APPEAL NO. 101781
FILED FEBRUARY 24, 2011

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 20, 2010. The issues before the hearing officer were:

1. Does the respondent's (claimant) compensable injury of _____, extend to and include disc herniations at the L4-5 and L5-S1 spinal levels?

2. Has the claimant sustained disability since November 11, 2009?

3. Is the appellant (carrier) liable for payment of temporary income benefits (TIBs) based on the report of the designated doctor appointed to address the extent of the compensable injury and disability?

The hearing officer determined that: (1) the claimant's compensable injury of _____, does not extend to or include disc herniations at the L4-5 or L5-S1 spinal levels; (2) the claimant has sustained no disability since November 11, 2009; and (3) the carrier is liable for the payment of TIBs from April 12 through May 12, 2010.

The carrier appeals the hearing officer's determination regarding the carrier's liability for TIBs for the period of April 12 through May 12, 2010. In its appeal, the carrier argues that the hearing officer cannot find that the carrier is liable for one month of TIBs pursuant to Section 408.0041(f) because: (1) the hearing officer lacked the jurisdiction and authority to address the validity and reasonableness of the carrier's dispute; (2) the hearing officer determined there was no disability after November 11, 2009, therefore the dispute on the TIBs issue was resolved; and (3) the designated doctor was not appointed to determine whether disability was a direct result of the compensable injury but only to determine the extent of the compensable injury and the ability of the claimant to return to work (RTW); therefore, the hearing officer erred in finding benefits were owed based on the designated doctor's report. The appeal file does not contain a response from the claimant.

The hearing officer's extent of injury and disability determinations have not been appealed and have become final pursuant to Section 410.169.

DECISION

Reversed and rendered.

The claimant testified that he sustained a low back and left shoulder injury while at work on _____. It is undisputed that the claimant was initially diagnosed with a lumbar strain and left shoulder strain.

In evidence is an EES-14 letter dated March 24, 2010, in which the Texas Department of Insurance, Division of Workers' Compensation (Division) appointed (Dr. N) as the designated doctor to address the following: (1) determine the ability of the employee to RTW; and (2) determine the extent of the employee's compensable injury. There is no evidence that Dr. N was appointed to determine whether the claimant's disability is a direct result of the work-related injury.

In his report dated April 12, 2010, Dr. N stated he was requested to determine the ability of the employee to RTW and to determine the extent of the employee's compensable injury. In response to the first question, Dr. N stated:

> At this time, this patient is still undergoing physical therapy now with rehabilitative and aquatic therapy, I would suggest that this patient could potentially work light duty, half days at this current time, and also attending physical therapy; however, with continued success of the physical therapy and progression of his exercises, it is this examiner's feeling that this patient should be able to return to his regular duties at work. I would estimate that the patient will likely require between 30 and 60 days of physical therapy or potential work conditioning program to reestablish his strength and then should be reassessed potentially for potential return to a regular type of work he has performed in the past.

Dr. N attached to his report a Work Status Report (DWC-73) which states that the injured employee's medical condition resulting from the workers' compensation injury will allow the employee to RTW as of April 12, 2010, with the restrictions identified, specific to the left leg and back, which are expected to last through May 12, 2010. Dr. N determined that the extent of the compensable injury was a herniation of disc material at L4-5 with the decompression of the L4-5 and L5-S1 levels in the lumbar spine for treatment of radiculopathy or "lumbar spine with radiculopathy left leg."

In evidence is a PLN-11 dated May 23, 2010, in which the carrier disputed the claimant's entitlement of disability, stating:

> Carrier disputes that [the claimant] suffered disability. Any inability of [the claimant] to earn his preinjury wage is not a result of a compensable injury. [The claimant] was terminated from his employment for cause. Had [the claimant] not been terminated, he could have continued working for his employer, who could have accommodated his restrictions, earning his preinjury wage.

The claimant submitted to a post-designated doctor required medical examination by (Dr. M) on June 24, 2010. In his report, Dr. M stated:

> The patient was able to return to a light duty type position early on and within three weeks was released to full duty. . . .

* * * *

> Since the patient developed an acute lumbar radicular complaint and subsequently underwent surgery that in my opinion is unrelated to his original injury, he obviously at this point in time would be restricted potentially from doing heavy bending and lifting activities because of some continued complaints of a lumbar radicular nature.

Pursuant to Section 402.001(b), the Division was established "to administer and operate the workers' compensation system of this state as provided by this title." Pursuant to Section 410.002 and 28 TEX. ADMIN. CODE § 140.1 (Rule 140.1), the Hearings Division is given the authority to resolve benefit disputes, which are defined as a dispute regarding compensability or eligibility for, or the amount of, income or death benefits. Section 401.011(5) defines "[b]enefit" to mean a medical benefit, an income benefit, a death benefit, or a burial benefit based on a compensable injury.

Section 408.0041(a) provides that at the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about: (1) the impairment caused by the compensable injury; (2) the attainment of maximum medical improvement (MMI); (3) the extent of the employee's compensable injury; (4) whether the injured employee's disability is a direct result of the work-related injury; (5) the ability of the employee to RTW; or (6) issues similar to those described by Subdivisions (1)-(5). Rule 126.7(c)[1] 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 employee's compensable injury; (4) whether the employee's disability is a direct result of the work-related injury; (5) the ability of the employee to RTW; or (6) issues similar to those described by paragraphs (1)-(5) of this subsection.

Section 408.0041(f) provides, in part, that unless otherwise ordered by the commissioner, the insurance carrier shall pay benefits based on the opinion of the designated doctor during the pendency of any dispute. *See also* Rule 126.7(r) which provides that the insurance carrier shall pay any accrued income benefits, and shall begin or continue to pay weekly income benefits, in accordance with the designated doctor's report for the issue(s) in dispute, not later than five days after receipt of the report or five days after receipt of notice from the Division, whichever is earlier.

In the instant case, when Dr. N was appointed as the designated doctor to address the extent of the compensable injury and the ability of the claimant to RTW, the carrier was disputing the issues of extent of injury and disability. Pursuant to Section 408.0041(f) and Rule 126.7(r), the carrier was required to pay benefits in accordance with the designated doctor's report for the issues in dispute. However, there is no

[1] We note that the Division has adopted new rules concerning designated doctor scheduling and examinations effective February 1, 2011. The pertinent part of Rule 126.7(c) cited above is provided in the new Rule 127.1(a); however, the applicable rule in this case is Rule 126.7.

evidence that Dr. N was appointed by the Division to determine whether disability is a direct result of the claimant's compensable injury of _____. The hearing officer erred in finding that the Division appointed Dr. N as the designated doctor regarding the claimant's disability and in finding that Dr. N opined that the claimant had sustained disability from April 12 through May 12, 2010. Under the facts of this case, the hearing officer erred in finding that the carrier is liable for the payment of TIBs from April 12 through May 12, 2010, pursuant to Section 408.0041(f).

Accordingly, we reverse the hearing officer's decision that although the claimant's compensable injury of _____, does not extend to include disc herniations at the L4-5 or L5-S1 spinal levels, and although the claimant has not sustained the disability alleged, the carrier is liable for payment of TIBs from April 12 through May 12, 2010, pursuant to the opinion of the designated doctor. We render a new decision that the carrier is not liable for the payment of TIBs from April 12 through May 12, 2010.

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.

_____
Cynthia A. Brown
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Carisa Space-Beam
Appeals Judge