APPEAL NO. 991978

Following a contested case hearing held on August 9, 1999, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer resolved the disputed issues by determining that the respondent (claimant) is entitled to supplemental income benefits (SIBS) for the first and second compensable quarters, March 10 through June 8, 1999, and June 9 through September 7, 1999, respectively. The appellant (carrier) asserts error in the hearing officer's findings that during the first and second quarter filing periods, claimant's unemployment was "a direct result of his impairment," that he was unable to perform work in any capacity, and that his inability to work satisfied the requirement that he has made a good faith effort to obtain employment commensurate with his ability to work. The carrier contends, in essence, that in making these findings the hearing officer considered as part of claimant's impairment his health problems resulting from an apparent stroke he suffered sometime after the compensable injury, none of which were rated for impairment. The carrier further contends that the hearing officer erred in not admitting an exhibit offered to impeach some of claimant's testimony, notwithstanding that it had not been previously exchanged with claimant. Claimant filed a response, urging the correctness of the challenged findings and conclusions and the hearing officer's evidentiary ruling.

DECISION

Reversed and remanded.

We note at the outset the carrier's complaint that the hearing officer's Decision and Order reflects that the carrier introduced only Carrier's Exhibits A and B while the record reflects that the carrier also offered Carrier's Exhibits C, D (E was withdrawn), F, G, H, and I, and that all but Carrier's Exhibit I were admitted into evidence. We grant the carrier's request and reform the hearing officer's Decision and Order to so reflect.

The parties stipulated that on _____, claimant, then employed by (employer), sustained a compensable injury; that claimant reached maximum medical improvement (MMI) with an impairment rating (IR) of 15% or greater; that claimant has not commuted any portion of his impairment income benefits (IIBS); that the first compensable quarter began on March 10 and ended June 8, 1999; and that the second compensable quarter began on June 9 and ended September 7, 1999. Though the filing or qualifying period dates were not stipulated, claimant averred, without objection, that these periods extended from December 9, 1998, through May 25, 1999. Only one Statement of Employment Status (TWCC-52) is in evidence. It is Carrier's Exhibit B, signed by claimant on December 17, 1998, and stating that no wages were earned during the 15 weeks which ended on September 27, 1998, through January 3, 1999.

Claimant testified that on _____, while working as an insulation installer on a building being constructed, he injured his low back and neck when he was crawling on his back through a crawlspace above wall joists, pulling insulation through, and got "hung up." At another point in his testimony, he indicated that he also injured his mid-back, arms, legs and chest, developed arm rash, and got insulation in his eyes. Claimant said that he underwent fusion surgery on his cervical spine in January 1997 after which his neck condition, including range of motion (ROM) and pain, improved for a while; that following the surgery he could still walk and talk; and that he was never released to return to work, at even light duty. Claimant indicated that in late October 1997 he underwent a lumbar discogram and shortly thereafter suffered an apparent stroke. He said that he has since been confined to a wheelchair to avoid falling while attempting to walk; that he is unable to speak clearly; that he is unable to read and write due to his hands shaking; and that he requires assistance with bathing, dressing, eating and so forth. According to his wife, she assists claimant in these matters and they also have a home health care provider come to the residence five mornings a week. Claimant also said he has been awarded Social Security benefits.

Claimant further testified that although his neck condition was initially improved after the surgery, he nevertheless has neck pain and popping when he moves his head in certain positions and also some limitation in ROM; that he cannot sit for long periods; that he has leg pain; that he uses a wheelchair and would fall if he attempted to walk due to a loss of balance; that he takes Soma and Tylenol No. 3 with Codeine; and that he also is depressed. Claimant also stated that there is no type of work that he could perform and that his condition remained about the same during both filing periods. He said he would not disagree with reports of diagnostic tests, including a CT scan, myelogram, and discogram, which showed that he did not have a herniated disc in his lumbar spine. Although stating that he could not recall who filled out the TWCC-52 in evidence, claimant indicated that it was prepared by another attorney's office. He acknowledged that written on the form as the reason he did not earn wages "during the 90 days before the start date of this quarter" are the words "physically unable to stand and unable to speak coherently."

The Report of Medical Evaluation (TWCC-69) signed by Dr. L on "03-27-98" reflects that he was a carrier-selected required medical examination doctor and that he determined that claimant reached MMI on "03-27-98 (statutory)" but that he did not rate claimant's impairment. In his accompanying narrative report of the same date, Dr. L stated that claimant is 58 years of age with complaints of neck pain, back pain, lower extremity weakness and numbness, and upper extremity weakness and numbness; that claimant says he is off balance and cannot walk due to leg weakness; and that claimant is in a wheelchair secondary to his difficulty with ambulation. Dr. L further reported that claimant sustained a work-related injury on _____, while pulling on some insulation in a confined space; that claimant underwent neck surgery by Dr. SE and Dr. J on January 2, 1997, after which his headaches resolved and he had no weakness in his legs; that claimant underwent a discogram by Dr. SE on October 27, 1997, which did not show anything operable; that claimant reported that the next day while in the shower, he had to

hold onto the bars to stay erect and thereafter had trouble walking; that he went to an emergency room and had a brain MRI; and that he has since had to use a wheelchair due to problems with walking and has also experienced coordination problems with his upper extremities.

Dr. L's report contains a detailed summary of claimant's numerous medical records created by many doctors beginning with Dr. SM on July 13, 1995, and ending with Dr. J on February 26, 1998. According to Dr. L's summary, Dr. SM's "07/13/95" report stated a diagnosis of lumbar and dorsal spine strain; Dr. D conducted an independent medical examination on "10/09/95," noted that claimant subjectively complained of pain in his ribs and upper and lower back and some numbness radiating into his legs and feet, that there were very little true orthopedic and neurological findings, that claimant had a rash on his leg, that claimant has reached MMI with regard to his back, thoracic region and ribs, that no invasive therapy is necessary, and that claimant is not a surgical candidate; Dr. D certified on "10/25/95" that claimant reached MMI on "10/09/95" with an IR of "0%"; Dr. J diagnosed left cervical radiculopathy on 12/19/95; Dr. K reported on 01/02/96 that an MRI of the head revealed abnormal signal intensity most likely representing microinfarcts; and Dr. N reported on 09/23/96 that claimant's lumbar myelogram was normal, that his chest films were normal, that his lumbar CT scan revealed a minimal bulge at L5-S1, but that he had advanced cervical spondylosis with stenosis at C3-4, C5-6, and C6-7 from disc degeneration, herniation and spurring. The summary further reflects that on 01/22/97 claimant underwent a cervical fusion from C3 through C7; that a lumbosacral CT scan on 08/28/97 ordered by Dr. SE showed no disc herniation or spinal stenosis; that on 11/12/97 claimant had an MRI of the brain; that on 2/21/98 Dr. M diagnosed ataxia (failure of muscular coordination); dysarthria (imperfect speech articulation due to muscular control disturbance from peripheral or central nervous system damage); upper and lower extremity weakness, new onset; history of severe degenerative cervical spine disc disease related to a job injury of _____, slightly improved; history of spondylosis of the lumbar spine with herniation at L4-5 and L5-S1 diagnosed by MRI of 9/11/97; history of right eye blindness and left eye decreased vision; and history of hiatal hernia and diverticulosis; and that on 02/26/98 Dr. J diagnosed lumbar radiculopathy/ mechanical back pain; C3-4, C4-5, and C6-7 spinal and formaminal stenosis with cervical radiculopathy, status post fusion; and dermatitis.

Dr. L further stated that his impression was probable cerebellar-brainstem lesion; C3-4, C4-5, C6-7 spinal and foraminal stenosis with history of cervical radiculopathy and status post anterior interbody fusions/plating (1/22/97); and lumbar radiculopathy/ mechanical back pain. Dr. L stated that he suspected that claimant had a brainstem infarct superimposed on a cerebellar degenerative disorder; that this is supported by MRI scans of the brain; that diffuse atrophy of the brainstem and cerebellum may be due to claimant's history of alcoholism and has caused his ataxia; and that in his opinion, the sudden onset of ataxia is unrelated to the discogram or work-related accident of _____. Dr. L further stated that claimant's overall total physical impairment is marked and that he is essentially totally disabled in terms of his ability to return to his previous work; that he doubts claimant

can perform his routine activities of daily living; that claimant is at MMI for his work-related injury; that he recommends that claimant be evaluated by a neurologist; and that if he were to assign an IR, it would be in the range of 20% for claimant's cervical and lumbar spine injuries.

The TWCC-69 signed by Dr. L on "07-01-98," which reflects that he was a "designated doctor," certifies that claimant reached MMI on "7/8/97 (statutory)" with an IR of 26%. Dr. L's narrative report contains the detailed summary of claimant's medical records previously set out in his March 27, 1998, report. Dr. L assigned an 11% rating for the cervical spine specific disorders under the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association; 10% for abnormal cervical ROM; and seven percent for claimant's lumbar spine under Table 49, which combined to a total IR of 26%. Dr. L stated that lumbar ROM could not be measured because claimant could not stand independently due largely to his ataxia, which Dr. L did not believe to be related to the work-related injury. Dr. L also stated that he found no neurological abnormalities.

Dr. L reported the diagnoses as probable bilateral cerebellar-brainstem lesion; C3-4, C4-5, and C6-7 spinal and foraminal stenosis with history of cervical radiculopathy, status post fusion; and lumbar radiculopathy/mechanical back pain. Concerning the probable brain stem lesion, Dr. L stated that in his opinion, claimant's sudden onset of ataxia is unrelated to the discogram or the work-related accident of _____; that despite the symptoms occurring 24 to 48 hours after the discogram, he saw no evidence that the ataxia symptoms are causally related to the procedure; that claimant's symptoms are neuro-anatomically referable to a site far above and geographically distinct from the site of the lumbar discogram; and that claimant has ataxia of his upper as well as his lower extremities.

The TWCC-69 signed by Dr. R on "1-29-99" reflects that he, too, was a designated doctor and certifies that claimant reached MMI on "07/08/1997" with an IR of 29%. In his narrative report of January 27, 1999, Dr. R states the history, as related by claimant with difficulty because of his speech deficit, summarizes the medical records, and states that he assigned 20% for claimant's cervical ROM and 11% for the cervical specific disorders, for a total IR of 29%. Dr. R further states that claimant "has obviously had some sort of cerebellar brainstem stroke unrelated to his work injury or diagnostic tests," that claimant apparently had some of these symptoms before his injury, and that "[t]here may be other diagnoses for his cerebellar symptoms but certainly they are not related to the work sustained injury."

If indeed both Dr. L and Dr. R were designated doctors, the record contains no explanation as to why a second designated doctor was appointed, much less does it reflect whether Dr. R was selected by the Commission or the parties themselves.

Dr. J's disability certificate of December 15, 1998, states that claimant has been under Dr. J's care since December 19, 1995, and that claimant is "100% disabled." Dr. J's January 28, 1999, report states his assessment as "(rule out) malignancy; lumbar radiculopathy/mechanical back pain; C3/4, C4/5, C6/7 spinal and foraminal stenosis with cervical radiculopathy; status post multiple anterior interbody fusions/plating (1/22/97); dermatitis; and severe coordination impairment/severe dysarthria." In nearly identical reports of February 25, March 30, and May 13, 1999, Dr. J added the following sentence: "**It is important to note that patient's neurological deficit (?stroke) developed during his treatment of a workers' compensation injury**. [Emphasis in original.]" On a paper dated June 29, 1999, Dr. J answered "Yes" to the question, "Is it your opinion that the impairment resulting from [claimant's] injuries from his 6/29/95 workers' compensation accident helped cause him to be 100% disabled between 12/1/98 and 6/1/99?"

In evidence is the carrier's Payment of Compensation or Notice of Refused or Disputed Claim (TWCC-21) dated April 20, 1998, stating in part that the carrier has accepted compensability for claimant's neck and low back only and disputes the compensability of all other conditions identified by Dr. L in his March 27, 1998, report, since they are ordinary diseases of life. The Request for Benefit Review Conference (TWCC-45) in evidence states that the carrier disputes claimant's entitlement to SIBS, as his inability to earn 80% of his preinjury wage is not a direct result of his impairment, that claimant sustained an intervening stroke unrelated to the compensable injury, and that the effects of the stroke may prevent claimant from working.

Claimant had the burden to prove by a preponderance of the evidence that he is entitled to SIBS for the first and second compensable quarters. Sections 408.142(a) and 408.143 provide that an employee is entitled to SIBS when the IIBS period expires if the employee has: (1) an IR of at least 15%; (2) not returned to work or has earned less than 80% of the employee's average weekly wage as a direct result of the impairment; (3) not elected to commute a portion of the IIBS; and (4) made a good faith effort to obtain employment commensurate with his or her ability to work.

The Appeals Panel has held in Texas Workers' Compensation Commission Appeal No. 931147, decided February 3, 1994, that if an employee established that he or she has no ability to work at all, then seeking employment in good faith commensurate with this inability to work "would be not to seek work at all." Texas Workers' Compensation Commission Appeal No. 950581, decided May 30, 1995. The burden of establishing no ability to work at all is "firmly on the claimant," Texas Workers' Compensation Commission Appeal No. 941382, decided November 28, 1994, and a finding of no ability to work must be based on medical evidence or "be so obvious as to be irrefutable." Texas Workers' Compensation Commission Appeal No. 950173, decided March 17, 1995. *See also* Texas Workers' Compensation Commission Appeal No. 941332, decided November 17, 1994. A claimed inability to work is to be "judged against employment generally, not just the previous job where the injury occurred." Texas Workers' Compensation Commission Appeal No. 941334, decided November 18, 1994. The absence of a doctor's release to

return to light duty does not in itself relieve the injured worker of the good faith requirement to look for employment, but may be subject to varying inferences. Appeal No. 941382, *supra*.

The problem with the hearing officer's findings is that they do not distinguish between claimant's impairment from the compensable injury and his impairment from an ordinary disease of life or other conditions not part of his compensable injury. The record does not indicate that the issue of extent of claimant's compensable injury has been adjudicated. In her discussion of the evidence, the hearing officer includes among the lasting effects of impairment from the _____, injury not only neck pain, popping, and restricted ROM, but also headaches, mid and low back pain, chest pain, pain, numbness and tingling in the arms, numbness and weakness in the legs, impaired vision, speech deficit, balance and coordination deficits, and being confined to a wheelchair.

In Texas Workers' Compensation Commission Appeal No. 980773, decided May 22, 1998, an 11th quarter SIBS case, the majority opinion reversed the hearing officer's decision of nonentitlement and remanded for further consideration consistent with the content of the majority's opinion. The majority opinion, noting that the hearing officer appeared to have conducted a bifurcated analysis of the employee's ability to work based on impairment from both his compensable injury and his other health problems, stated its disagreement with the notion that impairment from the compensable injury and impairment from other health problems are properly considered independently in analyzing the "good faith attempt" criterion of the SIBS statute (Section 408.142(a)(4)), citing Texas Workers' Compensation Commission Appeal No. 950471, decided May 10, 1995. Concerning the requirement that the unemployment or underemployment be "a direct result of the employee's impairment" (Section 408.142(a)(2)), however, the majority opinion stated that "[t]he appropriate place to consider the effects of the claimant's other health problems in a determination of SIBS entitlement is in the analysis of the direct result criterion." Although the "direct result" finding was not appealed in that case, the majority nonetheless remanded for reconsideration of whether the employee had any ability to work in the filing period with reference to his overall medical condition and not just based on the impairment from the compensable injury.

We caution that the amended SIBS rules appear to have been in effect for purposes of the determination of the second quarter of SIBS entitlement. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE §§ 130.102(b)(1) and 130.102(c) (Rules 130.102(b)(1) and 130.102(c)) refer to the unemployment/underemployment being "a direct result of the impairment from the compensable injury." Rule 130.102(d)(3) provides that an employee has made a good faith effort if the employee "has been unable to perform any type of work in any capacity, has provided a narrative report from a doctor which specifically explains how the injury caused a total inability to work, and no other records show that the injured employee is able to return to work; . . . [Emphasis supplied.]"

We find no abuse of discretion in the hearing officer's exclusion of Carrier's Exhibit I, an August 6, 1997, letter from Dr. SE to the carrier's adjusting firm, which the carrier offered following claimant's testimony for the purpose of impeaching claimant's testimony concerning the extent to which the cervical surgery relieved his neck injury symptoms. The carrier did not contend that the document had been timely exchanged pursuant to the requirements of Section 410.160 and Rule 142.13(c)(1)(A) and (B). Rather, the carrier urged that the document was admissible to impeach claimant's testimony notwithstanding the evidence exchange requirements of the 1989 Act and Commission's rules. In Texas Workers' Compensation Commission Appeal No. 92204, decided July 6, 1992; Texas Workers' Compensation Commission Appeal No. 94432, decided May 20, 1994; and Texas Workers' Compensation Commission Appeal No. 94910, decided August 26, 1994 (Unpublished), the Appeals Panel indicated it was unaware of any blanket exception to the exchange rule for witnesses and documents characterized as "rebuttal" or "impeachment" witnesses and documents.

We reverse the decision and order of the hearing officer and remand for such further consideration, findings, and conclusions as are necessary and consistent with this opinion.

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 Commission's Division of Hearings, pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

_____
Philip F. O'Neill
Appeals Judge

CONCUR:

_____
Gary L. Kilgore
Appeals Judge

_____
Elaine M. Chaney
Appeals Judge