APPEAL NO. 93783

A contested case hearing was held in (city), Texas, on August 16, 1993, (hearing officer) presiding as hearing officer, to determine the date the appellant (claimant) reached maximum medical improvement (MMI) and whether the respondent (carrier) paid impairment income benefits (IIBS) for claimant's 18% impairment, that is, for 54 weeks, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 408.121(a) (1989 Act) (formerly V.A.C.S., Article 8308-1.01, *et seq.*). Based on a number of factual findings, the hearing officer concluded that claimant reached MMI on December 30, 1991, the date determined by claimant's treating doctor, and that the carrier had paid IIBS for 54 weeks, the full amount owed as a result of the designated doctor's impairment rating of 18%. Claimant's request for review, translated from Spanish, appears to dispute the MMI date because he did not understand the significance of such date in terms of the income benefits payable under the 1989 Act, and did not feel his treating doctor helped him. Claimant also appears to contend that he received IIBS for just 39 weeks, rather than for the 54 weeks determined by the hearing officer, because had he understood the significance of the MMI date and known of the requirement that such had to be disputed within 90 days, he would have done so and, ostensibly, would have extended the period for which temporary income benefits (TIBS) were due and be entitled to an additional 15 weeks of IIBS. In a timely supplemental statement claimant asserts that the Texas Workers' Compensation Commission's (Commission) computer database shows his MMI date as April 3, 1993, and he apparently adverts to supplemental income benefits (SIBS) discrepancies. In its response the carrier first asks the Commission Appeals Panel to disregard claimant's request for review because it was written in Spanish pointing out that at the hearing claimant did not request a translator and demonstrated "a command of the English language." Carrier asserts that "[i]t is unreasonable to allow an English speaking claimant the opportunity to file a request for review in another language and thereby put all other parties at a disadvantage." Carrier also urges the sufficiency of the evidence to support the decision and asserts that claimant did not dispute his treating doctor's MMI date within 90 days of receiving a copy of that doctor's report stating his MMI date and impairment rating.

DECISION

Finding the evidence sufficient to support the challenged factual findings and legal conclusions, we affirm.

The carrier requests that claimant's appeal be "disregarded" because it was written in Spanish. As for the carrier's perception of claimant's having "a command of the English language throughout the proceedings," communication difficulties with the claimant were readily apparent in the record and the claimant consulted with the Commission's ombudsman in Spanish. Also, the carrier's counsel encountered substantial difficulty in conducting, in English, the claimant's cross-examination and, at one point, stated to the claimant: "I realize we may have a communication problem so that's why I'm going to try to be as concise as possible." The carrier cites us to no authority for its request and we consequently determine it lacks merit.

Claimant testified that on (date of injury), he was employed by the (employer) as a maintenance worker and that he fell down some stairs injuring his right knee and lower back. The parties stipulated that claimant was injured in the course and scope of his employment. Although there was evidence that the carrier had disputed whether claimant's low back condition was part of the compensable injury, there was no disputed issue at the hearing concerning the scope or extent of claimant's injury. Claimant, the sole witness, testified that he was initially treated by (Dr. F). Dr. F's report indicated he saw claimant on June 24, 1991, for complaints of right ankle and knee pain, that x-rays revealed no ankle or knee fractures but rather some degenerative knee joint disease, and that claimant was prescribed light duty for two weeks and medication. Claimant said that Dr. F referred him to (Dr. V), an orthopedic surgeon, with whom he treated from August through December 1991. Claimant complained to Dr. V of low back pain in addition to his knee pain. Claimant said that on December 3 (Dr. V's report stated the date as December 30th), 1991, Dr. V discussed the status of his knee and back conditions, advised him these conditions had stabilized, returned him to work with restrictions, and suggested retraining. Thereafter, claimant said he sought treatment from a chiropractor.

Claimant further testified that on March 13, 1992, he received a copy of a Report of Medical Evaluation (TWCC-69) from Dr. V, together with the narrative report referenced therein, which certified that claimant reached MMI on December 30, 1991, with a 16% whole body impairment rating for his knee. He acknowledged that the carrier thereafter disputed Dr. V's 16% rating; that he received a copy of the carrier's Payment of Compensation or Notice of Refused/Disputed Claim form (TWCC-21), dated March 30, 1992, which disputed Dr. V's 16% rating and which assessed a five percent rating; that the carrier's dispute ultimately resulted in his being examined for impairment rating only by a designated doctor, (Dr. C), on June 25, 1992; that Dr. C did not issue his TWCC-69 until January 1993; that he attended a benefit review conference (BRC) in March 1993 at which time he agreed to be examined by another Commission-selected designated doctor, (Dr. O); and that Dr. O, on April 3, 1993, determined his impairment rating to be 18%. There was no disagreement that Dr. O's 18% impairment rating required carrier to pay IIBS for 54 weeks. *See* Section 408.121(a). The carrier asserted, with support in its documentary evidence, that it first paid claimant TIBS up to claimant's MMI date of December 30, 1991; that it disputed Dr. V's 16% rating and thereafter paid 15 weeks of IIBS based on its five percent assessment (*see* Section 408.121(c) and Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5 (Rule 130.5)); that after receiving Dr. O's 18% rating it paid an additional 39 weeks of IIBS; and that it thereafter paid SIBS.

Claimant did not appear to dispute receiving the various income benefit payments shown to have been paid by the carrier but rather seemed to contend that he was nonetheless due an additional 15 weeks of IIBS. Claimant's apparent positions on the two disputed issues were that, notwithstanding Dr. V's discussion with him in December 1991 of the stable status of his knee and back conditions, and his having received Dr. V's TWCC-69 by March 13, 1992, and his having had subsequent contact with a Commission

ombudsman, and his having attended a BRC and having been examined by two designated doctors, he nevertheless did not understand the significance of the MMI date. He also seemed to indicate he did not understand its effect on his income benefits or the requirement to dispute it within 90 days of learning of it (*see* Rule 130.5(e)). He first disputed MMI sometime in the summer of 1993 when he talked with a Commission official at the Commission's central office. Therefore, claimant apparently reasoned, because he would have timely challenged Dr. V's MMI date but for his lack of knowledge of its significance and of the 90-day dispute rule, the IIBS he received for 15 weeks pursuant to the carrier's five percent assessment should be considered as a continuation of his TIBS and he should receive an additional 15 weeks of IIBS.

According to Dr. V's records, he first saw claimant on August 6, 1991. Claimant's chief complaint was of right knee pain and, based on x-rays and an MRI, Dr. V diagnosed a torn lateral meniscus and early osteoarthritis. At his August 27th visit claimant also complained of back pain. Dr. V's December 30, 1991, report stated that as regards claimant's knee condition, "he has accomplished full medical benefits," his recovery "has plateaued," and his "permanent partial disability of the knee is 40 percent which is equivalent to 16 percent of the person." Dr. V also stated that he expected the knee to get worse, did not believe surgery would improve it, and that based on that prognosis claimant declined surgery at that time. As for claimant's back, Dr. V's report indicated that the carrier would not authorize an MRI of claimant's lumbosacral area and that "as far as his back, his permanent partial disability is 10 percent." No impairment rating for claimant's back appeared in Dr. V's TWCC-69 however.

Claimant, apparently on his own initiative, was next examined by (Dr. B) who, in his February 2, 1992, report assigned claimant a whole body impairment rating of 16%, but did not state an MMI date. This rating had components for claimant's cervical and lumbar spines and was reduced from 21% due to pre-existing arthritic conditions. Dr. B assigned no impairment rating for claimant's knee because he felt it could be improved. Claimant was next examined by (Dr. K); however, the record was not developed as to which party requested that exam. Dr. K's March 24, 1992, report concluded that claimant sustained an aggravation of lumbar arthritis and "sprained it," but that he had reached maximum improvement for his back. As for his knee, Dr. K noted the lateral meniscus tear, felt that if the symptoms persisted arthroscopic evaluation would be required, and further opined that eventual degeneration could progress to a total knee replacement. Dr. K's TWCC-69 stated that claimant had reached MMI on "3-24-92 BACK ONLY -NO DISABILITY."

On March 30, 1992, the carrier prepared a TWCC-21 stating that it disputed the 16% rating (presumably that of Dr. V) and was "rendering a reasonable rating of 5%." No mention was made of disputing the MMI date. The Commission wrote claimant on April 28, 1992, advising that the carrier had disputed and assessed a five percent rating, that if the parties could not agree on a designated doctor in 10 days the Commission would select one, and that a Commission ombudsman was available for consultation. By letter of May 22, 1992, claimant was advised that Dr. C had been selected to examine him for the sole

purpose of determining his impairment rating. Dr. C examined claimant on June 25, 1992. His report to the carrier of August 4, 1992, with copy to the Commission, stated that 1991 x-rays suggested knee and lumbar spine degenerative changes, that claimant did not want to leave his medical records, and that Dr. C wanted the MRI report as well as the previous medical records in order to determine the impairment rating. It closed with a request that claimant's medical records be provided. In an undated TWCC-69, received by the Commission on January 15, 1993, Dr. C stated that claimant reached MMI on "06-25-92" with a 15% whole body impairment rating. In the TWCC-69, Dr. C stated that eight percent was assigned for the knee and, apparently, the remainder was for loss of spinal range of motion which, Dr. C noted, "was a subjective one and the patient was complaining of pain." Dr. C also stated he could not assign a rating for the discogenic component of claimant's back pain because he did not have an MRI report on the back. According to references in the medical records, the carrier had refused to authorize an MRI of the back. By its TWCC-21 of January 28, 1993, the carrier disputed Dr. C's 15% rating as not being "in accord with the AMA guides 3rd ed."

Though no report of such was in evidence, the carrier asserted and claimant agreed that a BRC was conducted in March 1993 and that the parties there agreed that claimant would be examined by another designated doctor selected by the Commission, namely, Dr. O, and that Dr. C's report would be disregarded. According to Dr. O's TWCC-69, which incorporated his April 3, 1993, narrative report, claimant had reached MMI but Dr. O did not state an MMI date because it was "not requested." The impairment rating assigned was 18% and consisted of several component ratings for both the back and the knee.

The hearing officer found, among other things, that Dr. V determined that claimant reached MMI on December 30, 1991, with an impairment rating of 16%, that claimant received Dr. V's report on March 13, 1992, that claimant's assertion that he did not know until sometime after April 3, 1993, that he could dispute MMI was not reasonable, that claimant did not dispute Dr. V's determination of MMI or his impairment rating within 90 days of March 13, 1992, which was the latest possible date he could have received notice of it, and that the carrier paid 15 weeks of IIBS from December 31, 1991, through April 13, 1992, and another 39 weeks of IIBS in a lump sum following Dr. O's 18% impairment rating. The hearing officer concluded that claimant reached MMI on December 30, 1991, and that the carrier had paid 54 weeks of IIBS, the full amount owed claimant as a result of his 18% impairment rating.

Rule 130.5(e) provides that the first impairment rating assigned to an employee becomes final if not disputed within 90 days after it is assigned. The Appeals Panel has held that a timely dispute under Rule 130.5(e) is also required where a party disputes MMI. *See* Texas Workers' Compensation Commission Appeal No. 92693, decided February 8, 1993. In Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993, the Appeals Panel observed that the rule "allows a liberal time frame within which the parties may ask for resolution of a dispute through the designated doctor provisions of the Act," and that the rule "applies with equal force to the carrier and the claimant." In Texas

Workers' Compensation Commission Appeal No. 93489, decided July 20, 1993, we observed our prior holding that "ignorance of the law, or in this situation, rules of the Commission, does not provide a basis to be excused from complying with the law or rules. *See* Texas Workers' Compensation Commission Appeal No. 92657, decided January 15, 1993." And in Texas Workers' Compensation Commission Appeal No. 93139, decided April 18, 1993, we held that even where a claimant is unaware of the 90-day requirement of Rule 130.5(e), that rule contains no good cause exception for failure to timely dispute.

In this case, the carrier elected to dispute only Dr. V's impairment rating and there was no issue concerning the timeliness of the carrier's dispute. As found by the hearing officer, and with sufficient support in the record, the claimant did not timely dispute either Dr. V's rating or the MMI date. Since Dr. V's MMI date was not disputed by either party and was not later submitted for determination by a designated doctor, the hearing officer's conclusion that claimant reached MMI on December 30, 1991, is sufficiently supported by the evidence. Claimant acknowledged that he had Dr. V's report by March 13, 1992, and that he also was advised that the carrier shortly thereafter disputed Dr. V's impairment rating. We have noted that the 90-day deadline for disputing an impairment rating runs not from the date a doctor issues a report but rather from the date the parties become aware of the rating. Texas Workers' Compensation Commission Appeal No. 92693, *supra*. Further, claimant acknowledged on the record that he agreed at a BRC in March 1993 to be examined by Dr. O for the sole purpose of determining his impairment rating. *Compare* Texas Workers' Compensation Commission Appeal No. 93377, decided July 1, 1993, where, unlike the case before us, the designated doctor, selected to determine the impairment rating went on to also determine an MMI date. The Appeals Panel affirmed the hearing officer's finding that the claimant's MMI date was the date determined by the designated doctor because the first MMI date had not become "final" under Rule 130.5(e). Similarly, claimant's MMI date in this case did not become "final" under Rule 130.5(e) given the carrier's dispute of the impairment rating. It was, however, a fact issue for the hearing officer to decide and, as earlier noted, the December 30, 1991, date is supported by the evidence.

We are satisfied that the hearing officer's findings and conclusions concerning both disputed issues have sufficient support in the evidence and that the claimant's request for review lacks merit. The challenged findings and conclusions are not so against the great weight and preponderance of the evidence as to be manifestly unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986).

The decision of the hearing officer is affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Lynda H. Nesenholtz
Appeals Judge