CONFIDENTIAL
Pursuant to Texas Labor Code
§402.083

DOCKET NO. 453-96-1907.C1
[TWCC VTRA #31011]

CIGNA INSURANCE COMPANY OF TEXAS,	§	BEFORE THE STATE OFFICE
Petitioner,	§	
	§	
VS.	§	OF
	§	
TEXAS WORKERS' COMPENSATION COMMISSION,	§	
Respondent.	§	ADMINISTRATIVE HEARINGS

DECISION AND ORDER

This case involves the request by the Petitioner, Cigna Insurance Company of Texas, for a hearing to contest the allegations made in the "Notice of Administrative Violation(s) and Order to Respond" relating to Violation No. 31011 which violation notice letter, dated September 16, 1996, was issued by the Texas Workers' Compensation Commission (the Commission). The hearing, originally scheduled for December 13, 1996, was delayed by extensive discovery and other procedural complications. The Commission asserted the Petitioner had wrongfully terminated benefits to an injured worker and had failed to timely reinstate those benefits. The Commission recommended the Petitioner be assessed an administrative penalty of $18,000.00. The Petitioner denied any wrongdoing. This decision finds the action against the Petitioner should be dismissed.

PROCEDURAL HISTORY

The case was hotly contested. The rancor and lack of cooperation between the parties ultimately resulted in sanctions being applied against the Texas Workers' Compensation Commission for abuse of the discovery process. As a consequence, it is necessary to set out the extensive procedural history. Those actions pertinent to the movement of the case through the hearing process are described below.

On October 4, 1996, Pacific Employers Insurance Company (Pacific), through its attorney, filed its Original Answer and Request for Hearing in response to the "Notice of Administrative Violation(s) and Order to Respond" issued by the Commission in regard to Violation No. 31011. A Notice of Hearing was issued by the Commission on October 15, 1996, setting the matter for hearing on December 13, 1996, before an Administrative Law Judge (ALJ) employed by the State Office of

Administrative Hearings (SOAH). By agreement of the parties, the hearing was continued to a later date.

On December 17, 1996, the Commission filed a motion to change the name of the Petitioner from Pacific to Cigna Insurance Company of Texas. On the same date, the first of a chain of discovery problems was evidenced by the Commission's motion to order the Petitioner to supplement its answers to the Commission's Request for Admissions and Interrogatories. On December 20, 1996, the Petitioner filed a motion seeking production of 161 groups of documents from the Commission. Included among the items sought were all documents in the Commission's possession related to a prior Commission appeals panel decision in a case which had been appealed to the District Court in Dallas County, Texas, (Employers Casualty Company v. Maximiliano Davis, Cause No. 92-119784 in the 134th Judicial District Court of Dallas County, Texas).

In response to the Commission's filing a request to depose one of the Petitioner's representatives with an accompanying subpena duces tecum, the Petitioner, on December 30, 1996, filed a motion for protective order asserting certain of the documents covered by the subpoena were protected by the attorney-client privilege, the attorney work-product exemption, the anticipation of litigation exemption, the party communication privilege, and as trade secrets. On January 8, 1997, Administrative Law Judge Sarah G. Ramos ordered the Petitioner to produce for an in camera review those documents for which it claimed an exemption. The documents were produced to Judge Ramos about January 15, 1997.

On January 10, 1997, the Commission filed its response to the Petitioner's December 20, 1996, motion for production. In its response the Commission contended that any document associated with the Davis case was confidential pursuant to §§402.083 and 402.091 of the Texas Workers' Compensation Act (the Act), TEX. LABOR CODE ANN. ch. 401 et seq. On January 24, 1997, the Commission filed a motion seeking to have the Petitioner compelled to respond to the Commission's Request for Admissions and Interrogatories. On the same date the Petitioner filed a motion seeking to have the Commission compelled to respond to the Petitioner's Motion to Produce and the Petitioner's Interrogatories. On January 30, 1997, in response to the Commission's filing a request to depose two of the Petitioner's representatives, the Petitioner filed a motion for protective order again asserting various privileges and exemptions and further contending some of the requests were vague, overly broad, unduly burdensome and a "fishing expedition."

Judge Ramos issued orders on February 18, 1997, allowing the depositions and inviting the Petitioner to file for an in camera inspection any documents it believed to be privileged.

Following a prehearing conference which convened on January 31, 1997, Judge Ramos issued an Order, dated February 4, 1997, which ordered: (i) the Petitioner to be identified as Cigna Insurance Company of Texas; (ii) the Petitioner to produce to the Commission specified documents which had been reviewed in camera; (iii) the Commission to produce various documents including those documents associated with the Davis case; and (iv) the case referred to a settlement conference. About February 4, 1997, the Petitioner produced the documents to the Commission as ordered by Judge Ramos. On February 10, 1997, the Commission filed a motion seeking reconsideration of the ruling that it produce documents related to the Davis case. The Commission asserted the documents were confidential by statute. On the same date the Commission produced documents for an in camera review. On February 10, 1997, and February 21, 1997, the Petitioner also produced documents for an in camera review. On March 6, 1997, Judge Ramos ruled on the documents provided for in camera review. On the same date she again directed the Commission to produce documents related to the Davis case. On March 11, 1997, the Petitioner produced documents ruled discoverable by Judge Ramos.

On February 20, 1997, the Commission filed a preemptive motion for protective order seeking to prevent the Petitioner from deposing Commission employees who were appeals panel members on the Davis case when it was before the Commission. On February 28, 1997, the Petitioner filed the request to depose the employees described in the Commission's February 20, 1997, filing. The Petitioner also sought to depose other employees of the Commission. On March 5, 1997, Judge Ramos issued an Order allowing the deposition of the Commission's employees including the appeals panel members. The Order limited the questioning of the members of the appeals panel.

On February 24, 1997, the parties filed "Stipulations" which included nine procedural stipulations, 61 factual stipulations, and 11 exhibits. The stipulations and exhibits are addressed below in the section entitled "Background" and some facts contained in the stipulations are included in the Findings of Fact.

On March 5, 1997, the Petitioner filed a request to depose the Commission with the Commission designating the person who would testify on its behalf. On March 11, 1997, the Commission filed a motion for protective order seeking to deny the Petitioner's request to depose the Commission. The request to depose the

Commission was denied by Judge Ramos on March 13, 1997. On March 14, 1997, the Petitioner requested Judge Ramos reconsider her ruling related to the deposition of the Commission.

On March 11, 1997, the Commission notified Judge Ramos by letter that it was refusing to comply with the Order to produce documents related to the Davis case.

On March 14, 1997, the Petitioner filed eight groups of documents and requested the ALJ take official notice of the documents filed. On March 24, 1997, the Commission responded to the Petitioner's request for official notice. The Commission did not object to the request for official notice but did object to a representation included in one of the Petitioner's motions. The requests for official notice were ruled on at the hearing on the merits which convened on November 2, 1998.

On March 18, 1997, the parties participated in a mediated settlement conference before SOAH. Following the conference the parties submitted a joint motion for continuance which was granted. The order granting the continuance set a prehearing conference for March 25, 1997.

On March 21, 1997, the Commission filed a motion for protective order seeking to halt the deposition of a Commission employee. The request for the deposition had been filed by the Petitioner on March 17, 1997. The Commission asserted the evidence sought was repetitive and duplicative.

On March 25, 1997, at the prehearing conference, the Petitioner filed a Motion for Sanctions asserting the Commission had abused the discovery process by failing to produce documents in its possession which were responsive to the Petitioner's Request for Production and which were favorable to the Petitioner's case. Judge Ramos considered the motion and did not act on the request for sanctions. Following the prehearing conference she declined to reconsider her ruling related to the deposition of the Commission and ordered the Commission to produce certain documents, to make a diligent search for specific records and documents, and to arrange for the Petitioner to have access to minutes of Commission meetings.

On July 10, 1997, the Petitioner filed a Motion for Sanctions and a Motion to Determine Sufficiency of Responses to Request for Admissions. In relation to the request for sanctions, the Petitioner asserted the Commission was refusing to comply with discovery orders issued by Judge Ramos and that the Commission was filing frivolous pleadings in the case. The Petitioner sought $12,580.00 in attorneys fees

and $1,066.83 in expenses relating to responding to what the Petitioner considered the Commission's frivolous filings. In regard to the request to examine the Commission's responses to the Petitioner's Request for Admissions, the Petitioner asserted the Commission had raised unjustified objections, failed to make reasonable inquiry, and made evasive and incomplete answers. On July 17, 1997, the Commission filed its response to that portion of the Petitioner's request for sanctions which related to frivolous filings. On the same date the Commission responded to the Petitioner's motion complaining of the Commission's responses to the Request for Admissions. On July 22, 1997, the Petitioner objected to the Commission's responses as untimely.

About July 15, 1997, the Commission sued Judge Ramos in a case styled Texas Workers' Compensation Commission v. The Honorable Sarah G. Ramos, Administrative Law Judge in the District Court of Travis County, Texas. The Commission asked the Court to issue a Writ of Mandamus ordering Judge Ramos to rescind portions of her Orders dated February 4, 1997, and March 6, 1997, regarding production of documents relating to the Davis case. On April 8, 1998, the Honorable John K. Dietz, issued his order denying the Writ of Mandamus and ordering the Commission to, within 30 days of the Order, produce to the Petitioner the documents ordered produced by Judge Ramos.

On June 23, 1998, the instant case was transferred from Judge Ramos to Administrative Law Judge Earl A. Corbitt.

On July 10, 1998, the Petitioner filed a Motion to Compel Production of Documents and for Imposition of Sanctions. The motion listed 11 documents which it claimed were referenced in documents produced pursuant to the orders of Judges Dietz and Ramos but which were missing from the documents produced. The Petitioner asserted it had requested production of the documents without success. The Petitioner sought attorneys' fees and expenses. On July 27, 1998, the Petitioner filed a Motion to Compel Answers to Questions Propounded at Deposition and a Motion for Sanctions on Proof of Request for Admissions. The Petitioner sought a hearing on its pending motions. On August 3, 1998, having received no response from the Commission to the Petitioner's request, the ALJ set a prehearing conference on August 28, 1998, to consider the Petitioner's pending motions and any remaining discovery problems.

As a result of the prehearing conference convened on August 28, 1998, the ALJ issued four Orders. The first Order: (i) took the Petitioner's motions for sanctions under advisement and required the parties to brief the question of whether the ALJ

had authority, under the rules of SOAH effective April 1996, which were applicable to the hearing, to order the Commission to pay costs, including attorney's fees, as requested by the Petitioner; (ii) granted the Petitioner's Motion to Compel Production which had been filed on July 10, 1998; (iii) required the Commission to reconsider each question identified in the Petitioner's Motion to Determine Sufficiency of Responses to Request for Admissions which had been filed on July 10, 1997, and to file a proper response to each; and (iv) required the Commission to reconsider each question set out in the Petitioner's Motion for Sanctions on Proof of Admissions, which had been filed July 27, 1998, and to answer each or state its reason why it could not answer the question. The Order set deadlines for the accomplishment of each requirement.

The second Order resulting from the prehearing conference partially granted the Petitioner's Motion to Compel Answers to Questions Propounded at Deposition. The Order required Appeals Panel Judges Susan Kelley and Joe Sebesta, whose depositions had been approved previously by Judge Ramos, to again submit to oral deposition by the Petitioner and to answer some questions which the deponents had refused, under instructions from counsel for the Commission, to answer at their prior depositions.

The third Order arising out of the prehearing conference established a prehearing schedule and established deadlines for: (i) completion of discovery; (ii) requests for procedural relief; (iii) exchange and filing of witness lists and proposed exhibits; and (iv) filing objections to proposed exhibits. The Order provided that failure to timely exchange exhibits would result in the inability to offer those exhibits at the hearing. The Order also provided that failure to timely designate witnesses would act to preclude the untimely designated witnesses from testifying. The final Order established November 2, 1998, as the date to convene the hearing on the merits.

On the due date, October 1, 1998, the Petitioner timely filed a witness list. The Commission relied upon its list of witnesses filed on January 28, 1997, which did not include a designation of an expert witness. On October 5, 1998, the Commission filed late a document which named two additional witnesses and requested additional time to designate expert witnesses. The Petitioner objected to the Commission's late filed document.

On September 18, 1998, the Petitioner filed a Motion for Sanctions asserting the Commission had violated the ALJ's Order, i.e. the "first Order" which issued after the prehearing conference convened on August 28, 1998. The parties agreed to a date for a prehearing conference to consider the Petitioner's motion and such

prehearing conference was convened on October 20, 1998. At the prehearing conference, the Commission asserted that it had decided to refuse to abide by the ALJ's order to produce Susan Kelley and Joe Sebesta for deposition. The ALJ announced he would sanction the Commission for such action.

Considering the Commission's position, and that discovery had closed on October 14, 1998, the ALJ declined the Commission's suggestion that the sanction should be to again direct the Commission to produce the subjects for questioning. The ALJ asked the Petitioner to submit proposed sanctions in writing. The ALJ stated he would not impose a "death penalty" sanction on the Commission.

In addition to the issue of sanctions, the parties addressed the time frame for submitting and objecting to proposed exhibits. The ALJ agreed to allow exhibits to be exchanged, and filed with SOAH, by noon on October 22, 1998, rather than 3:00 p.m. on October 20, 1998. The time for filing objections to proposed exhibits was extended to 3:00 p.m. on October 29, 1998, from the same time on October 27, 1998. At the prehearing conference the ALJ sustained the Petitioner's objections to the Commission's late-filed request to add three witnesses and to have additional time to name an expert witness.

The Petitioner timely filed its proposed exhibits. The Commission filed its proposed exhibits at 2:46 p.m. on the due date. The Petitioner objected to the Commission's late filed exhibits and requested they be excluded pursuant to the ALJ's third Order which issued following the August 28th prehearing conference.

The hearing on the merits convened on November 2, 1998, as scheduled. At the convening the ALJ announced the following rulings on pending matters:

1. In regard to sanctions against the Commission for its refusal to produce Appeals Panel Judges Susan Kelley and Joe Sebesa to complete their depositions as ordered by the ALJ, the Commission would not be allowed to argue, assert, contend, or elicit testimony or offer any evidence indicating a decision of the Commission's Appeals Panel can create, establish, set, institute, modify, or otherwise affect any Commission-wide rule or policy.

2. In regard to witnesses, the Commission would be limited to calling those witnesses named in its witness list dated January 28, 1997, and the Commission would not be allowed to have an expert witness testify.

3. In regard to exhibits, the Petitioner's objection to the Commission's exhibits was sustained because the Commission did not file its exhibits by the time they were due.

4. In regard to the Petitioner's requests filed March 14, 1997, that the ALJ take official notice of eight groups of documents, there had been no objection of substance filed by the Commission and the requests were granted.

5. The stipulations signed by the parties and filed with SOAH on February 24, 1997, were marked as Exhibit No. 3 and admitted.

The hearing convened on November 2 through 4, 1998. The record was left open until November 10, 1998, on which date the hearing was closed. The Petitioner was represented by John Pringle and Catharina Haynes, attorneys. The Commission was represented by Yvonne M. Williams, attorney, Chief of the APA-Litigation Hearings Division. ALJ Earl A. Corbitt presided.

At the hearing, the Petitioner offered a document entitled "Facts Admitted by TWCC." The Commission was given until 4:00 p.m. on November 6, 1998, to file a response to the document. The Commission filed its response by facsimile received at 11:50 a.m. on November 10, 1998. The Petitioner objected to the late filed response. The Petitioner's objection is sustained.

On November 10, 1998, the Commission timely filed its written Offer of Proof of Respondent's Exhibits. The exhibits had been previously filed, albeit late, with SOAH. The Commission's exhibits were not admitted into evidence and were not considered by the ALJ in the preparation of the decision.

JURISDICTION AND VENUE

The Texas Workers' Compensation Commission has jurisdiction over this matter pursuant to §415.034 of the Texas Workers' Compensation Act, TEX. LABOR CODE ANN. ch. 401 et seq.[1] SOAH has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to TEX. LABOR CODE ANN. §415.034(a) and TEX. GOV'T CODE ANN., ch. 2003. Venue is established in this matter in accordance with 28 TEX. ADMIN. CODE §148.6. This hearing was conducted pursuant to the Administrative Procedure Act, Chapter 2001,

[1]Applicable portions of the Act are set out in Appendix A attached to this decision

TEX. GOV'T CODE ANN. as allowed; the Commission's rules, 28 TEX. ADMIN. CODE §§133.305(g) and 148.001-148.028; and, SOAH's rules of practice, 1 TEX. ADMIN. CODE Chapter 155.

DISCUSSION OF THE EVIDENCE

A. Positions of the Parties

1. The Commission's position

The Commission contended that an insurer can not lawfully, under §408.123 of the Act, terminate temporary income benefits (TIBs) to an injured worker based solely on a finding of maximum medical improvement (MMI)[2] following a required medical examination (RME)[3] by a doctor selected by the insurer.[4] The Commission took the position that a finding of MMI can be effective for ending TIBs only if made by the "treating doctor" or a "designated doctor." The Commission further asserted that the Commission is the final arbiter of when MMI occurs.

2. The Petitioner's position

The Petitioner contended the Commission's position is contrary to the Act and is contrary to the intended interpretation of the Act as shown in the Act's legislative history. The Petitioner contended that §408.123 of the Act allows MMI to be certified by a "doctor," which term together with "treating doctor" and "designated doctor," is defined in the Act. The Petitioner argued that the doctor conducting a required medical examination at the instance of an insurer is "a doctor" as that term is used in §408.123. It was the Petitioner's position that TIBs can be terminated based upon a certification of MMI by the RME doctor. The Petitioner further contended the Commission is bound, under the doctrine of stare decisis, by the decision enunciated in the Davis case which decision is consistent with the Petitioner's position.

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[2]Maximum medical improvement is defined in Section 401.011 of the Act in Appendix A.

[3]See Section 408.004 of the Act in Appendix A for the provisions related to the required medical examination. The doctor performing a required medical examination at the instance of the carrier is frequently referred to in this Decision as a "RME doctor."

[4]At issue in the hearing is the interpretation and interaction of Sections 408.102, 408.121, and 408.123 of the Act. Those sections are included in Appendix A.

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B. Background

On May 22, 1995, [redacted] sustained a compensable injury while employed by Intsel Southwest. (Stips. 1 and 5). The Petitioner was the workers' compensation insurance carrier for Intsel Southwest. (Stip. 6). About July 31, 1995, the Petitioner filed a request with the Commission to have [redacted] examined by Charles Xeller, M.D., to determine if [redacted] had reached maximum medical improvement. (Stip. 9). The Commission, on August 11, 1995, ordered [redacted] to submit to the requested medical examination. (Stips. 10-11). The medical examination was performed by Dr. Xeller who issued a medical report on September 27, 1995, indicating [redacted] was not at MMI but anticipated that MMI would be reached in six to eight weeks. He indicated [redacted] could do light duty work at a desk. (Stips. 12-15). Intsel Southwest, about October 31, 1995, in writing, offered [redacted] a light duty job which [redacted] did not accept. (Stips. 16-17).

In a report dated February 7, 1996, Donald Lazarz, M.D., who began treating [redacted] about June 16, 1995, estimated [redacted] would reach MMI in April 1996. In a report dated February 23, 1996, Dr. Lazarz forecast that [redacted] would reach MMI in March 1996 and could be released to return to work in April 1996. (Stips. 8 and 24-26). About February 27, 1996, the Petitioner filed a request with the Commission to have [redacted] examined by its doctor, Dr. Xeller, to determine if [redacted] had reached MMI, and if so, what was his impairment rating. The Commission approved the request on March 11, 1996. (Stips. 27-28).

The examination by Dr. Xeller, on April 3, 1996, resulted in a finding by Dr. Xeller that [redacted] had reached MMI as of December 22, 1995. Dr. Xeller assigned [redacted] a zero percent impairment rating. (Stips. 32-37). A copy of Dr. Xeller's report was sent to Dr. Lazarz who, on April 16, 1996, disagreed with Dr. Xeller's findings related to MMI and the impairment rating. (Stips. 38-41). The Petitioner, on April 18, 1996, requested the Commission appoint a designated doctor to examine [redacted] On April 25, 1996, the Petitioner suspended the temporary income benefits it had been paying to [redacted]. (Stips. 42 and 44).

On May 9, 1996, [redacted], through his attorney, requested an expedited benefit review conference, asked that an interlocutory order be issued, and asked that the Petitioner be assessed violations under 11 provisions of §415.002 of the Act.[5] (Stip.

[5]The provisions cited by Gallegos' attorney apparently came from an outdated version of Section 415.002, which had been changed effective September 1, 1995. Many of the provisions cited are wholly inapplicable to the events which

46-47). The benefit review conference convened on June 4, 1996. On the conference date, the Petitioner resumed the payment of TIBs to [redacted] and brought the TIBs payments up to date. (Stips. 48 and 52-53).

The designated doctor, J. Barton Kendrick II, M.D., examined [redacted] on June 12, 1996. He was of the opinion that [redacted] had not yet reached MMI. (Stips. 45, and 54-59).

About September 16, 1996, the Commission charged the Petitioner with administrative violations because of its suspension of temporary income benefits to [redacted] The "Amended Notice of Administrative Violation(s) and Order to Respond," dated January 28, 1997, asserts the Petitioner violated §§409.023 and 409.024(b) by unreasonably terminating income benefits to [redacted] and by failing to pay benefits promptly as and when they accrued as required by §408.081(b) of the Act. The document also asserts that §§408.004(e), 408.102, 408.122 are applicable to this proceeding. The Petitioner was notified in the document that the Commission proposed a penalty of $18,000.00 but that the maximum penalty which could be assessed, based on the alleged violations, at hearing was $530,000.00 and revocation of the Petitioner's right to do business under the workers' compensation laws of the State of Texas. The Commission cited §§409.023, 409.024, and 415.022 as grounds for the maximum penalties available. (Exh. Nos. 1 and 3). The Petitioner requested a hearing related to the alleged administrative violations and the proposed penalty. That request led to the instant hearing.

The events directly related to the medical treatment of [redacted] occurred in Houston, Texas.

C. Evidence offered by the Commission

1. Testimony of Tracy Hall

Tracy Hall is a self-employed attorney located in Houston, Texas. She has been licensed since 1988. From 1990 until early 1992 she was employed in Houston by the Commission as a hearings officer and benefits review officer. As such she conducted benefit review conferences. She testified she is familiar with the Act.

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transpired and some of the provisions cited do not exist under the more recent version of Section 415.002. Because the Commission did not allege any violation of Section 415.002 in either its Notice of Administrative Violations or its Amended Notice of Administrative Violations, the provisions of Section 415.002 are not included in Appendix A.

Ms. Hall testified she represented [redacted] beginning approximately three days after his injury. She referred [redacted] to Dr. Donald Lazarz, a doctor to whom she has referred other clients.

According to Ms. Hall, when she received the report from Dr. Xeller which indicated [redacted] was at MMI with a zero percent impairment rating, she requested a benefit review conference because she did not believe [redacted] was able to work at that time. She testified that as a benefits review officer she had, in instances where an insurer terminated TIBs based upon the insurer's RME doctor finding an injured worker at MMI, issued orders to the insurers to reinstate benefits. Ms. Hall testified that an insurer is not allowed to stop benefits based on the report of its own doctor, but should request a benefit review conference and an interlocutory order supporting its position.

She testified that at the benefit review conference which convened on June 4, 1996, the benefit review officer, Cordell Marshall, stated he would issue an order requiring that benefits be reinstated. The Petitioner then agreed to resume payment of TIBs and an agreement was signed at the benefit review conference. Ms. Hall agreed that she was upset at the benefit review conference but could not recall if her complaint and request for administrative sanctions against the Petitioner was discussed. She could not recall if she or if Mr. Marshall had threatened anyone, including the Petitioner, with sanctions at the benefit review conference.

Ms. Hall testified that [redacted] was examined by Dr. Kendrick, a designated doctor selected by the Commission, on June 12, 1996. Dr. Kendrick did not agree with Dr. Xeller's finding of MMI. [redacted] was not certified as reaching MMI until about a year later.

On cross-examination, Ms. Hall recalled that she had received notice from [redacted] employer that there was a light duty desk job available for [redacted] about October 1995. She contended he was unable to work and did not accept the job offer. She concurred in his decision. She also testified regarding her failure to attend a scheduled benefit review conference in December 1995. Ms. Hall stated she was double-booked and had another benefit review conference scheduled at the same time on the other side of Houston. According to Ms. Hall, the Petitioner's adjuster refused to agree to another time for the benefit review conference. She agreed that the Commission did not file a violation against her for her failure to attend the conference.

2. Testimony of Christian Hill

The Petitioner objected to the testimony of Christian Hill on the grounds the Commission was precluded by the ALJ's prior ruling from offering expert testimony. The Commission argued that it was not offering Mr. Hill as an expert but as a fact witness to address the frequency, in the Houston area, of insurers terminating TIBs based upon a finding of MMI by a RME doctor who conducts an examination of the injured worker at the instance of the insurer. The ALJ stated the Petitioner's objection would be ruled on in the decision rendered by the ALJ. The Petitioner's objection is overruled.

Christian Hill is an attorney located in Houston, Texas. His practice is limited exclusively to representing injured workers before the Texas Workers' Compensation Commission. He has had clients whose TIBs were cut off because the doctor selected by the insurer found the client to be at MMI following a required medical examination. According to Mr. Hill, when that event occurs he disputes the finding of MMI, requests a benefit review conference be set, and asks that a designated doctor be appointed. Mr. Hill testified he has not faced many instances when TIBs have been terminated under such circumstances.

On cross-examination the Petitioner used Mr. Hill to address the credibility of the Commission's assertion that neither the Petitioner nor its attorney had been threatened with administrative violations being lodged against them at the benefit review conference held in the [redacted] case on June 4, 1996. Mr. Hill identified the Petitioner's Exhibit No. 100 as his original petition for declaratory judgment filed in May 1996. He asserted that the Commission, through its benefit review officer, threatened him with severe sanctions including disbarment, and threatened his client with termination of benefits, if they insisted on a doctor, other than the client's treating doctor, attending the client's examination at a required medical examination. Mr. Hill sought to challenge the Commission's rules which hampered the attendance of a doctor chosen by the injured worker at the required medical examination.[6] Mr. Hill asserted the rules were contrary to §408.004 of the Act. According to Mr. Hill, his request for an injunction was never ruled on by the court. At the hearing before the court, the judge disagreed with the Commission's position and the Commission

[6]The Commission's rules provide at 28 TEX. ADMIN. CODE §126.6(c), "The employee's doctor, chosen under the Act, §4.62 [now Section 408.022 of the Act] may be present at [the required medical examination]." The stated section of the Act addresses the choice of a treating doctor At 28 TEX. ADMIN. CODE §134.5(d) the Commission's rules state: "The injured employee's treating doctor shall be the only doctor permitted to attend ... unless the treating doctor receives prior approval from the insurance carrier... ."

then announced it was withdrawing all of its threatened actions against Mr. Hill and his client.

Mr. Hill testified that the precipitating events which led to his lawsuit were perfunctory examinations given by RME doctors resulting in the RME doctors certifying injured workers to be at MMI with zero percent impairment ratings. He testified that one of the doctors he complained of was Dr. Xeller. He also testified that Dr. Xeller is on the Commission's list of designated doctors. That list, according to Mr. Hill, is for doctors used by the Commission to conduct fair and impartial medical examinations to resolve disputes regarding MMI and impairment ratings.

3. Rebuttal testimony of Cordell Marshall

Cordell Marshall is a Benefit Review Officer employed by the Commission in Houston. He has been so employed for approximately 11 years. He was the person who conducted the benefit review conference on June 4, 1996, in the [redacted] case.

Mr. Marshall did not recall the Petitioner signing the agreement under duress. He testified all parties must understand an agreement and be willing to sign it. He denied he threatened or coerced the Petitioner's representative at the benefit review conference.

On cross-examination Mr. Marshall agreed he was acquainted with counsel for [redacted] because she had been employed as one of six Benefit Review Officers and worked in the same office as did Mr. Marshall. He agreed she worked there several years.

Also on cross-examination, Mr. Marshall recalled that counsel for [redacted], Tracy Hall, had been adamant and repeatedly asked for sanctions against the Petitioner. He testified he had authority to refer the matter to the Commission's Compliance and Practices Division for investigation. He agreed he did not inform the Petitioner's counsel, Jim Cleary, that he had no authority to impose sanctions. He also agreed he is required to inform all parties of their rights but did not recall whether he had done so.

Mr. Marshall testified he disregarded the ruling in the Davis case on instructions from his supervisors.

The ALJ considered the credibility of Mr. Marshall to be weakened because he initially testified he could not recall the attorney who represented the Petitioner at the benefit review conference and could not recall how he looked. However, when pressed on cross-examination about whether the Petitioner's attorney was coerced into signing the agreement at the end of the conference, Mr. Marshall testified he recalled the look on the attorney's face. The look was a "look of agreement." Based on that look, Mr. Marshall concluded there was no coercion. The ALJ does not find Mr. Marshall's recollection of the look on the attorney's face to be credible.

D. Evidence offered by the Petitioner

Following the presentation of the Commission's direct case, which consisted of the testimony of Ms. Hall and Mr. Hill, the Petitioner moved to have the case against the Petitioner dismissed. The ALJ reviewed the stipulated evidence and denied the motion. The Petitioner then presented its evidence.

1. Testimony of Neal Moreland

Neal Moreland is the Director of Texas Workers' Compensation Commission Services for Employers Claims Adjustment Services in Austin, Texas. He serves as a liaison between insurance carriers and the Commission. He represents insurance carriers at benefit review conferences and contested case hearings. He does not now represent the Petitioner and never has.

Mr. Moreland formerly worked for Texas Employers Insurance Association (TEIA), an insurer which wrote workers' compensation insurance exclusively, and which was ultimately put into receivership by the Texas Department of Insurance because it paid out more in workers' compensation claims than it received in premiums.

According to Mr. Moreland the workers' compensation system in Texas in the late 1980's suffered from high loss ratios and insufficient income. Some insurers announced they were pulling out of the state. Employers were dropping their workers' compensation insurance coverage because of the high cost. Courts were overcrowded with worker's compensation cases. Mr. Moreland testified the legislature in 1989 passed workers' compensation insurance reform which replaced

the Industrial Accident Board with the Commission.[7] Mr. Moreland testified that he adjusted workers' compensation claims under the law prior to 1989 and has continued to work with workers' compensation insurers under the Act.

Mr. Moreland was the custodian of records for TEIA, which included Employers Casualty Company, throughout the time the claim of Maximiliano Davis was processed. He represented Employers Casualty Company in the associated proceedings before the Commission.[8] Maximiliano Davis was certified as reaching MMI with a zero percent impairment rating by a RME doctor in November 1991. The matter proceeded through a benefit review conference and a contested case hearing. In the decision arising out of the contested case hearing, the hearings officer did not specifically address the issue of whether it was proper for an insurance carrier to terminate TIBs based upon certification of MMI by a RME doctor. The contested case hearing decision was appealed to the Commission by both parties. On an unspecified date, an appeals panel rendered its decision that certification of MMI by a non-treating doctor, alone, does not constitute a basis for the carrier to stop TIBs. Mr. Moreland testified he had the appeals panel's decision appealed to District Court in Dallas, Texas. He filed all documents related to the case with the Commission and expected the Commission to intervene.[9] The Commission did not intervene in the case. The District Court issued a summary judgment upholding the right of Employers Casualty Company to suspend TIBs based on the certification of MMI by a RME doctor. Mr. Moreland testified that prior to the appeals panel decision which was appealed in the Davis case, the Commission's position on the issue of terminating TIBs based on a certification of MMI from a RME doctor was not known.

At an unspecified time after the decision in the Davis case, Mr. Moreland learned the Commission did not intend to follow that decision. He testified he believed he obtained that knowledge prior to the time the Commission considered adopting Rule

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[7]Senate Bill No. 1 passed by the legislature in 1989 was entitled the Texas Workers' Compensation Act (the Act), it was later codified without substantive change at TEX. LABOR CODE ANN. ch. 401 et seq.

[8]The claim of Maximiliano Davis was ultimately resolved by Summary Judgment issued on March 5, 1993, by the 134th Judicial District Court of Dallas County, Texas, in Employers Casualty Company vs. Maximiliano Davis. The court reversed the Commission's decision in appeal number DA-91-130215-02-CC-DA41, set the decision aside, and held it for naught as clearly erroneous as a matter of law. The Davis case has been previously mentioned in the Procedural History portion of this decision. It was the seed out of which the instant case sprung.

[9]Section 410.254 of the Act gives the Commission the right to intervene in any judicial proceeding involving an appeal of an appeals panel decision.

129.6 which was never finally adopted.[10] Mr. Moreland testified that TEIA considered filing an action seeking a declaratory judgment requiring the Commission to abide by the judgment in the Davis case, but it was not filed because TEIA was about to be placed in receivership.

On cross-examination Mr. Moreland refused to agree with counsel for the Commission that money was the sole issue involved in the TIBs question. He contended the primary issue was fairness. According to Mr. Moreland, the Act allows carriers to terminate TIBs when a RME doctor certifies the injured worker to be at MMI and the Commission, rather than construing the Act fairly and as written, has attempted to construe the Act against the rights of the carriers. Mr. Moreland testified the Commission fails to follow the Act or its own rules. He contended the Commission selectively enforces its rules.

2. Testimony of Robert Persico

Robert Persico is the Vice-President of Product Management for Cigna Property and Casualty Insurance in Philadelphia, Pennsylvania. In 1991 he was the Claims Manager for the Petitioner in Houston, Texas. In September 1992, he was promoted to Claims Vice-President for the Petitioner in Houston, and in July 1996 was promoted to his present position.

As Claims Vice-President he had oversight over claims handling, including workers' compensation claims, in south Texas, Louisiana, and Mississippi. He did not supervise the Petitioner's office in Las Colinas, Texas, which is near Dallas. He testified the Houston office and the Las Colinas office were not always consistent in their methodology on claims.

Mr. Persico testified that after the Act was passed in 1989, he and others in the Petitioner's Houston office concluded the Act allowed a carrier to suspend payment of TIBs after any doctor certified an injured worker to be at MMI. It became their practice to suspend TIBs according to that interpretation of the Act. About 1993 he learned the Commission took a different position when Todd Brown, the then Executive Director of the Commission, issued an advisory stating a carrier could only suspend TIBs upon a finding of MMI by the treating doctor. Mr. Persico testified that while he did not agree with the Commission's position, the Petitioner did not wish to anger the regulator and so the Petitioner paid TIBs in accordance with the advisory.

[10]The proposed Rule 129.6 is more fully discussed under the testimony of Kevin McGillicuddy below.

According to Mr. Persico, he had the question researched and concluded the Commission's position was incorrect. He did not, at that time, choose to act on the research. About 1994 or 1995 he learned of the Davis case. The decision in the case was consistent with his interpretation of the Act and inconsistent with the Commission's position. Mr. Persico testified he instructed his subordinates to resume suspending TIBs upon a certification of MMI by a RME doctor.

Mr. Persico testified attorneys representing the Petitioner were informed at workers' compensation hearings in Houston that the Davis decision was not recognized as valid in Houston. The Petitioner was threatened with severe fines for suspending TIBs upon certification of MMI by a RME doctor. He called the Petitioner's Las Colinas office and learned that the Commission followed the Davis decision in Dallas. He also learned the Davis decision was accepted as valid by the Commission's office in Beaumont, Texas. After Mr. Persico learned of threats of severe administrative penalties for the Petitioner's following the Davis case in Houston, he again instructed his subordinates to pay TIBs in accordance with the advisory issued by Todd Brown.

Mr. Persico testified the Petitioner never tried to hide its actions from the Commission. All forms relating to benefits were timely filed. He attempted to have a meeting arranged with the "commissioners" and with Todd Brown.[11] A meeting was ultimately arranged with the commissioners, but Mr. Brown was not in attendance. Mr. Persico complained the Petitioner was never able to get a response from Mr. Brown regarding the Petitioner's position. The Petitioner continued to pay TIBs in accordance with the advisory of Mr. Brown while contending the Commission's position was wrong. Mr. Persico testified the Petitioner did not want to pay large administrative penalties or be put out of business in Texas.

On cross-examination Mr. Persico agreed that insurers must comply with the Act. He contended the Petitioner's position was consistent with the Act. He contended insurers have a right to suspend TIBs based on a certification of MMI by any doctor, whether it be treating doctor, designated doctor, or RME doctor. He agreed that, pursuant to §408.004(e) of the Act, if a doctor releases an injured worker to return to work without a certification of MMI, then TIBs would not be suspended at that time. He testified that is not the circumstance which attended the [redacted] case.

[11]According to Section 402.001 of the Act, the Commission's governing body is composed of six commissioners appointed by the governor with the advice and consent of the senate. Three commissioners must be employers of labor and three must be wage earners

On cross-examination Mr. Persico denied the Petitioner was having any special problem with the Commission taking a long time setting benefit review conferences at the time of the [redacted]. He testified the problem was industry-wide. He testified the Petitioner was not faced with special concerns related to claimants not attending scheduled required medical examinations. He testified he did not know if the Petitioner was losing an "inordinate amount" of money by following the procedures set out in the Todd Brown advisory. He testified his concern is that benefit payments be appropriate and that they be timely.

3. **Testimony of Kevin McGillicuddy**

Kevin McGillicuddy is the President of Hammerman and Gainer Insurance Adjusters. The firm adjusts workers' compensation claims for self-insured employers, political subdivisions, and insurers. The Petitioner is not a client of Hammerman and Gainer. Mr. McGillicuddy has been employed at Hammerman and Gainer since 1976 and has been president of the firm since 1996. He is a 1980 law school graduate and is a licensed insurance adjuster.

Mr. McGillicuddy testified he adjusted workers' compensation claims both before and after the change in the workers' compensation law which occurred in 1989. He is familiar with the process used in workers' compensation disputes both before and after the 1989 change in the workers' compensation law. He testified the concept of "maximum medical improvement" did not exist under the prior law but was included in the new law from the outset.

Mr. McGillicuddy testified he was cognizant of the Joint Select Committee which was appointed in 1985 and 1987 to study the workers' compensation insurance problems in Texas. He served as an advisor to Representative Richard Smith who was the House sponsor of the companion bill to Senate Bill 1. That bill ultimately was enacted, following the offering of numerous amendments, and became the Texas Workers' Compensation Act. Mr. McGillicuddy testified that the House and Senate, while considering the legislation which became the Act, considered language

which would have specifically required that MMI be certified by the treating doctor.[12] The adopted language did not require that MMI be certified by the treating doctor.

According to Mr. McGillicuddy, he heard of the Davis case in the spring of 1993. About that time the staff of the Commission proposed an amendment to the Commission's rules to add a Rule 129.6. The proposed rule would have precluded an insurer from terminating TIBs unless a finding of MMI was made by the injured worker's treating doctor. The staff presented the proposed rule for consideration of the six commissioners periodically over a two-year period. The commissioners discussed the proposed rule, but never adopted it. Mr. McGillicuddy regularly attended meetings of the commissioners in 1992, 1993, and most of 1994. He could not recall precisely what his position was regarding the proposed rule but did recall he felt it did not track the statute because it did not recognize a carrier's right to suspend TIBs upon a certification of MMI by a RME doctor.

Mr. McGillicuddy was of the opinion the Commission's position that only a treating doctor or designated doctor could make a finding of MMI is in conflict with the Commission's rule at 28 TEX. ADMIN. CODE §130.5(e) which states: "The first impairment rating assigned to an employee is considered final if the rating is not disputed within 90 days after the rating is assigned."[13] He wondered how the RME doctor's finding could be insufficient to suspend TIBs yet be sufficient to become final if not disputed. He was of the opinion the Commission's staff takes positions contrary to the Act and the Commission's rules.

On cross-examination, Mr. McGillicuddy testified that most of the carriers he represents continue to pay TIBs in accordance with the advisory issued by Todd Brown. He testified he regularly attended meetings of the commissioners until late 1995. His reasons for attending the meetings was that he was regularly asked by the

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[12]The legislative history of Senate Bill 1, of which official notice was taken at the Petitioner's request, reflects that drafts of §4.26(d) provided: "After the employee has been certified by the treating physician as having reached medical stability, or is released to return to work, the treating physician shall .... assign an impairment rating. (Senate Journal, 71st Legislature, 2nd Called Session, p. 63; House Journal, 71st Legislature, 2nd Called Session, pp. 91 and 219). As finally passed, §4.26(d) stated: "After the employee has been certified by a doctor as having reached maximum medical improvement, the certifying doctor shall .... assign an impairment rating." (Texas Session Laws 1989, 71st Legislature, 2nd Called Session, p. 40). Section 4.26(d) was later codified, without change, at §408.123 of the Act.

[13]Section 408.123 of the Act requires the doctor who certifies an injured worker to be at MMI also assign the worker an appropriate impairment rating.

commissioners to provide input and that many rules were under consideration. He felt it necessary to stay abreast of the Commission's rules.

4. Testimony of Ron Beal

Ron Beal is a professor of law at Baylor University School of Law. He is a tenured professor having been at Baylor since 1983. Professor Beal teaches in two areas, Administrative Law and Statutory Construction. He was retained by the Petitioner to provide expert testimony relating to statutory construction. He testified he has read the Act in its entirety and then focused on what he considered the specific relevant parts.

In relation to the question raised in the instant hearing, Professor Beal testified he began with §§408.101 and 408.102 of the Act which provide an employee an entitlement to TIBs if the employee has a disability and has not reached MMI. In this case, the question does not deal with the entitlement to, but the suspension of, TIBS. For that question, the Act provides at §408.121(a) that the employee's entitlement to impairment income benefits begins on the day after the date the employee reaches MMI. Impairment income benefits are paid subsequent to, and not in conjunction with, TIBs.

The next step, according to Professor Beal is to determine when MMI is "reached." The Act, at §408.121(b), imposes a duty on the insurer to begin to pay impairment income benefits by the fifth day after it receives the doctor's report certifying MMI. Professor Beal testified that report is clearly the medical report described in §408.123 which certifies MMI and establishes the impairment rating. He stated §408.123(b) requires the certifying doctor to provide a copy of his report to the insurer.

Professor Beal described several rules of statutory construction. One of those rules requires that when the words of a statute are not ambiguous, they should be construed according to their normal meaning. Another rule requires a legislatively defined term to be used as defined, if it makes sense. Professor Beal pointed out that "doctor," "treating doctor," and "designated doctor" are each defined at §401.011 of the Act. Professor Beal was of the opinion that reading §408.123 as making the treating doctor the only doctor with the authority to certify an injured worker as reaching MMI would violate both rules of statutory construction set out above. Firstly, the term "a doctor" used in the statute is not ambiguous. Secondly, the Legislature defined the term "doctor." That the Legislature chose the term "a doctor" when more restrictive terms were available and defined, implies the more restrictive terms were

not meant to apply. In addition, the second sentence of §408.123(a) refers to the "treating doctor" and specifies procedures to be followed when a "doctor other than the employee's treating doctor" certifies MMI and performs an evaluation of impairment rating.

Professor Beal was of the opinion the action of the Petitioner in terminating TIBs in the [redacted] case was reasonable as described in §409.024(b) of the Act. The Petitioner had received a report from a doctor which certified Gallegos to be at MMI and which assessed an impairment rating. Pursuant to §§408.101, 408.102, and 408.121 the Petitioner was obligated to make the adjustment from TIBs to impairment benefits upon receiving the report of MMI.

Professor Beal testified he reviewed the legislative history related to enactment of the Texas Workers' Compensation Act. He testified that looking at the different versions which were considered is helpful, albeit not determinative, in ascertaining legislative intent. According to Professor Beal when a word is included in one version of a bill, then is withdrawn from the final version which is passed, then there is a presumption that the withdrawal of the word was intentional.

In regard to the application of §408.004(e) to the events giving rise to this case, Professor Beal was of the opinion it did not apply. That section addresses the situation where a RME doctor indicates that an injured worker is able to return to work immediately. It specifies procedures to be followed in such a case and precludes the insurer from suspending TIBs until the process is completed. Professor Beal noted that §408.004(e) does not refer to MMI, which is a defined term. He noted too, that the procedures established under §408.004(e) are not the same as those to be followed under §408.121(b) when an impairment rating is disputed, or the same as those to be followed under §§408.122 and 408.123 when a finding of MMI is disputed.

According to Professor Beal §§402.001, 402.004, and 402.061 of the Act establish a commission of six members which has the authority to adopt rules to implement and enforce the Act and which can only act by a majority vote of the members. Under §402.063 the six commissioners appoint the Executive Director. Under §402.042 the Executive Director has authority to administer the Commission but has no power to make rules. Professor Beal was of the opinion that when the Executive Director of the Commission issued an advisory, then attempted to enforce it through issuance of administrative violations against the Petitioner the acts were (i) inconsistent with the powers granted the six members of the Commission's governing body; (ii) inconsistent with the rule making provisions of the Administrative Procedure

Act, TEX. GOV'T CODE ANN. §§2001.021 through 2001.037; and (iii) in excess of the Executive Director's statutory authority.

In regard to the decision in the Davis case, Professor Beal was of the opinion the decision was binding on the Commission as to the issue considered. He testified a constitutional court has the authority to set aside an agency decision which is inconsistent with the law. Professor Beal testified that the Commission knew of the lawsuit, considered intervening but did not, and had notice of the final judgment. According to Professor Beal, the Commission is unique in that it has statutory authority to intervene in actions at the local district court level. The Commission thus has an opportunity to become a party in an action and to appeal adverse decisions to the Court of Appeals and to the Texas Supreme Court.

On cross-examination Professor Beal agreed that district court decisions are not published in any reporter system. He contended the Commission, being on notice of the appeal from the Commission's Appeals Panel decision, refused to intervene at its own peril. He contended that because the action was an appeal of an agency decision, the decision of the District Court impacted the decision of the appeals panel and should be precedent in like cases.

Professor Beal was asked to explain his position that the Petitioner had reasonable grounds for suspending TIBs in the [redacted] case when §409.024 requires that the reasonableness of the grounds is "as determined by the commission." Professor Beal testified that the Commission is bound by its enabling legislation. It has the power to make the determination in a rational and reasonable manner. It must not be arbitrary or capricious in its determination.

Professor Beal contended the statute was unambiguous when it comes to the duties and rights of the insurers upon the receipt of a report from a doctor certifying MMI of an injured worker. He argued that to read the statute and come to the same conclusion as the Commission would be coming to a position contrary to the statute.

5. Jim Cleary

Jim Cleary is an attorney. From 1992 until 1998 he worked for Bracewell & Patterson. He represented the Petitioner in the [redacted] case.

Mr. Cleary testified he appeared for a scheduled benefit review conference before one of the Commission's benefit review officers in December 1995. Neither Gallegos nor his attorney appeared. He testified that in February 1996 he sent a letter

to Tracy Hall, [redacted] attorney, on behalf of Intsel Southwest and offered three light duty positions. Ms. Hall informed him none of the positions were acceptable.

Mr. Cleary testified he participated in the benefit review conference held on June 4, 1996. It was conducted to consider Ms. Hall's complaint about the Petitioner's suspension of TIBs to [redacted]nd her request for sanctions. In her opening statement, Ms. Hall said sanctions must be levied against the Petitioner, Mr. Cleary, and Intsel Southwest.

According to Mr. Cleary, he showed the benefit review officer a copy of the Davis decision and was informed that it was meaningless in Houston. Mr. Cleary testified the benefit review officer instructed him to reinstate TIBs to Gallegos immediately or be sanctioned. He testified it was not clear to him whether the sanctions would be applied to the Petitioner, the employer, or him personally. He testified he agreed to reinstate the benefits based on the instructions of the benefit review officer. He signed the agreement presented by the benefit review officer. Mr. Cleary testified the benefit review officer told him that if benefits were reinstated within 10 days, there would be no sanctions and no administrative action. He further testified the Petitioner's adjuster on the case had the TIBs reinstated the next day.

6. **William Michael Roblin**

William Michael Roblin is the Regional Claims Manager for the Petitioner in its Las Colinas (Dallas) office. He has been with the Petitioner for more than 12 years. All of his experience is in the area of workers' compensation claims.

Mr. Roblin testified that following the enactment of the Act in 1989, it was the practice in the Las Colinas office to suspend TIBs upon the certification of MMI by any doctor. He believed that position was correct. He testified that at an unspecified time he learned of an advisory issued by the Commission instructing insurers not to suspend TIBs under those conditions. He felt the advisory was wrong, but chose to abide by the advisory because the Commission is the regulator.

Mr. Roblin testified he learned of the decision in the Davis case in early 1994. He stated it was consistent with his understanding of the Act. After learning of the Davis decision, the Petitioner's Las Colinas office resumed suspending TIBs when any doctor certified a worker to be at MMI.

According to Mr. Roblin, the Commission's Dallas field office has issued no violations to the Petitioner for suspending TIBs following a certification of MMI. The Commission's Tyler field office, upon being advised about the Davis decision, did not issue any violations for suspending TIBs following a certification of MMI by a RME doctor.

Mr. Roblin testified he was unfamiliar with the position taken by the Petitioner's offices in south Texas. The position of the region controlled by the Las Colinas office was consistent.

He agreed on cross-examination that about 1995 the Las Colinas region again began to follow the position of the Commission's advisory because they were interested in resolving the issue without a fight.

7. **Darlene Simpson**

Darlene Simpson is an adjuster employed by the Petitioner in its Houston office. She testified she was the adjuster assigned to the [redacted] case. She testified when she received the first report of injury relating to [redacted] she immediately initiated benefits and waived his waiting period. Because [redacted] was represented by an attorney, all her contact with him was through the attorney, Ms. Hall.

Ms. Simpson testified that Ms. Hall refused to allow [redacted] to be examined by a doctor selected by the Petitioner. Ms. Simpson filed a request with the Commission to have [redacted] submit to a required medical examination. He was examined by Dr. Xeller on September 20, 1995. Dr. Xeller did not find [redacted]s to be at MMI, but did find he could do light duty work. Ms. Simpson testified she saw the letter offering light duty work by Intsel Southwest and that [redacted] did not accept the work offered.

After learning of the refusal to accept light duty work, Ms. Simpson requested a benefit review conference which was set for December 1995. Ms. Simpson received a call from Ms. Hall immediately prior to the conference but was unable to agree to reschedule the conference because the Petitioner's representative was already at the conference. Ms. Simpson testified no issues were resolved at the benefit review conference, no contested case hearing was set, and no benefit review conference was rescheduled. She continued to authorize TIBs for [redacted] because he had not yet been released to return to work.

According to Ms. Simpson, on February 14, 1996, a second letter was sent to [redacted], through his attorney, offering three light duty jobs. No response was received. Ms. Simpson testified she requested another benefit review conference which was held without settling any issues. She continued to authorize TIBs.

Ms. Simpson again requested a RME and one was authorized. Dr. Xeller, the RME doctor, certified [redacted] to have reached MMI on December 22, 1995 with a zero percent impairment rating. Ms. Simpson testified she sent the report to the treating doctor, Dr. Lazarz to see if he agreed with Dr. Xeller. He did not. Ms. Simpson testified she, on April 18, 1996, requested the Commission appoint a designated doctor to resolve the dispute. She testified she subsequently received a copy of a form from the Commission which was addressed to [redacted] and which informed him: "The doctor's statement that you have reached maximum medical improvement means that you will no longer receive temporary income benefits." After receiving the Commission's form letter, Ms. Simpson terminated TIBs payments to Gallegos and filed notice of such with the Commission.

Ms. Simpson testified she was surprised when Ms. Hall requested penalties be assessed against the Petitioner. Ms. Simpson had Mr. Cleary attend the benefit review conference and upon receiving information from Mr. Cleary after the conference immediately reinstated TIBs for [redacted]. She testified her understanding was that no violations would be issued if the Petitioner immediately reinstated the benefits. She stated she was shocked when the Commission charged the Petitioner with administrative violations in the [redacted] case.

On cross-examination, Ms. Simpson testified she has adjusted workers' compensation claims since 1993. Her instructions regarding suspending TIBs following a certification of MMI by a RME doctor was by memo from Robert Persico. She agreed that at the time she requested a benefit review conference she knew [redacted] and his attorney disputed the finding of MMI made by Dr. Xeller. She testified a benefit review conference should be set when there is a dispute regarding a finding of MMI.

Ms. Simpson testified on cross-examination that when she received the report from Dr. Xeller certifying [redacted] to be at MMI, she forwarded it to Dr. Lazarz, the treating doctor. When she received the report back from Dr. Lazarz indicating he did not agree that [redacted] was at MMI, she requested the Commission to name a designated doctor to resolve the issue. The Commission appointed Dr. Kendrick as the designated doctor and he later disagreed with Dr. Xeller and found [redacted] had not reached MMI. By the time she received Dr. Kendrick's report, the benefit review

conference had occurred and TIBs had already been reinstated for [redacted]. Ms. Simpson testified that she complied with §408.004(e) of the Act.

Ms. Simpson testified that Petitioner's Exhibit No. 247 is a Form EES-19 sent by the Commission to [redacted]. She interpreted the letter to mean that the Commission recognized the findings of Dr. Xeller regarding maximum medical improvement for [redacted] and the findings would be final in 90 days unless they were disputed.[14] She agreed [redacted] through his attorney, disputed the finding of MMI and the impairment rating.

8. James C. Guidos

James C. Guidos currently works for the Insurance Company of North America. From May 1995 to December 1996 he was the workers' compensation claims manager in the Petitioner's Houston office. He was supervised by Robert Persico.

He testified he first learned that the Commission considered the Act to preclude the suspension of TIBs upon a finding of MMI by a RME doctor about May 1996. He was of the opinion the Commission's position was contrary to the Act.

Mr. Guidos testified he attended a meeting sponsored by the American Insurance Association. Representing the Commission at the meeting was Todd Brown, the Executive Director, and Bart Griffin. According to Mr. Guidos, Todd Brown stated at the meeting that the Commission was not aware of any of the proceedings in the Davis case until after its conclusion. He also advised the representatives of the insurers in attendance that he would prefer they come and talk to him about problems rather than instituting declaratory judgment lawsuits involving the Commission as a party.

Bart Griffin, a Commission employee, talked to Mr. Guidos about the practice of the Petitioner of suspending TIBs after receiving a finding of MMI by a RME doctor. Mr. Griffin opposed the Petitioner's practice and suggested a meeting be set up to discuss the matter. Mr. Guidos testified he made arrangements for the meeting with the expectation of being able to address the Petitioner's concerns to the Executive

[14]A portion of the Form EES-19 states: "The doctor's statement that you have reached maximum medical improvement means you will no longer receive temporary income benefits ... If you do not agree with the certification of maximum medical improvement or the percentage of impairment assigned for any reason, you must dispute these issues ... within 90 days after you receive notice ..."

Director. When the meeting occurred, Mr. Brown was unavailable. The Petitioner was not able to work out any accommodation with the Commission regarding the issue.

Mr. Guidos testified he researched matters related to complying with the Commission's position on a finding of MMI by a REM doctor. The research reflected that in some cases it took months to obtain the appointment of and examination by a designated doctor. It also reflected the practice caused significant overpayments to claimants. Mr. Guidos testified the overpayments could only be recovered in some instances and only upon an order from the Commission. He testified the total loss occasioned by overpayments has not been estimated.

On cross-examination, Mr. Guidos testified that when an insurer pays TIBs based on an interlocutory order and, based upon a finding of MMI by the designated doctor, an overpayment results, then it is possible to recover the overpayment from the Subsequent Injury Fund which is administered by the Commission. He also testified that under some circumstances it is possible to recover some overpayments from Impairment Income Benefits payable to an injured worker.

9. Deposition of Nick J. Huestis

Nick J. Huestis is a non-attorney employee of the Roan and Autry law firm in Austin, Texas. He has been there since December 1990. He was a board member of the Texas Industrial Accident Board (IAB)[15] from December 1983 until December 1987. The Industrial Accident Board was made up of three members, one representing employers, one representing employees, and one representing the general public. Mr. Huestis testified he was the employer representative. The board members were the policy makers for the IAB and the executive director of the IAB had no policy-making responsibilities and no authority to promulgate rules.

Following his term on the IAB, Mr. Huestis was employed by the Texas Association of Business during the period of time the Texas Legislature engaged in adopting legislation reforming the workers' compensation system in Texas. Mr. Huestis testified the reform issue was hotly contested. His job was to educate members of the Texas Association of Business, to coordinate their testimony before the legislature, and to participate with other interest groups in drafting and negotiating provisions for workers' compensation reform. He testified that during the legislative process he met several times with the lieutenant governor, the speaker of the House,

[15]Following the adoption of the Texas Workers' Compensation Act, the functions of the Industrial Accident Board were assumed by the Commission.

and most, if not all, of the members of the legislature. He met with legislators on a daily basis. His role became more of a lobbyist than an educator during the process. Mr. Huestis testified the reform of the workers' compensation system involved numerous draft bills being sent between the House and the Senate.

According to Mr. Huestis, in debating the reform legislation that led to adoption of the Texas Workers' Compensation Act, the legislature considered a provision which would have required that a certification of MMI and the evaluation of impairment rating be made only by the treating doctor. He noted that "doctor," "treating doctor," and "designated doctor" are all defined in the Act. Ultimately the legislature adopted the provision which allowed certification of MMI and evaluation of impairment rating to be by "a doctor." The requirement that the certification and evaluation be by the treating doctor was not adopted. The Act made specific provisions for procedures to be followed if the certification of MMI and evaluation of impairment rating were made by a doctor other than the treating doctor.

Following passage of the Act in December 1989, Mr. Huestis was hired by the American Insurance Association to coordinate a teleconference regarding the transition from the prior law to the Act. In addition he was a consultant to several clients on the subject of workers' compensation. After about 11 months as a private consultant, Mr. Huestis joined the law firm of Roan and Autry.

In his current position, Mr. Huestis routinely attends the open meetings and the advisory committee meetings of the Commission. He opined, without objection, that only the six commissioners have authority to make policy for the Commission.[16] He also opined that the Executive Director is without authority, under the Act, to engage in rule making. Rule making authority is reserved specifically for the six commissioners.

Mr. Huestis testified the Act provides that when an injured worker is certified to be at MMI by a doctor selected by the insurer, then the insurer can suspend TIBs and proceed to pay impairment income benefits if they agree with the impairment rating. He did not agree that the insurer is required to wait until after a benefit review conference to suspend TIBs under the stated circumstances. According to Mr. Huestis

[16]The introductory remarks of the deposition of Mr. Huestis reveal the deposition was noticed to start at 9:00 a.m. Counsel for the Commission did not appear at that time and the deposition was delayed. It commenced at 10:10 a.m. without counsel for the Commission in attendance. Counsel for the Commission did, however, make his appearance prior to the time the deponent was asked questions which elicited legal opinions. Counsel for the Commission did not lodge objections to the witness expressing legal opinions or to his interpreting provisions of the Act.

the determination of MMI is the event that triggers the beginning of impairment income benefits, if any, and the end of TIBs. The two forms of benefits are not paid simultaneously. Based upon his reading of §408.123 of the Act, he disagreed with the Commission's position that TIBs can not be suspended upon a certification of MMI by a RME doctor.

The income benefit process was described by Mr. Huestis. He testified that when a finding of MMI is first made by any doctor, whether treating doctor or RME doctor, then there is a presumption that the finding is accurate. The doctor making that finding is required to, at the same time, evaluate the injured worker and ascertain an impairment rating. The finding of MMI constitutes the transition point between TIBs and impairment income benefits. The insurer is duty bound, upon being notified that an injured worker has reached MMI, to suspend payment of TIBs and to initiate impairment income benefits within five days. The insurer has the option of accepting the impairment rating provided by the doctor or of making a reasonable assessment of impairment and basing its impairment income benefits on their own reasonable assessment. He testified that it is possible that the finding of MMI by a RME doctor may be subsequently overruled by a designated doctor. When that happens the insurer will have to go back and pick up any TIBs not paid, less the impairment income benefits paid, plus interest.

In regard to the authority of the Commission's appeals panels, Mr. Huestis testified he knew of no provision in the Act which indicates the appeals panels have authority to enact policy for the Commission. He also testified he knew of no provision in the Act which indicates the appeals panels decisions have any precedential authority.

Mr. Huestis testified there is a difference between a release to return to work and a certification of MMI. The release to return to work indicates the person's disabilities are no longer an impediment to gainful employment at wages at or higher than the pre-injury wage. Certification of MMI indicates that, in the doctor's opinion, the injured worker will no longer receive any substantive medical improvement from continued treatment. He testified it is possible to be released to return to work prior to reaching MMI and it is possible to reach MMI without being released to return to work.

According to Mr. Huestis, he was informed about the decision in the Davis case soon after the judgment was rendered. He received the information from Neal Moreland, an employee of Employers Casualty Company. He testified Mr. Moreland was concerned because he expected the Commission to intervene and to appeal the

decision. Mr. Moreland stated his company was on the brink of receivership and did not want the issue to die. Mr. Huestis testified when he next heard of the Davis case he learned the Commission had not intervened and the judgment had become final. Mr. Huestis also testified he was informed by public and private pronouncements from Todd Brown, then Executive Director of the Commission, that the Commission never received notice of the judgment in the Davis case.

Mr. Huestis testified that subsequent to the Davis decision, the six commissioners discussed the issue relating to suspension of TIBs following a certification of MMI by a RME doctor at numerous public meetings over an extended period of time. The Commission's staff made efforts to have the Commission's rules revised. The staff proposed requiring insurers to continue paying TIBs until after the treating doctor certified the injured worker to be at MMI or until the Commission's benefit review officer, following a benefit review conference, issued an order allowing the cessation of TIBs. The efforts at revision resulted in a deadlock. The commissioners repeatedly tabled the issue. The proposed Rule 129.6 was never adopted by the six commissioners or published in the Texas Register. Mr. Huestis testified he provided the three commissioners who represented employers with copies of the Davis decision and each informed him they opposed the proposed Rule 129.6 as drafted by the staff.

Mr. Huestis testified that the Act gave the Commission specific authority to intervene in the district courts throughout the state when an appeals panel decision was appealed. He testified that the author of the Act, Senator Montford, and two of Senator Montford's law partners, one of whom assisted Senator Montford in drafting the bill, authored a book entitled A Guide to Texas Workers' Comp Reform. The authors of the book assert the courts of the state should liberally allow intervention by the Commission in cases in which a construction of the Act contrary to that urged by the Commission is at issue.

Regarding the Advisory 92-05 issued by Todd Brown on August 12, 1992, Mr. Huestis testified the document is advisory only and does not rise to the level of a rule of the Commission. It is an executive communication to those that practice within the workers' compensation system.

Mr. Huestis testified he was instrumental in coordinating a meeting sponsored by the American Insurance Association on May 1, 1996, which was convened to discuss issues which were troublesome in the workers' compensation system, in preparation for the legislative session in 1997. At the meeting Todd Brown spoke. He stated the Commission was interested in working with insurers to resolve common

concerns. He indicated he would rather sit down and try to work out problems than get involved in litigation filed by insurers. The Davis case was discussed. Mr. Brown stated the Commission did not recognize the ruling of the district court as precedential.

As a follow-up to the meeting on May 1, 1996, Mr. Huestis participated in setting up a meeting about July 15, 1996, at which the Petitioner and others expected to be able to discuss with Mr. Brown and others the possibility of seeking declaratory judgments in those cases where the Commission and the insurers differed. The expectation was that such actions would be quicker and less confrontational than other forms of litigation and would result in the resolution of certain issues. On the date of the meeting Mr. Brown was unavailable. Those attending the meeting were without authority to act on any of the proposals. Mr. Huestis testified he was dismayed at Mr. Brown's failure to attend the meeting.

On cross-examination, Mr. Huestis did not agree that only the Commission can determine when and if an injured worker has reached MMI. Mr. Huestis testified that there must first be differing opinions among doctors regarding whether the injured worker has reached MMI. When the objective medical opinions of a RME doctor and the treating doctor regarding MMI differ, then a third doctor selected by the Commission is used to resolve the dispute. He further testified that the insurer has the right to support the position that MMI has been reached when that is indicated by their doctor, and they are mandated under the Act to initiate impairment income benefits, if an impairment rating is issued along with the finding of MMI. He contended the insurer is allowed under the Act to suspend TIBs upon a certification of MMI by a RME doctor. That the certification is disputed does not impede the insurer from suspending TIBs and initiating impairment income benefits, if any be due. According to Mr. Huestis, even if there is no impairment rating, the insurer had the right to suspend TIBs until any dispute that results is resolved.

Mr. Huestis testified that there are instances in which the injured worker's treating doctor certifies the worker to be at MMI and the worker disputes the finding. In those instances the insurer is obligated to suspend payment of TIBs and to initiate payment of impairment income benefits pending a resolution of the dispute over MMI by a designated doctor appointed by the Commission. If the designated doctor agrees with the injured worker, the Commission is authorized to order reinstatement of TIBs.

Upon being challenged on cross-examination to find anyplace in the Act or rules of the Commission where the insurer is allowed to "suspend" TIBs, Mr. Huestis referred to the Commission's rule 130.4(d) which sets out circumstances under which

TIBs may not be suspended without an interlocutory order granting suspension of benefits.[17] He drew the inference that since the rule precluded suspension of TIBs under some circumstances, then suspension was allowed under other circumstances. Mr. Huestis testified that a suspension of TIBs based upon a certification of MMI becomes a termination of TIBs if the certification is not contested. Mr. Huestis contended the TIBs are not terminated at the certification of MMI because they are subject to being reinstated following an examination by a designated doctor provided the designated doctor disagrees with the certification of MMI.

10. Deposition of Joe Sebesta

Joe Sebesta is an attorney employed by the Commission as a member of the appeals panel which consists of approximately 12 judges. Appeals from contested cases are considered by panels of three judges.

Judge Sebesta testified that the appeals panels, when considering an appeal, follow precedents set in prior decisions. He testified he follows prior decisions even if he disagrees with them. Even when he has written a dissent on a decision, he considers the majority position to be precedential and subsequently follows the majority position with which he previously disagreed. He was not aware of any appeals panel which had reversed a prior appeals panel's decision. He testified there have been decisions which reconsidered and redefined matters resulting in different decisions. However, if a case can not be distinguished from a prior case, the prior case is precedent and is followed. Judge Sebesta agreed that neither the Act nor the rules of the Commission contain any specific reference to decisions of the appeals panel as having precedential value.

Judge Sebesta testified he does not feel bound to follow a decision of a district court which has reversed one of the decisions of the Commission's appeals panel. He was the author of the appeals panel decision giving rise to the Davis case. Judge Sebesta testified he does not feel bound by the decision of the Dallas district court. He would feel bound by a decision of the court of appeals if it were published and if the subject was not addressed by another court of appeals.

[17]Rule 130.4 is titled "Presumption that Maximum Medical Improvement has been Reached and Resolution when MMI has not been Certified." Subsection (d) provides: "The insurance carrier shall not suspend temporary income benefits based on this section, unless a benefit review officer issues an interlocutory order granting suspension of benefits." 28 TEX. ADMIN. CODE §130.4(d).

Judge Sebesta does not consider advisories issued by the Executive Director to be directory. They do not constitute a rule which must be followed.

11. Deposition of Susan Martha Kelley

Susan Martha Kelley is an attorney employed by the Commission as a member of the appeals panel. She worked for the Commission as general counsel from May 1990 until January 1992 when she was appointed an appeals panel judge. She was a member of the appeals panel which issued the decision appealed in the Davis case. Judge Kelley testified the appeals panel decisions are not issued en banc, but by panels of three judges.

In regard to advisories issued by the Executive Director, Judge Kelley testified she considers them to be a policy pronouncement of the Commission and an authoritative source of Commission policy. On advice of counsel, she refused to state whether she considered advisories to rise to the level of an agency rule.

Judge Kelley testified she knew of only one case in which a prior decision of the appeals panel was reversed by a subsequent decision. She testified that as different permutations of facts arise they may lead to a prior decision being refined. She agreed the appeals panels have rendered approximately a thousand decisions per year beginning about 1993. She also testified that rules changes by the six commissioners have caused decisions to be rendered which differed from prior decisions.

Judge Kelley testified that decisions of the district courts of the state do not have precedential value beyond the specific case. She does not consider the court's findings in the Davis case to be binding on the appeals panel. She does consider published decisions of the court of civil appeals to provide guidance.

12. Deposition of John Skrhak

John Skrhak is an attorney and a member of the law firm of Looper, Reed, Mark and McGraw in Dallas, Texas. He has practiced law since 1974 with an emphasis on workers' compensation litigation, business litigation, and insurance defense.

Mr. Skrhak testified that the adoption of the Act in 1989 led to greater difficulty in overturning or reversing administrative decisions made by the Commission. He testified that for a period of time following the enactment of the Act, insurers followed the instructions of the Commission and its appeals panels while the insurers attempted

to gain an understanding of the provisions of the Act. This resulted in a significant reduction in attorney participation in the process.

Mr. Skrhak testified he was contacted by Neal Moreland after the Commission's appeals panel rendered its decision regarding Maximiliano Davis. Mr. Moreland believed the decision was contrary to the Act. The contact led to the lawsuit filed in the district court in Dallas County which led to the Davis case. Mr. Skrhak testified forthrightly that he chose not to join the Commission as a party in the Davis case for two reasons. First, he wanted to maintain the suit in Dallas County which he considered a friendlier venue than Travis County. Second, all of the participants in the suit expected the Commission would intervene.

According to Mr. Skrhak, he served a copy of the original petition in the case on the Commission. He expected, and wanted, the Commission to intervene in the case. He subsequently received a telephone call from a representative of the Commission who informed him the Commission would not intervene. Mr. Skrhak could not recall the name of the individual to whom he spoke. He testified the purpose of the lawsuit had not been to recover the payments erroneously made to Mr. Davis, but to obtain a ruling that reversed the appeals panel decision so that it would have a prospective effect on an insurers ability to suspend TIBs upon certification of MMI.

Mr. Skrhak testified he filed a motion for summary judgment in the case and notified the Commission of the filing. The attorney for Mr. Davis filed a response and vigorously opposed the motion in a hearing before the court. The judge in the case listened to the arguments of the parties and asked numerous questions. The judge ruled in favor of the Plaintiff, Employers Casualty Company, and granted the summary judgment.

Following the issuance of the order in the Davis case, Mr. Skrhak called the Commission and spoke to the same individual who had declined to intervene in the case. He again could not recall the name of the individual. Mr. Skrhak advised the Commission it was his position that under the doctrine of virtual representation, the Commission was bound by the court's decision. The representative advised Mr. Skrhak that because the Commission had not intervened it was not a party to the suit and would not be bound by the decision. As a result of the Commission's position, Employers Casualty Company decided to file a declaratory judgment action in Travis County for a determination of whether the Dallas court's decision was binding on the Commission. However, Employers Casualty Company was in conservatorship at the time and an effort was made to minimize attorneys' fees. The declaratory judgment

action was not initiated. Employers Casualty Company was later placed in receivership.

Mr. Skrhak testified he believes the Commission is bound by the Davis decision under the doctrine of virtual representation. Mr. Davis represented the same interest as the Commission and vigorously resisted the summary judgment. He contended the decision has precedential value. He understands the Commission and its appeals panel do not agree and have refused to follow the decision in the Davis case.

13. Depositions of Claudia Nadig

Claudia Nadig is the Assistant General Counsel for the Commission. She was deposed as the Commission's designated representative on October 4, 1996, in Cause No. 43008 in the 43rd Judicial District Court of Parker County, Texas, in the case styled St. Paul Fire and Marine Insurance Company v. Valerie Meador and as the Commission's designated representative on November 14, 1996, in Cause No. 96-10158-A in the 14th Judicial District Court of Dallas County, Texas, in the case styled Old Republic Insurance Company v. Texas Workers' Compensation Commission, et al.[18]

In the deposition taken on October 4, 1996, Ms. Nadig was not provided a copy of the subpoena duces tecum or deposition notice issued in the case and consequently attended the deposition without bringing any of the documents requested by the Plaintiff. Ms. Nadig testified that in addition to her duties as Assistant General Counsel, she supervises the intervention program (which maintains the database of cases referred to the Attorney General's office for possible intervention) and is the administrator of the Subsequent Injury Fund.

Ms. Nadig testified she reviews all petitions that are received by the Commission, and she then sends the petition to the Executive Director who approves sending them to the Attorney General's office so that the Commission may intervene in the case if it is desirable. She testified there are no written memos, policies, guidelines, or procedures concerning the intervention program which came into existence in 1992. The intervention database reflects that, as of the date of the

[18]The Petitioner sought to depose the Commission's designated representative in the instant case. Judge Ramos declined to issue a commission to conduct the deposition. The two depositions of Claudia Nadig were offered and admitted pursuant to Texas Rule of Procedure 207. The Petitioner was required, and the Commission was offered the opportunity, to specify, by page and line number, those portions of the depositions which it wished to have considered.

deposition, approximately 1600 intervention files had been opened. The intervention files are maintained in the general counsel's office.

According to Ms. Nadig, the Commission intervenes in cases to ensure that the Workers' Compensation Act is properly administered and to see that parties to cases do not circumvent the provisions of the law. She testified the Commission's position is to intervene in all cases. She agreed the policy regarding interventions is not in writing. All files are referred to the Attorney General's office with approval to intervene.

In regard to questions about the operation of the Subsequent Injury Fund, Ms. Nadig agreed the only process available to an insurer to obtain reimbursement of overpayments made after entry of an order of the Commission is by claim upon the Subsequent Injury Fund. She testified that if an insurer paid benefits based on an appeals panel decision and the decision is reversed by a district court summary or default judgment, the Subsequent Injury Fund will deny reimbursement for overpayments. She agreed the Commission has no written rule, policy or procedure regarding conditions under which an insurer will be reimbursed from the Subsequent Injury Fund. The decision is left to Ms. Nadig's discretion.

14. Documentary Evidence

a. Official Notice

The Petitioner filed motions requesting the ALJ to take official notice of the following:

(1) Minutes of the Texas Workers' Compensation Commission Public Meetings on 19 different dates between April 22, 1993, and July 7, 1994.

(2) Minutes of the Commission's public meetings on August 3, 1992; September 3, 1992; and October 1, 1992.

(3) Draft proposed rules of the Commission's staff and/or SubCommittee of the Commission on the subject of whether an insurance carrier can suspend temporary income benefits based upon the certification of MMI by a RME doctor.

(4) Draft proposed rule of the Commission's staff with unknown comment on the subject of whether an insurance carrier can suspend temporary income benefits based upon the certification of MMI by a RME doctor.

(5) Draft Agendas and Agendas of the Commission's public meetings for 12 dates between June 25, 1992, and July 7, 1994.

(6) December 9, 1988, Joint Select Committee on Workers' Compensation Insurance Report to the 71st Texas Legislature.

(7) Legislative history of the Texas Workers' Compensation Act.

(8) 1990 Report of the Legislative Oversight Committee on Workers' Compensation.

The Commission filed no objections to the Petitioner's requests to take official notice except to the request to take official notice of the legislative history. The objection was not to the legislative history, but was directed to an interpretation of the legislative history included in the Petitioner's motion. The Petitioner's requests to take official notice were granted.

b. Admissions

In the process of discovery, the Petitioner filed requests for approximately 291 admissions on the Commission. At the hearing, the Petitioner filed a document entitled "Facts Admitted by TWCC." The Commission was given an opportunity to file a written response, but failed to timely do so. The Petitioner objected to the Commission's late filed response and that objection is sustained because the Commission's response was not timely.

The ALJ will not recite the matters admitted by the Commission, but will summarize them even though much of what has been admitted by the Commission is duplicative of evidence adduced at the hearing. Those admissions not relevant to the case are not included in the summary which follows. There were numerous admissions relating to the genuineness of documents identified as attached to the request for admissions. The exhibits admitted at the hearing were not specifically tied to the requests for admissions. Consequently, references to such documents are generally not included in this summary.

The Act defines "designated doctor," "doctor," "treating doctor," "disability," "income benefit," and "maximum medical improvement." The Commission admitted to the definitions of "doctor" and "treating doctor" as set out in §401.011 of the Act. The Commission admitted to matters provided in §408.004(a)(3), (b), and (e) of the Act.

TEX. REV. CIV. STAT. art. 8307 §4, was, prior to its repeal in 1989, a part of the Texas Workers' Compensation Act. The Commission admitted to matters provided in subsections (a) and (b) of §4. Article 8307 §4 was amended in 1987. The Commission admitted to matters contained in §4 prior to the amendment. In 1993, TEX. REV. CIV. STAT. art. 8308 §4.26 was codified, without substantive changes as §§408.121 and 408.123 of the Act. The Commission admitted to the contents of §408.123 of the Act.

[redacted] was employed by Intsel Southwest on May 22, 1995, and on that date Intsel Southwest carried workers' compensation insurance. The proper form to request a change in treating doctors is TWCC Form 53. [redacted] did not complete a TWCC Form 53 requesting his treating doctor be changed from Dr. Massimo Morandi to Donald Lazarz, M.D. and the Commission did not approve or authorize the change of treating doctors. When Dr. Lazarz began treating [redacted] on June 16, 1995, no medical emergency existed justifying the failure of [redacted] to comply with §408.022 of the Act and TWCC rule 126.9.

Tracy L. Hall, a former employee of the Commission, was authorized to represent workers before the Commission at all times pertinent to the instant proceeding and had represented workers prior to the time she began to represent [redacted] on May 26, 1995. Ms. Hall represented [redacted] on June 16, 1995. Ms. Hall did not complete a TWCC Form 53 for [redacted] to change treating doctors from Dr. Morandi to Dr. Lazarz. On June 16, 1995, Dr. Lazarz notified the Commission, by filing a TWCC Form 61, that he was [redacted] treating doctor. The Commission did not make any effort to take disciplinary administrative action or seek any monetary penalty against [redacted] Tracy Hall, or Dr. Lazarz for their failure to comply with §408.022 of the Act and the Commission's Rule 126.9.

On September 27, 1995, Dr. Charles Xeller issued a medical report indicating [redacted] could do light duty work at a desk and that [redacted] would be at MMI in six to eight weeks. Section 410.028 creates a Class D administrative violation for a worker's representative to fail to attend a benefit review conference without good cause. On February 14, 1996, James Cleary, on behalf of Intsel Southwest, sent a letter to Tracy Hall. The letter included an offer of employment to [redacted] who did

not accept the offer. Neither the Commission nor any court has found that Gallegos did not reject a bona fide offer of employment.

As a general rule, the Commission's benefit review officers are familiar with the Act, the rules of the Commission, the Commission's Advisories, and the Commission's general policies. Cordell Marshall is a benefit review officer who is familiar with the Act, the rules of the Commission, the Commission's Advisories, and the Commission's general policies. Cordell Marshall and other benefit review officers can act within the scope of their authority as defined in the Act and rules. Benefit review officers can request the initiation of administrative violations pursuant to §415.031 of the Act. On June 4, 1996 Cordell Marshall was the benefit review officer in the benefit review conference on the [redacted] claim. Cordell Marshall knew at that time he had no authority to issue an administrative violation.

The Commission's Advisories are not administrative rules adopted by the commissioners. In promulgating Advisories, the Commission does not provide notice prior to issuance. In promulgating Advisories, the Executive Director does not allow for public comment of individuals affected by the advisories. The Texas Administrative Procedure Act requires both prior notice and allowance for public comment when promulgating agency rules.

The Commission's appeals panel cannot make rules within the meaning of Chapter 2001, Subchapter B of the Texas Government Code. Appeals panel decisions are not published in the Texas Register nor are they provided without charge to the general public.

Each of the Commission's appeals panels is made up of three judges who are attorneys. One judge is assigned as principal author on each case. As a general rule, the judge who reviews the case drafts the written opinion and the other two judges review the written opinion, the record, if necessary, and then either concur or dissent from the opinion.

An insurer would be guilty of an administrative violation if it were to fail to comply with §408.121 of the Act. The Petitioner has no past administrative violations for violating the statutory provisions listed in Violation No. 31011 in the manner described in Violation No. 31011.

The Commission and its Dallas Field Office had actual notice of the Davis case prior to the court's rendering of judgment but did not intervene in the case. The Commission did not file a motion for new trial in the Davis case and did not file a bill

of review. The Commission received a copy of the Plaintiff's Original Petition, and had actual notice thereof, filed in the Davis case within 40 days of the filing of the petition in the court. The Commission did not give notice to the Petitioner of the appeal of the Davis case to the district court in Dallas County. The Commission did not intervene in the Davis case. The Commission had actual notice of the summary judgment in the Davis case within 30 days of the date the judgment was rendered. The Commission did not file a writ of error in the Court of Appeals of the summary judgment in the Davis case. The Commission did not request an Attorney General's opinion regarding the validity of the judgment in the Davis case. The Commission did not give notice to the Petitioner by way of an advisory that the appeals panel decision had been reversed and set aside in the Davis case. The Commission's appeals panel members were advised of the court's decision in the Davis case.

The Commission did not give notice to the Petitioner regarding the contested case hearing, the request for appeal, the response to the appeals panel, or the appeals panel decision relating to the case involving Maximiliano Davis and Employers Casualty Company.

The Commission has never requested an Attorney General's opinion regarding whether an insurer can suspend TIBs based upon certification of MMI by a RME doctor.

Todd Brown was employed as Executive Director of the Commission from July 1992 until at least the date of his deposition on March 18, 1996. At the deposition he testified the statute governing the Commission takes precedence over the Commission's rules which take precedence over advisories. He agreed the Commission can only enforce and apply the law as it is written. He agreed the six commissioners have proposed, adopted, and amended rules from 1991 to the date of the deposition. He agreed he notified the six commissioners of the Davis decision.

The six commissioners have not adopted a formal rule addressing the issue of whether an insurer can suspend TIBs based on a certification of MMI by a RME doctor. The staff of the Commission proposed to the six commissioners a Rule 129.6 providing an insurer could not suspend TIBs based on a certification of MMI by a RME doctor following the Davis decision. The six commissioners reviewed the draft rule on more than one occasion and did not adopt it. The Commission has not, since the adoption of the Act, requested the Texas Legislature amend what is now §408.123.

Appeals panel decisions are not sent to the six commissioners before they are issued. Neither are they sent to the six commissioners for their consideration in promulgating rules. Appeals panels do not comply with the Open Meetings Act.

The Commission does not recognize district court default and summary judgments to have precedential value.

Claudia Nadig was employed as assistant general counsel for the Commission on November 2, 1992, and October 4, 1996.

The following documents are genuine: (i) the Summary Judgment Order in the Davis case; (ii) the draft of proposed Rule 129.6; and (iii) the unsigned, unfiled draft of the Commission's Petition in Intervention and Original Answer in the Davis case.

ANALYSIS OF THE EVIDENCE

In a contested case, the findings of fact must be based upon the evidence presented and matters officially noticed. TEX. GOV'T CODE ANN. §2001.141(c). This case is properly considered a contested case and the ALJ therefore will follow the admonition of §2001.141(c). Argument of counsel, however eloquent or passionate, is not evidence and was not the basis for the decision in this case.

As previously stated, the case was hotly contested. To make matters worse, the parties wandered a little ways down each rabbit trail they passed. In this analysis, the ALJ will attempt to generally limit remarks to the questions presented for resolution and to avoid spending undue time on matters which are interesting but not necessary to the disposition of the case.

Considerable time was consumed in various depositions, in the testimony of witnesses, and in the admissions in an attempt to show Todd Brown was less than truthful when questioned about the date when the Commission had notice of the actions in the Davis case. The veracity of Todd Brown was not a relevant issue.

A second matter upon which time was spent concerned how the appeals panels, in other unrelated cases, ignored other district court decisions. That, too, was not relevant inasmuch as by testimony and admissions, the Commission readily made clear it does not consider a district court decision to have precedential value for the Commission except in the specific case before the court.

A third matter upon which unnecessary time was spent was whether [redacted] properly notified the Commission when he changed his treating doctor from Dr. Morandi to Dr. Lazarz. The ALJ recognizes such evidence was tied to evidence showing the Commission did not seek administrative penalties against [redacted] his attorney, or his treating doctor for their failure to provide proper notification of the change. However, in the stipulations filed on February 24, 1997, the Petitioner agreed not to pursue its defense of selective or discriminatory enforcement. Consequently, the evidence adduced in this regard was not relevant to this proceeding.

Finally, the Petitioner asked that the ALJ declare the Commission is bound, under the doctrine of stare decisis, by the decision of the 134th Judicial District Court of Dallas County in Employers Casualty Company v. Maximiliano Davis. The ALJ declines to make such a declaration for several reasons. First, the Commission was not a party to the Davis case. The Plaintiff, Employers Casualty Company, considered naming the Commission as a Defendant then deliberately did not in order to maintain the case in Dallas County. The Commission was not a necessary party and the case proceeded to judgment without the Commission's participation. The Commission had the right, but not the obligation, to intervene. Had the Commission been obligated to intervene, then it would have been a necessary party and the judgment invalid without its participation. Second, it is axiomatic the decision of a district court does not establish a precedent in any case except the one in which the decision is rendered. A sister district court in another county, or in the same county, is free to ignore the decision and its rationale. Since the Commission may intervene in any district court in the state when a decision of an appeals panel is challenged, the Commission could face a multitude of conflicting decisions on a single issue. A group of conflicting decisions could not all be precedent setting.

The ALJ considered the Petitioner's position that the Commission had proper notice of the filing of the Davis case, of the motion for summary judgment, and of the decision of the court. The ALJ considered that the Commission failed to intervene, to appeal the decision, to file a motion for new trial, to file a bill of exceptions, to appeal, or to file for a writ of error in the case. The ALJ also considered the assertion that the Commission was virtually represented in the proceeding by the Defendant. The ALJ further considered that the actions of the Commission were, to say the least, inimical to judicial economy. The ALJ agrees the Commission runs a substantial risk with such an approach, but the ALJ is not convinced the Commission is bound by the decision of a district court except in regard to the specific case in which the decision is rendered.

The central question presented to the ALJ was this, "Did the Petitioner violate the Act when it suspended temporary income benefits to [redacted] on April 25, 1996, after it had been notified by Dr. Charles Xeller about April 16, 1996, that he certified [redacted] as attaining maximum medical improvement on December 22, 1995, and that [redacted] had a zero percent impairment rating?" A secondary question was, "If the Petitioner did so violate the Act, what amount of administrative penalty would satisfy the requirements of §415.021 of the Act?" The Commission had the burden of proving both the violation it alleged and the amount of administrative penalty which would satisfy §415.021. For the reasons which follow, the Commission wholly failed to establish by a preponderance of the evidence its position on either of the two questions.

The secondary question, being the easiest, is addressed first. The Act, at §415.021, requires the Commission to consider various factors in assessing an administrative penalty. The evidence offered by the Commission which was directed to the standards of §415.021 was paltry. The only evidence adduced at the hearing relating to the first standard, i.e., "the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act," was a single question asked of Mr. Hill, which was objected to by the Petitioner because Mr. Hill was not an expert witness. The question asked how claimants are affected when TIBs are cut off. The only information relating to the second standard, i.e., "the history and extent of previous administrative violations," was provided in the admissions made by the Commission at the request of the Petitioner. The Commission admitted the Petitioner had no history of similar violations.

In regard to the fourth standard, i.e., "the economic benefit resulting from the prohibited act," counsel for the Commission did address the issue on cross-examination of several of the Petitioner's witnesses, but the questions elicited information that was of essentially no value. The witnesses either testified they did not know of the amount of economic benefit or denied it was an important or significant issue. The Petitioner offered testimony of several witnesses which addressed the fifth standard, i.e., "the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act." They testified the Petitioner had made efforts to meet with Commission representatives, including the Executive Director, to reconcile their differences without success. The Commission offered no evidence related to the standard. Neither party addressed the final two standards which the reader will find in Appendix A.

The Commission, the party with the burden of proof, presented insufficient evidence by which the ALJ, even if it were shown that the Petitioner violated the Act as alleged, could ascertain any sum certain that would satisfy §415.021.

In regard to the primary question before the ALJ, not only did the Commission fail to demonstrate by a preponderance of the evidence that the Petitioner violated the Act, the Petitioner demonstrated conclusively that it did not. The Commission presented only one witness who addressed the issue of whether an insurer can legally suspend TIBs upon a certification of its RME doctor that an injured worker has reached MMI. Ms. Hall testified an insurer is not allowed to stop benefits based on the report of its own doctor. She gave no justification for her position other than that was the position she held when she was an employee of the Commission.

The only justification for the Commission's position which was presented as evidence in this case is that found in the appeals panel decision which was the basis for the Davis case. That decision was reversed in a court of law and held for naught as clearly erroneous as a matter of law. In the appeals panel decision the position of the author of the decision was that because the designated doctor, in a case involving a dispute as to MMI, makes his report to the Commission, he does not determine when MMI is reached. According to the appeals panel decision that determination is reserved to the Commission. Based on that, the appeals panel decision opines, "It would appear illogical to allow a doctor, requested by the carrier, to solely determine when TIBs should be stopped when a doctor designated by the Commission cannot make such a decision." The discussion below reflects the ALJ's disagreement with the opinion expressed in the appeals panel's decision.

The Commission was wrong even regarding its conception of the Commission's duty. The Commission argued the central issue in the case was just a question of money. The theme of the Commission's position on the case was, this is a case of a big insurance company against a little worker and the Commission is duty bound to protect the worker from the big insurance company. The ALJ does not agree with the staff's interpretation of the Commission's duty. The Commission has the duty to see that the Act is faithfully implemented and enforced. In doing so the Commission is obligated to be impartial. The legislature clearly had that concept in mind when it created the Commission with a governing body composed of three wage-earner representatives and an equal number of employer representatives. See Section 402.001 of the Act. If the Commission were intended to favor either workers or employers, then the legislature would not have created an equally balanced governing body.

The Commission's position in this case was wrong based on a plain reading of the Act. The legislature did not write an ambiguous statute crying for interpretation by the Commission. The Act is clear regarding the period of time during which an injured worker is entitled to TIBs. The injured worker is entitled to TIBs until the injured worker "has attained" MMI. See §408.101(a). The attainment of MMI marks the end of TIBs and the beginning of impairment income benefits, if such be due. The insurer is mandated by the Act to begin paying impairment income benefits not later than the fifth after "the date on which the insurance carrier **receives** the doctor's report **certifying maximum medical improvement.**" (My emphasis) See §408.121.

The Act is clear regarding required medical examinations. It specifically authorizes the insurer to request that its doctor examine the injured employee when it has a question relating to the injured employee's "attainment" of MMI or the employee's impairment. The Act gives the Commission the authority to order such an examination. See §408.004. The Act clearly anticipates the insurer's RME doctor may certify the employee to have reached MMI and may evaluate the employee's impairment rating. See §408.123. The Act also clearly anticipates there may be a dispute between the insurer's RME doctor and the employee's treating doctor regarding whether the employee has reached MMI. See §408.122(c).

The Act establishes a procedure to be followed when there is a dispute relating to whether the employee has reached MMI. See §408.122(c). The procedure provides for the Commission to direct the employee to be examined by a designated doctor whose report is to be given presumptive weight by the Commission. The ALJ notes that the procedure established in the Act does not specifically preclude the insurer from suspending income benefit payments pending the report of the designated doctor or pending resolution of the dispute.

The Act also establishes a procedure to be followed when the insurer's RME doctor reports that an injured employee can return to work immediately. In that case, the insurer is specifically directed not to "suspend" income benefit payments pending a benefit review conference. See §408.004(e). The evidence received at the hearing indicates an injured worker may be released to return to work prior to reaching MMI, and conversely, an injured worker may reach MMI without being released to return to work. The ALJ is of the opinion that the Legislature, in choosing to preclude suspension of benefits in §408.004, and in choosing not to preclude suspension of benefits in §408.122, knew what it was doing when it differentiated between the two sections.

The Commission was wrong in its interpretation of "a doctor" as it is used in §408.123(a). The Act defines three categories of doctors. It defines "designated doctor." See §401.011(15). It defines "treating doctor." See §401.011(42). It also defines "doctor." See §401.011(17). The Legislature had the opportunity to select either of the two more narrowly defined designations but chose the lesser restricted one. The Legislature chose "doctor," not "treating doctor" or "designated doctor." Testimony from several witnesses and the documented legislative history reveal that the Legislature, in its deliberations relating to the provision which became §408.123, considered using the term "treating doctor." The Legislature opted instead to use "doctor." "The deletion of a provision in a pending bill discloses the legislative intent to reject the proposal." Transportation Insurance Company v. Maksyn, 580 S.W.2d 334 (Tex. 1979). The provision is not ambiguous. This ALJ has no authority to interpret the provision other than as adopted by the Legislature. Furthermore, the testimony of Professor Beal regarding the rules of statutory construction, as they apply to this provision of the Act, was uncontroverted. The ALJ is of the opinion §408.123 allows, and anticipates, that the certification of MMI may be made by the insurer's RME.

Unable to gainsay the force of Professor Beal's assertions, the Commission sought refuge in its position that only the Commission has authority to declare when an injured worker has reached MMI. The ALJ is of the opinion that even that position is not wholly correct. A fair reading of §408.122(c) reveals that there is only one circumstance, out of many, under which the Commission is called upon to settle the question of MMI. When the treating doctor finds his patient has reached MMI and the injured worker does not dispute it, the question does not come before the Commission for a ruling. When the insurer's RME doctor finds the injured worker to be at MMI and the finding is not contested, the question does not come before the Commission for a ruling. When there is a dispute about MMI and the designated doctor issues a report relative to MMI and the Commission does not disagree with it, the designated doctor's finding stands. The Act requires the Commission, under normal circumstances, to abide by the findings of the designated doctor.

Consequently, under the circumstances of normal disputes, the designated doctor, contrary to the position of the appeals panel decision discussed above, determines when MMI is reached and thus when TIBs ceases. Only when there is a dispute about MMI and only when the Commission disagrees with the designated doctor does the Commission have input. The Commission is allowed to disagree with the designated doctor "when the great weight of the other medical evidence is to the contrary." When the Commission is called upon to determine the date MMI is reached, it is the exception, rather than the rule.

There is an additional limitation under which the Commission must labor. The Commission may not interpret the Act as it sees fit without regard to the language selected by the Legislature. The Commission is constrained to fairly administer the Act and not to act arbitrarily and capriciously. The Commission is not allowed to unilaterally amend the Act by inserting or implying language declined by the Legislature.

The Commission was wrong in its contention that it had authority to enforce the Executive Director's Advisory by charging the Petitioner with administrative violations for failing to follow it. The Advisory does not rise to the level of a rule of the Commission. Even the Commission's own employees agreed to that. In fact the staff of the Commission lobbied regularly for some two years seeking to have the six commissioners, who alone have rule making power at the agency, adopt the asserted position as a rule of the Commission. The six commissioners can only act by majority vote, and half of them oppose the position taken by the staff of the Commission. The Commission could not charge the Petitioner with violation of a rule of the Commission because none exists which prohibits the action taken by the Petitioner.

Finally, the inaction by the Commission in two instances reveals the Commission has no real confidence in its position but rather chose to go forward hoping its position would not be challenged. The first instance occurred when the Commission had the opportunity in the Davis case to intervene and defend its position. The Commission chose to refrain from intervening so it could claim the decision lacked precedential value. The second instance is revealed in the Commission's admissions. The Commission has never asked for an opinion from the Attorney General regarding its position that no insurer can suspend TIBs based on the certification of MMI by the insurer's RME doctor.

In this case the Commission had the burden of proof. The Commission failed to carry its burden. The Petitioner showed conclusively that the Commission's charges were without merit. The case against the Petitioner should be dismissed.

FINDINGS OF FACT

1. About September 16, 1996, the Texas Workers' Compensation Commission (the Commission) served Pacific Employers Insurance Company (Pacific), with a "Notice of Administrative Violation(s) and Order to Respond" asserting Pacific had wrongfully terminated benefits to an injured worker and had failed to timely reinstate those benefits.

2. About October 4, 1996, Pacific, through its attorney, John D. Pringle, The Vaughn Building, 807 Brazos, Suite 603, Austin, Texas 78701, timely requested a hearing to contest the administrative violations charged.

3. Notice of the hearing was issued on October 15, 1996.

4. On February 4, 1997, Cigna Insurance Company of Texas (the Petitioner) was substituted for Pacific.

5. Discovery in the case was attended by serious disputes between the parties.

6. From about July 15, 1997, until April 8, 1998, the matter was held in abeyance while the Commission unsuccessfully sought a writ of mandamus ordering Administrative Law Judge Sarah G. Ramos to rescind a portion of her order requiring the Commission to produce documents in its possession relating to the case styled Employers Casualty Company v. Maximiliano Davis, Cause No. 92-119784 in the 134th Judicial District Court of Dallas County, Texas.

7. On June 23, 1998, this case was transferred from Administrative Law Judge Sarah Ramos to Administrative Law Judge Earl A. Corbitt who presided over the hearing on the merits which convened on November 2, 1998 and lasted three days.

8. At the hearing on the merits, the Commission was represented by Yvonne M. Williams, attorney, Chief of the APA-Litigation Hearings Division. The Petitioner was represented by John Pringle, attorney, and Catharina Haynes, attorney.

9. At the hearing on the merits:

   a. The Commission was sanctioned for discovery abuse. The Commission was not allowed to take the position or offer evidence indicating a decision of the Commission's appeals panels was effectual in establishing or changing a Commission-wide rule or policy.

b. The Commission was limited to calling witnesses named on its witness list dated January 28, 1997, because the Commission failed to timely request the addition of other witnesses.

c. The Commission was not allowed to offer exhibits during its case in chief because the Commission's proposed exhibits were not timely exchanged with the Petitioner or filed with the State Office of Administrative Hearings.

10. On May 22, 1995, while an employee of Intsel Southwest, [redacted], suffered a compensable injury at a time when the Petitioner was the workers' compensation carrier for Intsel Southwest.

11. The Petitioner timely began paying the Claimant temporary income benefits (TIBs) based upon his injury.

12. Donald Lazarz, M.D., began treating the Claimant about June 16, 1995.

13. The Claimant attended a required medical examination (RME) at the instance of the Petitioner after which Charles Xeller, M.D., reported the

Claimant was not at maximum medical improvement (MMI) and projected the Claimant would be at MMI in six to eight weeks.

14. In a report dated February 7, 1996, Dr. Lazarz estimated the Claimant would reach MMI in April 1996, and in a report dated February 23, 1996, estimated the Claimant would reach MMI in March 1996 and could be released to work in April 1996.

15. On April 3, 1996, the Claimant attended a RME at the instance of the Petitioner and Dr. Xeller reported that the Claimant reached MMI on December 22, 1995. Dr. Xeller certified the Claimant had a zero percent impairment rating. Dr. Xeller's report was provided to the Petitioner and to Dr. Lazarz.

16. On April 16, 1996, Dr. Lazarz responded that he disagreed with Dr. Xeller's findings both as to the Claimant reaching MMI and the zero percent impairment rating.

17. On April 18, 1996, the Petitioner asked the Commission to appoint a designated doctor to examine the Claimant to settle the dispute relating to MMI and the impairment rating.

18. About April 19, 1996, the Commission issued a Form EES-19 which advised the Claimant that Dr. Xeller's finding of MMI meant the Claimant would no longer receive TIBs and advised him of his appeal rights. A copy of the form was sent to the Claimant, his attorney, and the Petitioner.

19. On April 25, 1996, the Petitioner stopped paying TIBs to the Claimant.

20. On June 4, 1996, the Petitioner resumed payment of TIBs to the Claimant following a benefit review conference conducted by the Commission.

21. About June 4, 1996, the Petitioner brought the back payments of TIBs up-to-date, with interest, by making a lump sum payment to the Claimant.

22. On June 12, 1996, J. Barton Kendrick II, M.D., the designated doctor, examined the Claimant and reported the Claimant had not yet reached MMI.

23. The events described in Findings of Fact No. 15-21 gave rise to the issuance of the "Notice of Administrative Violation(s) and Order to Respond" described in Finding of Fact No. 1.

24. The Second Called Session of the 71st Texas Legislature passed workers' compensation reform in December 1989 when it enacted TEX. REV. CIV. STAT. art. 8308, the Texas Workers' Compensation Act (the Act).

25. The Act was later codified, without substantive change, and incorporated into the Texas Labor Code. Section 4.26(d) of Article 8308, the pre-codification Act, became §408.123 of the codified Act, TEX. LABOR CODE ANN. §§401.001 et seq.

26. The 71st Legislature considered wording Section 4.26(d) so as to require an injured employee's treating doctor to certify the injured employee to be at MMI and to assess the injured employee's impairment rating to establish the point at which TIBs end and impairment income benefits begin.

27. The 71st Legislature declined to adopt the wording of Section 4.26(d) as described in Finding of Fact No. 26.

28. From mid-1992 until approximately mid-1994, the six commissioners who govern the Commission considered whether to adopt a rule which would require an injured employee's treating doctor to certify the injured employee to be at MMI and to assess the injured employee's impairment rating to establish the point at which TIBs end and impairment income benefits begin. As of the date of the hearing, the commissioners have not adopted such a rule.

29. The Executive Director of the Commission issued an advisory in 1992 which asserted he would not allow an insurer to suspend TIBs based upon the certification of the insurer's RME doctor that an injured employee is at MMI.

CONCLUSIONS OF LAW

1. The Texas Workers' Compensation Commission has jurisdiction to decide the issue presented pursuant to §§415.031-415.034 of the Act.

2. The State Office of Administrative Hearings has jurisdiction over matters related to the hearing in this proceeding, including the authority to issue a decision and order, pursuant to §415.034(a) of the Act and TEX. GOV'T CODE ANN. ch. 2003.

3. The six commissioners described in Finding of Fact No. 28 are the sole rule making body for the Commission. See §402.061 of the Act.

4. The Executive Director of the Commission is prohibited from adopting rules for the Commission. See §402.041.

5. The Act separately and distinctly defines the terms "doctor," "treating doctor," and "designated doctor." See §401.011.

6. Charles Xeller, M.D., is a "doctor" as that term is defined in §401.011(17) of the Act.

7. An injured employee is not entitled to receive temporary income benefits after attaining MMI. See §§408.101 and 408.102.

8. An insurance carrier is required to begin payment of impairment income benefits, if any be due, not later than the fifth day after the carrier receives a doctor's report certifying an injured employee has attained MMI. See §408.121.

9. The Act provides that "a doctor" may certify MMI and assess an injured employee's impairment rating. See §408.123.

10. Based upon Findings of Fact Nos. 26 and 27 and Conclusion of Law No. 9, the preponderance of the evidence indicates the Legislature intended that any doctor, not solely the injured employee's treating doctor or a designated doctor, be authorized to certify the attainment of MMI.

11. The Act permits the certification of MMI to be made by a doctor chosen by the insurer and permits the injured employee or his treating doctor to dispute the certification. See §§408.123 and 408.122(c).

12. An injured employee may be required to submit to the examination of a doctor chosen by the insurer to resolve any question about the attainment of MMI. See §408.004(a) and (b).

13. The Act provides a procedure for resolving disputes as to whether an injured employee has reached MMI. The procedure provided does not require the insurer to continue paying TIBs pending resolution of the dispute. See §408.122.

14. The Act contains no provision precluding an insurer from suspending payment of TIBs to an injured employee upon being notified that a doctor of its choice has certified the injured employee has attained MMI.

15. The Commission has adopted no rule precluding an insurer from suspending payment of TIBs to an injured employee upon being notified that a doctor of its choice has certified the injured employee has attained MMI.

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§402.083

16. Based upon Finding of Fact Nos. 10-19 and 24-29 and Conclusions of Law Nos. 3-15, the Petitioner did not violate the Act or a rule of the Commission when it suspended paying TIBs to the Claimant on April 25, 1996.

17. Based upon Conclusion of Law No. 16, the administrative violation described in Notice of Administrative Violation No. 31011 should be dismissed.

ORDER

IT IS, THEREFORE, ORDERED that the administrative violations alleged against Cigna Insurance Company of Texas in Notice of Administrative Violation No. 31011 be, and the same are hereby, dismissed.

The decision is final on the date the parties are notified, pursuant to 28 TAC §148.22. No motion for rehearing will be entertained. A party dissatisfied with the decision of the Administrative Law Judge may seek judicial review by filing a petition within 30 days after the decision is final in a District Court of Travis County, Texas, as provided by Section 2001.171 of the Administrative Procedure Act. TEX. LABOR CODE ANN. §402.073.

SIGNED this 22nd day of December, 1998.

EARL A. CORBITT
SENIOR ADMINISTRATIVE LAW JUDGE
STATE OFFICE OF ADMINISTRATIVE HEARINGS

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APPENDIX A

Selected Sections of Texas Labor Code, Title 5, Subtitle A
(Texas Workers' Compensation Act)

§401.011. General Definitions

. . .

(15) "Designated doctor" means a doctor appointed by mutual agreement of the parties or by the commission to recommend a resolution of a dispute as to the medical condition of an injured employee.

. . .

(17) "Doctor" means a doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

. . .

(24) "Impairment rating" means the percentage of permanent impairment of the whole body resulting from a compensable injury.

. . .

(30) "Maximum medical improvement" means the earlier of:

(A) the earliest date after which, based on reasonable medical probability, further medical recovery from or lasting improvement to an injury can no longer reasonably be anticipated; or

(B) the expiration of 104 weeks from the date on which income benefits begin to accrue.

. . .

(42) "Treating doctor" means the doctor who is primarily responsible for the employee's health care for an injury.

§402.001. Membership Requirements

(a) The Texas Workers' Compensation Commission is composed of six members appointed by the governor with the advice and consent of the senate.

. . .

(c) Three members of the commission must be employers of labor and three members of the commission must be wage earners.

§402.004. Voting Requirements

(a) The commission may take action only by a majority vote of its membership.

§402.041. Executive Director

(a) The executive director is the executive officer and administrative head of the commission. The executive director exercises all rights, powers, and duties imposed or conferred by law on the commission, except for rule making and other rights, powers, and duties specifically reserved under this subtitle to members of the commission.

§402.061. Adoption of Rules

The commission shall adopt rules as necessary for the implementation and enforcement of this subtitle.

§402.063. Appointment of Executive Director

The commission shall appoint the executive director of the commission.

§408.004. Required Medical Examinations

(a) The commission may require an employee to submit to medical examinations to resolve any question about:

(1) the appropriateness of the health care received by the employee;
(2) the impairment caused by the compensable injury;
(3) the attainment of maximum medical improvement; or
(4) similar issues.

(b) The commission may require an employee to submit to a medical examination at the request of the insurance carrier, but only after the insurance carrier has attempted and failed to receive the permission and concurrence of the employee for the examination. The insurance carrier is entitled to the examination only once in a 180-day period. A subsequent examination must be performed by the same doctor unless otherwise approved by the commission.

(d) An injured employee is entitled to have a doctor of the employee's choice present at an examination required by the commission at the request of an insurance carrier. The insurance carrier shall pay a fee set by the commission to the doctor selected by the employee.

(e) If the report of a doctor selected by an insurance carrier indicates that the employee can return to work immediately, the commission shall schedule a benefit review conference on the next available docket. The insurance carrier may not suspend medical or income benefit payments pending the benefit review conference.

§408.081. Income Benefits

(b) Except as otherwise provided by this subtitle, income benefits shall be paid weekly as and when they accrue without order from the commission.

§408.101. Temporary Income Benefits

(a) An employee is entitled to temporary income benefits if the employee has a disability and has not attained maximum medical improvement.

§408.102. Duration of Temporary Income Benefits

(a) Temporary income benefits continue until the employee reaches maximum medical improvement.

(b) The commission by rule shall establish a presumption that maximum

medical improvement has been reached based on a lack of medical improvement in the employee's condition.

§408.121. Impairment Income Benefits

(a) An employee's entitlement to impairment income benefits begins on the day after the date the employee reaches maximum medical improvement.

(b) The insurance carrier shall begin to pay impairment income benefits not later than the fifth day after the date on which the insurance carrier receives the doctor's report certifying maximum medical improvement. Impairment income benefits shall be paid for a period based on the impairment rating, unless that rating is disputed under Subsection (c).

(c) If the insurance carrier disputes the impairment rating used under Subsection (a), the carrier shall pay the employee impairment income benefits for a period based on the carrier's reasonable assessment of the correct rating.

§408.122. Eligibility for Impairment Income Benefits

(a) A claimant may not recover impairment income benefits unless evidence of impairment based on an objective clinical or laboratory finding exists. If the finding of impairment is made by a doctor chosen by the claimant and the finding is contested, a designated doctor or a doctor selected by the insurance carrier must be able to confirm the objective clinical or laboratory finding on which the finding of impairment is based.

(b) To be eligible to serve as a designated doctor, a doctor must meet specific qualifications, including training in the determination of impairment ratings. To the extent possible, a designated doctor must be in the same discipline and licensed by the same board of examiners as the employee's doctor of choice.

(c) If a dispute exists as to whether the employee has reached maximum medical improvement, the commission shall direct the employee to be examined by a designated doctor chosen by mutual agreement of the

parties. If the parties are unable to agree on a designated doctor, the commission shall direct the employee to be examined by a designated doctor chosen by the commission. The designated doctor shall report to the commission. The report of the designated doctor has presumptive weight, and the commission shall base its determination of whether the employee has reached maximum medical improvement on the report unless the great weight of the other medical evidence is to the contrary.

§408.123. Certification of Maximum Medical Improvement

(a) After an employee has been certified by a doctor as having reached maximum medical improvement, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating using the impairment rating guidelines described by Section 408.124. If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation shall be submitted to the treating doctor, and the treating doctor shall indicate agreement or disagreement with the certification and evaluation.

(b) A certifying doctor shall issue a written report certifying that maximum medical improvement has been reached, stating the employee's impairment rating, and providing any other information required by the commission to:

(1) the commission;
(2) the employee; and
(3) the insurance carrier.

§408.125. Dispute as to Impairment Rating

(a) If an impairment rating is disputed, the commission shall direct the employee to be examined by a designated doctor chosen by mutual agreement of the parties.

(b) If the parties are unable to agree on a designated doctor, the commission shall direct the employee to be examined by a designated doctor chosen by the commission.

(c) The designated doctor shall report in writing to the commission.

(d) If the designated doctor is chosen by the commission, the report of the designated doctor shall have presumptive weight, and the commission shall base the impairment rating on that report unless the great weight of the other medical evidence is to the contrary. If the great weight of the medical evidence contradicts the impairment rating contained in the report of the designated doctor chosen by the commission, the commission shall adopt the impairment rating of one of the other doctors.

§409.023. Payment of Benefits

(a) An insurance carrier shall continue to pay benefits promptly as and when the benefits accrue without a final decision, order, or other action of the commission, except as otherwise provided.

(b) Benefits shall be paid solely to the order of the employee or the employee's legal beneficiary.

(c) An insurance carrier commits a violation if the insurance carrier fails to comply with this section. A violation under this subsection is a Class B administrative violation. Each day of noncompliance constitutes a separate violation.

(d) An insurance carrier that commits multiple violations of this section commits a Class A administrative violation and is subject to:

(1) the sanction provided under Section 415.023; and

(2) revocation of the right to do business under the workers' compensation laws of this state.

§409.024. Termination or Reduction of Benefits

(a) An insurance carrier shall file with the commission a notice of termination or reduction of benefits, including the reasons for the termination or reduction, not later than the 10th day after the date on which benefits are terminated or reduced.

(b) An insurance carrier commits a violation if the insurance carrier does not

have reasonable grounds to terminate or reduce benefits, as determined by the commission. A violation under this subsection is a Class B administrative violation.

§410.021. Purpose

A benefit review conference is a nonadversarial, informal dispute resolution proceeding designed to:

(1) explain, orally and in writing, the rights of the respective parties to a workers' compensation claim and the procedures necessary to protect those rights;

(2) discuss the facts of the claim, review available information in order to evaluate the claim, and delineate the disputed issues; and

(3) mediate and resolve disputed issues by agreement of the parties in accordance with this subtitle and the policies of the commission.

§410.023. Request for Benefit Review Conference

On receipt of a request from a party or on its own motion, the commission may direct the parties to a disputed workers' compensation claim to meet in a benefit review conference to attempt to reach agreement on disputed issues involved in the case.

§410.026. Powers and Duties of Benefit Review Officer

(a) A benefit review officer shall:

(1) mediate disputes between the parties and assist in the adjustment of the claim consistent with this subtitle and the policies of the commission;

(2) thoroughly inform all parties of their rights and responsibilities under this subtitle....

(3) ensure that all documents and information relating to the employee's wages, medical condition, and any other information pertinent to the resolution of disputed issues are contained in the claim file at the conference.

§410.028. Failure to Attend

(a) A scheduled benefit review conference shall be conducted even though a party fails to attend unless the benefit review officer determines that good cause exists to reschedule the conference.

(b) A party commits a violation if the party fails to attend a benefit review conference without good cause as determined by the benefit review officer. A violation under this subsection is a Class D administrative violation.

§410.029. Resolution at Benefit Review Conference

(a) A dispute may be resolved either in whole or in part at a benefit review conference.

(b) If the conference results in the resolution of some disputed issues by agreement or in a settlement, the benefit review officer shall reduce the agreement or the settlement to writing. The benefit review officer and each party or the designated representative of the party shall sign the agreement or settlement.

§410.030. Binding Effect of Agreement

(a) An agreement signed in accordance with Section 410.029 is binding on the insurance carrier through the conclusion of all matters relating to the claim, unless the commission or a court, on a finding of fraud, newly discovered evidence, or other good and sufficient cause, relieves the

insurance carrier of the effect of the agreement.

§410.032. Payment of Benefits Under Interlocutory Order

(a) If a benefit review officer recommends that benefits be paid or not paid, the benefit review officer may issue an interlocutory order to pay or not pay the benefits.

(b) The subsequent injury fund shall reimburse an insurance carrier for any overpayments of benefits made under an order entered under this section if that order is reversed or modified at a contested case hearing or at arbitration.....

§410.251. Exhaustion of Remedies

A party that has exhausted its administrative remedies under this subtitle and that is aggrieved by a final decision of the appeals panel may seek judicial review under this subchapter and Subchapter G, if applicable.

§410.254. Commission Intervention

On timely motion initiated by the executive director, the commission shall be permitted to intervene in any judicial proceeding under this subchapter or Subchapter G.

§415.021. Assessment of Administrative Penalties

(a) The commission may assess an administrative penalty against a person who commits an administrative violation.

(b) The commission may assess an administrative penalty not to exceed $10,000.00 and may enter a cease and desist order against a person who:

(1) commits repeated administrative violations;
(2) allows, as a business practice, the commission of repeated

administrative violations; or

(3) violates an order or decision of the commission.

(c) In assessing an administrative penalty, the commission shall consider:

(1) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(2) the history and extent of previous administrative violations;

(3) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(4) the economic benefit resulting from the prohibited act;

(5) the penalty necessary to deter future violations; and

(6) other matters that justice may require.

(d) A penalty may be assessed only after the person charged with an administrative violation has been given an opportunity for a hearing under Subchapter C.

§415.022. Classification of Administrative Violations

Administrative violations are classified as follows:

(1) a Class A administrative violation, punishable by an administrative penalty not to exceed $10,000.00;

(2) a Class B administrative violation, punishable by an administrative penalty not to exceed $5,000.00;

(3) a Class C administrative violation, punishable by an administrative penalty not to exceed $1,000.00; and

(4) a Class D administrative violation, punishable by an administrative

penalty not to exceed $500.00.

§415.031. Initiation of Administrative Violation Proceedings

Any person may request the initiation of administrative violation proceedings by filing a written allegation with the director of the division of compliance and practices.

§415.032. Notice of Possible Administrative Violation

(a) If investigation by the division of compliance and practices indicates that an administrative violation has occurred, the division shall notify the person alleged to have committed the violation in writing of:

(1) the charge;

(2) the proposed penalty;

(3) the right to consent to the charge and the penalty; and

(4) the right to request a hearing.

(b) Not later than the 20th day after the date on which notice is received, the charged party shall:

(1) remit the amount of the penalty to the commission; or

(2) submit to the commission a written request for a hearing.

§415.034. Hearing Procedures

(a) On the request of the charged party or the executive director, the State Office of Administrative Hearings shall set a hearing. The hearing shall be conducted in the manner provided for a contested case under Chapter 2001, Government Code (the administrative procedure law).

(b) At the close of the hearing, the hearing officer conducting the hearing shall make findings of fact and conclusions of law and shall issue a written decision....

(c) The findings of fact, the decision, and the order shall be sent immediately to the charged party.