APPEAL NO. 93200

Pursuant to the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN., art. 8308-1.01 *et seq*. (Vernon Supp. 1993) (1989 Act), a contested case hearing was held in (city), Texas, on February 12, 1993, (hearing officer) presiding as hearing officer. She determined the appellant (claimant) reached maximum medical improvement (MMI) on July 9, 1992, with a six percent whole body impairment rating and that he failed to advise the Commission that he wished to dispute the impairment rating within 90 days of the date it was assessed. She also determined that the claimant did advise, within 90 days, the employer and the employer's workers' compensation carrier that he did not agree with the impairment rating assessed by his treating doctor. She further determined that claimant has had disability since September 25, 1992. Claimant appeals urging error in the hearing officer's determination that the claimant reached MMI on July 9, 1992 with a whole body impairment of six percent and that it has become final inasmuch as claimant is not required by either rule or statute to file a statement of dispute with the Commission and that, in any event, a good cause exception should be applied in this case since the claimant cannot read or write and he was not aware of any requirement to file a dispute with the Commission. Respondent (carrier) asks that the decision be affirmed.

DECISION

Finding error in the Decision and Order of the hearing officer, we reverse and remand.

The facts in this case are not complicated, and for the most part, not disputed. The claimant injured his knee in a work-related accident on (date of injury), and was treated by Dr. B culminating in a partial arthroscopic medial meniscectomy on February 19, 1992. His doctor's reports indicate that in April 1992, it was obvious that the claimant was experiencing some pain and discomfort over his knee joint. He was prescribed medication and continued his physiotherapy treatment and exercise. According to the claimant, because he could not live on the weekly temporary income benefits, he asked Dr. B to return him to work on July 9, 1992, which he did. Dr. B also filled out a report indicating MMI on July 9, 1992, with a six percent whole body impairment rating. The claimant went back to work on July 19th and about a week or two after returning, the employer's safety director, Mr. S, read him the letter assessing the six percent impairment rating. The claimant told Mr. S that he did not agree with this rating and Mr. S indicated he needed to tell the "insurance lady." Mr. S immediately placed a call to Ms. N, an adjuster for the carrier, and claimant told her he did not agree with and did not want to accept the rating and was told by Ms. N that that was all he was going to get, or words to that effect. He continued working for about the next 2 months during which time his knee pained him and kept getting worse to where he would drag his leg. On September 25th, he returned to Dr. B who took him off work, arranged for an MRI and determined that he needed another operation on his knee which was performed on December 10, 1992. Claimant has not been released to return to work as of the date of the hearing.

A letter dated September 28, 1992, from Dr. B to the carrier's adjusting firm indicated that claimant was having recurring problems and that further surgery was indicated. This letter was date stamped in at the adjusting firm on October 26, 1992. Claimant introduced a letter written by his wife (both he and his wife indicated he does not read or write) to the Texas Workers' Compensation Commission and stamped received on November 17, 1992, which asked for a hearing, advised of the need for further surgery, and indicated that the claimant had been told he could not receive any benefits for being off work. Attached to this handwritten letter was a letter dated November 12, 1992, from Dr. B to the carrier's adjusting firm which provided as follows:

> Since my last report, (claimant) was to have been scheduled for arthroscopic examination of his left knee for excision of a recurrent, torn, posterior horn, medial meniscus. At that time, the patient was advised that his weekly benefits would run out on November 1, 1992, as part of his 6% whole person disability rating.
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> In light of this patient's history, it would appear to me that he probably was not at maximum improvement whenever this determination was made. There is also a strong possibility that the patient may have sustained this recurrent tear when he return (sic) to work. Notwithstanding, he does have a recurrent tear in the posterior horn of his medial meniscus, and I've advised him that he needs additional surgery as soon as possible.

The issues agreed to at the commencement of the hearing were whether the claimant had reached MMI on July 9, 1992, whether the six percent impairment rating assessed on July 9, 1992 had become final, and whether the claimant had disability, entitling him to temporary income benefits if he had not reached MMI. The hearing officer found that although the claimant advised his employer and the carrier's representative that he did not agree with the impairment rating assessed by the treating doctor (July 9, 1992), he failed, within 90 days, to advise the Commission that he wished to dispute the impairment rating. Accordingly, the rating (affecting both MMI and impairment rating) became final when it was not disputed within 90 days. The hearing officer also determined that the claimant had disability since September 25th.

We have held that the requirements of Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (TWCC Rule 130.5(e) which provide for the finality of the first assigned impairment ratings, if not disputed within 90 days, applies with equal force to the designation of MMI that accompanies the impairment rating. Texas Workers' Compensation Commission Appeal No. 92693, decided February 8, 1993; Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993. We have also noted that the 90 day period runs from the time that the party desiring to dispute the matter is notified of or

has knowledge of the rating since a party could hardly dispute something unknown to him. *See* Texas Workers' Compensation Commission Appeal No. 93046, decided March 5, 1993; Texas Workers' Compensation Commission Appeal No. 93111, decided March 29, 1993. Appeal No. 92693, *supra*. We have also stated that TWCC Rule 130.5(e) applies to both carriers and claimants. Texas Workers' Compensation Commission Appeal No. 92542, decided November 30, 1992. We have not held that a claimant must register his dispute in writing with the Commission to preclude finality under the provisions of TWCC Rule 130.5(e), although the preceding subsections of that rule, specifically applying only to carriers, state that a carrier desiring to dispute a rating "shall file with the Commission" a statement concerning disputed benefits. In Appeal 92542, *supra*, where notice of a dispute was made to the treating doctor and to a carrier representative we stated that the form that a claimant takes to dispute an impairment rating and whether he had actually disputed an impairment rating is fact specific in each case. We reversed in that case on the ground that notice to the treating doctor and carrier representative could not have been made before the claimant became aware of the rating (he complained about the particular referral doctor before the doctor had even rendered his report) and not because notice was not given by the claimant to the Commission but rather to the doctor and carrier representative. It seems to us, particularly where the regulatory requirements do not specify that notice must be given to the Commission or be done in any particular manner, that uncontroverted and clear notice of a dispute to the carrier's representative would be sufficient notice (there was nothing to controvert the claimant's testimony concerning notice to the employer and the carrier's representative and the hearing officer found that such notice was given within 90 days). In a case such as this where the claimant is disputing the matter, it is the carrier, the entity that administers and has the duty to pay the benefits, which would be most concerned with knowing a dispute is being lodged. While the Commission may ultimately become involved with the approval of a carrier selected doctor or the appointment of a designated doctor, for the purposes of resolving the disputed matter, notice to the carrier appears to us to meet all the necessary concerns of the statute, rules and the affected parties. This is not to diminish the finality purpose expressed in our decision in Appeal 92670, *supra*, where we stated:

> This rule (Rule 130.5(e)) affords a method by which the parties may rely that an assessment of impairment and MMI may safely be used to pay applicable benefits, by providing the time limit in which such assessment will be open to dispute. On the other hand, the rule also allows a liberal time frame within which the parties may ask for resolution of a dispute through the designated doctor provisions of the Act. This rule applies with equal force to the carrier and the claimant.

As we read Rule 130.5(e), in conjunction with the dispute resolution provisions Articles 4.25 and 4.26, the focus is to have disputes timely raised, that is, made known to the parties within specified time frames. This does not necessarily mean the notice of a dispute will be found only when communicated to the Commission by a claimant (as

opposed to the other interested parties) particularly where there is no specific statutory or regulatory direction to do so. However, we emphasize that any claimant having a dispute about MMI or impairment ratings under the provisions of the 1989 Act should notify the Commission in an expeditious manner about a dispute so that the dispute resolution process can be initiated by the Commission when needed or required.

Under the specific circumstances presented in this case, and in view of the hearing officer's finding that the employer and the carrier's representative were on notice of the claimant's dispute with the impairment rating and, in essence, that MMI had ever been reached, together with the compelling evidence, including the statement of the rating doctor that indicated the initial MMI determination was erroneous (as verified by subsequent objective medical evidence) and that, indeed, the on-the-job injury suffered by the claimant required additional surgery (the claimant's unrebutted testimony discounted any new injury or aggravation amounting to a new injury) and the lack of any indication that the claimant was unnecessarily or unreasonably delaying the resolution or ultimate improvement of his injury, we determine that the matter of the impairment rating and MMI had not become final. We also note that we have previously held that even a designated doctor can amend his determination of MMI and impairment rating under limited and appropriate circumstance. *See* Texas Workers' Compensation Commission Appeal No. 93062, decided March 1, 1993; Texas Workers' Compensation Commission Appeal No. 92491, decided October 8, 1992. It appears that this was the situation with the treating doctor here, and that the change or amendment was well supported by objective medical evidence.

For the above reasons, we reverse that portion of the hearing officer's findings, conclusions and Decision and Order holding that the claimant's reaching of MMI on July 9, 1992 with a six percent whole body impairment rating has become final, and that portion holding the claimants' disability does not entitle him to receive temporary income benefits since he has reached MMI. We also set aside the award of 18 weeks of impairment income benefits and the provision for credit against this award. This is not to rule out appropriate credit as a result of this decision. The case is remanded for further consideration of the issues remaining as a result of and not inconsistent with this decision, and development of evidence, as deemed necessary and appropriate by the hearing officer.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Texas Workers' Compensation Commission's division of hearings, pursuant to Article 8308-5.41. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Stark O. Sanders, Jr.
Chief Appeals Judge

CONCUR:

Joe Sebesta
Appeals Judge

CONCURRING OPINION:

I concur in this decision, under the facts of this case. In so doing, I want to make clear that the decision should not be construed as "carte blanche" for finding in far weaker cases that an MMI or impairment dispute was raised, based upon mere expressions of discontent to any bystander with a doctor's opinion. Before the "90 day rule" is found not to apply in a situation where the Commission is not notified, there should be clear evidence of the expression of a dispute, which would hopefully be bolstered, as in this case, with medical evidence against the MMI finding. The bolstering evidence in this case of a dispute is that the treating doctor had, as the majority decision notes, essentially amended his original MMI conclusion. (Although not argued, his amendment raises to some extent an inference that there was a substantial change in condition which the 1989 Act has clearly given a court, in Article 8308-6.62, the power to evaluate.) For these reasons, I concur.

Susan M. Kelley
Appeals Judge