APPEAL NO. 93884

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 April 6, August 19, and September 20, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. He determined that appellant (claimant) reached maximum medical improvement (MMI) on March 4, 1992, with five percent impairment. Claimant appeals, stating that at one point the designated doctor, (Dr. L) found MMI to be "near," that Dr. L did not evaluate him for impairment, no functional capacity testing was performed on him, that a TWCC form 69 was "prospective," that Dr. L did not state how the five percent impairment was derived, that Dr. L changed findings with no basis for doing that, and that he could not attend the hearing sessions on August 19th and September 20th because he was ill but states that he would have had meaningful input had he been there. The carrier replies that the hearing officer should be upheld.

DECISION

We affirm.

Claimant apparently had worked for approximately three months as a pipefitter for B (employer). His injury occurred when he rose up after bending over and hit his head on an overhead pipe in the period of (time period). Since then, he has not worked; he has severe headaches.

On March 4, 1992, claimant saw (Dr. G) for an independent medical evaluation. Dr. G referred to prior testing including MRI, discograms of the neck, and CT scan and myelogram; plus CT scan of the head. Dr. G stated that claimant was 62 years old and found degenerative discs at C3-4, C4-5, C5-6, and C6-7. While Dr. G's TWCC form 69 (Report of Medical Evaluation) showed MMI on March 4, 1992 with 10% impairment, his narrative states, "[a]fter this length of time he has probably reached maximum medical improvement." (over 11 months after injury). Dr. G considered surgery but did not recommend it.

The Texas Workers' Compensation Commission (Commission) then appointed Dr. L as the designated doctor to perform an exam "to resolve a dispute regarding. . . maximum medical improvement and/or impairment rating." Dr. L replied in narrative only on August 17, 1992, stating that records were provided, refers to the history, and discusses his examination. Dr. L mentions that he palpated the neck area, did an axial compression test, and described his range of motion as follows:

> He limits his cervical range of motion, although passively I was able to place him through a near full range of motion.

Dr. L added that claimant had full range of motion of the shoulders and arms. Strength and reflexes were noted without finding any abnormality. After concluding that the claimant had "moderate degenerative disc disease," Dr. L stated that claimant's evaluation and treatment

have been comprehensive. He added:

> I feel he has reached near maximal medical benefit. Perhaps evaluation for myofascial trigger point treatment could be helpful. I am afraid that his final disability rating will be controversial without doing some from (sic) of objective evaluation with functional capacity testing.

In November 1992, Dr. L added a TWCC form 69 stating that MMI was reached on March 4, 1992 with five percent impairment.

With the designated doctor's opinion as stated above, the April 6, 1993, session of the hearing adjourned. When the August 19, 1993, session convened, the hearing officer stated that the hearing had been recessed to "obtain additional medical information and additional evidence clarifying the medical evidence that had already been presented." The record does not contain a copy of any written submission to the designated doctor asking for clarification. Communication of some nature may be implied because the designated doctor prepared a new TWCC form 69 dated August 16, 1993. He apparently included no new narrative with the form, which said that MMI was reached on August 31, 1992, with five percent impairment. Claimant was not present at this session (he had been present on April 6, 1993), and the hearing officer, upon closing this session, stated that the claimant would be contacted to see why he had failed to appear.

On September 20, 1993, the hearing came back into session with the hearing officer noting that the claimant had been ill at the time of the previous session and, again, was not present. Copies of the notices that went to claimant for both the August 19th session and the September 20th session were made part of the record. In addition the hearing officer stated that he had personal knowledge that claimant had been to the (city) field office on September 17, 1993, and had been specifically told of the time and place of today's (September 20th) session. Apparently claimant stated then that he had had headaches and commented that if he had a severe one, he would not be present for the September 20th session. At this session the carrier also introduced a letter from Dr. L dated September 3, 1993, in which Dr. L stated that he was replying to a letter from the ombudsman; Dr. L said that the reference to "near" in the original TWCC form 69 had not been in his dictation at the time. He added, "His MMI date is the original date 3-4-92 with 5% impairment."

The claimant takes issue with the fact that two sessions of the hearing took place without him. Written notice had been sent to him prior to both sessions. He does not allege that he had notified the Commission of a change of address between the first session, attended, and the subsequent ones, not attended. No one indicates that he was absent for other than health reasons. While incapacity would appear to be a valid reason to continue a hearing as long as necessary to allow a claimant to be present, three observations can be made of the circumstances in this hearing: (1) the claimant was present at the first session; (2) the first session of the hearing did not conclude the record because clarification was needed from the designated doctor--several hearing officers in similar instances have closed hearings with the record left open in order to query the designated doctor; comments or

replies to the designated doctor's response have been elicited without always convening additional hearing sessions (*See* Texas Workers' Compensation Commission Appeal No. 93424, decided July 12, 1993); and (3) the claimant does not indicate what he would have testified to, or provided for the hearing officer to consider, had he been present at either of the subsequent sessions. We note that claimant foresaw on September 17th, while at the (city) field office, that he might not be able to attend the September 20th session of this hearing; he could have provided a written statement to be introduced at that session to add anything not said at the session he attended. No statement by claimant was offered by the ombudsman at the September 20th session. Concluding the hearing without the claimant being present was not reversible error in this instance.

The only medical evidence before the hearing officer indicated that MMI had been reached. Both Dr. G and Dr. L stated that it had been reached on March 4, 1992. In addition, Dr. L stated in one TWCC form 69 that it had been reached on August 31, 1992. (Claimant for some reason calls this last date of MMI "prospective" because it was after the date he had been examined by Dr. L. However, the rating was given almost one year later on August 16, 1993.) What occurred between the time of his examination of claimant on August 17, 1992, and August 16, 1993, is not in evidence, but we note that the designated doctor was to be provided additional medical evidence when clarification of the earlier TWCC form 69 was sought. The record contains no indication from Dr. L in 1993 that he reviewed medical records prior to asserting on August 16, 1993, that the MMI date should be August 31, 1992.

The hearing officer in considering the question of MMI had three separate documents from Dr. L to consider; he may determine the content of the designated doctor's report as to MMI and impairment rating from considering all of that doctor's input as a whole. *See* Texas Workers' Compensation Commission Appeals No. 92469, decided October 15, 1992, and Texas Workers' Compensation Commission Appeal No. 93077, decided March 15, 1993. In this instance, the hearing officer decided that the designated doctor found MMI on March 4, 1992. The hearing officer is the sole judge of the weight and credibility of the evidence. *See* Section 410.165(a). The hearing officer could believe the designated doctor's statement indicating that the word "near" was not meant to be in the narrative and that MMI was reached on March 4, 1992, rather than August 31, 1992, a date for which the designated doctor did not provide a basis. (*See* Texas Workers' Compensation Commission Appeal No. 93705, decided September 27, 1993, which said that the hearing officer is not obligated to give weight to any change not explained.) The date of MMI, March 4, 1992, was found not to have been overcome by the great weight of other medical evidence. Dr. G's finding that MMI was on the same date supports, rather than is contrary to, the MMI date. The date of MMI found by the hearing officer is sufficiently supported by the evidence.

At the hearing there was no evidence presented that Dr. L did not follow the "Guides to the Evaluation of Permanent Impairment" third edition, second printing, dated February 1989, published by the American Medical Association (Guides). . .or did not conduct an impairment examination. At the last session of the hearing on September 20, 1993, the ombudsman may have tried to assert that Dr. L did not give a rating at the time he wrote his

first narrative. (Claimant on appeal refers to Dr. L "never performed an evaluation on me for an impairment rating as shown in the last paragraph of his narrative of August 17, 1992. It is my understanding that the Ombudsman brought this to the parties (sic) attention at the last contested case hearing.") Dr. L does describe in his narrative dated August 17, 1992, what tests he did in evaluating claimant. There was no evidence that these tests were not performed. While a designated doctor normally prepares a TWCC form 69 within a short period after an examination, he is not precluded from later providing a TWCC form 69 which includes an impairment rating based on his examination of the claimant, in this case performed on August 17, 1992.

The narrative of Dr. L made it clear that there was only one area of the spine involved--cervical. While it is always preferable for a designated doctor to specify the body part and the rating in Section 17 of the TWCC form 69, without an objection to this point at the hearing, it will not cause a remand in this case. *Compare to* Texas Workers' Compensation Commission Appeal No. 92613, decided December 28, 1992, which remanded a case, in part, for lack of body part ratings when that point was brought up at the hearing and two parts of the spine were involved in a large percentage impairment rating which necessitated reference to the Combined Values Chart of the Guides.

Dr. L in his narrative apparently believed that any question of "disability rating" would be controversial without functional capacity testing. He does not say that a rating could not be provided without such testing. There is no indication that the Guides require a "functional capacity test" be conducted, although that document does describe other tests in certain situations. *Compare to* Appeal No. 93705, *supra*, in which the report of a designated doctor, who recommended a neurosurgical consult (never accomplished) and then limited his opinion as to MMI as "from a neurological standpoint," was not given presumptive weight.

The findings of fact that state the claimant was examined by Dr. L on August 17, 1992, that Dr. L found "near" maximal medical benefit was achieved on March 4, 1992, with five percent impairment, that Dr. L clarified his findings in a letter of September 3, 1993 (which explained the reason why "near" had been earlier used) stating that MMI was reached on March 4, 1992, with five percent impairment, and that the designated doctor's report was not overcome by the great weight of other medical evidence were all supported by sufficient evidence of record. The findings of fact sufficiently support the conclusions of law, and the Decision and Order are sufficiently supported by the evidence and are affirmed.

Joe Sebesta
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Gary L. Kilgore
Appeals Judge