APPEAL NO. 93952

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act) (formerly V.A.C.S., Article 8308-1.01 *et seq*.). In a prior decision (Texas Workers' Compensation Commission Appeal No. 93084 (Unpublished), decided March 9, 1993), the Appeals Panel considered the contention of Appellant and Cross-Respondent (claimant) that when he fell approximately 12 feet to a concrete floor while descending a ladder at work on (date of injury), he injured not only his ankle, knee, and low back, which injuries were not disputed, but also his neck. The hearing officer determined that while claimant had injured his ankle, knee and low back, he did not injure his neck. Noting the differences between claimant's testimony and the content of his medical records, and further noting that claimant's credibility was for the hearing officer to determine, the Appeals Panel affirmed the hearing officer's determination that claimant did not injure his neck in that accident.

At a contested case hearing held in (city), Texas, on September 22, 1993, the hearing officer, EV, considered the following disputed issues: 1. Whether Respondent and Cross-Appellant British American Insurance Company (carrier) should reimburse claimant for travel expenses incurred in seeking health care in (city) and (city), Texas; 2. when claimant reached maximum medical improvement (MMI) and what is his whole body impairment rating; and 3. whether claimant's (date of injury), accident has caused him to develop impotence, incontinence, headaches, memory loss, and stress/psychological problems. Adversely to claimant's contentions, the hearing officer determined that claimant's compensable injury of (date of injury), did not cause him to develop impotence, incontinence, headaches, memory loss, and stress/psychological problems, and that, consistent with the report of the designated doctor selected by the Texas Workers' Compensation Commission (Commission), claimant reached MMI on April 2, 1993, with a whole body impairment rating of five percent for the injuries attributable to his compensable injury. The carrier filed a response urging the sufficiency of the evidence to support the hearing officer's determinations adverse to the claimant.

Finding that claimant's choice of treating doctor in (city), Texas, was made in conformity with the 1989 Act and the rules of the Commission, the hearing officer concluded that the carrier must reimburse claimant for his travel expenses to (city) and/or (city), Texas, to obtain reasonable and necessary medical care for his compensable injury. Though not contesting the aforesaid factual finding, the carrier has appealed the conclusion contending that claimant failed to prove he could not obtain reasonable and appropriate medical care in (city), Texas, where he resided. Claimant did not file a response to the carrier's appeal.

DECISION

Finding the evidence sufficient to support the challenged findings and conclusions, we affirm.

We first address the claimant's appeal. With respect to the adverse determination as to the scope of claimant's injury, the hearing officer noted that all the evidence of

claimant's symptoms came from him either directly in his testimony or indirectly in the various histories of his injury which he related to the numerous doctors involved in his case and, thus, that his reliability was of paramount importance. The hearing officer stated that claimant "is not a credible witness" and that neither his testimony nor his statements to health care providers "can be relied upon to support a judgment in his favor." The voluminous evidence in this case, including the testimony from the previous hearing concerning claimant's alleged neck injury and his two depositions of July 16, 1992, and February 9, 1993, was carefully reviewed. We do not disagree with the hearing officer's assessment.

Claimant offered the undated report of (Dr. C) whom claimant described as his treating psychiatrist. Dr. C's report recited a history of claimant's falling off a pipe rack 13 feet to a cement floor and injuring "his head, his neck, his back, right hip and right leg." Claimant acknowledged he told Dr. C he hit his head, was unconscious for a few minutes, and was dazed. Dr. C diagnosed "organic affective disorder, depressed type, severe, due to closed head injury on the job (date of injury);" severe chronic pain syndrome involving the right hip, right leg, neck and back; and chronic, severe iatrogenic habituation to prescribed pain medications. Dr. C goes on to state that claimant requires psychiatric treatment for anxiety and depression "from the closed head injury sustained in his fall of (date of injury)," and for chronic pain management.

In the September 20, 1993, report of his examination for the carrier, (Dr. G), also a psychiatrist, stated that claimant told him he "fell approximately 13 ft. landing on the right side of his head and sustaining injuries to his back and leg, as well as to his head." Claimant agreed he gave that history to Dr. G. Dr. G diagnosed a mild organic mental disorder and depression which he said "do appear to be directly related to the injuries that he experienced and the changes in his life that have come about since that time." Dr. G also noted evidence of chronic pain syndrome with previous medication dependency and the need for psychiatric treatment.

Claimant testified at the hearing that when he fell approximately 10 to 13 feet to the concrete floor after slipping from a pipe rack, he landed on his right leg and back and hit his head breaking his safety glasses and cracking his hard hat. He also testified, variously, that he was unconscious for one to three minutes, that he was told he was unconscious, that he was "in a daze," and that he did not know how long he was unconscious. In his August 6, 1991, interview by carrier's adjuster, claimant stated he came down on his lower back and leg and did not mention any head injury. In his July 16, 1992, deposition, claimant testified he hit the ground and started thanking God he was alive, that he "came down on my right leg, and right side, my back," and that he "hit my head a little." He further stated, when directly asked if he was knocked unconscious: "I was just kind of in a shaky -- I wouldn't say just blacked out, but I was just . . . in a daze." Claimant's coworker (Mr. L), who saw claimant fall, stated in his April 20, 1993, deposition, that after the fall claimant sat on the ground and the safety supervisor came up and asked how his leg was and inquired whether he wanted go to a hospital to have it checked out. Mr. L said that claimant declined, got up and moved his foot around, said he thought it would be fine though sore,

and walked to the safety shack where he remained until the shift ended.

Claimant said that after leaving the safety shack at the end of his shift, he went home and his wife felt he needed medical attention and took him to a hospital emergency room (ER). The ER record reflected that claimant complained of pain in his right ankle, knee, hip, and low back; that he said he landed on his right foot; that he was able to walk on the leg afterwards but later experienced swelling and pain; and that he had no other complaints. X-rays were obtained of claimant's right ankle, knee and lumbar spine; he was given crutches and pain medications and was released. Claimant testified, however, that he gave a complete history of his injuries to the ER doctors including being knocked unconscious and hitting his head, but did not then know he had a closed head injury. During the contested case hearing on January 5, 1993, concerning whether claimant sustained a neck injury from the fall, he testified as follows: "I had a gash on the back of my head that I sustained in the fall. . ., " and, that at the ER "they put a bandage over my head. I had a cut over my -- on my head when I fell." The ER record contains no reference to a head cut or to the application of a bandage to claimant's head.

Claimant began treating with (Dr. N) who, on May 8, 1991, diagnosed right ankle and right knee sprains and lumbar strain. Claimant's history related a fall from 10 to 13 feet and hitting on right heel and leg. On May 14th claimant also complained of testicular pain. An MRI of May 21st revealed Grade III disc bulging at the L5-S1 level. On and after May 22nd, the testicular pain complaint did not further appear in Dr. N's records of claimant's visits. Claimant testified he complained to Dr N of "having tremendous headaches" and neck pain. However, Dr. N's records, which indicate he saw claimant approximately 15 times between May 8th and June 11th, do not reflect such complaints.

On June 10, 1991, upon the referral of Dr. N, claimant saw (Dr. R), a neurosurgeon, for back pain. The record of that visit stated that claimant "came down on his leg and in some way on his back," but contained no reference to a head injury. Dr. R's report of June 27th indicated he was to obtain EMG studies of claimant's back injury. Claimant said he discontinued seeing Dr. R because he said he did not prescribe pain medications. In a June 22, 1992, report, Dr. R stated that claimant had returned after not having been seen since June 27, 1991, that the EMG studies were not done since claimant failed to keep the appointment, and that claimant "states that he told me about some headaches and pain in his neck when I saw him, but I do not have any record of that in my records." In a June 24, 1992, report, Dr. R opined that claimant did not need either lumbar or cervical spine surgery. In an August 10, 1993, report, Dr. R stated he did not know of claimant's bladder symptoms or problems with attaining an erection but saw no reason for such complaints on the basis of claimant's spinal canal.

Claimant said he next saw (Dr. Ru), a chiropractor with whom he had previously treated after a 1987 auto accident. Dr. Ru's July 1, 1991, record recited a history of claimant's fall and stated: "He landed on his right leg & back." Dr. Ru diagnosed lumbosacral sprain, disc protrusion, and radiculoneuropathy. In a July 2nd report, Dr. Ru noted that claimant "reported some loss of sexual function but defined it more as a lack of

desire rather than function." Dr. Ru's records contained no history or diagnosis of a head injury related to claimant's fall.

Claimant said he next began treatment with (Dr. S), an orthopedic surgeon in (city), who, in October 1991, performed arthroscopic surgery on his knee and who also recommended claimant undergo both cervical and lumbar spine surgery. Claimant stated that Dr. S was going to perform surgery on his lumbar spine in October 1993 notwithstanding that the Commission, after obtaining two other opinions, determined it was "not necessary."

Dr. S's initial report of July 22, 1991, stated that claimant gave a history of his fall and "[t]he patient came down on his right leg and his ankle." Claimant's complaints were noted to be of pain in his back, right knee, and right ankle. Dr. S diagnosed internal derangements of claimant's knee and ankle and a bulging lumbar disc with radiculopathy. In a hospital admission record of September 5, 1991, Dr. S stated: "The patient hit his back and right leg when he fell about 10 feet." This report also indicated claimant sustained injury to his neck, back, and right knee and ankle, that he then complained of pain in his neck, back and right lower extremity. Dr. S's impression was acute cervical sprain, acute lumbosacral sprain with lumbar radiculopathy, and knee and ankle derangement. This was the first mention of neck pain and injury in claimant's medical records. Noting the nearly four month hiatus between the accident and the appearance of this complaint in his medical records, the hearing officer in the earlier hearing, as previously mentioned, determined that claimant did not sustain a neck injury in the (date of injury) fall. Dr. S's records of follow-up visits on September 25th and December 2nd (following the arthroscopic knee surgery in October) reflected no complaint nor diagnosis related to a head injury. As recently as April 9, 1993, Dr. S, who claimant said was still his treating doctor, reported to the Commission that claimant sustained multiple injuries as a result of his fall which included his neck, back, and right knee. However, Dr. S did not mention any head injury nor complaints of headaches, memory loss, impotence, incontinence, and stress/psychological problems.

Apparently at the request of the carrier, claimant was seen by (Dr. B), a neurosurgeon, who in his report of October 8, 1991, stated that claimant fell landing on his right hip and leg, that he has low back and right lower extremity pain, and that he complains of difficulty with urination since September. He recommended against cervical or lumbar spine surgery and felt claimant's problem was in the sacroiliac joint.

At the request of the Commission, claimant was examined on January 23, 1992, by (Dr. M), an orthopedic surgeon, and Dr. M's report of that date stated claimant's history of the fall as follows: "At the time of the fall, he landed on his right side, hitting his right leg and lower back. He also reported that he jammed his right knee and ankle. The patient was not rendered unconscious." Dr. M also reported that claimant complained of constant pain in his lower back radiating into both of his extremities, cervical spine pain, right knee pain, and urinary incontinence for the past two months. Dr. M diagnosed cervical spondylosis, cervical disc herniation, lumbar disc degeneration with bulging at L4-5 without radiculopathy. He recommended cervical spine surgery but not lumbar spine surgery.

On April 29, 1992, claimant was examined by (Dr. F), a consulting neurosurgeon, on behalf of Dr. S. Dr. F reported that claimant fell, "jammed his right side," and "hurt his knee, lower back, and neck." Dr. F diagnosed chronic pain syndrome with severe lumbar and cervical myositis, cervical spondylosis, and lumbar spine bulging disc. He thought claimant to be an "extremely poor candidate" for surgery and noted that "[t]his patient has a multitude of complaints, many not explained on an anatomical basis."

Claimant testified that he had been impotent since his fall at work and, variously, that he has had incontinence "since my injury" and that it started sometime later. Claimant said he was first treated for his impotence and bladder problems by (Dr. A) in December 1992, approximately 20 months after his accident. However, no records of Dr. A were introduced and none of the other doctors' records in evidence appear to indicate diagnosis and treatment of impotence and incontinence problems.

An employee claiming a work-related injury under workers' compensation has the burden of proving by a preponderance of the evidence that the injury occurred in the course and scope of employment and there must be evidence establishing a causal connection between the injury and the employment. *See* Texas Workers' Compensation Commission Appeal No. 92160, decided June 8, 1992. Whether claimant's accident of (date of injury) caused him to develop impotence, incontinence, headaches, memory loss, and stress/psychological problems was a question of fact for the hearing officer as the trier of fact. Section 410.165(a) provides that the hearing officer is the sole judge of the relevance and materiality of the evidence as well as of the weight and credibility it is to be given. Claimant presented no expert evidence linking his claimed impotence, incontinence, and headaches to his accident and in our view such maladies are not within the common knowledge of mankind and require expert evidence. In Hernandez v. T.E.I.A., 793 S.W.2d 250 (Tex. Civ. App.-Corpus Christi 1989, no writ) the court stated that where the course of disease is difficult to ascertain, ". . . expert testimony may be required where a claimant alleges that employment caused or aggravated a disease and the fact finder lacks the ability from common knowledge to find a causal basis." *And see* Texas Workers' Compensation Commission Appeal No. 93569, decided August 20, 1993. While claimant did present evidence relating his stress/psychological problems, and perhaps even his memory loss, to his accident, such evidence was dependent upon the diagnosis of a closed head injury which, in turn, was based on claimant's having given a history of having fallen on his head. As noted, the hearing officer did not find such history reliable given claimant's lack of credibility. In further regard to his credibility, claimant insisted he had not previously received treatment for mental health problems. However, the medical records from the institution where he was incarcerated for approximately 10 years before his accident reflect that he was treated with psychotropic drugs for mental health disorders. An appellate tribunal, not being a fact finder, does not normally judge the credibility of witnesses or substitute its own judgment for that of the trier of fact, even if 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).

The hearing officer resolves conflicts and inconsistencies in the evidence. Garza v.

Commercial Insurance Co. of Newark, N.J., 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). The hearing officer also judges the weight to be given expert medical testimony and resolves conflicts and inconsistencies in the testimony of expert medical witnesses. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-(city) [14th Dist.] 1984, no writ); Atkinson v. United States Fidelity Guaranty Co., 235 S.W.2d 509 (Tex. Civ. App.-San Antonio 1950, writ ref'd n.r.e.); Highlands Underwriters Insurance Co. v. Carabajal, 503 S.W.2d 336, 339 (Tex. Civ. App.-Corpus Christi 1973, no writ). We will not disturb the hearing officer's findings unless they are so against the great weight and preponderance of the evidence as to be manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 751 S.W.2d 629 (Tex. 1986).

As for the hearing officer's determinations that claimant reached MMI on April 2, 1993, with a five percent impairment rating, based on the designated doctor's report, we are satisfied the great weight of the other medical evidence is not to the contrary. (Dr. H), the designated doctor, certified on a Report of Medical Evaluation (TWCC-69), dated April 19, 1993, that claimant reached MMI on April 2, 1993, with a nine percent whole body impairment consisting of four percent for his specific disorder of the cervical spine and five percent for his specific disorder of the lumbar spine. However, since the Commission determined in the prior hearing that claimant did not sustain a neck injury in the accident of (date of injury), the hearing officer correctly disregarded the four percent attributable to the cervical injury. Claimant asserted that Dr. H did not examine him and complains of Dr. H's failure to assign any impairment rating for abnormal range of motion (ROM). However, Dr. H's TWCC-69 stated that claimant's "cervical and lumbar [ROM] were limited by significant subjective components and there was difficulty in repeating the tests with consistent results." The hearing officer could credit this statement and believe that Dr. H did in fact examine claimant and did test, albeit unsuccessfully, for ROM impairment.

Dr. S's substantially illegible TWCC-69 stated, apparently prospectively, that claimant would reach MMI on May 8, 1993, "after evaluation possible surgery," with a 37% impairment rating which appeared to include components for a cervical injury, knee, and sexual dysfunction. In a letter dated March 23, 1993, to the Commission, Dr. S stated, among other things, that he was enclosing a "Form 69 in which I estimate MMI to be reached by statute on 5/7/93." We have held that reports purporting to state a prospective date for MMI do not amount to a statement or certification that MMI has been reached. *See* Texas Workers' Compensation Commission Appeal No. 93361, decided June 23, 1993. Dr. R's TWCC-69 stated that claimant reached MMI on "6/24/92" with a zero percent impairment rating. Dr. B's TWCC-69 stated that claimant reached MMI on "8/92" with a three percent impairment rating. Dr. B's TWCC-69 did not indicate the body part or system rated at three percent but referred to an attached report. However, no report was attached to the exhibit (introduced by both parties) and none of Dr. B's other reports in evidence referred to the TWCC-69. We do not agree with claimant that the great weight of the other medical evidence was contrary to the report of Dr. H. We have had frequent occasion to comment on the status of the designated doctor. *See* e.g. Texas Workers' Compensation Commission Appeal No. 92412, decided December 2, 1992. A designated doctor's report should not be rejected absent "a substantial basis to do so" (Texas Workers' Compensation

Commission Appeal No. 93039, decided March 1, 1993), and the medical opinions must be weighed according to their "thoroughness, accuracy, and credibility with consideration given to the basis it provides for opinions asserted" (Texas Workers' Compensation Commission Appeal No. 93493, decided July 30, 1993.

Finally, we are satisfied with the correctness of the hearing officer's determination that the carrier must reimburse claimant for his travel expenses incurred in traveling to (city) or (city), Texas, to obtain reasonable and necessary medical care for his compensable injury.

In its request for review, the carrier notes that it filed a Notice of Refused/Disputed Claim (TWCC-21), dated "11/20/92," which stated: "Carrier controverts mileage reimbursement request by clmt., as clmt. selected an MD beyond 75 miles for treatment. Same treatment would be available to him at a lesser distance." While not clearly developed, it appeared from the evidence that claimant's initial choice of treating doctor was Dr. N, whose office was in (city), Texas, and that claimant changed to Dr. S whom he first saw on July 22, 1991, having been unable to get an appointment with another doctor in (city) he wished to see and having heard about Dr. S from a friend.

Section 408.021(a) provides, in part, that "[a]n employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed." Section 408.022 provides, in part, that the Commission shall require the employee to receive medical treatment from a list of Commission-approved doctors, that the employee is entitled to his or her initial choice of a doctor from the list, that if an employee becomes dissatisfied with the initial choice, the employee may notify the Commission and request authority to select an alternate doctor, and that the Commission shall prescribe criteria to be used by the Commission in granting the employee authority to select an alternate doctor. Section 408.023(a) provides that every doctor licensed in this state on January 1, 1993, is on the Commission's list of approved doctors unless later deleted and not reinstated. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 126.8(b) (Rule 126.8(b)) provides for doctors in other jurisdictions to be added to the list. Section 408.024 provides that after notice and opportunity for hearing the Commission may relieve an insurance carrier of liability for health care that is furnished by a health care provider or another person selected in a manner inconsistent with Subchapter B. The 1989 Act does not directly address the matter of travel expenses incurred by an employee in obtaining medical care from a doctor selected pursuant to the provisions of Subchapter B.

Rule 134.6(a) provides that "[w]hen it becomes reasonably necessary for an injured employee to travel in order to obtain appropriate and necessary medical care for the injured employee's compensable injury, the reasonable cost shall be paid by the insurance carrier." This rule then sets forth certain guidelines for such travel expense reimbursement. No issue was presented for the hearing officer respecting the application of these guidelines in this case. Rule 134.6(e) provides, in part, that disputes relating to the expense of travel for medical care shall be resolved through benefit review conferences, contested case hearings, and appeals to the Appeals Panel.

Rule 126.9 pertains to choice of treating doctor and liability for payment. This rule provides, among other things, that an injured employee is entitled to the employee's initial choice of treating doctor from the Commission-approved list; that as of January 1, 1993, any change in treating doctor after the initial choice requires Commission approval; that the employee's request shall be on a Commission form and state the reasons why the current treating doctor is unacceptable; that the Commission shall issue an order within 10 days approving or denying the request; that, with good cause, the employee or the carrier may dispute the order regarding a change to an alternate treating doctor within 10 days after its receipt; that the dispute will be handled through the dispute resolution process described in Chapters 140 through 143; and that after holding a benefit contested case hearing, the Commission may relieve the carrier of liability for health care furnished by a doctor if the doctor is not on the Commission-approved list or the employee failed to comply with the Commission's rules regarding a change in treating doctor.

As previously noted, the hearing officer found that "Claimant's choice of treating doctor in (city), Texas, has been made in conformity with the [1989 Act] and the Rules of the [Commission]." The carrier did not appeal that finding but did appeal the conclusion that it "must reimburse claimant for travel expenses incurred in traveling to (city) and/or (city), Texas, to obtain reasonable and necessary medical care on account of Claimant's compensable injury of (date of injury)." In her discussion of this issue, the hearing officer stated that Rule 134.6 and Appeals Panel decisions "mandates such reimbursement when a Claimant travels more than twenty miles each way to obtain reasonable and necessary medical care for his compensable injury." The hearing officer noted that even though the evidence failed to establish that claimant was unable to obtain appropriate medical care closer to his home [(city), Texas] than (city), claimant was nonetheless entitled to obtain reasonable and necessary medical care from his choice of treating doctor, and that since he chose Dr. S in conformity with the provisions of the 1989 Act and the Commission's rules, the carrier is liable for his travel reimbursement when he travels to obtain reasonable and necessary medical care from his treating doctor for his compensable injury.

The carrier asserts that, unlike the hearing officer, it reads Rule 134.6 to require that claimant first prove the reasonable necessity of his travel in order to recover his reasonable travel expenses in seeing Dr. S notwithstanding that his change in treating doctor was accomplished in compliance with the 1989 Act and the Commission's rules. The carrier further states that Rule 134.6 requires not only that the medical care be appropriate and necessary but also that the travel itself be reasonably necessary. We disagree with the carrier's assessment. It seems to us that when the Commission has approved an injured employee's change in treating doctor, as in this case, and when the distance involved is more than 20 miles (*see* Rule 134.6(a)(1)), then, in the words of Rule 130.6(a), it has become "reasonably necessary" for the injured employee to travel in order to obtain appropriate and necessary medical care from the approved doctor for the compensable injury. The injured employee could hardly be said to enjoy the statutory right to treatment from a Commission-approved treating doctor (when such approval is not appealed by the carrier) if such employee still had to prove the reasonable necessity of the travel in order to obtain appropriate and necessary treatment from such doctor.

The carrier here did not assert that any particular travel expense of the claimant in traveling to see Dr. S was unreasonable, such as was the case in Texas Workers' Compensation Commission Appeal No. 93264, decided May 7, 1993, where we affirmed the hearing officer's determination that reimbursement of the injured employee for a rental car used to drive to another city for therapy appointments was not reasonably necessary, and as was the case in Texas Workers' Compensation Commission Appeal No. 93235, decided May 12, 1993, where we reversed and rendered that, under the circumstances of that case, the reimbursement of claimant for her payments to a driver to drive her to the doctor did not meet the "reasonable" expenses standard of Rule 134.6. The carrier simply globally attacked the reasonable necessity of claimant's traveling to see Dr. S in the first place not having proven appropriate medical care was not available to him closer to his residence. In Texas Workers' Compensation Commission Appeal No. 93361, decided June 23, 1993, the claimant, who resided in Silsbee, Texas, sought to change her treating doctor to one in (city) and the carrier, at the Benefit Review Conference simply objected to a change in treating doctors at that time. At the contested case hearing, the carrier withdrew its opposition to claimant's seeing the doctor in (city) but stated it did not want to reimburse mileage because there were other doctors in the (city), Texas, area that claimant could have selected as her treating doctor. The claimant argued that she should be paid her mileage since she would get it were she seeing a doctor in the area of her residence. We reversed the hearing officer's determination that the carrier need only reimburse the claimant for travel from her residence to (city), Texas, on the apparent assumption that had she made the effort claimant could have found an orthopedic surgeon within that distance, and rendered that claimant was entitled to her reasonable travel expenses to (city) to obtain medical care from her doctor. We stated that when the carrier agreed that claimant could commence treatment with her doctor in (city), she thereafter became entitled to her reasonable travel expenses, and that if the carrier desired to limit claimant's travel expenses to visit a new treating doctor, it should have insisted that claimant find a new treating doctor closer to her residence. *And see* Texas Workers' Compensation Commission Appeal No. 93441, decided July 16, 1993, where we reversed the hearing officer's determination that the claimant was not entitled to travel expenses because he did not show it was reasonably necessary for him to travel to anther city to see the doctor the carrier had agreed he could see.

The carrier distinguishes those cases pointing to its TWCC-21 of November 1991 purporting to contest payment of claimant's travel expenses beyond 75 miles. However, in this case claimant had been seeing Dr. S since July 22, 1991, apparently with the Commission's approval, and was operated on by Dr. S in October 1991. Carrier contends its situation is more akin to that in Texas Workers' Compensation Commission Appeal No. 93520, decided August 5, 1993, where the Appeals Panel affirmed the hearing officer's determination that it was not reasonably necessary for the claimant to travel to another city to obtain appropriate and necessary medical care for the aggravation of his prior back injury from the doctor who had treated the prior injury. In that case, unlike the one we here consider, the decision did not indicate that claimant had changed treating doctors pursuant to the provisions of the 1989 Act and Commission rules. And in Appeal No. 93520, *supra*, we recognized that neither the statute nor Commission rules impose any territorial

restrictions on a claimant's choice of treating doctor. We find carrier's assertion of error on this issue without merit.

The challenged findings and conclusions being sufficiently supported by the evidence, we affirm the hearing officer's decision.

Philip F. O'Neill
Appeals Judge

CONCUR:

Susan M. Kelley
Appeals Judge

Gary L. Kilgore
Appeals Judge