APPEAL NO. 931154

This appeal is considered in accordance with the Texas Workers' Compensation Act (1989 Act), TEX. LAB. CODE ANN. § 401.011 *et seq*. (formerly TEX. REV. CIV. STAT. ANN. Art. 8308-1.01 *et seq*.). On November 23, 1993, a contested case hearing was held ion (city), Texas, with presiding, to determine the correct impairment rating and date of maximum medical improvement (MMI) for the claimant, MA, who is the appellant. She was injured on (date of injury), in the course and scope of her employment with the (employer), a self-insured governmental entity which shall be referred to herein as either employer or carrier, depending upon its role.

The hearing officer determined that claimant had not disputed her treating doctor's impairment rating within 90 days after she became aware of it, and therefore her impairment rating and underlying certification of MMI became final. Her treating doctor had certified MMI effective December 14, 1991, with a five percent impairment.

The claimant has appealed, arguing that the impairment rating of her second treating doctor (18%) should be adopted. The carrier asks that the decision be upheld.

DECISION

We affirm the hearing officer's decision.

The claimant, who was employed as a sewing instructor for the employer, said that she was injured when she slipped and fell while going into the school building, on (date of injury). Although treated for two weeks by chiropractor (Dr. R), she eventually began treating with (Dr. H). An MRI examination conducted July 28, 1992, found degenerative disc disease in claimant's lumbar spine, and a "focal area of small hemangioma vs. fat island" at L3. There was no evidence of either a herniated or extruded disc.

In Dr. H's December 14, 1992, report certifying MMI and five percent impairment, Dr. H noted mild limitations on range of motion and disc degeneration consistent with degenerative osteoarthritic changes. Dr. H's report indicated that copies were sent to the adjuster and to the claimant.

Claimant said that at this point Dr. H discharged her. She said she received his written report two to three weeks after December 14, 1992. Claimant did not contact the Texas Workers' Compensation Commission (Commission) or the carrier prior to receiving a higher rating from her second treating doctor on June 22, 1993. Her stated reason was that she did not know she had to. Her second treating doctor, (Dr. P), assessed impairment for both the thoracic and lumbar spine. He diagnosed "post traumatic thoracic, lumbar spondylogenic . . . discogenic pain syndrome." The elements of his 18% impairment rating are generally noted as range of motion plus injury due to specific disorders of two areas of the spine.

Claimant noted that she had been back at work by the time of the hearing. The date

she returned to work was not clear from the record. The claimant testified that she had been paid in excess of $4,000 for the impairment income benefits due according to Dr. H's impairment rating.

The rules of the Commission, specifically TEX. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e), state that the first impairment rating assigned to an injured worker becomes final if not disputed within 90 days. We have noted before 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 party becomes aware of the rating. We noted that it is hard to envision that one could dispute something of which one is not aware. *See* Texas Workers' Compensation Commission Appeal No. 92693, decided February 8, 1993. In this case, the claimant testified that she received the report two to three weeks after December 14, 1992, which would mean around January 5, 1993, at the latest. She did not convey a dispute with this rating until after she received a second and higher rating on June 22, 1993. She had, by this time, been paid the impairment income benefits that were due according to Dr. H's rating.

The hearing officer is the sole judge of the relevance, the materiality, weight and credibility of the evidence presented at the hearing. Section 410.165(a). The decision of the hearing officer will be set aside only if the evidence supporting the hearing officer's determination is so weak or against the overwhelming weight of the evidence as to be clearly wrong or unjust. Atlantic Mutual Insurance Co. v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.). Here, there is essentially no evidence that the claimant disputed the rating within the 90 days provided by the rule. The hearing officer correctly applied the rule to the facts at hand.

We note that in her appeal claimant asks that present and future medical visits be covered. Because medical treatment was not in issue in the hearing, there is nothing in the decision that affects claimant's right to reasonable and necessary medical treatment that she otherwise has, or that affects the carrier's ability to dispute aspects of medical treatment (in accordance with applicable statutes and Commission rules).

We affirm the determination of the hearing officer.

Susan M. Kelley
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Alan C. Ernst
Appeals Judge