APPEAL NO. 120918
FILED JULY, 2012

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on March 2, 2012, and concluded on April 17, 2012, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by determining that: (1) income benefits began to accrue on February 10, 2010; (2) the respondent (claimant) has not reached maximum medical improvement (MMI); and (3) because the claimant has not reached MMI, an impairment rating (IR) is premature.

The appellant (self-insured) appealed the hearing officer's MMI and IR determinations, contending that: (1) it was legal error for the hearing officer to determine that the claimant is not yet at MMI when the date of statutory MMI is a date that occurred prior to the CCH; (2) the initial certification of MMI/IR by [Dr. C], the designated doctor most recently appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division), should have been given presumptive weight and adopted (that the claimant reached MMI on June 15, 2006, with either 5% or 10% IR);[1] (3) that the letter of clarification (LOC) sent by the hearing officer to Dr. C was misleading and incorrect; (4) Dr. C's response to the LOC should not be considered because it was requested after the record closed and was based on incorrect medical information and incomplete medical records; and (5) Dr. C's amended MMI date of May 12, 2011, done without a re-examination, is invalid and in violation of 28 TEX. ADMIN. CODE § 130.1(b)(4)(B) (Rule 130.1(b)(4)(B)).[2]

The claimant responded, urging affirmance.[3]

[1] The self-insured contended that the correct IR is 5%, but in the alternative, because the Division in a prior CCH determined that the compensable injury extends to L5-S1 spondylolisthesis and S1 bilateral radiculopathy, these conditions are included in Dr. C's alternative IR of 10%. The self-insured stated in their appeal that "[t]his extent of injury finding is currently in disputed [*sic*] in a judicial review proceeding."
[2] The self-insured relies on Appeals Panel Decision (APD) 010297-s, decided March 29, 2001. The facts in this case are distinguishable from the case before us. In APD 010297-s, the Appeals Panel reversed the hearing officer's MMI determination and remanded the issue of MMI to the hearing officer because the hearing officer adopted a prospective date of MMI. The certifying doctor conducted only one examination of the injured employee and later amended his certified MMI date subsequent to the date of his sole examination without a re-examination of the claimant. In this case before us, in response to a LOC, Dr. C did not amend the MMI date to a prospective date of MMI because he placed the claimant at MMI on the date of his examination.
[3] The claimant relies on APD 111393, decided November 23, 2011. The facts in this case are distinguishable from the case before us. In APD 111393, a written decision was issued to clarify that a hearing officer can determine that the claimant is not at MMI in the absence of a Report of Medical Evaluation (DWC-69) when the only DWC-69 in evidence certifying a date specific for MMI is contrary to the preponderance of the other medical evidence.

The hearing officer's determination that income benefits began to accrue on February 10, 2010, was not appealed and has become final pursuant to Section 410.169.

DECISION

Reversed and remanded.

The parties stipulated that: (1) the claimant sustained a compensable injury to her low back, in the form of a low back sprain/strain, on [date of injury]; (2) the Division has determined after a prior CCH that the compensable injury includes L5-S1 spondylolisthesis and S1 bilateral radiculopathy; (3) Dr. C is the Division-appointed designated doctor for MMI/IR; (4) Dr. C assigned the claimant 10% IR; and (5) Dr. C certified that the claimant reached MMI on June 15, 2006.

The claimant testified that she injured her low back in a lifting incident at work and first missed time because of her injury in February of 2010. The hearing officer found that the claimant's eighth day of disability was February 10, 2010. In the Background Information section of his decision, the hearing officer stated that "[b]ased on an accrual of disability date of February 10, 2010, . . . the claimant reached statutory [MMI] on February 8, 2012."

The claimant also testified that she has not yet had lumbar fusion surgery first recommended in 2006 by her surgeon and repeatedly denied by the self-insured. The claimant stated that because of this her condition has worsened.

In evidence is the decision and order of the CCH held on September 15, 2010, in which the hearing officer determined that the compensable injury of [date of injury], extends to L5-S1 spondylolisthesis and S1 bilateral radiculopathy but does not extend to L4-5 spondylolisthesis.

There are five certifications of MMI/IR in evidence:

1. [Dr. P], who was appointed initially by the Division to address MMI/IR and extent of injury, examined the claimant on August 25, 2010, and certified that the claimant has not yet reached MMI but is expected to reach MMI on or about November 25, 2010;

2. Dr. C, the subsequent designated doctor for MMI/IR, examined the claimant on May 12, 2011, and certified (if the compensable injury is limited to a lumbar sprain/strain) that the claimant reached clinical MMI on June 15, 2006, with 5% IR;

3. Dr. C, in the alternative (based on the May 12, 2011, exam) certified (if the lumbar injury includes S1 radiculopathy resulting from spondylolithesis) that the claimant reached clinical MMI on June 15, 2006, with 10% IR (Dr. C's three certifications are discussed in more detail in subsequent paragraphs);

4. Dr. C, in a response to a LOC dated March 20, 2012, provided an amended DWC-69 certifying that the claimant reached MMI on May 12, 2011, with 10% IR; and

5. [Dr. F], the claimant's treating doctor, examined the claimant on February 20, 2012, and certified that the claimant has not yet reached MMI but is expected to reach MMI on August 24, 2012.

It is undisputed that Dr. C examined the claimant on May 12, 2011, to determine MMI/IR. Dr. C stated that he provided alternative certifications of MMI/IR because there was a dispute as to the extent of the [date of injury], compensable injury. In his narrative report dated May 12, 2011, Dr. C noted that the self-insured had accepted only a lumbar sprain/strain, and certified that the claimant reached clinical MMI on January 20, 2006, with 5% IR; however, his DWC-69 certified that the claimant reached clinical MMI on June 15, 2006, with 5% IR.

In that same narrative, based on the May 15, 2011, exam, Dr. C provided an alternative certification for a lumbar injury including S1 radiculopathy resulting from spondylolisthesis. Dr. C certified that the claimant reached clinical MMI on June 15, 2006, with 10% IR. The 10% IR was based on placement of the claimant in Diagnosis-Related Estimate (DRE) Category III: Radiculopathy (with his narrative detailing the claimant's loss of relevant reflexes) using 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).

Following the CCH held on March 2, 2012, the hearing officer re-opened the record in order to send a LOC to Dr. C. The specific question addressed to Dr. C by the hearing officer is as follows:

> The medical history in this case shows that beginning as far back as August, 2006, and continuing through the present, several doctors have recommended back surgery for the claimant and opined that such surgery would materially approve [*sic*] her condition. In fact, the [self-insured's] utilization reviewer [UR] as recently as February, 2012, has said that such surgery is reasonable and necessary care for the claimant's work-related

injury. However, you placed the claimant at MMI in June, 2006, prior to the medical reports stating, in one instance, that there was an 85% chance of improvement in the claimant's condition with back surgery. It appears that your decision was based on three physical therapy reports from January, 2006, only three months following the compensable injury. Even though you noted in your report that the claimant was pending surgery at the time of your examination [May 12, 2011], you had difficulty accepting that the claimant had more than a lumbar sprain/strain despite the decision of a hearing officer at a [CCH] that the extent of the injury went beyond a sprain/strain.

The Appeals Panel has ruled that MMI is to be based upon whether, in reasonable medical probability, material recovery or lasting improvement could reasonably be anticipated. The Appeals Panel has further held 'it is of no moment that the treatment did not ultimately prove successful in providing material recovery or lasting improvement in the [c]laimant's condition, where . . . the recovery and improvement could reasonably be anticipated . . . .'

It is my determination as a [h]earing [o]fficer that the record in this case, including the opinion of the prior designated doctor [Dr. P], establishes that lumbar surgery for the claimant, which has been proposed and sought for years, can reasonably be anticipated to result in her recovery and the improvement of her condition.

Statutory [MMI] in this case is February 8, 2012. In light of, and based on, the above discussion I would appreciate your revisiting your previously determined date of MMI to determine if a different date would be more consistent with the facts and medical record in this case.

In a response, dated March 21, 2012, to the LOC, Dr. C stated:

I saw [the claimant] on [May 12, 2011]. There was some confusion in the records regarding the extent of injury. There were clearly differing opinions on this case. Subsequently, I have been informed that the statutory [MMI] date in this case is [February 8, 2012]. In view of the correspondence from . . . the hearing officer at the [Division], in a [LOC] on [March 20, 2012], and in view of my review of the medical records I have revised the MMI date to [May 12, 2011]. The [designated doctor] may not provide a prospective MMI date.

> The whole person [IR] remains 10% under DRE [C]ategory III for lumbosacral impairment according to the [AMA Guides].

Dr. C attached an amended DWC-69 to his response certifying that the claimant reached clinical MMI on May 12, 2011, with 10% IR. The LOC, the response to the LOC, and the amended DWC-69 are in evidence as Hearing Officer's Exhibit No. 3.

On March 22, 2012, the hearing officer sent a letter to the parties' attorneys, attaching Dr. C's response to the LOC sent and informing them that he would accept written responses and comments in regards to Dr. C's amended DWC-69 through the close of the business day, March 30, 2012. After that, he would close the record and issue a decision. This correspondence is in evidence as Hearing Officer's Exhibit No. 4.

In a letter dated March 28, 2012 (Hearing Officer's Exhibit No. 5), the self-insured states that Dr. C's amended MMI date is invalid because Dr. C was not provided with complete medical records and Dr. C did not perform a complete medical examination prior to amending his certification of MMI. The self-insured also argues that the LOC was sent without an opportunity for the self-insured to correct a misstatement concerning the determination by the UR, which had made an adverse determination when reviewing the request for a lumbar fusion. The self-insured also stated that "[i]t is the [Independent Review Organization's (IRO)] opinion that surgery at the L5-S1 level would not address the pathology at the L4-5 level. However, the pathology at L4-5 has been finally determined to not be part of the compensable injury."

In a letter dated March 30, 2012, the claimant states to the hearing officer that Dr. C "never acknowledges or reveals that he understands or appreciates that the 'extent of injury' was not a question he had (or has) before him." The claimant also contends:

> Based on the rather awkward statement that 'the [designated doctor] may not provide a ***prospective*** MMI date' which immediately follows his revision, it is wholly unclear as to whether or not [Dr. C] understands or even appreciates that a re-examination of the claimant may in fact be necessary based on his otherwise obvious desire to change the claimant's MMI date ***and/or*** that a re-examination of the claimant is even an option/possibility for him. [Emphasis in the original.] The claimant believes that a second [LOC] should be sent to [Dr. C] advising him there is a legally binding [decision and order] from a [hearing officer] that is in place relative to the extent of the claimant's injuries . . . . Likewise, the claimant believes that this additional [LOC] should make it totally clear that a re-examination of the claimant may in fact be necessary based on his indication to change the claimant's MMI date.

Also in that letter, the claimant states that the logic in the adverse determination by the UR and the upholding in the IRO are that both the L4-5 and compensable L5-S1 levels are symptomatic and the most appropriate surgical intervention would consist of a L4-S1 fusion regardless of the fact they are not both compensable body parts. This letter is admitted as Hearing Officer's Exhibit No. 6.

The hearing officer found that: (1) [t]he [IR] and date of [MMI] assigned by [the] designated doctor [Dr. C] are contrary to the preponderance of the other medical evidence; (2) [a]s of the date of examination [May 12, 2011] by [Dr. C], medical and surgical procedures had been recommended for the claimant and were pending that could reasonably and likely result in an improvement in the claimant's condition; and (3) [t]he preponderance of the other medical evidence is contrary to the determination by [Dr. C] that the claimant had reached [MMI] as of the date of his designated doctor examination.

LOC

Rule 127.20(a) provides in part that the Division may contact the designated doctor if it determines that clarification is necessary to resolve an issue regarding the designated doctor's report. Rule 127.20(b) provides in pertinent part that requests for clarification must:

> (3) include questions for the designated doctor to answer that are neither inflammatory nor leading; and
>
> (4) provide any medical records that were not previously provided to the designated doctor and explain why these records are necessary for the designated doctor to respond to the request for clarification.

In this case, as stated above, the hearing officer stated in his March 20, 2012, LOC that "[i]t is my determination as a [h]earing [o]fficer that the record in this case, including the opinion of the prior designated doctor [Dr. P], establishes that lumbar surgery for the claimant, which has been proposed and sought for years, can reasonably be anticipated to result in her recovery and the improvement of her condition." We hold that the March 20, 2012, LOC was worded in a manner that could potentially mislead the designated doctor in violation of Rule 127.20(b)(3). Additionally, the hearing officer failed to provide the claimant's complete medical records to Dr. C, including the UR determination itself, which is a violation of Rule 127.20(b)(4).

Consequently, the hearing officer's determinations that the claimant has not reached MMI and because the claimant has not reached MMI, an IR is premature is based on a LOC that does not meet the requirements of Rule 127.20(b). Therefore, we

reverse the hearing officer's determination that the claimant has not reached MMI. We reverse the hearing officer's determination that because the claimant has not reached MMI, an IR is premature. We remand the issues of MMI and IR to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

Dr. C is the designated doctor in this case. On remand, the hearing officer is to determine whether Dr. C is still qualified and available to be the designated doctor. If Dr. C is no longer qualified or available to serve as the designated doctor, then another designated doctor is to be appointed to determine MMI/IR for the compensable injury of [date of injury].

The hearing officer is to provide any of the claimant's medical records that were not previously provided to the designated doctor, including the UR determination and the IRO decision, so that the designated doctor has the claimant's complete medical records.

The hearing officer is to advise the designated doctor that the date of statutory MMI is February 8, 2012. The hearing officer is to advise the designated doctor that he may re-examine the claimant in order to determine MMI/IR.

The hearing officer is to advise the designated doctor that the compensable injury of [date of injury], a lumbar sprain/strain (as stipulated to by the parties) has been administratively determined by the Division to extend to L5-S1 spondylolisthesis and S1 bilateral radiculopathy, but does not extend to L4-5 spondylolisthesis.

The hearing officer is not to advise the designated doctor that it is his determination, or the opinion a prior designated doctor, that as of the date of Dr. C's examination on May 12, 2011, medical and surgical procedures had been recommended for the claimant and were pending that could reasonably and likely result in an improvement in the claimant's condition.

The designated doctor is then to be requested to give a certification of MMI/IR for the claimant's compensable injury of [date of injury], based on the injured employee's condition as of the MMI date, which can be no later than the date of statutory MMI (February 8, 2012), considering the claimant's medical record and the certifying examination.

The parties are to be provided with the hearing officer's letter to the designated doctor and the designated doctor's response. The parties are to be allowed an

opportunity to respond. The hearing officer is then to make a determination on MMI and IR consistent with this 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 Division, 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* APD 060721, decided June 12, 2006.

The true corporate name of the insurance carrier is **(a self-insured governmental entity)** and the name and address of its registered agent for service of process is

[JG]
[ADDRESS]
[CITY], TEXAS [ZIP CODE].

Cynthia A. Brown
Appeals Judge

CONCUR:

Carisa Space-Beam
Appeals Judge

Margaret L. Turner
Appeals Judge