APPEAL NO. 131323
FILED JULY 24, 2013

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 April 1, 2013, with the record closing on May 2, 2013, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that: (1) the compensable injury of [date of injury], does not extend to herniated discs at L4-5 and L5-S1, lumbar facet syndrome, right sacroiliac joint sprain/strain, and lumbar radiculopathy; (2) the appellant (claimant) reached maximum medical improvement (MMI) on July 5, 2012; (3) the claimant's impairment rating (IR) is 5%; and (4) the claimant had disability as a result of the [date of injury], compensable injury from September 5, 2012, through February 20, 2013. The claimant appealed the hearing officer's extent of injury, MMI and IR determinations. The respondent (carrier) responded to the claimant's appeal, urging affirmance. The hearing officer's disability determination was not appealed and has become final pursuant to Section 410.169.

DECISION

Affirmed in part, and reversed and remanded in part.

The parties stipulated that the claimant sustained a compensable injury on [date of injury]. The claimant sustained an injury while setting up a rig. It is undisputed that the carrier has accepted a compensable injury of lumbago and lumbar strain, and that the Texas Department of Insurance, Division of Workers' Compensation (Division) appointed [Dr. H] as the designated doctor on issues of MMI and IR.

EVIDENTIARY AND PROCEDURAL RULINGS

We first address the claimant's evidentiary objections. The claimant contends in his appeal that he received an exchange from the carrier after the CCH. The claimant did not state in his appeal which documents were exchanged by the carrier after the CCH. To obtain reversal of a decision based upon error in the admission or exclusion of evidence, it must be shown that the evidentiary ruling was in fact error, and that the error was reasonably calculated to cause, and probably did cause the rendition of an improper decision. *See* Appeals Panel Decision (APD) 051705, decided September 1, 2005. Review of the record shows that the claimant did not object to the carrier's Exhibits A through M being admitted at the CCH, therefore, the claimant did not preserve error. We conclude that the claimant has not shown that the hearing officer abused his discretion in admitting the carrier's evidence nor has the claimant shown that the error, if any, amounted to reversible error.

Second, the claimant also alleges that the hearing officer was biased, contending that the hearing officer and the carrier's representative were friends because they were discussing a mutual friend's funeral. We find no support in the record for the claimant's contention that the hearing officer was motivated by or in any way demonstrated bias against the claimant. The mere fact that the hearing officer issued a decision adverse to the claimant does not, in our view, demonstrate bias but is the prerogative of the hearing officer as the sole judge of the weight and credibility of the evidence. *See* APD 023289, decided February 20, 2003. Accordingly, we find no basis to reverse the hearing officer's decision.

EXTENT OF INJURY

The hearing officer's determination that the claimant's compensable injury of [date of injury], does not extend to herniated discs at L4-5 and L5-S1, lumbar facet syndrome, right sacroiliac joint sprain/strain, and lumbar radiculopathy is supported by sufficient evidence and is affirmed.

MMI/IR

Section 408.1225(c) provides that the report of the designated doctor has presumptive weight, and the Division shall base its determination of whether the employee has reached MMI on the report of the designated doctor unless the preponderance of the other medical evidence is to the contrary. *See also* Section 401.011(30)(A). Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Division shall base the IR on that report unless the preponderance of the other medical evidence is to the contrary, and that, if the preponderance of the medical evidence contradicts the IR contained in the report of the designated doctor chosen by the Division, the Division shall adopt the IR of one of the other doctors. *See* 28 TEX. ADMIN. CODE § 130.1(c)(3) (Rule 130.1(c)(3)).

Dr. H, the designated doctor, examined the claimant on May 31, 2012, and in a Report of Medical Evaluation (DWC-69) dated that same date, certified that the claimant had not reached MMI but is expected to reach MMI on or about July 31, 2012. In a narrative report dated May 31, 2012, Dr. H opined that:

> It is my opinion that the claimant would benefit from three weeks of physical therapy. It is my impression that the pain is coming from a painful facet joint and this could be relieved with therapy. I do not feel the claimant is presently at MMI but if he is allowed to have the therapy, I think he should be at MMI by July of 2012.

Dr. H re-examined the claimant on September 5, 2012, and in a DWC-69 and narrative report dated that same date, he certified that the claimant reached MMI on September 5, 2012, with a 5% IR. In that narrative report, Dr. H states that "[s]ince the last exam, no records of further care have been provided. On the last exam, I recommended that the claimant undergo physical therapy. . . . [The claimant] advised me that he underwent 12 physical therapy sessions."

In evidence is a letter of clarification dated April 8, 2013, in which the hearing officer asked Dr. H to explain why he opined that the claimant reached MMI on September 5, 2012. Dr. H responded in a letter dated April 12, 2013, that he made a transcription error as to the "7" for the month of July and the "9" for the month of September and that the correct date of MMI was July 5, 2012. Dr. H further explained that he placed the claimant at MMI on July 5, 2012, "because on my previous exam of [May 31, 2012], it was recommended that the claimant have several weeks of physical therapy which might help his mechanical back pain. The claimant was authorized to have 12 physical therapy sessions . . . and I felt that it would take a week to get it approved and he would then have his four weeks of therapy and therapy would have ended by [July 5, 2012], which is why it shows that date." In evidence are physical therapy progress notes dated June 13, 2012, through July 16, 2012. The physical therapy progress notes show that the claimant had 12 physical therapy sessions for his lumbar spine that began on June 13, 2012, and ended on July 16, 2012.

In APD 062068, decided December 4, 2006, the Appeals Panel held that the 1989 Act and the Division rules require that the designated doctor conduct an examination of the claimant and review the claimant's medical records. The Appeals Panel stated that ". . . Rules 130.1(b)(4)(A) and 130.1(c)(3) specifically require that the certifying doctor, including the designated doctor, review the medical records before certifying an MMI date and assigning an IR." *See* APD 130187, decided March 18, 2013, in which the designated doctor did not have the post-operative physical therapy medical records prior to making his first MMI/IR certification, therefore, his certification of MMI and IR could not be adopted. Rule 127.10(a)(1) provides in part that the treating doctor and insurance carrier shall provide to the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor. For subsequent examinations with the same designated doctor, only those medical records not previously sent must be provided. *See also* APD 112010, March 2, 2012.

In this case, Dr. H initially examined the claimant on May 31, 2012, and opined that the claimant had not reached MMI because he needed physical therapy for his injury. The claimant received 12 physical therapy sessions beginning June 13, 2012, and ending on July 16, 2012. Dr. H re-examined the claimant on September 5, 2012,

and noted in his narrative report that the claimant had informed him that he had undergone12 physical therapy sessions; however, "no records of further care have been provided." The physical therapy notes were in existence prior to Dr. H's re-examination of the claimant on September 5, 2012. Although Dr. H did not have any medical records to show when the claimant completed his physical therapy sessions, he determined that the claimant should have completed his physical therapy sessions by July 5, 2012. Dr. H certified that the claimant reached MMI on July 5, 2012, however, there was evidence of reasonable expectation of further material recovery at the time of Dr. H's certification of MMI and IR. The evidence does not support Dr. H's certification of MMI and IR, therefore, Dr. H's certification cannot be adopted. Accordingly, we reverse the hearing officer's determination that the claimant reached MMI on July 5, 2012, with a 5% IR.

In evidence are two certifications of MMI and IR from [Dr. P], the treating doctor. Dr. P initially examined the claimant on October 10, 2012, and in a DWC-69 dated that same date, he certified that the claimant had not reached MMI but is expected to reach MMI on or about November 4, 2013. We note that Dr. P's DWC-69 includes a single diagnosis code of "722.10" which is identified as a "lumbar HNP" by Dr. P in the two Functional Capacity Evaluations performed on October 4, 2012, and February 19, 2013. In an undated narrative report, Dr. P stated that the claimant had 12 sessions of physical therapy and that the claimant had not received treatment in the form of a lumbar ESI, facet injections or work hardening/conditioning. Dr. P stated that the claimant was in need of further medical care. As previously mentioned, the carrier has accepted lumbago and lumbar strain as the compensable injury. Further, as determined by the hearing officer and affirmed by the Appeals Panel, the claimant's compensable injury does not extend to herniated discs at L4-5 and L5-S1, lumbar facet syndrome, right sacroiliac joint sprain/strain, and lumbar radiculopathy. Dr. P considered a condition not determined to be a part of the compensable injury, lumbar HNP, therefore, Dr. P's certification cannot be adopted. *See* APD 110463, decided June 13, 2011; and APD 101567, decided December 20, 2010.

Dr. P re-examined the claimant on February 20, 2013, and in a DWC-69 dated February 28, 2013, certified that the claimant reached MMI on February 20, 2013, with a 10% based on Diagnosis-Related Estimate Lumbosacral Category III: Radiculopathy. Dr. P considered and rated lumbar radiculopathy which is not part of the compensable injury. *See* APD 110463, *supra*; and APD 101567, *supra*. Accordingly, Dr. P's certification of MMI and IR cannot be adopted.

As there are no certifications of MMI and IR in evidence that can be adopted, we remand the MMI and IR issues back to the hearing officer for further action consistent with this decision.

SUMMARY

We affirm the hearing officer's determination that the claimant's compensable injury of [date of injury], does not extend to herniated discs at L4-5 and L5-S1, lumbar facet syndrome, right sacroiliac joint sprain/strain, and lumbar radiculopathy.

We reverse the hearing officer's determination that the claimant reached MMI on July 5, 2012, with a 5% IR, and we remand the MMI and IR issues to the hearing officer to make a determination consistent with this decision.

REMAND INSTRUCTIONS

Dr. H is the designated doctor. The hearing officer is to determine whether Dr. H is still qualified and available to be the designated doctor. If Dr. H is no longer qualified or available to serve as the designated doctor, then another designated doctor is to be appointed pursuant to Rule 127.5(c) to determine MMI, which cannot be later than the statutory date of MMI (*see* Section 401.011(30)), and the IR.

The hearing officer is to inform the designated doctor that the compensable injury of [date of injury], includes lumbago and lumbar strain. The hearing officer is to inform the designated doctor that the compensable injury of [date of injury], does not include herniated discs at L4-5 and L5-S1, lumbar facet syndrome, right sacroiliac joint sprain/strain, and lumbar radiculopathy. The hearing officer is to request from the designated doctor a certification of MMI and IR that considers and rates the entire compensable injury of [date of injury]. The hearing officer is to ensure that the designated doctor has all the pertinent medical records to determine MMI and IR. The parties are to be provided with the hearing officer's letter to the designated doctor, the designated doctor's response, and to be allowed an opportunity to respond. The hearing officer is to make MMI and IR determinations which are supported by the evidence and 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 **AMERICAN ZURICH INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TEXAS 78701-3218.

Veronica L. Ruberto
Appeals Judge

CONCUR:

Carisa Space-Beam
Appeals Judge

Margaret L. Turner
Appeals Judge