APPEAL NO. 94106

This appeal is considered in accordance with the Texas Workers' Compensation Act (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq.* On December 6, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The issues were the correct impairment rating to be assigned to appellant AC, who is the claimant herein, and whether the carrier had timely disputed, within 90 days, the first impairment rating which had been assigned to claimant by her treating doctor.

The hearing officer determined that the carrier had timely disputed the first impairment rating, and that claimant's impairment rating, based upon the report of the designated doctor, was 10%.

The claimant has appealed for several reasons. The claimant complains about the hearing officer's failure to grant a continuance of the hearing. The claimant also complains that she did not receive effective assistance from an ombudsman at the "first" contested case hearing. She disputes an observation in the hearing decision that she refused to be examined at an impairment center to which she was sent by the Texas Workers' Compensation Commission (Commission). She complains about the qualifications of the designated doctor and the method in which his examination was performed, and notes that he failed to take into consideration neurological damage. She complains that the hearing was not fair. She stated that she presented additional information concerning another impairment evaluation done on her which was ignored by the hearing officer. She argues that her own doctor's rating is more accurate. Claimant also complains about the admission of an adjuster's notes with no affidavit or testimony from the adjuster who ostensibly made the notes. The claimant asserts once more that the carrier did not timely contest her treating doctor's impairment rating. The carrier responds that claimant had numerous continuances, citing a history not present in the record of this hearing, and argues that there was no abuse of discretion. The carrier further asserts that the notes of the adjuster were kept in the ordinary course of business. The carrier further argues that the "evidence" is clear that the examination of the designated doctor was thorough, and that the great weight of other medical evidence was not contrary to that of the designated doctor.

DECISION

We reverse and remand the decision of the officer, specifically for completing the record of this case in accordance with this decision. We further remand for findings of fact to support the hearing officer's conclusion of law on whether there was a timely dispute of the first impairment rating, specifically findings which indicate the date that the carrier became aware of the initial impairment rating, and the date the carrier effectively disputed this rating. If the hearing officer determined that a timely dispute was made through filing a letter with the Commission, a finding should be made as to the date the Commission received such dispute.

There was a little background information developed at the December 6, 1993, hearing about claimant's injury. The date of injury is not found as fact, but is referred to in the discussion of evidence as (date of injury). Claimant was employed on her date of injury by Alamo Community College District. The sparse medical evidence submitted as evidence at the December 1993 hearing indicated that claimant fell at her job and sustained two herniated cervical discs in her neck. There was also a reference in an EMG test report filed by (Dr. A), on January 28, 1992, to thoracic and arm pain. Dr. A's report noted some indications of radiculopathy.

Claimant's treating doctor was (Dr. D), whose specialty is not described in the record. Dr. D recommended physical therapy with (Center). A report from Center dated January 21, 1992, indicated that claimant would be in therapy for six weeks.

Dr. D's February 12, 1992, notes stated that he agrees with Dr. A's assessment of radiculopathy. Dr. D's opinion stated claimant should have surgery, but that he will follow her apparent election to live with the pain. Dr. D diagnosed thoracic sprain and herniated cervical disc on that date. These notes also stated that Dr. D believed that claimant would be at maximum medical improvement (MMI) in another month.

The claimant stated that Dr. D never discussed an impairment rating with her before he filed a TWCC-69 Report of Medical Evaluation with the Commission on September 21, 1992. This report certified that claimant reached MMI on February 12, 1992, with an 18% impairment. Although it is not completely legible, the basis for the 18% is described in the appropriate portion of the TWCC-69 form.

The record contains an August 29, 1992, memo from the adjuster for the carrier to Dr. D; it requested that he complete an enclosed TWCC-69 form.

The carrier presented no witnesses. Although the TWCC-69 from Dr. D contained a TWCC file-stamped date of September 21, 1992, there was no testimony as to when the carrier either received this form, or first became aware of Dr. D's impairment rating. Most of the testimony at the hearing was devoted, instead, to when the claimant first became aware that the carrier had disputed the impairment rating. A November 3, 1992, letter from the adjuster to the Commission disputed Dr. D's rating; there is no evidence when, or if, this letter was received by the Commission. On November 12, 1992, the adjuster wrote the claimant conveying a dispute; claimant denied she had received the letter, although sent to her address. What was submitted as the adjuster's notes indicated telephone conversations with claimant on November 23rd and 27th about trying to reach agreement on a designated doctor. Claimant's testimony was somewhat vague as to whether she discussed this on the 23rd, although she agreed she talked with the adjuster on November 27th. Claimant stated she thought this was merely to obtain a second opinion.

The record indicated that on February 4, 1993, the Commission appointed a clinic, rather than a doctor, to evaluate claimant's impairment as a designated doctor. Claimant

testified that she went to the clinic and there was no doctor in attendance, so she refused to be examined. She testified, and it is corroborated somewhat unclearly by the Commission's order that she was sent to the clinic in error by the Commission, which thereafter designated (Dr. T) as designated doctor. (The order appointing Dr. T, however, is not in the record). Although there was some attempt before the appointment to agree on a designated doctor, it appears that claimant was left to fend for herself in contacting doctors suggested by the carrier, only to find that these doctors were not accepting new patients. (We observe, however, that a designated doctor examination would not ordinarily involve accepting a claimant as a patient).

Notwithstanding the references in the hearing officer's discussion to Dr. T's comprehensive "narrative," the only document from Dr. T admitted into evidence at this hearing was a TWCC-69 form stating that claimant reached MMI on February 12, 1992, with a 10% impairment. This TWCC-69 has written across it "AMENDED." There is no indication as to why it was amended. The document recited that the proper version of the American Medical Association Guides to the Evaluation of Permanent Impairment was used. The underlying bases for the 10% rating are nowhere disclosed on the face of this form, which plainly refers to documents not attached to the form or made part of this record. This form is dated August 18, 1993, although the testimony indicated (but did not clarify) that Dr. T's examination was sometime in February 1993.

The claimant stated that she discussed this rating with Dr. D, who sent her back to the Center for an impairment rating. She stated that this rating was 25%. At this point, the ombudsman submitted a document from the Center. However, this was the January 28, 1992, report referred to above, not any subsequent impairment report. There was no 25% impairment rating put into evidence.

The claimant raised many questions about how her examination by Dr. T was conducted. First, she indicated that her first physical evaluation was conducted by a staff member who kept referring to a book as he examined her, and was simultaneously evaluating two other persons. She stated that in the course of the consultation, he received two personal phone calls. For these reasons, she felt that the evaluator was not focused on her case, and questioned the accuracy of his evaluation.

Claimant said that when she insisted upon seeing a doctor, she was brought to Dr. T. She stated that Dr. T's eyes were bloodshot and he did not appear to care about her as a person. She said his examination was conducted like a regular physical (although she could not describe or recall specifics) and that it lasted about ten minutes. She testified to her understanding that Dr. T was an ear, nose and throat doctor rather than a bone doctor or someone with experience with the spine.

THE MOTION FOR CONTINUANCE

According to the benefit review conference (BRC) report in the record, the BRC was held November 1, 1993. The report was attached to a cover letter dated November 8, 1993. However, the records that accompany the Appeals file show that it was distributed on November 15, 1993. The contested case hearing was set for December 6, 1993.

Understandably (on the face of this record), claimant filed a written request for a continuance on November 22, 1993, in order to obtain more documents to present at the hearing. She stated her belief that the setting was made to accommodate a representative of the employer. She asked that a new hearing officer conduct the hearing. The motion was received by the Commission on November 30, 1993, and denied the next day by the hearing officer. Claimant reasserted her motion at the hearing, where the representative for the carrier admitted that it had made a request for expedited hearing because the employer's representative was to have surgery. Carrier argued that claimant had had the benefit of the Thanksgiving holidays to prepare. Notwithstanding the apparent passage of 21 days between the date the BRC report was sent out by the commission and the date of the hearing, the carrier argued that there had been numerous continuances in the case. The hearing officer denied claimant's motion, stating that he did not find good cause. We note that the ombudsman who assisted her at the contested case hearing was not the same ombudsman who appeared with her at the BRC.

It is clear to this Appeals Panel that the action on the motion for continuance, and the references in the hearing decision to matters, arguments, and evidence that are not contained in the documents or the tape of this case resulted from a procedure alluded to in the first paragraph of the hearing decision's discussion:

> This case was originally convened on July 26, 1993, at which time the claimant pointed out certain problems with the designated doctor's report. The case was cancelled, removed from the docket, and returned to the benefit review officer for further management. After the record was closed the Hearing Officer discovered that the order cancelling the first hearing and returning it to the benefit review officer had not been included in the record. It was also discovered that none of the parties admitted into evidence the original TWCC-69 from the designated doctor nor had the impairment and disability report from the Impairment Center, which provided support for that TWCC-69, been offered. Determining those to be indispensable documents for the development of a full record in this case, the Hearing Officer reopened the record, sent those documents to the parties, with the explanation that they would be offered as Hearing Officer exhibits and allowed them ten (10) days to provide any comments which they chose. There was no response from either party.

We find no authority in the 1989 Act or applicable rules of the Commission for cancelling a hearing that has already been held. Indeed, such action would seem to go against the express direction of Section 410.168(a) that the hearing officer "shall" issue a

written decision, and the provision in Rule 142.16(a) that it be issued "after the record closes." Although Rule 142.2(13) grants a hearing officer authority to recess, postpone, or dismiss a hearing, this refers to actions that may be taken to reschedule or dispense with a setting prior to closing the record.

Parties have the right to a determination of issues brought to the hearing officer, and the further right to appeal an adverse decision to the Appeals Panel and the courts. This cannot be done in the absence of a written decision. According to Section 410.163(b), a hearing officer must preserve the rights of the parties, and ensure full development of the facts necessary to a determination; neither objective is fostered when a consummated proceeding is expunged through a so-called "cancellation" (absent a mutual request by the parties to dismiss an issue).

Because the hearing officer had no power to cancel the hearing, his action is tantamount to a recess or a continuance. Consequently, the record from the "cancelled" hearing is part of the record of the entire proceeding, and must be weighed by the hearing officer. Documents received as part of the first portion of this proceeding must be listed as in the hearing decision. The case here is consequently remanded for incorporation of the full record of this case into the decision of the hearing officer.

Claimant's disagreement with the refusal of the hearing officer to grant claimant's motion for continuance will be resolved by this remand. On remand, claimant should be given opportunity to present additional documents which may include the 25% impairment rating which she apparently thought was presented, along with any clarifying information from Dr. D about how he calculated the 18% rating.

THE ADJUSTER'S NOTES

At the end of carrier's case, it offered what it described as the adjuster's notes. There was no affidavit or even a signature on any of these documents, nor was any proof offered that same were kept in the ordinary course of business. They were admitted over claimant's objection. Such evidence was offered primarily on the tangential point of when claimant was aware that the carrier disputed the impairment rating. However, some matters relevant to the date carrier may have notified the Commission of a dispute are on those notes. There are no entries for November 3rd, or anytime, for that matter, for the period between September 16, 1992, and November 27, 1992; the entry dated November 27, 1992, indicated that the file had been reviewed, Dr. D's TWCC-69 had been received, and that the Commission had been written that there was a dispute over the impairment rating. It further stated that claimant had been contacted on November 23, 1992, to solicit agreement on a "second opinion" for the impairment rating.

Section 410.163(a)(4) & (5) allows a hearing officer to accept documents and other tangible evidence, and allows presentation of evidence by affidavit. Section 410.163(b) allows the use of summary procedures to expedite a hearing. However, it would seem that

documents purporting to be notes, which are presented for the truth of matters therein, and are not signed or supported by affidavit, need some qualification that they are what they purport to be before being admitted. While the Rules of Civil Evidence are not binding on our contested case hearings, we have noted before that they are instructive. *See* Texas Workers' Compensation Commission Appeal No. 92192, decided July 1, 1992. Rule 803(6), Tex. Rules of Civ. Evid., requires some testimony or affidavit that supports the business records exception to hearsay. We believe that this practice, which is neither arduous nor time consuming, is advisable for presentation of notes from a carrier's file. While we believe the hearing officer should not have admitted such unqualified notes over objection, we observe that a remand will allow the carrier the opportunity to properly qualify these notes as business records.

WHETHER THE GREAT WEIGHT OF OTHER MEDICAL EVIDENCE IS AGAINST THE DESIGNATED DOCTOR'S REPORT

Because we do not have before us Dr. T's narrative which was evidently the basis of the hearing officer's decision, we cannot evaluate whether Dr. T took into account the EMG report on claimant, or whether his report is otherwise outweighed by the great weight of other medical evidence. We would note that claimant has raised many points about the designated doctor's examination, some of which are more significant than others. While we cannot agree that the bloodshot condition of Dr. T's eyes has anything to do with the medical accuracy of his evaluation, her point about Dr. T's area of medical expertise, compared to that of Dr. D, as it bears upon the evaluation of a spinal injury is medical evidence that can be considered by the hearing officer in assessing the weight of contrary medical evidence. The point raised by claimant that her range of motion measurements may have been done simultaneously with other patients, and the effect this might have on the accuracy of data supplied to Dr. T, is another point worthy of consideration by the hearing officer. However, we cannot emphasize too strongly that a party who seeks to overcome the designated doctor's report must realize that such report is given presumptive weight. Sections 408.122(b), 408.125(e). The amount of evidence required to overcome the presumption, a "great weight," is more than a preponderance, which would be only greater than 50%. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. It is medical evidence, not lay testimony, that is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992. Whether Dr. T and his staff were perceived by claimant as focused, or caring, is not generally medical evidence that will overcome the presumptive weight of Dr. T's report.

TIMELINESS OF IMPAIRMENT RATING DISPUTE

Finally, we note that there are no findings of fact to support the hearing officer's conclusion that the carrier timely disputed the first impairment rating assigned to the claimant. The only dates listed in the hearing officer's findings of fact are the date that Dr. D's TWCC-69 was received by the Commission, and the date on an unsigned copy of a

letter contained in the carrier's files. Neither fact indicates when the carrier first became aware of the impairment rating, or when it made known to the Commission that it disputed this rating. While evidence concerning the claimant's awareness of a dispute might have been developed because she contended (primarily in closing argument) that the carrier had violated Texas W.C. Comm'n Rules, 28 TEXAS ADMIN. CODE § 130.5 (Rule 130.5) in several respects, the only basis on which Dr. D's impairment rating could have been taken as final would be if the carrier had not first filed a written dispute to the impairment rating with the Commission within 90 days. *See* Texas Workers' Compensation Commission Appeal No. 93200, decided April 14, 1993. The fact that the carrier filed its own reasonable assessment of impairment more than five days after receiving Dr. D's certification and rating would not mean that a valid dispute was not otherwise made.

It is possible to review other documents in the record and conclude that carrier knew about the impairment rating before August 29th, when the adjuster asked Dr. D to complete a TWCC-69, and that a dispute was not conveyed prior to November 23rd, when the purported adjuster's notes first refer to filing of a dispute with the Commission.

For these reasons, the determination of the hearing officer is reversed, and remanded to ensure completion of the record, taking of additional evidence, and findings of fact to support the hearing officer's conclusions as to timely dispute. Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order 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 such new decision is received from the Texas Workers' Compensation Commission's division of hearings, pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Susan M. Kelley
Appeals Judge

CONCUR:

Gary L. Kilgore
Appeals Judge

Alan C. Ernst
Appeals Judge