APPEAL NO. 941333

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). On August 23, 1994, a contested case hearing was held. The record was closed on September 6, 1994. The issues unresolved from the benefit review conference (BRC) were the date claimant reached maximum medical improvement (MMI), his correct impairment rating (IR), whether he had disability from his injury, and whether his first IR became final (because it was not disputed within 90 days). Part of the finality issue was to identify which IR was claimant's "first" rating, that of Dr. W, or that of the treating doctor, Dr. Y.

The hearing officer determined that claimant had disputed the first IR he received, that of Dr. W, within 90 days, so that it did not become final; that claimant reached MMI on February 14, 1993, and had a 12% IR as certified by the designated doctor, Dr. D, appointed by the Texas Workers' Compensation Commission (Commission). She further determined that claimant had disability, the inability to obtain and retain employment equivalent to his pre-injury wage due to his compensable injury, from _____, until February 14, 1993, the date he reached MMI.

The carrier has appealed, arguing that Dr. W's rating was not the first because it was invalid due to the failure to certify a date of MMI; that the "first" IR was zero percent rendered by Dr. Y, and it became final because it was not disputed; that Dr. D was not properly designated by the Commission and therefore his opinion was not entitled to presumptive weight; and that Dr. Y's purported "decertification" and amendment of his zero percent IR had no effect; and that there can be no disability after MMI, which was "finalized" in this case as December 16, 1991, the date certified by Dr. Y. The carrier further argues that the finding of disability was made in spite of the lack of evidence of claimant's inability to work. No response has been filed.

DECISION

We affirm the hearing officer's decision and order.

Claimant stated he was hurt on _____, when he fell off a ladder onto his back and left side. Claimant was employed at the time by (employer). Claimant went to the emergency room on (day after date of injury); records indicate he complained he hurt his back, neck, and legs, especially the left leg. He was taken off work for 7-10 days pending re-examination. X-rays taken at the hospital were negative. Claimant was referred to physical therapy for acute lumbar strain. Claimant said he had no history of back or leg problems prior to his fall. Medical records refer to the distance fallen as six feet.

Claimant was initially treated by Dr. A, but changed to Dr. Y as his treating doctor beginning in August 1991, and was treated through December 1991. On September 23, 1991, claimant was examined by Dr. W on behalf of the carrier, pursuant to an order for an independent medical examination. The carrier's instruction in a letter to Dr. W stated that

Dr. W was to determine if claimant reached MMI and "if so, what percentage of disability would you assign per the AMA Guidelines, III edition?" Dr. W wrote a six page report that does not specifically assign a date of MMI, but noted that claimant should be released to work. This same report assigned an impairment rating of 12% based upon "Table 53 of the 1990 Guides to the Evaluation of Permanent Impairment (Guides)." This report attributed nine percent to claimant's preexisting degenerative spinal condition and three percent to his current injury; however, Dr. W also opined that "[t]here is no question that the lumbar spine problem has been aggravated by the patient's fall. . . ." Although no impairment percentage was assigned to claimant's knee by Dr. W, the doctor recorded that claimant complained that his knee locked up.

Through his attorney, claimant disputed this rating by a letter to (City 1) office of the Commission dated October 26, 1991. The record does not furnish an explanation of the Commission's failure to act upon this letter. On October 28, 1991, Dr. Y wrote that he fully agreed with Dr. W's report, but reserved judgment on whether claimant could return to work pending an upcoming appointment. The record includes a TWCC-69 Report of Medical Evaluation from Dr. Y stating that claimant reached MMI on December 16, 1991 with a zero percent impairment. The accompanying narrative misspells claimant's name as "Jarraine Wilborne" and refers to claimant throughout as "she." Claimant was returned to work with lifting restrictions.

Claimant was next treated by Dr. WD, who treated him for back strain and left knee sprain. Dr. WD took claimant off work beginning January 16, 1992, continuously through June 1992.

Claimant changed treating doctors in July 1992 to Dr. S, who was his doctor at the time of the hearing. There was some indication that Dr. S was an agreed "designated physician", but neither side pursued an issue at the hearing as to whether Dr. S was an agreed designated doctor. Dr. S's notes of July 27, 1992, stated that claimant "has reached MMI." An MRI of claimant's lumbar spine in early September 1992 showed desiccation of the L5-S1 disc; of the knee, a possible ganglion cyst, small osteophytes, and degenerative meniscal signal with no frank tear. It was later determined that claimant had a meniscal tear. Claimant had arthroscopic surgery of the left knee on October 6, 1992.

On February 14, 1993, Dr. S determined that claimant reached MMI with a 24% impairment rating. For the lumbar spine, seven percent was assigned; for claimant's knee, 18%. The carrier filed a dispute to this on February 26, 1993, but did not include a dispute over the extent of the injury as part of this. Nor was the 90-day issue raised; the carrier asserted that Dr. Y's zero percent IR should be adopted because claimant failed to keep his appointment with a designated doctor other than Dr. D. A letter from the Commission to claimant's attorney dated April 21, 1993 indicated that Dr. Y's report had become final because it was not disputed in 90 days, and that the earlier designated doctor had been appointed in error and the appointment was cancelled.

However, the record indicates that a BRC was held August 2, 1993, and that the benefit review officer there determined that claimant had not yet been examined by a designated doctor. Dr. D was appointed. There is no evidence that the carrier disputed this appointment.

Dr. Y wrote a letter on March 10, 1993, to claimant's attorney. He stated he had no evidence in claimant's file that he had ever assigned a zero percent impairment, stated he agreed with Dr. S that claimant should have a seven percent impairment for his lumbar spine, and stated he could not comment about claimant's knee because he had not treated it.

Dr. D examined claimant on August 30, 1993, and assigned a 12% IR. Apparently at the request of the Commission, Dr. D revised his MMI date to February 14, 1993, stating that he disagreed that claimant would have been MMI on the earlier date certified by Dr. Y.

We note that at the hearing the carrier admitted that it had not disputed compensability of claimant's knee until well after 60 days from receiving written notice. The evidence indicated that the dispute was filed April 25, 1994. The carrier did not contend that this occurred because of newly discovered evidence. The carrier indicated, however, that it did not wish to add an issue as to the knee and was not prepared to go forward. The carrier's attorney implied that it reserved the right to go forward on this at a later date, and speculated that claimant would respond by raising the defense of untimely dispute. The carrier argued that the hearing officer could resolve the issues before her without reaching the extent of injury. We disagree, and point out that the extent of injury was necessarily reached by the hearing officer in this case. We believe it was incumbent upon the carrier to activate any dispute over the extent of the injury well before any dispute is formulated on the correct IR, which must be based upon the compensable injury; to hold otherwise would be to render our hearing officer's decision on impairment in this case advisory or conditional. If the carrier still intended to mount an active dispute as to whether the knee was part of the compensable injury in this case, it was waived once the issue was essentially adjudicated through inclusion of the knee as part of the compensable injury here for purposes of impairment. In any case, the frank admission of the carrier that it filed a dispute in 1994, after having received notice of injury in 1992, constitutes a waiver under the Act. *See* Section 409.021(c).

The Appeals Panel has earlier rejected the proposition advanced by the carrier to the effect that an impairment rating not chronologically the first can become final. Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)) states that the first impairment rating assigned to an injured worker becomes final if not disputed within 90 days. We reject that point here, for the same reasons outlined in Texas Workers' Compensation Commission Appeal No. 941137, decided October 10, 1994:

> However, the effect of the validity or invalidity of a certification. . . of MMI and IR on the application of Rule 130.5(e) is, we believe, a separate and distinct issues from questions about the continuing applicability of the rule to later attempts to certify MMI and IR after the failed first attempt. We conclude that Rule 130.5(e) applies only to the chronologically first, written certification of MMI or IR. Whether that certification is ultimately found valid or invalid is important for considerations of finality under the rule. . . . A. . . determination that it is invalid serves only to make the rule inapplicable to that certification. It does not preserve the rule for possible reapplication to a later "first valid" rating. To hold otherwise would expose the parties to numerous possible "final" ratings, each succeeding the other, without any confidence as to which is the "first" until all prior ratings in due course are determined invalid. This would force a party to dispute each rating as he or she received written documentation of it. We do not consider this to have been the intention of the Commission when the rule was promulgated and do not so interpret the rule.

Therefore, the hearing officer was correct in finding that Dr. W's IR was the first IR, and it did not become final because it was disputed within 90 days.

It was for the hearing officer, as trier of fact, to resolve the inconsistencies and conflicts in the evidence. Garza v. Commercial Insurance Company of Newark, N.J., 508 S.W.2d 701, 702 (Tex. Civ. App.-Amarillo 1974, no writ). This is equally true of medical evidence. Texas Employers' Insurance Ass'n v. Campos, 666 S.W.2d 286, 290 (Tex. App.-Houston [14th Dist.] 1984, no writ). In considering all the evidence in the record, we cannot agree that the findings of the hearing officer are so against the great weight and preponderance of the evidence as to be manifestly wrong and unjust. In re King's Estate, 244 S.W.2d 660 (Tex. 1951). Concerning the findings on the disability issue, we note that there is sufficient evidence to support the hearing officer's findings. Further, we would note that disability, defined as the inability to obtain and retain employment equivalent to the pre-injury wage, may exist after MMI, contrary to what carrier argues on appeal. However, the existence of MMI does end eligibility for temporary income benefits. Section 408.101.

The hearing officer's decision and order are affirmed.

Susan M. Kelley
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Thomas A. Knapp
Appeals Judge