APPEAL NO. 991589

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on July 8, 1999. The appellant (claimant) and the respondent (carrier) stipulated that the claimant reached maximum medical improvement on May 19, 1997, with a 23% impairment rating (IR) and that the filing period for the third quarter for supplemental income benefits (SIBS) began on December 15, 1998, and ended on March 15, 1999. The hearing officer found that during the filing period for the third quarter for SIBS the claimant had some ability to work, that he made one contact to look for work, that he did not make a good faith effort to obtain employment commensurate with his ability to work, and that his unemployment was a direct result of his impairment from the compensable injury, and concluded that the claimant is not entitled to SIBS for the third quarter. The claimant appealed, contended that the medical evidence established that he was unable to work during the filing period, and requested that the Appeals Panel reverse the decision of the hearing officer and render a decision that he is entitled to SIBS for the third quarter. A response from the carrier has not been received.

DECISION

We reform a stipulation in Finding of Fact No. 1 to agree with the stipulation made at the hearing. We affirm the decision and order of the hearing officer.

At the hearing, the parties stipulated that the filing period for the third quarter for SIBS began on December 15, 1998, and ended on March 15, 1999. Finding of Fact No. 1, states "[c]laimant's 3rd quarter compensable quarter for [SIBS] ran from December 15, 1998 through March 15, 1999." We reform that part of Finding of Fact No. 1 to state "[t]he filing period for the third quarter for [SIBS] began on December 15, 1998, and ended on March 15, 1999."

In a report dated August 26, 1997, the designated doctor assigned 12% impairment for loss of cervical range of motion (ROM), 11% for loss of lumbar ROM, and one percent for loss of right knee ROM and used the combined values chart to assign a 23% IR. The claimant testified that his treating doctor released him to return to work at light duty on July 13, 1998, but did not specify what the restrictions were; that he had a lot of pain, the doctor would not give him stronger medication, and he changed treating doctors to get better treatment a couple of months after July 1998; that during the filing periods for the first and second quarters, he had some ability to work and looked for work; that his new treating doctor took him off work; and that he followed the doctor's orders and did not look for work after he was taken off work.

Dr. LL saw the claimant on November 24, 1998; examined him; and requested his records and an MRI of the cervical and lumbar areas. A report of an MRI of the lumbar spine dated December 7, 1998, contains the following impression:

> At the L5-S1 level, there is evidence for a 5mm central to right parasagittal soft tissue disc herniation which touches and effaces the thecal sac. Narrowing of the neuroforamen for the right L5 nerve root is demonstrated bilaterally. Minimal displacement of the S1 nerve root sleeve axilla is demonstrated bilaterally (right slightly greater than left). Facet sclerosis is also demonstrated at this level.
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> At L4-5, a 3mm central to right parasagittal and slightly right lateral soft tissue disc protrusion is seen to minimally touch and efface the thecal sac with minimal bulging of the disc annulus complex into the inferior neuroforaminal epidural fat bilaterally.
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> Moderate facetal sclerosis is demonstrated at this level, as well as the L1-2 through L3-4 level.

In a follow-up report dated December 10, 1998, Dr. LL said that the cervical and lumbar MRIs were quite positive, especially on the lower back; provided the results of the lumbar MRI; stated that the cervical MRI showed a 1-2mm annular bulge minimally narrowing the subarachnoid space without touching the cervical cord at C6-7 and some sclerosis and spondylosis at C5-6; noted that he had pain radiating into his right leg and limited ROM; prescribed medication; and referred the claimant to Dr. R for a neurological evaluation. In a report dated January 13, 1999, Dr. R gave a detailed history of the claimant's illness and the results of a neurological examination; stated that his impression was right lumbar radiculopathy, right cervical radiculopathy, disc space narrowing at L5-S1 with central protrusion and facet and ligamentous hypertrophy, disc desiccation at L4-5 and L5-S1, C6-7 bulge, and history of Hemochromatosis; ordered a CT scan of the lumbar spine; scheduled bilateral lumbar facet injections; and stated that the claimant was unfit to return to work at the time. In a follow-up report dated January 22, 1999, Dr. LL set forth her diagnosis that is essentially the same as the impression of Dr. R in his January 13, 1999, report; said that his cervical and lumbar ROM have not changed from the prior examination, that his neck is still stiff, that he has less pain in his neck, that he has a lot of tenderness along the L4 to S1 region, and that he has some radiation of pain into his right leg; reported that a CT scan and facet injections were scheduled; and stated that the claimant was definitely to remain off work until treatment on the cervical and lumbar regions had been completed. On February 15, 1999, Dr. R reported that the CT scan of the cervical spine shows spondylosis at C3-4, C5-6, and C6-7; a small bulge at C3-4; and no disc herniations or stenosis. Dr. R stated that the CT scan of the lumbar spine shows degenerated L5-S1 disc with a partially calcified broad-based central protrusion, some facet and ligamentous hypertrophy producing some lateral recess stenosis, and probably some central stenosis of a mild to moderate degree. Dr. R also stated that the claimant was scheduled for bilateral facet injections the next day, that he has been unable to return to work because of continued pain, and that he had trouble sitting and taking classes. In a follow-up report dated April 12, 1999, Dr. R said that the claimant had facet injections on February 16, 1999; that he did very well for one month; that he then developed recurrent pain; and that the claimant was scheduled for facet injections on May 20, 1999. On April 23, 1999, Dr. LL

reported that the claimant had had an injection in February; that it provided some relief, but the pain returned; that repeat injections are scheduled; that the claimant has a significant herniated disc at L5-S1 and some radicular pain; that Dr. R advised the claimant to lose weight before proceeding with surgical correction; that the claimant has occasional numbness of his hands; and that he is to remain off work since he is still undergoing a facet injection by Dr. R.

Dr. H performed an independent medical examination on February 7, 1997. In a letter to the carrier dated March 10, 1997, Dr. H said that the claimant could return to any form of light duty which may be available to him and that he probably could perform light to medium duty. At the request of the carrier, Dr. DL reviewed some of the medical records of the claimant, the latest one dated August 26, 1997. In a letter dated January 7, 1999, Dr. DL stated that she saw no indication for continued treatment.

In Texas Workers' Compensation Commission Appeal No. 931147, decided February 3, 1994, the Appeals Panel stated that if a claimant established that he or she had no ability to work at all during the filing period in question, then seeking employment in good faith commensurate with this inability to work would be not to seek work at all. In Texas Workers' Compensation Commission Appeal No. 941382, decided November 28, 1994, we emphasized that the burden of establishing no ability to work is firmly on the claimant and in Texas Workers' Compensation Commission Appeal No. 941334, decided November 18, 1994, we noted that an assertion of inability to work must be judged against employment generally, not just the previous job where the injury occurred. In Texas Workers' Compensation Commission Appeal No. 941439, decided December 9, 1994, the Appeals Panel stated claimant's inability to do any work must be supported by medical evidence. In addition, in Appeal No. 941382, *supra*, we stated that medical evidence should demonstrate that the doctor examined the claimant and that the doctor considered the specific impairment and its impact on employment generally. In Texas Workers' Compensation Commission Appeal No. 962447, decided January 14, 1997, the Appeals Panel cited earlier decisions and stated that the medical evidence should encompass more than conclusory statements and should be buttressed by more detailed information concerning the claimant's physical limitations and restrictions and that "bald statements" of an inability to work are of limited use in assessing whether a claimant can work during the filing period because of a lack of any discussion of the nature of and the reasons for the claimant's inability to work. In Texas Workers' Compensation Commission Appeal No. 961918, decided November 7, 1996, the Appeals Panel stated that its comments about medical evidence being more than conclusionary did not establish a new or different standard of appellate review and that a finding of no ability to work is a factual determination which is subject to reversal only if it is so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust.

In her Decision and Order, the hearing officer wrote "[t]he medical opinions were conclusive in nature lacking specific reasons as to Claimant's off work status other than Claimant's complaints of pain and that facet injections were to be given." It appears that conclusive is a typographical error and that the intended word was "conclusory." The

medical reports from Dr. LL and Dr. R are not bald statements and include information concerning the claimant's condition. However, the reports state that the claimant is not to return to work and do not say that he has no ability to work. It can be inferred from the February 15, 1999, report of Dr. R that the claimant was able to attend class. The determination of the hearing officer that the claimant had some ability to work during the filing period is not so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. Pool v. Ford Motor Company, 715 S.W.2d 629, 635 (Tex. 1986); In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). The claimant urged that he sought employment with two employers during the filing period. The Statement of Employment Status (TWCC-52) indicates that he sought employment with two employers, but that he sought employment with one of the employers the day before the start of the filing period. The determinations that during the filing period the claimant did not make a good faith effort to obtain employment commensurate with his ability to work and that he is not entitled to SIBS for the third quarter are not so against the great weight and preponderance of the evidence as to be clearly wrong or unjust.

As stated earlier, we reform a stipulation in Finding of Fact No. 1 to properly state the filing period for SIBS for the third quarter. We affirm the decision and order of the hearing officer.

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Tommy W. Lueders
Appeals Judge

CONCUR:

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Philip F. O'Neill
Appeals Judge

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Alan C. Ernst
Appeals Judge