APPEAL NO. 040876
FILED MAY 21, 2004

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 March 18, 2004. With respect to the issues before him, the hearing officer determined that the appellant's (claimant) impairment rating (IR) is 10% as certified by the designated doctor selected by the Texas Workers' Compensation Commission (Commission); that the claimant is not entitled to reimbursement of travel expenses for medical treatment at the direction of her treating doctor; and that the respondent (carrier) "is not prohibited from reducing the Claimant's future income benefits to recoup an overpayment of temporary income benefits [TIBs] . . .." In her appeal, the claimant asserts error in each of those determinations. In its response to the claimant's appeal, the carrier urges affirmance.

DECISION

Affirmed in part and reversed and remanded in part.

Initially, we consider the claimant's assertion that the hearing officer erred in giving presumptive weight to the designated doctor's report and in determining that the claimant's IR is 10% in accordance with that report. The claimant argues that her IR should be the 20% certified by her treating doctor. The designated doctor assigned the 10% for diagnosis-related estimate (DRE) lumbosacral category III radiculopathy. The treating doctor assigned a 20% for DRE lumbosacral category IV loss of motion segment integrity. The hearing officer did not err in giving presumptive weight to the designated doctor's report. We cannot agree that the treating doctor's report constitutes the great weight of the other medical evidence contrary to the designated doctor's report. Rather, this is a case where there is a genuine difference of medical opinion between the designated doctor and the treating doctor as to the correct IR to assign to the claimant for her lumbar injury. We have long held that by giving presumptive weight to the designated doctor, the 1989 Act provides a mechanism for accepting the designated doctor's resolution of such differences. Texas Workers' Compensation Commission Appeal No. 001659, decided August 25, 2000; Texas Workers' Compensation Commission Appeal No. 001526, decided August 23, 2000. Accordingly, the hearing officer did not err in giving presumptive weight to the designated doctor's report and adopting the 10% IR.

We likewise find no merit in the claimant's assertion that proper use of the Guides to the Evaluation of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000) (AMA Guides 4th edition) required the designated doctor to use the range of motion (ROM) model as a differentiator in this case because of the difference between the IR he assigned and the IR assigned by the treating doctor. The Commission sent a letter of clarification to the designated doctor forwarding the

treating doctor's critique of the 10% IR to the designated doctor, which specifically stated that the designated doctor should have used the ROM model as a differentiator in this instance. In his response to the letter of clarification, the designated doctor stated "I feel [claimant] fits PRECISELY into Category III. The [ROM] model is to be used ONLY as a differentiator if the patient does NOT fit into the DRE categories. This is not [the] case for this patient. Surgery has NO bearing when using the DRE [model]." (Emphasis in original.) The designated doctor's interpretation on the use of the ROM model as a differentiator is specifically provided for in the AMA Guides 4th edition. Indeed, on page 3/99 the last paragraph in the left hand column states that "[i]f the physician cannot decide into which DRE category the patient belongs, the physician may refer to and use the [ROM] Model . . . ." That paragraph concludes that "[t]he proper DRE category is the one having the impairment percent that is closest to the impairment percent determined with the [ROM] Model." Accordingly, we perceive no error in the designated doctor's decision not to use the ROM model herein based upon his determination that the claimant "fit precisely" into DRE lumbosacral category III.

Next, we consider the claimant's assertion that she is entitled to reimbursement of travel expenses for medical treatment at the direction of her treating doctor. The claimant essentially argues that we should order reimbursement because the carrier paid reimbursement for some period and should not now be permitted to discontinue reimbursement because it's decision to do so "established a hardship" to the claimant. We find no merit in this assertion. Even assuming that as the claimant argued at the hearing, she and the carrier reached a "verbal agreement" that the carrier would reimburse the claimant for travel expenses to receive medical care from her treating doctor, the Commission simply has no enforcement mechanism to ensure the carrier's compliance with such an agreement. To the contrary, the Commission is limited to ordering reimbursement for travel expenses only in the circumstances established in Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 134.6(b) (Rule 134.6(b)). That is, in order for the Commission to have order reimbursement for travel expenses in this case the claimant would have had to demonstrate that "medical treatment for the compensable injury is not reasonably available within 20 miles of the injured employee's residence." The claimant made no effort to make such a showing in this case and, as such, the hearing officer did not err in determining that the claimant is not entitled to reimbursement for travel expenses.

Finally, we consider the recoupment issue. The parties stipulated that the claimant's average weekly wage (AWW) is $274.81; that the claimant was entitled to $23,523.82 in TIBs; that the carrier paid TIBs in the amount of $25,277.28; and that the amount of the TIBs overpayment was $25,277.28 - $23,523.82, or $1,753.46.[1] In a Payment of Compensation or Notice of Refused/Disputed Claim (TWCC-21) dated January 7, 2003, the carrier stated that it had overpaid TIBs by $6,251.52, which based upon the stipulation at the hearing, was inaccurate. It then deducted that amount from the total amount of impairment income benefits (IIBs) that it calculated the claimant was entitled to, $10,783.80, based upon the treating doctor's 20% IR (60 weeks of benefits)

[1] The hearing officer's decision contains a typographical error in that it identifies the overpayment amount as $1,753.26 rather than the correct figure of $1,753.46.

and the IIBs rate of 70% of the incorrect AWW figure then being used. The carrier divided the $4,532.28 (the difference between $10,783.80 and $6,251.52) by 60 and stated that it would reduce the claimant's IIBs payment to $75.54 per week in order to recoup the TIBs overpayment. In arguing that the hearing officer erred in determining that the carrier could reduce income benefits to recoup the TIBs overpayment, the claimant essentially argues the equities that the carrier should not be able to recoup because the overpayment was based upon its mistake and that to permit recoupment where the claimant continues to be disabled would create a hardship for the claimant. The claimant's focus in that respect appears to be based upon Appeals Panel cases that looked to such equities in considering recoupment issues. However, as we noted in Texas Workers' Compensation Commission Appeal No. 033358-s, decided February 18, 2004, much of our prior precedent has been superceded by the Commission's adoption of Rule 128.1(e)(2), which was not cited by either party or the hearing officer. Rule 128.1(e)(2), which became effective May 16, 2002, provides that if a carrier has overpaid benefits because the AWW is different than what the carrier had previously determined, the carrier is permitted to recoup the overpayment. Rule 128.1(e)(2)(A) provides that the carrier may recoup the overpayment in an amount not to exceed 25% of the benefits the claimant is entitled to based upon the new AWW, if the claimant's benefits are not being concurrently reduced to pay approved attorney's fees or to recoup a Commission approved advance. Rule 128.1(e)(2)(B) provides that if the claimant's benefits are being reduced to pay attorney's fees or to recoup a Commission approved advance, then the carrier may recoup the overpayment in an amount not to exceed 10%. Subsection (C) of Rule 128.1(e)(2) provides a mechanism for the carrier to recoup in an amount greater than the 10% or 25% permitted in subsections (A) and (B) by written agreement with the claimant or by contacting the Commission to set a higher recoupment rate. In light of Rule 128.1(e), it is apparent that the hearing officer's determination that the carrier is not prohibited from recouping the overpaid TIBs is not error. However, that determination does not fully resolve the issue in that it is apparent that the carrier was not permitted to unilaterally reduce the claimant's benefits in an amount in excess of the 10% or 25% established in Rule 128.1(e)(2)(A) and (B) as it did in this case. Accordingly, we remand the recoupment issue for the hearing officer to consider and resolve the issue of recoupment in accordance with Rule 128.1(e) and Appeal No. 033358-s, which interpreted that rule. At the hearing on remand, the parties should address the recoupment issue in light of Rule 128.1(e) and the hearing officer should determine what recoupment rate is appropriate under Rule 128.1(e).

The hearing officer's determination that the claimant's IR is 10% and that she is not entitled to reimbursement of travel expenses for medical treatment at the direction of her treating doctor are affirmed. The recoupment issue is remanded for further proceedings 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 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.

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Elaine M. Chaney
Appeals Judge

CONCUR:

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Robert W. Potts
Appeals Judge

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Edward Vilano
Appeals Judge