APPEALS PANEL NO. 94011
FILED FEBRUARY 16, 1994

On December 9, 1993, a contested case hearing was held in (City), Texas, with _____ presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers Compensation Act, TEX. LAB. CODE ANN. Section 401.001 *et seq*. (1989 Act). The issues at the hearing were: (1) whether (Dr. C's) November 16, 1992, certification of maximum medical improvement (MMI) and assignment of impairment rating had become final; (2) whether the respondent (claimant) reached MMI on November 16, 1992, or September 24, 1993; (3) whether the claimant has a zero percent impairment rating or a two percent impairment rating; and (4) whether the claimant had disability from August 6 through September 24, 1993. The hearing officer determined that Dr. C's certification that claimant reached MMI on November 16, 1992, with a zero percent whole body impairment rating was final; that the claimant reached MMI on November 16, 1992; that the claimant has a zero percent impairment rating; and that the claimant had disability from August 6 through September 24, 1993, but that the claimant was not entitled to temporary income benefits (TIBS) for that period because the claimant had reached MMI on November 16, 1992. The hearing officer decided that the claimant is not entitled to any additional income benefits. The claimant agrees with the finding of disability but disagrees with the hearing officer's findings on MMI and impairment rating. The claimant requests that we award him TIBS for the period of disability found by the hearing officer and award him six weeks of impairment income benefits (IIBS) based on a two percent impairment rating. The respondent (carrier) requests that we affirm the hearing officer's decision.

DECISION

We affirm the decision and order of the hearing officer.

The claimant testified that on (date of Injury), while working for the (Employer), he slipped and twisted his left knee while carrying a board. On (three days after injury), he went to a hospital emergency room and then started treatment with (Dr. C). The claimant was laid off work on June 24, 1992, and has been unemployed since that time.

An MRI scan of the claimant's left knee was performed on May 28, 1992, and (Dr. M) reported that in his opinion the scan revealed a "prominent effusion" but that no definite minuscule or tendinous injury was identified. Dorland's Illustrated Medical Dictionary, 27th Edition, defines "effusion" as the escape of fluid into a part or tissue.

Dr. C reported on June 10, 1992, that the claimant continued to complain of problems with the left knee, that the knee still had swelling, and that the claimant said it felt like something was tearing in his knee when he walked. Dr. C reviewed the results of the MRI scan and stated that his impression was that the claimant had an "internal derangement with probable torn medial meniscus." Dr. C fitted the claimant with a knee sleeve, sent him to physical therapy, and released the claimant to light duty work. On June 23, 1992, Dr. C said that examination revealed tenderness about the medial aspect of the left knee and a "prepatellar bursitis and bursa." The claimant again reported to Dr. C that it

felt like something was tearing in his knee when he walked, and also reported that he had swelling in his knee at night and that his knee occasionally "gives way." Dr. C aspirated fluid from the knee and ordered a "TENS unit" for pain. On July 9, 1992, Dr. C reported that the claimant's left knee was very sensitive, that the prepatellar bursa had recurred, and that the claimant advised him that his knee had given out three times since the last visit and that physical therapy did not seem to help. Dr. C felt that the claimant had some elements of reflex sympathetic dystrophy (RSD) along with the prepatellar bursa. Dr. C took the claimant off work.

In a Specific and Subsequent Medical Report (TWCC-64) dated July 29, 1992, Dr. C diagnosed an injury to the medial meniscus, RSD of the left knee, and prepatellar bursa. He also reported that he had again aspirated fluid from the prepatellar bursa and that it was unknown when the claimant would reach MMI. On August 10, 1992, Dr. C reported that the claimant's prepatellar bursa had not recurred, but that the claimant continued to complain of swelling and of his knee giving way. Dr. C further noted that the claimant had an effusion and was tender over the "entire aspect of the left knee." The claimant was continued on physical therapy. On August 25, 1992, Dr. C said that the claimant's knee was still sensitive to touch and that the claimant complained of pain on standing over about an hour. On September 4, 1992, Dr. C noted that the claimant was sent for a "Cybex which showed a torque pattern." The claimant told Dr. C that his knee was still giving out and that he had a "popping in his knee." Dr. C referred the claimant to (Dr. S) for an opinion.

In a report dated September 25, 1992, Dr. S noted the claimant's complaints of pain and tenderness and of his knee giving out, and stated that "[m]y impression is that there is no surgery or treatment that is going to help [claimant's] left knee. I strongly resist suggesting any surgery and I think that only time will be in his best interest with no medical intervention."

In a TWCC-64 dated December 1, 1992, Dr. C reported that he "anticipated" that the claimant would reach MMI on November 16, 1992, and could return to normal work activity on that date. It was also reported that the claimant continued to complain of burning about the top of his patella and that he felt like something was tearing inside his knee. Dr. C also noted that he was discharging the claimant from his care. The claimant testified that at the time he was discharged from treatment, his knee did not hurt and he did not have swelling. However, he said that when he stood for a long time, his knee would swell "a little bit."

In a Report of Medical Evaluation (TWCC-69) dated January 12, 1993, Dr. C certified that the claimant reached MMI on November 16, 1992, with a zero percent whole body impairment rating. Dr. C again diagnosed an injury to the medial meniscus, RSD of the left knee, and prepatellar bursa. Dr. C reported that he had seen the claimant intermittently since the injury, that he felt the claimant had improved, that the MRI showed

no definite "minuscule tenderness injury," that the claimant had had an effusion, and that the claimant had had a prepatellar bursa which responded to aspiration and treatment. Dr. C further noted that the claimant still complained of some discomfort about the knee, but that the claimant's range of motion was from "0-110" degrees with good stability.

The claimant testified that during the spring of 1993 his knee would sometimes "flare-up" depending on how much standing and walking he would do. The claimant further testified that on May 2, 1993, he felt his knee "pop" while he was sitting on a riding lawn mower mowing his lawn, that the knee "flared-up," and that he went to a hospital emergency room. (Dr. J), the emergency room doctor, noted that the claimant reported that while he was mowing his lawn he felt something pop in his left knee "with no specific or particular trauma" and that the knee began swelling and had been painful ever since. The report also indicated that the claimant stated that he had a history of a knee injury about a year ago "and was followed by [Dr. C] but seemed to get better." The claimant denied telling Dr. J that he got better. Dr. J stated that an x-ray of the knee done on May 3, 1993, was normal and that the knee was aspirated of serous non-bloody material which was sent to the laboratory. Dr. J diagnosed arthritis of the left knee "post-traumatic with effusion."

The claimant returned to Dr. C after going to the emergency room and in a TWCC-64 dated May 10, 1993, Dr. C stated that the anticipated dates of MMI and return to work were "undetermined at this time." Dr. C noted that the claimant had an effusion with generalized tenderness about his knee and he referred him to (Dr. A), a rheumatologist, for assistance in "determining the cause of the claimant's problems." Dr. A reported on June 4, 1993, that the claimant's recurrent effusions seemed to come without any provocation and that at no time had there been complications such as popliteal rupture or dissection. Dr. A found that the left knee had a bulge which indicated a small amount of fluid, but that there was no synovial thickness to indicate any ongoing synovitis. Dr. A further found moderate crepitation of the left knee but noted that range of motion was normal and that stability was adequate. He also noted that lateral stress on the left knee when partially flexed caused some discomfort. Dr. A reviewed laboratory findings of fluid from the knee and found the findings to be generally insignificant. Dr. A stated that he had reviewed the prior MRI which was normal and further stated that current knee x-rays showed minimal narrowing of the medial joint compartments, but with no effusions, eburnation, or osteophyte formation. Dr. A opined that the claimant's symptoms were suggestive of a torn meniscus and that a history of recurrent effusions "would go along with this." Dr. A concluded his report by stating that without MRI evidence of disease, he would leave it up to Dr. C as to whether an arthroscopic evaluation was warranted.

On July 6, 1993, Dr. C reported that the claimant was continuing to have swelling and effusions of his left knee and that Dr. A had recommended an arthroscopy. Dr. C scheduled the claimant for an arthroscopy of the left knee on August 6, 1993, and requested the carrier to pre-authorize that treatment which the carrier did on July 19, 1993.

In a TWCC-64 dated August 16, 1993, Dr. C reported that the claimant had an arthroscopy of his left knee performed on August 6, 1993, and that the claimant was found to have a lesion of the patellofemoral groove. Dr. C said that "this is a chondral type lesion." Dr. C also stated on the report that "I would like to rescind the permanent partial impairment rating that was done on November 16, 1992. This will be redone at a later date. The patient has not reached maximum medical improvement." On this report Dr. C diagnosed an internal derangement of the knee joint and "chondromalacia knee." Dorland's Illustrated Medical Dictionary, 27th Edition defines "chondromalacia" as a softening of the articular cartilage, most frequently in the patella. "Chondromalacia patellae" is defined as the premature degeneration of the patellar cartilage, the patellar margins being tender so that pain is produced when the patella is pressed against the femur. The "patella" is also called the knee cap. "Patellofemoral" pertains to the patella and the femur.

On September 3, 1993, Dr. C reported that the claimant was about four weeks "status post arthroscopy of his left knee with chondroplasty," that the claimant had improved but still had some soreness and occasional swelling. Dorland's Illustrated Medical Dictionary, 27th Edition, defines "chondroplasty" as plastic surgery on cartilage; repair of lacerated or displaced cartilage.

In a TWCC-69 dated September 24, 1993, Dr. C certified that the claimant reached MMI on September 24, 1993, with a two percent whole body impairment rating. Dr. C noted that the claimant had no effusion but that the claimant stated that he had been standing a lot in the last couple of days and had some soreness about his leg and that his knee and ankle were swollen at one point. Dr. C did not detect swelling on September 24, 1993, and reported that the claimant had excellent range of motion. Dr. C further stated that "[a]t this point I feel that he has reached maximum medical improvement. His permanent partial impairment is 2% to the whole body secondary to chondromalacia." Dr. C diagnosed an internal derangement of the knee joint and chondromalacia. Dr. C released the claimant to regular work on September 27, 1993. When the claimant was asked at the hearing how his knee was doing now, he replied: "Well, it really does better than it was. Every now and then like I say if I stand a long time or do a lot of walking, it will swell a little bit but not like it did." The claimant then said that he had "improved."

Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) provides that "[t]he first impairment rating assigned to an employee is considered final if the rating is not disputed within 90 days after the rating is assigned." We have held that if the impairment rating becomes final, so does the underlying finding of MMI. Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993. We have also held that the time for disputing the impairment rating runs from the time the claimant has actual knowledge of the impairment rating. Texas Workers' Compensation Commission Appeal No. 93423, decided July 12, 1993. In the instant case, the hearing officer determined that Dr. C's "certification" of January 12, 1993, is final; that the claimant reached MMI on

November 16, 1992, with a zero percent impairment rating as was initially reported by Dr. C on January 12, 1993; and that the claimant had disability from August 6 to September 24, 1993, but is not entitled to TIBS for that period since he had reached MMI on November 16, 1992.

The claimant does not assert that he was unaware of Dr. C's report of January 12, 1993, wherein Dr. C certified that the claimant reached MMI on November 16, 1992, with a zero percent impairment rating, nor does the claimant contend that he ever disputed the certification of MMI or zero percent impairment rating. Instead, the claimant asserts that the hearing officer erred in determining that Dr. C's initial report of MMI and impairment rating became final because Dr. C's initial determination of MMI and zero percent impairment rating are invalid and not subject to the 90-day dispute provision because Dr. C rescinded his finding of MMI "upon a newly discovered medical condition and prior improper treatment of the injury" and thus Dr. C changed his determination of MMI for "appropriate and proper reasons." In its response, the carrier acknowledges that the Appeals Panel has held that there are limited exceptions to the 90-day dispute provision but asserts that none of the exceptions apply to this case. The carrier concedes that the disability finding is supported by the evidence, but asserts that the hearing officer was correct in finding that the claimant is not entitled to TIBS for the period of disability found because the claimant failed to dispute Dr. C's initial MMI date of November 16, 1992. Section 408.101(a) provides that an employee is entitled to TIBS if the employee has a disability and has not attained MMI.

While Texas Workers' Compensation Commission Appeal No. 93207, decided May 3, 1993, did not address the 90-day dispute provision of Rule 130.5(e), we note that in that decision we reversed and remanded a hearing officer's decision that the injured employee reached MMI on August 20, 1992, with a four percent impairment rating as reported by the designated doctor because there was evidence that the claimant's injury was carpal tunnel syndrome (CTS), the designated doctor failed to take the CTS into account when certifying MMI and assigning an impairment rating, and surgery subsequent to the date the designated doctor found MMI was successful in relieving the claimant's CTS symptoms. We stated "[w]here subsequent diagnosis and resulting treatment clearly resolves a compensable injury and is inconsistent with a designated doctor's earlier and seemingly inconsistent diagnosis and determination of MMI, the record should be appropriately developed to remove conjecture and speculation as much as possible."

In Texas Workers' Compensation Commission Appeal No. 93259, decided May 17, 1993, the Appeals Panel reversed a hearing officer's decision that the injured employee failed to dispute her treating doctor's certification of MMI and assignment of an impairment rating within 90 days and, therefore the claimant reached MMI on June 19, 1992, with a five percent impairment rating as initially reported by the treating doctor. Our reversal was predicated upon our determination that the treating doctor had made a prospective certification of MMI in May 1992 that the claimant would reach MMI on June 19, 1992, and

upon our prior holding that an anticipated date of MMI is not a statement or certification that MMI has been reached. We also observed that the treating doctor had stated in February 1993 that the MMI he previously gave was erroneous, that he rescinded the prior MMI date, and that information he now had available was not available when he determined MMI. We stated "[w]e note also in this case that the doctor purportedly determining MMI and assessing an impairment rating subsequently rescinded his purported determination of MMI. We have held that a doctor can subsequently amend or change his determination of MMI for appropriate and proper reasons. [Citations omitted]. The reasoning of those decisions might apply with equal force under the circumstances of this case."

Texas Workers' Compensation Commission Appeal No. 93489, decided July 29, 1993, is a case where we upheld a hearing officer's decision that the initial treating doctor's certification of MMI and assignment of an impairment rating became final under the operation of Rule 130.5(e) despite the fact that ten months after the date of MMI found by the initial treating doctor the injured employee underwent an arthroscopic examination and patellar shaving of her injured knee by a second treating doctor and the injured employee testified that her knee improved dramatically after the treatment by the second treating doctor who did not find MMI. The injured employee had not disputed the initial treating doctor's certification of MMI and assignment of impairment rating within 90 days. We stated:

> While giving a strict application to the provisions of Rule 130.5 and recognizing that the application of time limits can, by their very nature, appear to be harsh in a given case, there is a sound basis, as apparently determined by the Commission, to require some definitive finality in resolving claims. Nevertheless, the application of Rule 130.5 is not absolute and Appeal No. 92670 does not so hold. For example, if an MMI certification or impairment rating were determined, based on compelling medical or other evidence, to be invalid because of some significant error or because of a clear misdiagnosis, then a situation could result where the passage of 90 days would not be dispositive. However, the particular circumstances must be evaluated in such situation. We do not find that to be the case here. Rather, we find there is sufficient evidence to support the hearing officer's decision.
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> We pause to observe here that MMI does not mean there will not be a need for some further or future medical treatment and that the need for additional or future medical treatment does not mean that MMI was not reached at the time it was certified. Likewise, we have held that pain is not, in and of itself, an indication that MMI has not been reached and that a person assessed

> with a permanent impairment may continue to experience some pain as a result of an injury. [Citation omitted].
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> In the case at hand, there is not compelling evidence of a new, previously undiagnosed, medical condition or prior improper or inadequate treatment of the claimant's injury which would render the certification of MMI invalid.

Another 90-day dispute decision of note is Texas Workers' Compensation Commission Appeal No. 93501, decided August 2, 1993. In that case the employee sustained a work-related back injury and her treating doctor performed back surgery and then certified that the claimant reached MMI March 5, 1992, with a 12 percent impairment rating. The claimant returned to the treating doctor in July 1992 and was informed she needed additional surgery. The Commission appointed a designated doctor who found MMI (without stating a date) with a 24 percent impairment rating. Subsequently, the treating doctor filed another report certifying that the claimant reached MMI on January 7, 1993, with a seventeen percent impairment rating. We upheld the hearing officer's determination that the employee had a 24 percent impairment rating as reported by the designated doctor. There was conflicting evidence as to when the employee first had knowledge of the impairment rating initially assigned by the treating doctor and when she disputed it. We stated:

> However, whether claimant had written notice [of the treating doctor's initial impairment rating] is a relative side issue in this case. Of greater substantive importance is the fact that the initial 12% impairment was rendered without knowledge of a recurrent herniated disc and was subsequently revised by the treating doctor upon reviewing new medical information.
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> Where there is compelling medical evidence that an impairment rating was rendered based upon lack of knowledge of a material change in the claimant's medical condition, a fact finder could determine that the certification was invalid when rendered. There can hardly be more compelling medical evidence than revision of that rating by [the] doctor who originally rendered it. There is sufficient evidence from this fact, coupled with the new MRI showing a residual or recurrent disc herniation at the same site of the prior injury, and Dr. S's [treating doctor's] July 1992, surgery recommendation to support the hearing officer's determination that the 90-day rule was moot in this case.

In yet another 90-day dispute case, Texas Workers' Compensation Commission Appeal No. 93987, decided December 14, 1993, we upheld a hearing officer's determination that the treating doctor's initial date of MMI of April 10, 1992, and assignment

of impairment rating of 13 percent became final under Rule 130.5(e) despite the fact that the claimant had shoulder surgery, which was discussed with the employee prior to the treating doctor's certification of MMI, almost a year later in March 1993. In August of 1993, the treating doctor submitted another report in which he certified that the claimant reached MMI on April 10, 1993, with a 25 percent impairment rating. In affirming that hearing officer's decision that the initial MMI date and impairment rating assigned by the treating doctor had become final because not disputed by any party within 90 days, we noted that the hearing officer had distinguished certain decisions wherein we had held that a doctor may amend his findings of MMI and impairment. We noted that in those cases there was either evidence of a new, previously undiagnosed medical condition or improper or inadequate treatment of an injury. The hearing officer found that none of those situations were present in the case before her.

In the instant case, Dr. C had from the very beginning of his treatment of the claimant diagnosed an internal derangement of the left knee, although the medical records reflect some uncertainty as to the exact cause of the claimant's derangement. The claimant testified that he would have "a little bit" of swelling in his knee from standing for prolonged periods when he was initially released from medical treatment in December 1992, and Dr. C noted that the claimant still had some discomfort in his knee when he initially certified MMI as of November 16, 1992. Although the claimant said he improved from the arthroscopy procedure done in August 1993, he described his condition at the time of the hearing in essentially the same language as he had described his condition when he was initially determined to have reached MMI, that is, on prolonged standing his knee would still swell "a little bit." And, while Dr. C indicated that the claimant had improved after the arthroscopy, he described the claimant's medical condition in essentially the same terms as he did about the time he initially determined MMI, that is, the claimant still had soreness and occasional swelling of the knee. Thus, the hearing officer was not faced with evidence of a subsequent diagnosis and treatment which clearly resolved the injury, as was the case in Appeal No. 93207. And, while Dr. C did not have the exact diagnosis of chondromalacia available to him at the time he initially certified MMI with a zero percent impairment rating, he was, according to his reports, well aware that the claimant had problems with the patella of his left knee which resulted in recurrent effusions and swelling, and diagnosed an internal derangement. Thus, we cannot say that the claimant's treating doctor was as lacking in information when he initially reported MMI and impairment rating as was the doctor in Appeal No. 93259, *supra*.

Nor can we conclude that Dr. C initially certified MMI and assigned an impairment rating based on a lack of knowledge of a material change in the claimant's medical condition as was discussed in Appeal No. 93501, *supra*. In fact, the claimant's medical condition appeared to stay about the same at the time MMI was initially determined in November 1992 and at the time it was later found in September 1993. He still had recurrent swelling of the knee on prolonged standing or walking. All in all, we cannot conclude that the hearing officer, who is the judge of the weight and credibility of the

evidence under Section 410.165(a), was compelled under the evidence presented to find that Dr. C's initial report of MMI and impairment rating was based on a significant error or a clear misdiagnosis. Nor can we conclude that there was compelling evidence of a new, previously undiagnosed medical condition or prior improper or inadequate treatment as was discussed in Appeal No. 93489, *supra*. Having reviewed the record, we conclude that the hearing officer's findings of fact, conclusions of law, and decision are sufficiently supported by the evidence and are not against the great weight and preponderance of the evidence.

The hearing officer's decision and order are affirmed.

Robert W. Potts
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Joe Sebesta
Appeals Judge