APPEAL NO. 020426
FILED APRIL 3, 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 (CCH) was held on January 18, 2002. The record closed on February 1, 2002. The hearing officer determined that the respondent's (claimant) depression is part of the compensable injury of _____, and that the claimant's impairment rating (IR) is 18%. The appellant (self-insured) alleged nine points of error (each discussed below), and urged reversal of the decision. The claimant responded, urging affirmance. The self-insured replied to the claimant's response, and again urged reversal of the decision.

DECISION

Affirmed.

We first note that Claimant's Exhibit No. 4, identified as "Progress report, [Dr. K]," is not included in its proper place among the exhibits in the case file, nor was the so-marked exhibit located anywhere in the record (which consists of four boxes of exhibits and related paperwork, five audiocassettes, and two videotapes), which accompanied the case file. From the discussion on the record (tape 2, side 1) about the contents of Claimant's Exhibit No. 4, it is apparent that the exhibit was provided to Dr. K while he was testifying, and we suspect that it is now missing because it was not retrieved from him after completion of his testimony. There is a handwritten list of the claimant's exhibits which further identifies Claimant's Exhibit No. 4 as being dated "12-04-00" and consisting of three pages. With this information, we have discerned that duplicates of the missing exhibit are found at three places in the self-insured's exhibits. The duplicates are located in Carrier's Exhibit No. 17 as a two-page document which has different margins (pages which are Bates-stamped 20-21) and as a three-page document (pages which are Bates-stamped as 24-26), and in Carrier's Exhibit No. 42 as a three-page document (pages which are Bates-stamped 128-130). In view of the fact that the exhibit is in the record at other locations and available for our review, and in view of our disposition of the case, any error in not having the exact document that was admitted as Claimant's Exhibit No. 4 is harmless.

We note also from our review of the case file that there are two exhibits bearing the designation "Hearing Officer's Exhibit No. 12." The first is "Carrier's Motion to Compel Answers to Interrogatories," which was discussed on the record and denied, even though it is not listed with the other hearing officer exhibits. The second exhibit bearing the designation "Hearing Officer's Exhibit No. 12" is the claimant's written final argument. This document is listed with the other hearing officer exhibits and it is apparent the hearing officer has just erroneously used the designation "Hearing Officer's Exhibit No. 12" twice. We perceive no prejudice to either party as the first Hearing Officer's Exhibit No. 12 was included in the case file, and the hearing officer provided a ruling on the motion.

The self-insured's first point of error is that the hearing officer improperly determined that the claimant sustained a compensable injury on _____ (Finding of Fact No. 2 and Conclusion of Law No. 3). The self-insured asserts that it raised the issue of "What is the extent of the [claimant's] injury?" at the August 13, 2001, benefit review conference (BRC), and again in its response to the benefit review officer's (BRO) report filed with the Texas Workers' Compensation Commission (Commission) on September 5, 2001. The self-insured also requested at the CCH that the issue relating to depression be changed to extent of injury as phrased above. The hearing officer denied that request at the beginning of the CCH and again at the end of the hearing, limiting the issue to that which had been certified at the BRC. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 142.7 (Rule 142.7), at subsections (d) and (e), is pertinent. Subsection (d) provides that additional disputes "not identified as unresolved in the [BRO's] report" may be added "by unanimous consent"; the consent shall be signed by all parties, be in writing, be sent to the Commission at least 10 days before the hearing, and explain why the issue was not raised earlier. Subsection (e) then states that additional disputes "not identified as unresolved" may be added by determination of the hearing officer based on a finding of good cause; this request shall be in writing, give the reason for the request, and shall be sent to the Commission no later than 15 days before the hearing. The request to add this issue was not done "by unanimous consent" nor did the hearing officer find that there was good cause to add the issue. We discern no error by the hearing officer in not adding the issue.

The claimant testified that the incident giving rise to the claim in this case was an electric shock injury sustained on _____. The claimant alleged that while cleaning a dishwasher she was shocked and thrown across the room. She initially reported the electric shock and problems with her ear, but soon thereafter complained of injuries to her neck and both shoulders, and also of migraine headaches. She was treated for those injuries and eventually sent to participate in a pain management program. The medical records document complaints of nightmares about being electrocuted and of mood swings, which caused the claimant trouble in dealing with her family. The claimant was eventually sent to see Dr. K for symptoms of chronic pain syndrome, including depression. Dr. K is a psychiatrist and confirmed that the claimant has been diagnosed with depression. He testified that, in his opinion, the claimant was not pretending to be depressed in order to get drugs, nor was this a diagnosis of preinjury depression, but rather one of depression that is due to the claimant's chronic pain syndrome.

The self-insured's second point of error is that the hearing officer improperly determined that the claimant suffered damage or harm to the physical structure of the body and a disease naturally resulting from the damage or harm in the form of depression while in the course and scope of her employment on _____ (Finding of Fact No. 3 and Conclusion of Law No. 3). The self-insured asserts that there is no competent, objective medical evidence to indicate that the claimant's alleged depression is permanent. The self-insured presented evidence, primarily testimony from Dr. A and Dr. S-G, that the claimant may not be depressed, but that she only has symptoms of depression due to the prescription medications she is taking. There was conflicting evidence in the record from Dr. S, Dr. SA, Dr. M, and Dr. K, from which the hearing officer could conclude that the

claimant suffered from long-term depression, a psychiatric disease, and not just from symptoms of depression. Extent of injury is a factual question for the hearing officer to decide. Section 410.165(a) provides that the hearing officer, as finder of fact, is the sole judge of the relevance and materiality of the evidence as well as the weight and credibility that is to be given the evidence. It was for the hearing officer, as trier of fact, to resolve the inconsistencies and conflicts in the evidence. Garza v. Commercial Insurance Company of Newark, New Jersey, 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). This is equally true regarding medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). The trier of fact may believe all, part, or none of the testimony of any witness. Aetna Insurance Company v. English, 204 S.W.2d 850 (Tex. Civ. App.-Fort Worth 1947, no writ). The evidence is sufficient to support the hearing officer's determination that the claimant met her burden of proof to establish that depression is part of the compensable injury. By this determination, the hearing officer rejected the self-insured's arguments that there is no competent, objective medical evidence of depression and that the claimant's depression is not a permanent condition. We will reverse a factual determination of a hearing officer only if that determination is so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); Pool v. Ford Motor Company, 715 S.W.2d 629, 635 (Tex. 1986). Applying this standard of review to the record of this case, we decline to substitute our opinion of the credibility of the witnesses and the evidence for that of the hearing officer.

The self-insured's third point of error is that the hearing officer improperly determined that the correct IR is 18% based upon the certification of Dr. T, the designated doctor (Finding of Fact No. 4 and Conclusion of Law No. 4). As a preliminary matter, the self-insured asserts that the claimant provided no evidence at the CCH which suggested that Dr. T's amended report should be considered and adopted by the hearing officer. As pointed out by the claimant, Texas Workers' Compensation Commission Appeal No. 013042-s, decided January 17, 2002, is applicable to this issue. Rule 130.6(i) provides that responses by designated doctors to requests for clarification are considered to have presumptive weight as they are part of the doctor's opinion. For reasons set forth in Appeal No. 013042-s, we decided that Rule 130.6(i) would apply immediately to all cases involving requests for clarification. We reject the self-insured's position that Rule 130.6(i) would not be applicable to this case.

With regard to the IR issue, a summary of the relevant facts is necessary. Dr. T, the designated doctor, first evaluated the claimant on November 24, 1999. In his report, Dr. T stated, as to the date of maximum medical improvement (MMI): "No dispute. Sept 7, 1999." He went on to assign a rating of 4% under the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), Table 49, for specific disorders of the spine, and a rating of 2% for range of motion (ROM). Based on the combined value table, Dr. T assigned a whole person IR of 6%. The evidence indicates that on September 18, 2000, the claimant's attorney pointed out in a letter to a Commission Disability Determination Officer (DDO) that Dr. T had invalidated ROM impairment based on lack of

consistency, and he requested that, in accordance with Rule 130.6(k), a new evaluation by the designated doctor be scheduled. The claimant's attorney followed up with a second letter to the DDO on October 31, 2000, referencing the earlier request. On November 15, 2000, the DDO sent a letter to Dr. T, mentioning that there was a dispute regarding the invalidation of ROM impairment based on lack of consistency. The DDO then said: "Please advise if you are willing to retest the cervical ROM. If so, please contact the Commission to reschedule the appointment. If you are not willing to retest, please explain." By letter dated December 11, 2000, Dr. T responded that he would be glad to recheck the claimant for cervical ROM. The self-insured was advised of the possibility of a reexamination by the designated doctor, and objected to any reexamination being done, primarily on the basis that a reexamination by the designated doctor was not authorized by the 1989 Act. Despite the self-insured's objections, the claimant was seen by the designated doctor on February 12, 2001. The claimant had been treating with various doctors, had been through a pain management program, had been hospitalized for 39 days in a locked hospital psychiatric ward, and was continuing to treat with a psychiatrist. The claimant's attorney submitted matters to the Commission which were forwarded to the designated doctor for his review. Although the self-insured lodged a continuing objection to a reexamination by Dr. T, the self-insured submitted questions for Dr. T to answer and material to be considered by Dr. T, but such items apparently were not sent to or considered by Dr. T. Dr. T noted that he received the documentation provided to the Commission by the claimant's attorney after he saw the claimant on February 12, 2001, and updated his report on February 20, 2001. He listed the documentation which he reviewed at the end of his Report of Medical Evaluation (TWCC-69). One of the items he reviewed was the transmittal letter from the claimant's attorney providing the records to the Commission field office, which included a request to "[a]sk him whether based on the history of depression resulting from the compensable injury he will award a rating for the depression." In listing the claimant's diagnoses, Dr. T wrote, "Depression, has been determined to be related to the injury and chronic pain. Class 2 to Class 3 impairment in activities of daily living, social functioning, concentration and adaptation." Dr. T then assigned a Table 49 rating of 4% for cervical strain, 0% for ROM, and 15% for depression, from chronic pain and, using the combined value table, certified a whole person IR of 18%.

The self-insured objects to the IR of 18% as being improper because it includes a 15% rating for depression which is not based on objective clinical or laboratory findings, that the rating is based upon "false information he was provided by the claimant's attorney," and that Dr. T did not administer any psychological tests to the claimant or rely on any objective medical tests.

While it is unfortunate that the self-insured's questions and material for the designated doctor's consideration did not get to the designated doctor before he performed his reexamination, in preparation for this CCH the self-insured was permitted to take the deposition of Dr. T on written questions. The hearing officer reviewed the questions prior to submission to Dr. T and permitted 96 of 133 proposed questions as written, and one other as modified. The hearing officer concluded that the self-insured obtained answers to all of the questions submitted earlier, and that the self-insured was not harmed by the

oversight of the Commission in not providing the questions to the designated doctor before the reexamination. We agree. The self-insured had the answers to the relevant questions prior to the CCH, and has made full use of the information to present its case at the CCH and on appeal.

Under procedures which have been utilized for some time, a designated doctor is permitted to provide an IR for any medical condition with which a claimant has been diagnosed. Separate ratings should be provided for each such diagnosis. A designated doctor's opinion as to the compensability of an injury or the extent of an injury is not entitled to presumptive weight; it is the hearing officer who determines compensability and extent of injury. Texas Workers' Compensation Commission Appeal No. 941023, decided September 13, 1994. In its reply brief, the self-insured references Section 408.0041(a)(1), effective June 17, 2001, for the proposition that the designated doctor is required to determine the nature and extent of the injury that is being rated. The self-insured is reading that section incorrectly, as cross-referencing to the new Rule 130.6(d)(5) shows:

> When the extent of injury may not be agreed upon by the parties (based upon documentation provided by the treating doctor and/or carrier or the comments of the employee regarding his/her injury), the designated doctor shall provide multiple certifications of MMI and [IRs] that take into account the various interpretations of the extent of injury so that when the commission resolves the dispute, there is already an applicable certification of MMI and rating from which to pay benefits as required by the statute.

If the hearing officer decides that the compensable injury includes less than was rated by the designated doctor, the hearing officer is permitted to recalculate the IR, including only such conditions as are found to be compensable. The designated doctor's rating provided a separate rating for each of the claimant's conditions, and the hearing officer determined which would be included in the compensable injury. In this case, the hearing officer was persuaded that depression is included in the compensable injury, and he accepted the entire rating of the designated doctor. In view of that determination, we discern no prejudice to the self-insured from Dr. T having the perception that the claimant's depression had already been determined to be related to her injury at the time that he saw her on February 12, 2001. Dr. T evaluated the claimant and the records that were provided, and was satisfied that the claimant's depression warranted a 15% IR. Despite the self-insured's contentions to the contrary, the hearing officer was satisfied that Dr. T was basing his rating on signs of depression as observed and noted by other doctors, and that doing so was a proper use of professional judgment and within the spirit and letter of the AMA Guides. We reject the self-insured's arguments that the 18% IR was improperly calculated.

The report of the designated doctor (including a clarification under Rule 130.6(i)) has presumptive weight, and the Commission shall base its determination as to the IR on that report "unless the great weight of the other medical evidence is to the contrary." Section 408.125(e). The presumption afforded the designated doctor's report and certification IR

is not rebutted "absent a substantial basis to do so." Texas Workers' Compensation Commission Appeal No. 950561, decided May 22, 1995, citing Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993. The designated doctor has a certain amount of discretion in assigning an IR based on his evaluation of an employee and his interpretation of the AMA Guides. *See* Texas Workers' Compensation Commission Appeal No. 962195, decided December 18, 1996. A mere difference of medical opinion is not enough to overcome the presumption afforded the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 960034, decided February 5, 1996. Whether the party challenging a designated doctor's report has produced the great weight of other medical evidence contrary to the report and whether the presumption afforded to the report is rebutted are questions of fact for the hearing officer. Appeal No. 950561, *supra.* The hearing officer determined that the 18% IR certified by the designated doctor, pursuant to the request for clarification, is not against the great weight of medical evidence. This tribunal will not upset the challenged factual findings of a hearing officer unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust. Cain, *supra*; In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). We do not find them so here.

The self-insured's fourth point of error is that the hearing officer improperly determined that the certification of 18% IR by Dr. T is not against the great weight of medical evidence (Finding of Fact No. 5 and Conclusion of Law No. 4). The essence of the self-insured's argument is that the designated doctor did not properly follow the AMA Guides because the AMA Guides do not provide for the rendition of a numerical IR for mental or behavioral disorders. As we said in Texas Workers' Compensation Commission Appeal No. 960420, decided April 11, 1996:

> The Appeals Panel has previously rejected the argument that the AMA Guides cannot be used to assess mental and emotional impairment, or that the Tables in Chapter 4 of the AMA Guides cannot be used to calculate impairment percentages. Texas Workers' Compensation Commission Appeal No. 951447, decided October 9, 1995.

We adhere to our previous ruling.

The self-insured's fifth point of error is that the hearing officer erred by not considering the issue "Why the Commission failed and/or refused to comply with the [1989] Act and its own Rules regarding the designated doctor and his opinion making process." The hearing officer denied the request that the above be added as an issue because he lacked jurisdiction to decide such a question and because it was encompassed within the dispute related to the IR. We agree. As phrased, the "issue" is not one which can be decided by a hearing officer, and, as the evidence developed, the hearing officer heard all about the self-insured's specific complaints about how the designated doctor process was accomplished in this case. Implicit in the hearing officer's decision in this case, and explicit in our decision is that there has been substantial compliance with the 1989 Act and no prejudicial legal error has resulted.

The self-insured's sixth point of error is that the hearing officer erred by denying or disregarding the self-insured's eight requests for official notice. Four of the requests for official notice were granted, two were denied as unnecessary, and two were denied as improper. The requests for official notice of two irrelevant versions of the AMA Guides were properly denied. The requests for official notice of the preamble to Rule 130.1 and specific provisions of the 1989 Act were denied as unnecessary, as the hearing officer could properly consider those matters without taking official notice. The other four requests were granted, and we can discern no basis for the assertion that the hearing officer disregarded the requests for official notice. The two sources of which the hearing officer took official notice cover all four requests for which official notice was granted.

The self-insured's seventh point of error is that the hearing officer erred in determining that an agreement was reached between the claimant and the self-insured regarding the reevaluation of the claimant by the designated doctor and/or it appears that the Commission felt there was an agreement made between the parties and acted on such an agreement. While the hearing officer discusses the history of this case in the Statement of the Evidence, and refers to the matters stated above, those matters do not have any impact on the ultimate resolution of this case. We have held that the hearing officer had sufficient evidence from which he could determine whether depression was part of the compensable injury and from which he could determine the claimant's IR. Those were the issues before the hearing officer, and we conclude that he could properly reach the decisions he reached.

The self-insured's eighth point of error is that the hearing officer erred by not following the prior ruling of the Commission on the claimant's IR. The carrier asserts that res judicata and collateral estoppel apply because "In [Medical Review Division] Tracking No. M2-01-0059-01, dated October 16, 2000, the Commission's Medical Review Division in its Decision found that the '[p]er the designated doctor, claimant was documented to have reached MMI on 9/7/99 with a 6% Whole Body Impairment Rating. This Decision is now final." The above-quoted matter is from the self-insured's appeal, page 40. The matter between the quotation marks is the entirety of the quoted paragraph. The single quotation mark before "[p]er" purports to start a quote from the referenced document [Carrier's Exhibit No. 32, pages Bates-stamped 565-571, at page Bates-stamped 570], but there is no quote mark to end the quoted material. A check of the exhibit shows that the ending quote mark should be after the word "Rating." The comment "This Decision is now final" belongs to the appeal writer, and is not part of the referenced Medical Review Division Decision. As presented in the appeal, this information is wrong and misleading. Further, it has no applicability to this case. The Medical Review Division was considering the issue of preauthorization of a 30-day chronic pain treatment program for the claimant, and we view the recitation of MMI and IR to be nothing more than an historical statement of the facts as they appeared to be before the Medical Review Division as that division evaluated whether the proposed medical treatment was medically necessary and appropriate. The Medical Review Division is not charged with determining either MMI or IR. The Medical Review Division adjudicates medical disputes. It did not, and could not, resolve either MMI or IR, and the historical mention of MMI and IR in a medical dispute

ruling does not serve as a decision of either MMI or IR. This point of error is without merit.

The self-insured's ninth point of error is that the hearing officer erred by failing or refusing to comply with the 1989 Act and the Commission's own rules regarding the designated doctor and his opinion-making process. The assertion here is that the 1989 Act and rules do not state that the Commission can seek clarification of the designated doctor's report from the designated doctor or anyone else. The self-insured cites to provisions of Rule 130.6 [effective January 25, 1991], which do not mention clarification of the designated doctor's opinion. We note that under Rule 130.6(i), effective December 1, 1995, communications with a designated doctor after an examination is completed may only be made through appropriate Commission staff members. (That provision is now located in Rule 130.5(d)(4), effective January 2, 2002.) *See, also,* Section 408.125(f) for injuries before June 17, 2001. Since we can conceive of no particular reason for a Commission staff member to contact a designated doctor after the examination is done, other than to request a clarification on some aspect of the designated doctor's report, we conclude that it is appropriate to seek clarification when it is believed to be necessary. We cite the self-insured also to the new Rule 130.6(i), effective January 2, 2002, which speaks directly to Commission requests for clarification from the designated doctor. As the self-insured concedes, our precedent has held that clarification may be sought from the designated doctor, and we will continue to follow that precedent.

For the foregoing reasons, we affirm the decision and order of the hearing officer.

The true corporate name of the insurance carrier is **TEXAS EDUCATION ENTITY COOPERATIVE** and the name and address of its registered agent for service of process is

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Michael B. McShane
Appeals Judge

CONCUR:

Elaine M. Chaney
Appeals Judge

Terri Kay Oliver
Appeals Judge