APPEAL NO. 980257
FILED MARCH 26, 1998

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held in (City), Texas, on December 3, 1997, with the record closing on January 9, 1998, to determine if the respondent (claimant) sustained a compensable injury on _____, and if he had disability. The hearing officer, determined that the claimant sustained a compensable left leg injury on _____, and that he had disability from August 25, 1997, through the date of the CCH. The appellant (carrier) requested review, urging that the hearing officer erred in determining that the claimant sustained a compensable left leg injury on _____, in the form of a trauma-induced hematoma and that the claimant had disability from August 25, 1997, through the date of the CCH. A response from the claimant has not been received. On March 4, 1998, the carrier filed a supplemental request for review, stating that it had received a medical record indicating that the mass was not a hematoma, but was a malignant fibrous histiocytoma and attaching a copy of a pathology report dated February 9, 1998. The supplemental request for review was not filed as a timely request for review.

DECISION

We reverse and remand.

The claimant testified that he struck his left leg on a pipe on _____, while working for the employer. There is some dispute as to what the claimant struck his leg on, but Mr. C, who was called by the carrier, said that he understood the claimant struck his leg on a handle that is a short pipe, that the claimant had a "little frog" or bruise, and that several weeks later the spot was about the size of a golf ball and the claimant said it was hurting. The claimant said that on July 29, 1997, he could not handle the pain any more, that he told Mr. C, that he was sent to (healthcare provider) where he saw Dr. G, and that Dr. G referred him to Dr. B. He stated that he worked full time until he was terminated on August 12, 1997; that he has not worked since that date because of the injury; that the knot started out as a small one; that it is now large; and that if he stands for 15 minutes his leg starts hurting.

Dr. G reported that he saw the claimant on July 29, 1997; that the claimant reported he struck his left upper leg on a pipe about two weeks ago and that the bump was getting larger; that the claimant had a four centimeter (cm) mass of his left upper leg; and that he referred the claimant to Dr. B for an orthopedic evaluation. Dr. B saw the claimant on July 30, 1997; noted that the claimant had a three inch soft mass four inches above the left knee; removed clotted blood from the area; had two x-rays of the left femur taken; reported that the x-rays were negative; and diagnosed a hematoma. Dr. J examined the claimant on August 15, 1997; noted a three cm by three cm mass;

diagnosed a traumatic hematoma on the left thigh; took the claimant off work; and recommended a surgical consultation. In a report dated August 25, 1997, Dr. J stated that the mass measured at 4.5 cm by 4.5 cm; again diagnosed a traumatic hematoma; requested an MRI; and started physical therapy, including moist heat and massage. On October 8, 1997, Dr. J noted that the mass was four inches by four inches. In a Specific and Subsequent Medical Report (TWCC-64) dated October 23, 1997, Dr. J diagnosed traumatic hematoma/contusion of thigh and musculoskeletal pain and in another report dated that day stated that she had not received approval for the MRI or the physical therapy. On November 3, 1997, Dr. J wrote that she had received a denial of all of the requested work-ups and referral to a general surgeon; that the mass was becoming larger; that she felt medical attention was urgently needed for a diagnosis of the left thigh mass; and that she referred him to (hospital) so that he can seek medical attention.

At the request of the carrier, Dr. B reviewed the medical records of the claimant and in a letter dated November 5, 1997, reported that since the mass was large and growing, the appropriate treatment was evaluation with an MRI, possibly followed by excision of the mass or biopsy; that if the MRI shows he has a hematoma, it is reasonable to assume it is a work-related injury; that otherwise he did not think it was work related; and that there is no way to determine with any degree of certainty whether this is a work-related injury without an MRI or surgical excision with examination of the mass by a pathologist.

The claimant testified that he had an MRI on November 28, 1997, and another one on December 2, 1997. The parties agreed that the record should be held open so the reports of the MRIs could be obtained, and the hearing officer did so. The hearing officer reconvened the CCH, stated that she received two reports of MRIs, that there were discrepancies, that she would write to the radiologist to seek clarification, and that she would close the record after she received a response from the radiologist. Dr. Dr. BC issued two reports of an MRI dated December 2, 1997. The first page of each of the reports is the same, and the impression appears on the second page of each report. One second page contains:

IMPRESSION:

1. Most likely, vascular enhancing soft tissues peripheral left thigh sarcoma. Benign features include no aggressive extension, smooth margination, and ellipsoid contours extrinsic to the vastus lateralis musculature.

2. A chronic hematoma would be unlikely. A hematoma would not be as well defined and should not exhibit inner vasculature to this extent.
3. No significant further examination abnormality.

The second page of the other report contains:

> IMPRESSION:
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> 1. A chronic hematoma involving an underlying vascular malformation like hemangioma possible and would explain the enlargement of this mass post trauma.
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> 2. Another possibility: An incidental occurrence of a soft tissue peripheral left thigh sarcoma. Benign features include no aggressive extension, smooth margination, and ellipsoid contours extrinsic to the lateralis musculature.
>
> 3. No significant further examination abnormality.

The hearing officer wrote a letter to Dr. BC dated December 19, 1997; provided him a copy of the two reports of the MRI; and asked for clarification. In a letter to the attorneys representing the parties dated December 22, 1997, the hearing officer stated that she received a telephone call and correct MRI report from Dr. BC. She stated that Dr. C said he generated a report, did additional research, generated another report, and redated the last report. The report is dated December 22, 1997; contains the last impression set forth earlier in this decision; and was sent to the attorneys representing the parties. Mr. T, the attorney representing the carrier, wrote a letter dated December 29, 1997, to the hearing officer with a copy to Mr. EG, the attorney representing the claimant. Mr. T stated that he had spoken with Dr. BC, that Dr. BC said he had not the "foggiest idea what the mass is," and that Mr. T thought it was essential that the CCH be reconvened to have Dr. BC testify by telephone. Mr. T also attached three excerpts from medical publications. In a letter dated January 8, 1998, to the hearing officer with a copy to Mr. T, Mr. EG stated his objection to medical data and a peer review by Dr. M dated December 31, 1997, offered by the carrier. In a letter to the hearing officer with a copy to Mr. EG dated January 9, 1998, Mr. T said that it was in follow-up to the brief hearing conducted in her office on January 7, 1998, in which the attorneys and the hearing officer discussed how to go forward on the case. Mr. T stated that the MRI films were obtained; that they were reviewed by Dr. M; and that Dr. M indicated the mass was not a hematoma, that he did not believe there was a trauma-induced mass, and that it will not be known what the mass is until it is removed and a pathology study is done. The report of Dr. M dated January 31, 1997, is attached to the letter from Mr. T. These letters and attachments are hearing officer exhibits. The record does not indicate how the carrier's request to have Dr. BC testify was handled. It does not contain a transcript or audiotape recording of the telephone conversation of the hearing officer and Dr. BC nor of the session of the CCH held on January 7, 1998. We reverse the Decision and Order of the hearing officer and remand for complete development of the record. Since the Appeals Panel may remand a case only once, the hearing officer should permit the parties to make arguments and

otherwise develop the record as she deems appropriate before rendering another 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 Texas Workers' Compensation Commission's Division of Hearings, pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Tommy W. Lueders
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Alan C. Ernst
Appeals Judge