

APPEAL NO. 030585
FILED APRIL 30, 2003

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on February 12, 2003. Regarding the issues disputed on appeal, the hearing officer determined that the appellant/cross-respondent's (claimant) _____, compensable injury includes a posterior disc herniation at L5-S1 in the nature of an extruded fragment; that the claimant had disability beginning _____, and continuing through the date of the hearing; and that the claimant reached maximum medical improvement (MMI) on October 2, 2001, with an impairment rating (IR) of 13% pursuant to the certification of the Texas Workers' Compensation Commission (Commission)-selected designated doctor. The claimant appealed the hearing officer's MMI and IR determinations, asserting that the designated doctor failed to address his entire injury. The respondent/cross-appellant (carrier) responded, urging affirmance of those determinations. The carrier appealed the hearing officer's determinations regarding extent of injury and disability, asserting that those determinations are not supported by the evidence, that the hearing officer used the wrong burden of proof regarding the extent-of-injury issue, and that the hearing officer incorrectly placed the burden of proof on the carrier. The file does not contain a response from the claimant.

DECISION

Affirmed in part and reversed and remanded in part.

The disputed issues of extent of injury and disability presented questions of fact for the hearing officer. The hearing officer is the sole judge of the weight and credibility of the evidence. Section 410.165(a); Texas Employers Ins. Ass'n v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). There was conflicting evidence presented on the disputed issues. It was for the hearing officer, as the trier of fact, to resolve the conflicts and inconsistencies in the evidence and to determine what facts had been established. Garza v. Commercial Ins. Co., 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). Nothing in our review of the record reveals that the hearing officer's determinations are so contrary to the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust. Additionally, we find nothing to indicate that the hearing officer used the wrong burden of proof or incorrectly placed the burden of proof on the carrier. Finally, a claimant may be found to have disability beyond the date of MMI. A finding of MMI merely establishes a date after which the claimant is no longer entitled to temporary income benefits. As such, no sound basis exists for us to reverse those determinations on appeal. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986).

We next turn to the issues of MMI and IR. The Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), is the proper edition of the AMA

Guides in this case. On May 23, 2001, the claimant underwent a lumbar MRI, which revealed no focal disc protrusion or extrusion at L5-S1. The designated doctor examined the claimant on December 20, 2001, and certified that the claimant had reached MMI on October 2, 2001, with a 13% IR. Included in the IR was 5% under Table 49 (II)(B) for a specific disorder of the lumbar spine. On July 17, 2002, the claimant underwent a lumbar myelogram, which revealed an “interspinal block at the level of the L5-S1 disc space consistent with herniated disc producing severe compression of the sac at this point.” That same day the claimant underwent a cervical CT, which revealed a “prominent posterior central disc herniation with a right lateral extruded fragment in the canal which is compressing the sac on its right lateral aspect and producing a spinal canal block at [L5-S1]. The extruded fragment impinges on the S1 nerve root. The extruded fragment measures up to 2.5 cm in diameter.” Both the myelogram and CT results were sent to the designated doctor. On September 3, 2002, the designated doctor issued a clarification letter declining to change his opinion regarding MMI and IR. In the letter, the designated doctor wrote:

Given all of this information, it is not convincing enough for me to consider changing my previous determination of [MMI] or the [IR] per se. This [claimant] has findings the cervical and lumbar regions which are diffuse and consistent more with a generalized spondylosis than with any focal herniation. The [claimant] has had, on my evaluation, no lateralizing symptoms that would correlate clinically to the description of disc herniations throughout the cervical and lumbar regions. By utilizing reasonable medical probability, these are diffuse changes to the cervical and lumbar regions as evidenced by the associated changes of facet joint arthrosis and foraminal narrowing at multiple levels.

In determining that the claimant reached MMI on October 2, 2001, with a 13% IR, the hearing officer gave the designated doctor’s December 20, 2001, certification presumptive weight. In the Statement and Discussion of the Evidence portion of his decision and order, the hearing officer wrote:

The claimant argued that [the designated doctor] failed to appreciate the significance of [the] L5-S1 herniation, which presumably would have authorized the assignment of [7%] under Table II.C instead of [5%] under Table II.B. [The designated doctor] commented on this suggestion in a “clarification letter” of September 17, 2002. In the letter, [the designated doctor] declined to change his date of [MMI] or [IR] because he believed that the actual impact in terms of impairment on the [c]laimant for his disc pathology was more consistent with “a generalized spondylosis than with any focal herniation.” His interpretation was based not only on the objective testing, but also on his clinical examination. Under these circumstances, he retained discretion to choose II.B. or II.C. as the most appropriate basis for a diagnosis related [IR] of the lumbar spine.

The designated doctor's clarification letter was written and issued prior to the time that the extent-of-injury issue was resolved. It appears from the designated doctor's letter that he did not believe that the claimant had a herniation at L5-S1 and that he further believed that any problems the claimant was having were being caused by some other condition. As such we cannot say that the designated doctor rated the claimant's entire injury in view of the fact that the hearing officer has determined, and we have affirmed, that the claimant's compensable injury does include a herniated disc at L5-S1.

The hearing officer's determinations that the claimant's compensable injury includes a posterior disc herniation at L5-S1 in the nature of an extruded fragment and that he had disability beginning _____, and continuing through the date of the hearing are affirmed. The hearing officer's determination that the claimant reached MMI on October 2, 2001, with a 13% IR is reversed and remanded for further consideration. On remand, the hearing officer is directed to contact the designated doctor and ask for clarification of his MMI and IR certification, taking into consideration that the claimant does have, and his compensable injury does include, the above-mentioned condition at L5-S1. The hearing officer will notify the parties of the designated doctor's response and afford them an opportunity to respond prior to issuing a new decision.

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 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. See Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **AMERICAN HOME ASSURANCE COMPANY** and the name and address of its registered agent for service of process is

**CORPORATION SERVICE COMPANY
800 BRAZOS, SUITE 750, COMMODORE 1
AUSTIN, TEXAS 78701.**

Daniel R. Barry
Appeals Judge

CONCUR:

Chris Cowan
Appeals Judge

Michael B. McShane
Appeals Panel
Manager/Judge