notwithstanding this contention, we would note that Tex. W.C. Comm'n Rules, 28 TEX. ADMIN. CODE § 126.7 (Rule 126.7), in effect at the time, clearly required "paperwork" on the Commission level, either as a notice of change to a second treating doctor or for approval of a change to a third or subsequent doctor.

The hearing officer is the sole judge of the relevance, the materiality, weight, and credibility of the evidence presented at the hearing. Section 410.165(a). The decision should not be set aside because different inferences and conclusions may be drawn upon review, even when the record contains evidence that would lend itself to different inferences. Garza v. Commercial Insurance Co. of Newark, N.J., 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). The decision of the hearing officer will be set aside only if the evidence supporting the hearing officer's determination is so weak or against the overwhelming weight of the evidence as to be clearly wrong or manifestly unjust. Atlantic Mutual Insurance Co. v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.). Clearly there was disability for some time after the accident. Whether a release is communicated to a claimant does not, in and of itself, prevent the hearing officer from considering such release on the issue of whether the claimant has disability. However, the medical evidence is conflicting and claimant's testimony is evidence that may be considered on the issue as well. In considering all the evidence in the record, we cannot agree that the findings of the hearing officer on disability are so against the great weight and preponderance of the evidence as to be manifestly wrong and unjust. In re King's Estate, 244 S.W.2d 660 (Tex. 1951).

WHETHER THE HEARING OFFICER ERRED IN APPROVING THE CHANGE OF DOCTOR FROM DR. K TO DR. S

The carrier's contention that the hearing officer erred in approving the change of doctor to Dr. S is utterly without merit. Whether or not claimant was seeking a change for a second opinion, the record is replete with evidence, much of it from the carrier's own adjuster, that the relationship between claimant and Dr. K had broken down, to the point where intervention by the adjuster was necessary to schedule a last appointment with Dr. K. The hearing officer's approval of the change is supportable, and essentially uncontroverted by any evidence indicating that the Commission abused its discretion in allowing the change.

WHETHER THE HEARING OFFICER ERRED IN ORDERING PAYMENT FOR SERVICES RENDERED OR PRESCRIBED BY DR. T

It may be that the hearing officer was troubled by evidence of previous denial of payment to health care providers. Be that as it may, the hearing officer clearly went beyond the scope of the issues in the hearing in specifically ordering payment for physical therapy prescribed by Dr. T. The hearing officer is restricted to consideration of issues reported as unresolved from the benefit review conference or allowed by agreement of the parties at the hearing, or upon a finding of good cause. Section 410.151(b). Unquestionably, this did not occur with respect to any matters relating to Dr. T,[4] and the hearing officer's order must

[4]We further note that at the time of the hearing, the Commission had not even acted upon claimant's request for change, so the matter was not ripe for determination by a hearing officer in accordance with Section 408.024 or

therefore be voided.

That being so, however, we would note that the hearing officer was correct in ordering payment of medical benefits in accordance with the Texas Workers' Compensation Act and associated rules. We would observe that a carrier may not simply relieve itself of liability for services rendered by an approved doctor without compliance with the procedures set forth in applicable statutes and rules relating to the reason for denial. Consequently, the fact that we void the hearing officer's specific order as to Dr. T should not be taken in any way as an advisory on whether the carrier must pay or may decline to pay for services rendered by Dr. T.

We affirm the hearing officer's decision regarding the two issues that were before her. We reverse and void her specific order requiring the carrier to pay for physical therapy prescribed by Dr. T.

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Susan M. Kelley
Appeals Judge

CONCUR:

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Robert W. Potts
Appeals Judge

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Lynda H. Nesenholtz
Appeals Judge

Rule 126.9.