APPEAL NO. 931115

This appeal is considered in accordance with the Texas Workers' Compensation Act (1989 Act), TEX. LAB. CODE ANN. § 401.001 *et seq*. (formerly V.A.C.S., Article 8308-1.01 *et seq*.). On November 10, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The issues were whether respondent (claimant) reached maximum medical improvement (MMI) and, if so, the date and correct impairment rating. The appellant's (carrier's) case on MMI and impairment was based on its contention that the claimant had not disputed her first impairment rating (and the underlying certification of MMI) within 90 days. No designated doctor had been appointed in the case.

The hearing officer determined that claimant had not yet reached MMI, and that there was no "ripe" impairment rating, for essentially two reasons: the doctor who originally certified MMI retracted his certification, and a more serious condition was subsequently diagnosed after MMI was certified which was not considered in the certification.

The carrier has appealed, arguing that the evidence was that the first "disability" (i.e. impairment) rating assigned by the treating doctor was undisputed and therefore became final. The carrier takes issue with the hearing officer's determination that claimant had a newly-discovered condition, and contends that all of claimant's doctors had diagnosed the same problem, a bulging disc, and thus the hearing officer's finding to the contrary is against the great weight and preponderance of the evidence. The carrier argues that the hearing officer abused his discretion to withdraw the "disability" rating because there was no new medical condition or clear misdiagnosis. The claimant responds that she has not reached MMI and recites certain facts in favor of this assertion.

DECISION

After reviewing the record, we affirm the hearing officer's decision.

The claimant, a 39 year old social worker who worked for the (employer), was transporting a handicapped child in a car on (date of injury). It was undisputed that she injured her back when attempting to lift the child from the car. Claimant stated that although she was taken off work, she was released back to work in April 1992, and worked fairly steadily until early January 1993, when she was taken off work again, for five weeks, and then went back on a half-day basis until May 6th, when she was taken off work again, through October 29, 1993. Claimant said she was dismissed because she did not return. Claimant explained that she was advised by an attorney that she would lose her medical benefits if she went back to work.

We will highlight a summary of medical information pertinent to the issue at hand. It must be frankly observed that although carrier contends that claimant has had the "same" diagnosis since her injury, this is not borne out by the medical records, which include those generated to and from a utilization review organization, Health Benefits Management, hired by the carrier. (Dr. WB) saw claimant on March 25, 1992, and wrote to the carrier, noting that claimant had a protrusion of the nucleus pulposus at L5-S1, and opining that claimant

had "acute back strain with no evidence of a herniated disc on clinical examination." (Correspondence from Dr. WB at other times in 1992 repeats this impression of back strain). On March 27, 1992, a report of a CT scan agreed that there was a protrusion and opined "it is believed to be posterior herniation of the nucleus pulposus" although this is not the ultimate impression. There are no other indications in 1992 of a herniated disc. Claimant's treating doctor was (Dr. H), a chiropractor. His records show that as of July 3, 1992, reciting only x-rays of the lumbar spine at that point, he recorded an impression of lumbar disc syndrome, lumbar myalgia, subluxation complex of the lower spine, and chronic cephalgia. Claimant said that Dr. H referred her in 1992 to (Dr. O); a medical report filed by Dr. O on August 26, 1992 relates his diagnosis of lumbar discopathy and lumbar facet joint syndrome.

In a Report of Medical Evaluation (TWCC-69) and attached narrative report,(Dr. W), referred by Dr. H to assess an impairment rating, determined that claimant reached MMI on November 5, 1992, with a nine percent impairment rating. This report assessed impairment and certified MMI for "post traumatic lumbar facet syndrome with protrusion of the L4-5 disk[1] with resultant subluxation of L4-5 and lumbosacral myofascial pain." The nine percent consisted of five percent from Table 49 of the AMA Guides to the Evaluation of Permanent Impairment (Guides) and another four percent for range of motion impairment. Another TWCC-69 in the record was signed by Dr. H and stated that claimant reached MMI on November 9, 1992 with a nine percent impairment rating. (This TWCC-69 says "see attached" and is in the thick medical exhibit tendered by claimant, sequentially located on top of a copy of Dr. W's TWCC-69 and narrative.)

A December 23, 1992, letter to Health Benefits Management recited and summarized claimant's medical treatment to date. There is nothing in that summary indicating a diagnosis of herniated disc. On January 27, 1993, authorization was requested by Dr. O for what appeared to be the first MRI examination performed on claimant. The examination was conducted February 1, 1993, and recorded an impression of a herniated disc at L5-S1. Records from April 1993 indicate that a myelogram was recommended but could not be performed due to claimant's iodine sensitivity. Another CT scan performed by April 19, 1993, corroborated the results of the MRI. Claimant was referred to (Dr. M), a neurosurgeon, who stated on April 30, 1993, that he questioned the herniated disc evaluation. A neurology clinic evaluation April 28, 1993, found no evidence of radiculopathy or sciatic nerve injury.

Claimant received physical therapy in May 1993, after being taken off work by Dr. M. (The carrier did not approve the full course of recommended physical therapy). By June 17, 1993, Dr. M wrote the carrier that claimant's findings did indicate a disc rupture at the L5-S1 level. A utilization review report from Health Benefit Management on August 19, 1993, indicated that this company was working from a diagnosis of lumbar radiculopathy.

Although claimant's testimony indicated that she was aware of her impairment rating

[1]This may be an error, because Dr. W earlier noted that claimant had protrusion of L5-S1.

at some point, no evidence was developed as to the date that claimant first became aware of the rating or received a copy of either Dr. H's or Dr. W's report.[2] Claimant said that Dr. H told her she had reached "maximum chiropractic improvement" and told her to go to Dr. O if she had further problems. The copies of the TWCC-69s and underlying reports from Dr. W and Dr. H contained in the record show various date stamps that say "SWC Received" on November 30, 1992, December 18, 1992, and yet again on a scratched out day in January, 1993. A copy of a certified mail receipt contained in the medical exhibits proximate to Dr. W's TWCC-69 (never explained in the testimony) showed that claimant signed the receipt on December 14, 1992.

The claimant stated that she received, sometime in December, a check from the carrier in a large amount that was mailed with no explanation. She said she called the carrier's adjuster and was told it was a "settlement." Another check was received thereafter. Claimant kept the checks uncashed, because she did not want to indicate her condition as settled or resolved. Claimant later cashed at least one on advice of an employee of the Texas Workers' Compensation Commission (Commission) (and was advised by the hearing officer to cash them all).

Claimant stated that Dr. O became her treating doctor. When the carrier stopped paying for his treatment, she contacted the Commission in February 1993 and was advised to seek approval of the change of her treating doctor. She filed this request on February 9, 1993, and the reasons listed did not indicate any dispute or disagreement with any impairment rating or MMI certification.

Dr. H wrote to the Commission on August 26, 1993, and retracted his earlier MMI certification based upon new information supplied by Dr. O. Although some medical records indicated that at one point claimant was under emotional stress, none of the records suggest that claimant's continuing pain or problems are subjective, rather than objective, in nature.

We do not regard the "retraction" by Dr. H as dispositive of the case, as it appears that the first rating may have been assessed by Dr. W from whom there is no retraction in the record. More to the point is that the rating the carrier seeks to finalize did not take into account the physical injury eventually diagnosed, a herniated lumbar disc.

[2]It is unclear, therefore, which is the "first" impairment rating. At the hearing, both parties appeared to assume that Dr. H issued the first report, as did the hearing officer. However, Dr. W's report is chronologically the first rating assigned.

Claimant's medical condition is essentially similar to that of the claimant in Texas Workers' Compensation Commission Appeal No. 93501, decided August 2, 1993. The Appeals Panel upheld the hearing officer's determination that the 90 day rule[3] did not apply to finalize an impairment rating which did not take into account a herniated disc that was later detected. In that case, as in this, the original impairment rating did not include a herniated disc that had not, at that point, been diagnosed.

In Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993, the Appeals Panel noted that there were "no exceptions" to Rule 130.5(e). It is important to read that statement in the context of that case, however, in which the Appeals Panel also noted the lack of medical information presented by the claimant to establish that the initial impairment rating was wrong. The Appeals Panel also stated in that case that it would agree with the principal that assignment of impairment for an injury other than the compensable injury would not start the 90-day deadline.

The Appeals Panel has also opined that compelling medical evidence of a new, previously undiagnosed medical condition or improper or inadequate treatment of an injury could render an initial certification of MMI invalid. *See* Texas Workers' Compensation Commission Appeal No. 93489, decided July 29, 1993.

The impairment rating in this case by Dr. W (which was incorporated by Dr. H) clearly was not based upon a diagnosis of herniated disc. Not only was a herniated disc not the recited diagnosis in his report, but the five percent figure Dr. W derived from Table 49 of the Guides is not the rating for a lumbar condition that would include an unoperated herniated disc (which would be seven percent).

We note that while the claimant argued that she had raised a dispute by filing a request for a change of treating doctor in February 1993, such an action alone would not automatically be a notice of dispute. *See* Texas Workers' Compensation Commission Appeal No. 93385, decided July 2, 1993. (As a response to carrier's calculation of the applicable 90-day period, we observe that we have said previously that the 90-day deadline for disputing an impairment rating does not run from the date a doctor issues a report, but from the date the parties become aware of the rating. *See* Texas Workers' Compensation Commission Appeal No. 92693, decided February 8, 1993.)

The hearing officer's conclusion that claimant had a work-related condition that was not taken into account in the impairment evaluation conducted in November 1992, and that Rule 130.5(e) therefore did not apply to finalize the rating, is sufficiently supported by the evidence, and grounded upon interpretation of Rule 130.5(e) by previous decisions of the Appeals Panel.

[3]Tex. W.C. Comm'n Rules, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)) 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."

For these reasons, the determination of the hearing officer is affirmed.

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Susan M. Kelley
Appeals Judge

CONCUR:

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Philip F. O'Neill
Appeals Judge

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Gary L. Kilgore
Appeals Judge