APPEAL NO. 93810

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act) (formerly TEX. REV. CIV. STAT. ANN. arts. 8308-1.01 *et seq.*). A contested case hearing was held in (city), Texas, on August 9, 1993, to determine the following issues: whether the claimant disputed maximum medical improvement (MMI) and his whole body impairment rating within 90 days; when did claimant reach MMI; and what is claimant's whole body impairment rating. The claimant, who is the appellant in this case, alleges error in hearing officer (hearing officer) determination that claimant was aware of the MMI date and impairment rating in question in February of 1992 and did not dispute them until November of 1992; he also alleges error in the determination that the doctor's impairment rating became final, due to the fact that the doctor in question was not claimant's treating doctor. With regard to both points of error, the claimant challenges the hearing officer's denial of claimant's discovery requests.

DECISION

The decision and order of the hearing officer are reversed and the case remanded for a determination of the precise date on which the claimant was first aware of the MMI date and impairment rating in question, which may or may not change the final decision given this panel's determination of error with regard to the date the hearing officer found dispute to have been made. We also remand to allow the hearing officer to provide further explanation regarding his denial of claimant's discovery request.

It was not in dispute that the claimant suffered an injury to his right knee while in the course and scope of his employment on (date of injury). Claimant said he was treated by (Dr. R) who had treated him for earlier injuries to the same knee, including performing surgery. After seeing Dr. R for several months, he was referred sometime around October of 1991 to (Dr. S), who performed surgery on claimant's knee. Claimant said he stopped treating with Dr. S in "early February" of 1992.

Dr. S completed a Report of Medical Evaluation (TWCC-69) giving a February 15, 1992, MMI date and a five percent impairment rating. The claimant said that at his next to last visit in January 1992, Dr. S performed minimal examination of him, which included moving his knee back and forth. He said Dr. S explained something about range of motion to him but did not discuss impairment or MMI, only stating that he was trying to get claimant back to work. He also said that on his final visit he told Dr. S that his knee was still bothering him, and that Dr. S said it was tendinitis and recommended two weeks of additional physical therapy; however, when he tried to obtain therapy he was told that the carrier refused to pay.

The claimant said he got no forms, including a TWCC-69 or other medical report, from either Dr. S, Dr. R, or the carrier referring to MMI or impairment. However, he said he got a form when his temporary income benefits (TIBS) stopped in February 1992, and in March he got a check for $1505.00 for impairment income benefits (IIBS), along with a form. He said the forms he received were similar to the Payment of Compensation or Notice of

Refused/Disputed Claim forms (TWCC-21) he was shown at the hearing. The TWCC-21 accompanying the check was dated March 27, 1992, and stated it was for IIBS for the period February 16 to March 30, 1992. No earlier TWCC-21 was made part of the record, although the claimant said that after his TIBS were reduced he received a form that said "temporary benefits" on it.

The claimant testified that he called carrier's adjuster, (Ms. L), on February 18th, the same day his physical therapy was denied, to complain about the denial of therapy and to ask if he could see another doctor because he was not happy with Dr. S's "proceedings." He said they did not discuss impairment or MMI, but that she told him the Texas Workers' Compensation Commission (Commission) would have to approve a change of doctors. The claimant also talked with Ms. L about getting another doctor "a couple of other times," but said he could not remember the dates.

Claimant also said he had called one of his attorneys on February 15th to say that he was still having problems with his knee and to ask what he should do to see another doctor. (The record shows there was some confusion on the part of the Commission as to which of two attorneys represented claimant.) He again contacted his attorney in March when he received the check for $1505.00 and said they discussed his seeing another doctor and getting his weekly benefits started again. He also said he spoke to his attorney in April about getting a new doctor, and again in June when the attorney told him the check was for Dr. S's impairment rating.[1]

On a date which he said was around the end of May claimant said he talked to (Mr. J), carrier's adjuster, who had taken over claimant's file from Ms. L. He said he could not recall their exact conversation, but that he told Mr. J his knee was still bothering him and asked whether he could get more weekly benefits; however, he said Mr. J told him that the carrier had already fulfilled its obligation and he could only get medical benefits. (When asked about the exact date this conversation occurred, claimant also said it was not long after he saw (Dr. P), with whom, the record shows, he began treating in July.) Mr. J testified that he took over claimant's file sometime in March, and that he received Dr. S's TWCC-69 and sent it to claimant's attorney, along with the TWCC-21 that accompanied the $1,505.00 check, on March 27, 1992. He said he first talked to claimant sometime in July, when they discussed changing doctors. Mr. J also said that on June 8, 1992, he spoke with one of claimant's attorneys; at that time, he said, claimant's attorney told him the claimant did not agree with Dr. S's finding of MMI and impairment rating, to which he responded that the benefits had been paid and the issue should be taken up with the Commission. Mr. J said a written dispute of Dr. S's impairment rating and MMI was received sometime after November 5, 1992.

On July 9, 1992, the claimant sent a letter to a Commission disability determination officer, copy to Mr. J, asking to change treating doctors because "I have been dissatisfied in

[1] We note that no objection was raised, based on attorney/client communication, with regard to claimant's testimony about conversations with his attorneys.

the medical treatment provided to me by [Dr. S]. I am still experiencing a lot of problems with my knee even though [Dr. S] released me to return to work. . . . " Claimant's request to change doctors was granted and he began treating with Dr. P in July of 1992. Following an MRI which showed "multiple problems," he had further arthroscopic surgery on August 20, 1992. (The July 30, 1992, MRI report notes claimant's history of knee problems and says claimant recently ". . . re-injured his knee," although it does not indicate whether or not the re-injury was actually the compensable injury which forms the basis of the instant claim.) Dr. P thereafter found he had reached MMI on October 26, 1992, with a 17% impairment rating. In a March 30, 1993, letter to claimant's attorney, Dr. S stated that he did not plan to change his impairment rating and MMI date because "for that mode of treatment at that time [claimant] had reached maximum medical improvement." He added that "[i]t is possible that the patient had deterioration of the joint surfaces after I had evaluated him. If this is true, then [Dr. P's] rating would be more valid than mine."

Claimant's first point of error concerns the hearing officer's failure to add the issue of whether Dr. S was claimant's treating doctor, and his denial of claimant's request to depose Dr. S by written questions. Claimant's argument, both at the hearing and on appeal, centers on his point that because Dr. S was a referral doctor and not a treating doctor, Dr. S's impairment rating should not be considered as the "first impairment rating assigned to an employee" for purposes of the 90-day dispute rule, Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)). He argues that certain Commission field office practices--including not requiring TIBS to cease when a referral physician recommends return to work, and not requiring that benefits start because of such recommendation--"strongly infer that the opinion of a referred physician has no weight unless ratified by the treating physician. It necessarily follows, that the referred physician's opinion on MMI and impairment rating that precedes the treating physician's opinion on the same should not require dispute within ninety (90) days."

Our reading of the plain language of the rule does not compel such a finding. The rule simply provides that 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. As this panel has held, the rule 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, it allows a liberal time frame within which the parties may ask for resolution of a dispute through the designated doctor provisions of the Act. *See* Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993. Neither the rule itself nor any interpretation by this panel has limited its applicability in the manner advanced by the claimant, namely, that Rule 130.5(e) applies only to a treating doctor's assignment of impairment rating. The hearing officer thus did not err in refusing to add the treating doctor issue or to allow discovery thereon. Claimant's first point of error is overruled.

Claimant's second point of error concerns the hearing officer's finding that claimant failed to timely dispute Dr. S's impairment rating. Along these lines, claimant contends that a timely dispute need not be in writing and/or made to the Commission's field office. He also

alleges harmful error caused by the hearing officer's denial of claimant's request to subpoena Commission field office records and adjuster's notes concerning conversations with the claimant.

This panel has broadly construed the rule's language with regard to the date the 90 days for dispute begins to run, holding that the 90-day period begins when the party disputing the rating receives knowledge of same, which is not necessarily the date on which the rating is assigned. Texas Workers' Compensation Commission Appeal No. 93111, decided March 29, 1993.

The hearing officer in this case found that the claimant was aware of Dr. S's MMI date and impairment rating in "February 1992." The claimant contends that the finding is not supported by the evidence, and that it is impermissibly imprecise. Further, the claimant challenges the hearing officer's finding that claimant did not dispute Dr. S's findings until November of 1992, contending that Mr. J's testimony shows the carrier on June 8th was informed by claimant's attorney that claimant was disputing Dr. S's findings, and that such verbal dispute is acceptable.

We agree with claimant's latter point. This panel has declined to hold that disputes by claimants must be made in writing, despite the fact that the carrier-specific portions of Rule 130.5 require a carrier to file with the Commission a statement concerning disputed benefits. Texas Workers' Compensation Commission Appeal No. 93200, decided April 14, 1993. That decision also declined to require that the dispute be conveyed to the Commission, indicating that "uncontroverted and clear notice of a dispute to the carrier's representative would be sufficient notice." (It did, however, emphasize that any claimant having a dispute about MMI or an impairment rating should notify the Commission expeditiously so that the dispute resolution process could be initiated.) In this case the carrier's adjuster testified unequivocally that he was informed of claimant's disagreement with Dr. S's findings on June 8, 1992. Thus, the hearing officer's finding that claimant did not dispute until November of 1992, when his written dispute was filed, is in error as a matter of law. We therefore reform this finding to state that the claimant disputed Dr. S's finding on June 8, 1992. The only remaining question is whether the June 8th notice of dispute was conveyed within 90 days of the date on which claimant was aware of the MMI date and impairment rating.

It is claimant's contention on appeal that the hearing officer's finding that claimant was "aware" of Dr. S's MMI date and impairment in "February 1992" is not sufficiently precise and is not supported by the evidence. Claimant cites Texas Workers' Compensation Commission Appeal No. 93167, decided April 19, 1993, wherein the Appeals Panel reversed a hearing officer's conclusion that the claimant's MMI and impairment rating became final because they were not timely disputed. That opinion said the hearing officer's decision lacked the "two critical findings" of the date the claimant was first aware of the MMI and impairment assessment and the date on which claimant disputed, and said the hearing officer had provided "no concrete information" to allow the panel to evaluate his ultimate determination. We do not hold that a hearing officer could never make a determination that

included a less than precise date on which a claimant or carrier became aware that MMI or impairment had been rendered, depending on the facts in evidence before him. However, in this case "February 1992" is not satisfactory given the fact that for the first half of that month no impairment rating had been assigned so that there was nothing to dispute and given the evidence that the IIBS check and TWCC-21 were not mailed until March 27, 1992. (*See, e.g.*, Appeal No. 92542, *supra*, which found it axiomatic that one could not dispute something of which he was not aware.) As noted earlier, any determination with regard to the date on which the 90 days began to run must be based on credible evidence as to when the claimant was first aware of the existence of the doctor's findings. (While the hearing officer's statement of the evidence says the claimant "discussed his case, MMI and impairment" with his attorney in February, this statement does not necessarily demonstrate the claimant's awareness of Dr. S's findings.) We therefore reverse the hearing officer's determination and remand for a more precise finding as to when the claimant first became aware of Dr. S's MMI date and impairment rating.

With regard to claimant's request to subpoena records of carrier and of the Commission field office, the record shows that the hearing officer issued an order reciting that no good cause had been shown. *See* Rule 142.12(b). A determination of good cause is within the sound discretion of the hearing officer and should be set aside only if that discretion is abused. Morrow v. H.E.B., 714 S.W.2d 297 (Tex. 1986). To determine whether there has been an abuse of discretion, the reviewing court must look to see if the judge below acted without reference to any guiding rules and principles; the mere fact that a trial judge may decide a matter within his discretion in a different manner than might an appellate judge in a similar circumstance does not demonstrate that an abuse of discretion occurred. Downer v. Aquamarine Operations, Inc., 701 S.W.2d 238 (Tex. 1985).

Despite the broad latitude accorded the hearing officer in this situation, we find in the record below insufficient information on which to base a determination as to whether the hearing officer's denial of the discovery request was an abuse of discretion; the only evidence in the record was the claimant's request and the hearing officer's order denying the request for lack of good cause. We therefore remand to allow the hearing officer to supplement the record to allow this panel to more adequately review his determination.

The hearing officer's decision and order are reversed and the case remanded for a precise finding as to the date on which the claimant became aware of Dr. S's MMI and impairment rating, which may or may not change the hearing officer's ultimate determination on the issue of timely dispute. While it does not appear that further evidence needs to be taken, whether or not to re-open the hearing is a matter for the hearing officer to decide. In addition, the hearing officer is instructed to supplement the record with regard to his denial of claimant's request for subpoena duces tecum for certain records of carrier and of the Commission. 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 Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Thomas A. Knapp
Appeals Judge