APPEAL NO. 071108-s
FILED AUGUST 15, 2007

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 May 11, 2007. The hearing officer resolved the disputed issues by deciding that the appellant (claimant) sustained a compensable injury on _____, and has sustained disability from August 16 through October 16, 2006. The claimant appealed, disputing the period of disability determined by the hearing officer. The claimant argues the hearing officer used an arbitrary period of disability set forth in the current edition of The Medical Disability Advisor, Workplace Guidelines for Disability Duration, excluding all sections and tables relating to rehabilitation published by the Reed Group, Ltd. (MDA) rather than rely on the medical evidence. The appeal file does not contain a response from the respondent (carrier).

The hearing officer's determination that the claimant sustained a compensable injury on _____, was not appealed and has become final pursuant to Section 410.169.

DECISION

Reversed and remanded.

The claimant testified that she was working as a material handler and while unloading a pallet, stacked with heavy boxes, she felt a sharp pain shoot through the middle of her back. The hearing officer noted in her Background Information that the claimant injured her neck and back as a result of this activity. The hearing officer found that on _____, the claimant sustained damage or harm to the physical structure of her body while she was engaged in the exercise of her job duties with the employer. Neither that finding nor the determination that the claimant sustained a compensable injury on _____, was appealed. The medical records in evidence reflect that the claimant has been treated for cervical radiculitis, "history of small disc herniation at C5-6 and C6-7" and myofascial syndrome of the "multifidus muscle or the right side at level T2." An operative report dated September 19, 2006, described the epidural steroid injection (ESI) the claimant underwent and contains pre-procedure and post-procedure diagnoses of chronic intractable cervicalgia and cervical radiculitis bilateral upper extremity.

Whether or not the claimant had disability was a disputed issue for the hearing officer to resolve. The hearing officer noted that the claimant was an exceptionally reliable witness, demonstrating an excellent and consistent recall of the details relevant to her case. However, the hearing officer then referenced both the MDA and the Official Disability Guidelines-Treatment in Workers' Comp published by Work Loss Data Institute

(ODG)[1] stating the MDA and ODG indicate that it is not appropriate to determine the claimant has sustained the full extent of disability alleged. The hearing officer referenced that the "guidelines contemplate that an injured worker in a physically demanding job, such as claimant described, would be expected to be off work a maximum of approximately two months for a sprain/strain injury to the neck or back." The hearing officer noted that the "[t]reatment [g]uidelines indicate that this type of injury generally resolves spontaneously within the time frame noted above [two months]."

The evidence reflects that the claimant was examined by a designated doctor on April 27, 2007, and that the purpose of the exam was to determine: (1) maximum medical improvement (MMI); (2) the claimant's impairment rating (IR); (3) the extent of the compensable injury; (4) whether the employee's disability is a direct result of the work related injury; (5) the ability of the claimant to return to work; and (6) reasonable and necessary medical treatment. With respect to the issues in dispute at the CCH, the designated doctor concluded the claimant's injury is directly caused by her on the job injury and that the claimant is able to return to work in a light duty capacity with a Functional Capacity Evaluation (FCE) to consider what type of duties are appropriate. There was no evidence that a FCE had been conducted as of the date of the CCH. The designated doctor states the injured and treated areas were the thoracic and lumbar spine but lists the cervical ESI performed on September 19, 2006, under her treatment history. The designated doctor opined that the extent of the compensable injury is "thoracic and lumbar spine" without further explanation. However, in assessing impairment the designated doctor rated the cervical spine as well as the thoracic and lumbar spine. No alternative ratings were provided. The narrative report from the designated doctor is internally inconsistent in that it does not identify the cervical spine as part of the compensable injury but assigns permanent impairment for the cervical region when assessing the claimant's IR. Further, although one of the purposes of the examination by the designated doctor was to determine the extent of the compensable injury, the designated doctor in response simply identifies the thoracic and lumbar levels of the spine without further explanation. The medical records in evidence indicate the claimant was treated for conditions beyond that of a sprain/strain and had been referred to pain management.

Rule 126.7(c) provides that a designated doctor examination shall be used to resolve questions about the following: (1) the impairment caused by the employee's compensable injury; (2) the attainment of MMI; (3) the extent of the compensable injury; (4) whether the employee's disability is a direct result of the work-related injury; (5) the ability of the employee to return to work; or (6) issues similar to those described by (1)–(5). Rule 126.7(d) provides that the report of the designated doctor is given presumptive weight regarding the issues in question and/or dispute, unless the preponderance of the evidence is to the contrary. Rule 126.7 became effective on

[1] We note that 28 TEX. ADMIN. CODE §137.100 (Rule 137.100) provides that the health care providers shall provide treatment in accordance with the current edition of the ODG, excluding return to work pathways. Rule 137.100(h) provides that Rule 137.100 applies to all health care provided on or after May 1, 2007.

January 1, 2007, and provides in subsection (w) that a request for a designated doctor under its provisions may be made on or after January 1, 2007.

Rule 137.10(a) provides that insurance carriers, health care providers, and employers shall use the disability duration values in the current edition of the MDA (Division return to work guideline) as guidelines for the evaluation of expected or average return to work time frames. Rule 137.10(c) provides that the Texas Department of Insurance, Division of Workers' Compensation (Division) return to work guidelines shall be presumed to be a reasonable length of disability duration and explains how health care providers, insurance carriers, employers, and injured employees are to use the guidelines. However, Rule 137.10(e) clarifies that the disability duration values in the guidelines are not absolute values and do not represent specific lengths or periods of time at which an injured employee must return to work. Further, Rule 137.10(d) provides that the health care provider, insurance carrier, employer, and Division may consider co-morbid conditions, medical complications, or other factors that may influence medical recoveries and disability durations as mitigating circumstances when setting return to work goals or revising expected return to work durations and goals. Rule 137.10(g) provides that Rule 137.10, which was adopted January 18, 2007, is effective on or after May 1, 2007. Rule 137.1(b) adopted January 18, 2007, provides in part that disability management tools, such as return to work guidelines, may be used by the Division to resolve income benefit disputes.

Both at the CCH and on appeal, the claimant argues that she had disability from August 16, 2006, through the date of the CCH.[2] Although the beginning date of disability was prior to the effective date of the adoption of the MDA by the Division as guidelines for the evaluation of expected or average return to work time frames, a portion of the disability period in dispute extends beyond May 1, 2007, the effective date of the adoption of the MDA as a return to work guideline. Since part of the claimed disability period was after May 1, 2007, it was not error for the hearing officer to consider the Division return to work guidelines in making her disability determination.

As previously stated, the report of the designated doctor on the issue of the ability of the employee to return to work is given presumptive weight, unless the preponderance of the evidence is to the contrary. Although Rule 137.10 provides the MDA shall be presumed to be a reasonable length of disability duration, the rule clarifies that the MDA provides disability duration expectancies and is not an absolute value and does not represent specific lengths or periods of time at which an injured employee must return to work. The designated doctor examined the claimant and reviewed her medical records and opined that the claimant could work light duty with a FCE evaluation to consider what type of duties are appropriate. It is apparent from her discussion, that the hearing officer believed that the evidence established that the claimant's job was physically demanding.

[2] We note that the hearing officer's statement that the claimant had not worked since August 16, 2007, is clearly a typographical error since at the date of the CCH, August 16, 2007, had not yet occurred.

The hearing officer does not discuss the designated doctor's report in her discussion of the evidence. We note that it is not necessary for the hearing officer to discuss each piece of evidence and she acknowledges that all of the evidence was considered. However, the hearing officer failed to make a finding that a preponderance of the evidence was contrary to the designated doctor's report. She simply stated "it appears logical to conclude that claimant sustained disability from August 17 through October 16, 2006." The narrative report of the designated doctor was internally inconsistent as previously discussed.

Therefore, we remand this case back to the hearing officer to send a letter of clarification to the designated doctor. The hearing officer should first determine if the designated doctor is still qualified and available. If the designated doctor is no longer qualified or is unwilling to serve as designated doctor, another designated doctor will have to be appointed. The hearing officer should then send a letter of clarification to the designated doctor. The letter should:

(1) inform the designated doctor that the Division has adopted the MDA as its return to work guidelines;

(2) inform the designated doctor that the parties pursuant to Rule 137.10(a) shall use the disability duration values in the current edition of the MDA as guidelines for the evaluation of expected or average return to work timeframes;

(3) inform the designated doctor that the Division return to work guidelines shall be presumed to be a reasonable length of disability duration but are not absolute values and do not represent specific lengths or periods of time at which an injured employee must return to work in the event the designated doctor wants to point to co-morbid conditions, medical complications, or other factors that may influence medical recoveries and disability durations as mitigating circumstances in giving his opinion regarding the claimant's ability to return to work; and

(4) inform the designated doctor of the claimant's specific job classification (sedentary, light, medium, heavy, or very heavy) because the disability duration values in the MDA are tied to job classifications.

If the hearing officer is unable to make a determination regarding the claimant's MDA job classification, she should request additional information from the parties to enable her to make such determination regarding the claimant's job classification prior to sending the letter of clarification. The hearing officer should point out the inconsistencies in the designated doctor's narrative and ask him to answer the extent of injury question with more specificity. The hearing officer should forward the designated

doctor's response to the letter of clarification to the parties and give them an opportunity to respond prior to making a determination regarding disability.

We note that an extent-of-injury issue was not in dispute at the CCH. However, use of the MDA requires knowledge of the specific condition or conditions that are part of the compensable injury. The disability duration tables differ not only according to job classifications but according to specified conditions. The Appeals Panel has held in the past that the resolution of a dispute over an IR cannot proceed unless the "threshold" issue of the extent of injury is resolved either by the parties or by the hearing officer even if not expressly raised by the parties. *See* Appeals Panel Decision (APD) 060170-s, decided March 22, 2006, APD 951097, decided August 17, 1995; and APD 941748, decided February 13, 1995. Similarly, consideration of the MDA requires knowledge of the specific conditions that are part of the compensable injury in order to determine the duration values listed. We caution however that diagnoses evolve over time and that claimants may claim that additional injuries and conditions are compensable. Nothing herein should be construed as limiting claimants from alleging that other conditions are included in the compensable injury. We further note that it has long been held that a claimant may have intermittent periods of disability. *See* APD 062634, decided March 1, 2007, and APD 012689, decided December 20, 2001. We note that the return to work guidelines are intended to be a starting place for the system participants to consider periods of disability and that Rule 137.1 states in part that return to work guidelines may be used by the Division to resolve income benefit disputes.

We reverse the hearing officer's disability determination. We remand this case back to the hearing officer for actions consistent with this decision and for reconsideration and to apply presumptive weight to the report of the designated doctor on the issue of disability and make a determination regarding the disability period, if any.

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 92642, decided January 20, 1993.

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

CORPORATION SERVICE COMPANY
800 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701.

_____
Margaret L. Turner
Appeals Judge

CONCUR:

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Thomas A. Knapp
Appeals Judge

_____
Veronica L. Ruberto
Appeals Judge