APPEAL NO. 012870
FILED JANUARY 4, 2002

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 October 18, 2001. The hearing officer was asked to determine whether the appellant (claimant) had disability from his undisputed compensable injury of _____, and the date that the claimant reached maximum medical improvement (MMI). The hearing officer set aside the report of the designated doctor, finding that the great weight of the medical evidence was contrary to her report, and found an MMI date of June 8, 1998, in accordance with a report of a doctor for the respondent (carrier). He further found that the claimant did not show that he had disability as a result of his injury.

DECISION

Reversed and rendered that the report of the designated doctor was entitled to presumptive weight. Reversed and remanded for an additional proceeding and development and consideration of the evidence to resolve other matters herein.

PRELIMINARY FACTS

The claimant was a software engineer who sustained an undisputed repetitive trauma injury to his upper right extremity. He complained of weakness and pain in his right hand. There have been various diagnoses, including carpal tunnel syndrome (CTS), flexor tendinitis of the right ring finger, possible cubital tunnel or ulnar nerve syndromes, and thoracic outlet syndrome. There are no medical records which indicate positive Waddell's signs or otherwise suggest that the claimant is magnifying or faking his symptoms. However, normal EMG testing is noted.

Although facts underlying the designated doctor's examinations are more fully detailed later in this opinion, we would note here, for clarity, that the designated doctor initially examined the claimant on August 23, 1999, and found that he was not at MMI. The designated doctor suggested that some of the claimant's pain could be referred pain in, addition to thoracic outlet syndrome, but suggested further evaluation to establish a firm diagnosis. As stated below, the claimant was also examined by a required medical examination (RME) doctor who did not change his assessment of the MMI date, although he decreased his impairment rating (IR) on the second examination.

The claimant changed his treating doctor in early 2000.[1] This treating doctor noted that the claimant was not at MMI throughout early 2000 and restricted the claimant to part-time duty at the sedentary level. Physical therapy and work hardening therapy were

[1] The doctor in question is shown as a member of the same orthopedic practice of which the designated doctor is also a member, although the qualifications of the designated doctor to continue service as such have not been challenged by the carrier. This may reflect that the designated doctor indeed is serving by agreement of the parties.

prescribed. A peer review doctor, who did not examine the claimant, evaluated the medical records on January 16, 2001, and opined that work hardening was unnecessary in that it was more extensive than that required for a software engineer whose work was primarily sedentary.[2] The peer review doctor noted that the claimant should be able to return to full-time work, and avoid repeated activities with his right upper extremity.

There are various other medical and therapist records that comment on the claimant's ability to work, and some set forth restrictions. The claimant put into evidence a one-page statement showing periods of time that he either worked or performed uncompensated volunteer work, and which also projected salary differentials as compared (presumably) to the average weekly wage (AWW). There are no underlying financial records showing the source of such information.

The claimant sought disability from August 24, 1998, and not before that, as he had either been receiving unemployment compensation or was employed by his previous employer. He testified that he accepted another job on August 24, and started September 1, 1998, at 20 hours a week, doing design work using the computer. He said that on the first day he discovered he was not able to work as he used to and could not keyboard for more than 15 to 20 minutes at a stretch. The claimant said that he was not able to perform the type of work he used to do. He said he actively sought work from time to time and was always willing to work but, based on his experience, could work no more than 10 hours a week, with no more than an hour a day computer work. (He noted that the treating doctor had also imposed such a restriction.)

The claimant's work history chart indicated that he worked for his 1998 employer from September 1, 1998, through November 25, 1998. The claimant stated that he completed three-week contracts for the same employer in December 1998 and February 1999. His chart indicated that he earned no wages for his February work. He also testified about a brief period of employment from October 1999 through November 1999 (his chart showed September 29 through November 2, 1999). The claimant stated that when he said he was "self-employed," that meant that he was doing contract work. At the very end of the CCH, the ombudsman asked the claimant what his AWW had been and he responded that it was $1,300.00 a week; this amount was unrefuted by the carrier.

Finally, the carrier indicated that it was not disputing IR and had paid benefits based upon the treating doctor's six percent IR. The claimant was asked if he had

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[2] While the hearing officer has evidently taken a position from the limited medical records presented at the CCH about whether this work hardening was necessary, this was a matter outside his jurisdiction in the case, and relevance of this to the issues he was asked to determine was not explained. The Medical Review Division retains primary authority to determine, from the full array of medical records, whether such treatment was necessary, if a proper dispute is filed.

disputed this rating and he said no, after a hesitation, because he had "signed . . ." (he did not complete the sentence).

"PURGED EXHIBITS"

The lengthy appeal is full of references and protests about what the claimant has described as "purged" exhibits, some of which, he asserts, would have clarified the issue of whether the designated doctor in this case was an agreed designated doctor and would further have explained his case. His appeal indicates that the hearing officer in some manner forced the "excision" of the exhibits that he brought to the CCH and had intended to offer.

The cover sheet for the claimant's exhibits lists several as "withdrawn." This designation does not reflect what occurred at the beginning of the record of this CCH. After preliminary announcements and identification of the parties and issues before him, the hearing officer immediately took up the exhibits of the claimant and began reading what they were into the record; on the exhibits characterized on the cover sheet as "withdrawn," the hearing officer announced "not offered." No discussion on the record preceded this characterization by the hearing officer. This sequence of events leads the Appeals Panel to conclude that there was a preliminary proceeding considering such records in which objections and rulings may have been made on these records, action that the claimant argues on appeal was a "purge."

Absent a record, and given that these documents have not been included in the record for purposes of appeal, we cannot evaluate how these records came to be "not offered" or whether they were "purged." The Appeals Panel has either not been furnished with the tape of such proceedings or a preliminary disposition was not recorded and preserved. We have previously stated that when questions arise, any discussion concerning documents considered in resolving those questions should be included in the record. Texas Workers' Compensation Commission Appeal No. 982586, decided December 17, 1998; *see also* Texas Workers' Compensation Commission Appeal No. 93178, decided April 26, 1993; Texas Workers' Compensation Commission Appeal No. 960420, decided April 11, 1996; Texas Workers' Compensation Commission Appeal No. 970474, decided April 30, 1997; and Texas Workers' Compensation Commission Appeal No. 970534, decided May 1, 1997. When it is clear that preliminary discussion about exhibits will not result in simple admission of everything a party has brought to the CCH, preliminary proceedings should be recorded.

Consequently, we reverse and remand in part so that the disposition of records that were brought to the hearing may be put into the record. Objections to any records should emanate from the parties and then be ruled on by the hearing officer. Exhibits may, of course, be voluntarily withdrawn or not offered, but this should also be conducted within a reviewable record.

OTHER EVIDENTIARY MATTERS

It is clear that at least two important matters about which the hearing officer indicates confusion, the nature of the accepted injury as well as whether the designated doctor in this case was an agreed designated doctor, may be resolvable by stipulation of the parties.

We note that while the claimant's upper extremity injury may have been difficult to diagnose, as the hearing officer notes at length, the existence of such injury was stated to be undisputed by the carrier, who should have an idea of what injury has been accepted by the carrier such that a stipulation could be made.[3] The parties may also wish to stipulate as to the amount of AWW. The CCH on remand should include consideration of stipulations on matters not in dispute.

MMI AND THE DESIGNATED DOCTOR'S REPORT

The carrier's RME doctor issued a report on January 19, 1999, after examining the claimant.[4] In the report, the RME doctor started out by noting that the claimant has "essentially" reached MMI. While he noted that the claimant had been recommended for surgery, the RME doctor dispensed with this recommendation by finding that the claimant's symptoms are not really compatible with CTS. He stated that because he was unaware of any further treatment that would significantly change the claimant's status, the claimant was, by definition, at MMI, and the date of MMI would be June 8, 1998, as it did not appear to the RME doctor that there was medical treatment after that date.[5] He opined that the claimant had an IR for sensory deficits. The RME doctor went on to say that the claimant has been on leave since December 15, 1998, due to atrial fibrillation problems. The doctor noted impressions of overuse syndrome of the right upper extremity and possible ulnar neuritis. His cover letter stated that the claimant's treatment was, at that point, reasonable and necessary and that the claimant should avoid repetitive work.

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[3] We observe that the carrier stated in final argument that the injury was thoracic outlet syndrome of the wrist.

[4] The RME doctor's complete report must be derived from reading each copy of the incomplete reports that the parties have put into evidence; the claimant's copy has both pages of the cover letter in evidence, while the carrier's copy, which lacks this page, includes a narrative attached to the report.

[5] While we would agree that a benefit CCH is not the forum for adjudicating denials of medical treatment by the carrier, such denial would be relevant in assessing the basis of the RME's stated reason for determining MMI on a date when active medical treatment appeared to have ceased.

The claimant was subsequently evaluated by the designated doctor on August 23, 1999, who found that the claimant had not reached MMI. A TWCC-69 was completed in connection with this examination.

On August 8, 2000, the RME doctor reexamined the claimant. Although the doctor stood by his earlier MMI date, in the very next sentence he noted that the conditions leading to his earlier assessment of a four percent IR, presumably permanent, "are no longer present" and that there was no clinical evidence of strength or sensory deficits. The basis for standing by the earlier MMI date is recited as the claimant's subjective statements that he has improved with pain felt only after exercise. The RME doctor expressed uncertainty about the nature of the claimant's problem, speculating that he could have a rheumatological or connective tissue disease. The RME doctor concluded by assigning a zero percent IR.

The designated doctor reexamined the claimant on November 10, 2000, and certified on a TWCC-69 that the claimant had not yet reached MMI. During the CCH, the hearing officer asked if the designated doctor was agreed upon or had been appointed by the Texas Workers' Compensation Commission (Commission). When the claimant said she was an agreed designated doctor, the hearing officer said he did not think so because he had not seen one in years. The claimant readily agreed that this was unusual, as he had been so told (by a person whose name was not audible). When the hearing officer responded that it was refreshing to see one, both parties are heard to chuckle. The hearing officer made no indication that he required further proof on the matter. The carrier's representative did not dispute that the designated doctor was agreed upon by the parties. Because of this, we are unable to concur with the hearing officer's observation that "the record is unclear" on this point.

We agree that the hearing officer erred in denying presumptive weight to the designated doctor's report. Although it appears from the record that the designated doctor was agreed upon by the parties, Section 408.122(c) does not contain a provision for giving conclusive weight regarding MMI to the report of such a doctor, although it is conclusive on IR (Section 408.125(d)). However, the designated doctor's report is still entitled to presumptive weight regarding MMI unless overcome by the great weight of contrary medical evidence. A "great weight" is more than a preponderance. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992.

There are no findings of fact nor is it indicated in the discussion how the report of the designated doctor is overcome by a great weight of the contrary medical evidence. We have stated that such findings of fact must be made when the report of the designated doctor is not given presumptive weight. Texas Workers' Compensation Commission Appeal No. 012471, decided November 30, 2001; Texas Workers' Compensation Commission Appeal No. 980995, decided June 22, 1998; Texas Workers' Compensation

Commission Appeal No. 961269, decided August 14, 1996; and Texas Workers' Compensation Commission Appeal No. 951125, decided August 28, 1995.

The discussion in the decision focuses only on the reports of the RME doctor as being "contrary" to the reports of the designated doctor. We cannot agree that the RME doctor's reports constitute a "great weight" of evidence against the reports of the designated doctor. As the claimant correctly notes, the assertion of the RME doctor that his previous MMI date is correct, even as he lowered the IR to zero percent based upon complete resolution of the previously assessed sensory deficit, shows that MMI was not reached at the earlier date. We are unwilling to hold that a decrease in IR from four percent to zero percent is not a "material recovery" as that term is used in the 1989 Act. Section 401.011(30)(A).

Because there are no findings describing how the great weight of medical evidence overcomes the designated doctor's report on MMI, and no medical evidence that sufficiently supports the generalized finding of a contrary "great weight," we reverse the decision of the hearing officer that the report of the designated doctor was not entitled to presumptive weight and render a decision giving presumptive weight to the designated doctor's reports that the claimant had not reached medical MMI as of the dates of those reports.

Whether and when the claimant reached MMI, by virtue of the statutory definition in Section 401.011(30)(B), is dependent upon the remanded issue of disability, specifically the date income benefits accrued.

DISABILITY

The claimant argued that he had disability from August 24, 1998, until January 1, 2001. He presented a chart outlining the periods of time that he was employed for wages (or when he volunteered his services) and what he projected as his lost wages when compared to his preinjury wages. This chart seems clear. Perhaps the hearing officer's expressed confusion and concern about the "fuzziness" of the records was due to the claimant's general testimony at the beginning of his case in chief that he also worked frequently out of his home. The claimant later stated, however, that he was doing the contract work on his list during these periods of self-employment. While underlying financial records might assist a hearing officer by corroborating testimony about diminished wages, such records are not required to support any findings of disability.

During opening statement and throughout its case, the carrier disputed disability because there was no "medical" establishing disability and because the claimant "worked" during portions of the period sought. The carrier also indicated in final argument that it believed temporary income benefits could only be due during periods of time when the claimant was not working at all. While medical evidence or work history is certainly

relevant to disability, neither is dispositive. Disability is an economic concept and it is possible for disability to exist where an injured worker returns to work but at wages less than the preinjury AWW. Section 401.011(16). A claimant's testimony alone, if believed, is sufficient to establish that an injury has caused disability. Gee v. Liberty Mutual Fire Insurance Company, 765 S.W.2d 394 (Tex. 1989). Medical evidence is not required to establish disability. Texas Workers' Compensation Commission Appeal No. 92500, decided October 30, 1992. A release to work with restrictions is evidence that disability continues. Texas Workers' Compensation Commission Appeal No. 950246, decided March 31, 1995; Texas Workers' Compensation Commission Appeal No. 91045, decided November 21, 1991.

Although the claimant argues "disability" in terms of whether he could return to his former job, this is also not dispositive if the claimant had the ability to work at another job equivalent to his preinjury AWW. The claimant bears the burden of proving both reduced wage and its connection to his injury. It appears from the evidence presented, including testimony, that the claimant was never reemployed for $1,300.00 a week. However, a voluntary reduction of wages (through, for example, volunteer work) or an inability to work, which results solely from an unrelated medical condition[6], may likewise preclude a finding of disability.

We are remanding the disability issue for reconsideration, in light of our decision giving presumptive weight to the designated doctor's report. Reconsideration of disability should be made with reference to the definition of disability in the 1989 Act. Section 401.011(16). The hearing officer should determine when the eighth day of disability occurred, and from that date whether and when the claimant reached "statutory" MMI during the period of time preceding the designated doctor's report or the date of the CCH.

Because the unrefuted evidence indicates that the claimant's AWW was $1,300.00, and, further, that he was intermittently employed for periods of time at earnings less than the AWW, under restrictions from his doctors, any periods of time found not to constitute disability should include an explanation as to whether any other physical conditions were the "sole cause" of diminished earnings, whether there were other factors based upon the evidence which caused the injury not to be a producing cause of the inability to obtain and retain employment at wages equivalent to the preinjury AWW, or why evidence of AWW or postinjury earnings was found not credible by the hearing officer.

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[6] The carrier would bear the burden of proving that the atrial condition was the sole cause of the claimant's inability to work for any of the time period under consideration.

After consideration of relevant evidence, the hearing officer should determine the periods of disability with reference to the definition of disability, and further determine whether and when the claimant reached statutory MMI.

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 (amended June 17, 2001). *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **HARTFORD UNDERWRITERS INSURANCE COMPANY** and the name and address of its registered agent for service of process is

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Susan M. Kelley
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Michael B. McShane
Appeals Judge