APPEAL NO. 941093

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held in._____, Texas, with a presiding hearing officer. The hearing officer closed the record on _____. The issues at the hearing were: (1) did the appellant (claimant) timely file a claim for compensation with the Texas Workers' Compensation Commission (Commission) within one year of the injury as required by Section 409.003, and if not, does good cause exist for failing to timely file a claim; (2) has the claimant reached maximum medical improvement (MMI), and if so, on what date; (3) if the claimant has reached MMI, what is the impairment rating (IR); and (4) is the respondent (carrier) entitled to a reduction of the claimant's impairment income benefits (IIBS) based on contribution from earlier compensable injuries, and if so, by what proportion. The hearing officer determined that the claimant did not timely file a claim for compensation with the Commission as required by Section 409.003 and the claimant did not have good cause for his failure to timely file his claim. The hearing officer found that the other issues were moot and did not make determinations to resolve them. The claimant appealed arguing that the determinations of the hearing officer relating to timely filing a claim are contrary to the great weight and preponderance of the evidence and that the issues that were not decided by the hearing officer are not moot. The carrier responds arguing that the decision and order of the hearing officer should be affirmed because the findings of fact and conclusions of law are supported by clear and convincing evidence and the issues not decided by the hearing officer are moot.

DECISION

We reverse and render on the issue of whether claimant timely filed a claim and remand for the hearing officer to make determinations on the remaining issues.

The claimant testified that he injured his back and neck on Friday, _____, when he and a coworker attempted to pick up a tool box that was stuck to tar on a roof. He worked the remainder of the day, thought that the pain would go away, the pain did not go away over the weekend, and he called the employer on Monday morning to report the injury. The employer told him to go to (Dr. T). Dr. T took him off work, took x-rays, used heat treatments, and prescribed medicine. After a while Dr. T told him to try light duty, but the employer told him that there was no light duty on the roof. He went to several other doctors. (Dr. W) said that he reached MMI on September 22, 1992. The claimant testified that he disputed the MMI certification on October 2, 1992. He said that the Commission appointed (Dr. SE) as the designated doctor. The claimant testified that Dr. SE examined him on November 12, 1992, and said that he had not reached MMI. Dr. SE became his treating doctor because the insurance carrier wanted him to keep going to Dr. SE. The claimant testified that the Commission appointed (Dr. O) as the second designated doctor. Dr. O had someone else test him for about one or one and one-half hours. Dr. O examined him for about five minutes and had his medical records to review. The claimant testified that Dr. O reported that he reached MMI on January 21, 1993, and that he does

not agree with the MMI date. He stated that Dr. O gave him 23% IR, but that he does not know anything about percentages. He testified that he had prior back injuries, had back surgeries, was cured, and was able to do roof work about a year after his last operation for a previous back injury.

The claimant also testified concerning his filing a claim. He said that a benefit review conference was held in January 1993 at which he was told that he had not filed a claim. He testified that he completed the form and mailed it to the Commission office in Austin in March or April. He did not keep a copy. He said that on September 13, 1993, (Ms. L), who works for the carrier, called him and told him that the carrier did not have a copy of the claim form filed by him. He said that he told her that he filed it about five or six months earlier. He called the local office of the Commission. He was told that they did not have a copy and that he should come to the office and fill out another copy. He testified that he did so the same day.

On cross-examination the claimant testified that in 1980 he was convicted of aggravated robbery. He said that he had about eight or nine workers' compensation claims in the past, attorneys represented him, and he may have handled one claim himself. He testified that he had back surgery in the past, had recovered from the surgery, and never had problems with his neck before this injury. He repeated that he sent the claim form to the Commission's Austin office in March or April 1993, thought that it had been received, and on September 13, 1993, filed another form after talking with someone in the local Commission office.

The record closed on July 6, 1994. Hearing officer's Exhibit No. 5 is a copy of a letter dated May 31, 1994, signed by the hearing officer. The body of the letter reads as follows:

I have just received a copy of Dr. O's report and I am enclosing a copy for your review.

If you have any comments or questions about this report, please advise me no later than June 15, 1994. At that time the record will be closed.

Attached to the copy of the letter is a piece of paper with a handwritten note stating "[c]laimant called & said he got a rept for (sic) DD (designated doctor). I found a report on shelf in a dummy file. P 5/27/94 [claimant] [claimant's telephone number]." This is some evidence that a claim filed by a claimant could be misplaced also.

The Claimant's Exhibit No. 3 includes an Initial Medical Report (TWCC-61), dated September 29, 1992, signed by (Dr. SA), who was at that time treating the claimant. The exhibit also contains a Specific and Subsequent Medical Report (TWCC-64) for a November 24, 1992, visit and a TWCC-64 dated December 30, 1992. Both forms TWCC-

64 are signed by Dr. SA. Claimant's Exhibit No. 8 is a Benefit Review Conference Agreement (Interim TWCC-24) dated January 5, 1993, and is signed by the claimant, a carrier's adjuster, and the benefit review officer. It contains the following entries:

	DISPUTED ISSUES		RESOLUTION
(1)	Whether the claimant's upper back and neck problems are related.	(1)	Carrier agrees to accept liability for reasonable and necessary treatment.
(2)	Treating doctor.	(2)	The claimant and the carrier agree that the claimant will treat with Dr. [SE].
(3)	Whether the claimant has reached [MMI] and is entitled to temporary income benefits [TIBS].	(3)	He has not reached [MMI] and the carrier will resume [TIBS] from 11/12/92 when the claimant first saw [Dr. SE.]

The three forms filed by Dr. SA and the agreement signed on January 5, 1993, are sufficient to meet the requirement that a claim be filed with the Commission not later than one year after the date on which the injury occurred. In Texas Workers' Compensation Commission Appeal No. 94546, decided June 7,1994, we wrote:

> With regard to the hearing' officer's finding and conclusion that claimant failed to prove that a claim was timely filed, we note that the case of Cadengo v. Compass Insurance Co., 721 S.W.2d 415 (Tex. App.-Corpus Christi 1986, no writ), held that a doctor bill filed with the Industrial Accident Board (predecessor of the Commission) constituted a "claim" for the purposes of the filing limitation. The court noted that the purpose of the claim filing requirement was to provide enough information to serve as a basis for proper investigation and determination whether the claim came under the workers' compensation statute. Information identifying the employer, the employee, the date of the injury, and the type of injury was held to be a sufficient "claim," even if not personally filed by the claimant in that case.
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> We note that Tex. W. C. Comm'n Rules, 28 TEX. ADMIN. CODE § 122.2(c) (Rule 122.2(c)) indicates that a claim for compensation "should" be on a TWCC-41; however, this form is not strictly required, and Rule 122.2(e) makes allowance for "other" written claim for compensation.

In Texas Employers' Ins. Ass'n. v. Garza, 675 S.W.2d 245 (Tex. App.-Corpus Christi 1984), writ ref'd n.r.e.), the court held that a letter written by a claimant's attorney to the

(IAB) informing it as to his representation of the claimant for compensation arising out of injuries while working was sufficient to satisfy statutory requirements of making a claim within six months, and the IAB's form filed by the claimant 14 months later when he filed his formal claim describing the accident and injury was a proper amendment to the original claim that was sufficient to give the carrier notice of matters in contention.

In Second Injury Trust Fund of State v. Texas Employers' Ins. Ass'n, 719 S.W.2d 655 (Tex. App.-El Paso 1986, no writ), the court held that when the carrier admitted liability and advised the IAB of that fact and the only issue was as to who qualified as beneficiary, it was not necessary for a beneficiary to file a claim form or otherwise make the claim with the IAB. The court wrote:

> We are cited to those cases which hold that filing a claim with the [IAB] is jurisdictional . . . . The more sensible approach is to hold the acknowledgment of liability gave the Board jurisdiction over this claim and over the carrier.

In this case in the agreement set forth above, the carrier agreed to accept liability for reasonable and necessary treatment and to resume TIBS. Under those circumstances, failure to file a claim not later than one year after the date of injury alone will not relieve the carrier of liability.

We reverse the decision and order of the hearing officer, render a decision that the claimant timely filed a claim, and remand the case for the hearing officer to make findings of fact and conclusions of law on the issues that she determined were moot. We note that in the system of resolving disputes established under the provisions of the 1989 Act a determination on one issue does not render the other issues before a hearing officer moot. The hearing officer should decide all issues before her or him so that the dispute resolution process may proceed in an orderly fashion with an opportunity to remand a hearing officer's decision on an issue if appropriate. Administrative and judicial economy is preserved by deciding all issues in dispute before the presiding officer. Had this panel affirmed on the one issue before it, and had a court reversed on that decision the other three issues would not be ripe for resolution by the court. *See* Sections 410.251 and 410.301.

Since the hearing officer did not make findings of fact and conclusions of law concerning MMI, IR, and contribution, we have not written a detailed review of the evidence related to those issues. However, we have reviewed the evidence, and the parties should fully develop the facts so that the hearing officer can make an informed decision. Of course, the hearing officer may invoke her powers and duties under Section 410.163(b), if necessary.

The decision and order of the hearing officer are reversed and the case is remanded for such further development of the evidence and for such further consideration, findings, and conclusions as are appropriate and not inconsistent with this opinion. 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 Commission's division of hearings, pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Tommy W. Lueders
Appeals Judge

CONCUR:

Lynda H. Nesenholtz
Appeals Judge

Alan C. Ernst
Appeals Judge