APPEAL NO. 990246

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on January 7, 1999. The issue before the hearing officer involved whether the first impairment rating (IR) assigned to the appellant, who is the claimant, became final because it was not disputed within 90 days after written notice of it was received by the claimant pursuant to 28 TEX. ADMIN. CODE § 130.5(e) (Rule 130.5(e)).

The hearing officer determined that the claimant had not timely disputed the first IR and that there was no major misdiagnosis or other condition that would obviate the effect of that first IR.

The claimant appeals, arguing that the bulge which appeared after the first IR constitutes a basis for obviating application of the 90-day rule and, because the doctor who did the first certification of IR could not have considered this, a significant condition escaped consideration in that IR. She argues that the hearing officer set forth a new standard which would require a claimant to prove the existence at the time of the first IR of the condition that later arises. Finally, the claimant argues that the hearing officer erred by not crediting the claimant's testimony that she timely disputed the IR. The respondent (carrier) responds that the hearing officer was not required to credit uncorroborated testimony that a timely dispute was made. The carrier further argues that the certifying doctor was a designated doctor, whose report was entitled to presumptive weight. Finally, the carrier argues that conditions that arise later do not comprise the basis for obviating finality for that reason alone and, further, that there was no evidence of misdiagnosis or improper or inadequate treatment. The claimant filed a response to this; there is no provision for filing or consideration of a response to a response, however, and we have consequently not considered it.

DECISION

Affirmed.

The claimant slipped and fell on the floor on _____, while employed by (employer). The claimant had a previous back injury and surgery in 1995 affecting L4-5. Her first treating doctor for the 1996 injury was Dr. K, a surgeon. Dr. K opined that the claimant did not require surgery and, therefore, urged her to seek treatment from a non-surgeon. A report from Dr. K stated that claimant's MRI was normal with no sign of recurrent herniation.

Claimant went to Dr. P, her treating doctor at the time of the CCH. Dr. P noted in an August 7, 1996, report that her MRIs were within normal limits, except for some degenerative changes at the site of her earlier surgery. Claimant testified (and Dr. P noted in his report) that she was fine after the surgery with respect to radiating leg numbness but after her slip and fall these sensations resumed.

Nerve conduction studies performed on April 30, 1996, found no evidence of new radiculopathy, although there were residual changes from her prior problem. Claimant said she was examined by a doctor for the carrier, Dr. W, an orthopedic surgeon, on April 10, 1997. His written narrative report which accompanied his Report of Medical Evaluation (TWCC-69) noted that the claimant had missed a week of work following her injury before returning. He noted she had basically conservative treatment. Dr. W recorded range of motion (ROM) measurements, essentially normal but for the flexion and extension, which were invalidated by the straight leg raising test. Dr. W commented that claimant's decreased ROM had a large voluntary component. He noted that she had recent bladder surgery which he believed accounted for a portion of her discomfort. Dr. W's diagnosis, after considering the MRI showing degenerative changes, was that claimant had a lumbosacral strain along with these changes, for which he assigned a seven percent IR from Table 49 II C, Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). Section II C is the section for disc or soft tissue lesions which are "unoperated, with medically documented injury and a minimum of six months of medically documented pain, recurrent muscle spasm, or rigidity associated with moderate to severe degenerative changes on structural tests, including unoperated herniated nucleus pulposus, with or without radiculopathy." The next highest category of ratings are for surgically treated discs. Dr. W certified that claimant reached maximum medical improvement (MMI) on April 10, 1997. There is no evidence in the record that Dr. W was a designated doctor.

Claimant said she was terminated about a month after she returned to work. She was being treated for depression. Dr. K noted depression in his reports fairly soon after the accident.

A report by Dr. C, a referral doctor, is dated March 11, 1998, and he stated that a second September 17, 1997, MRI report reported the L4-5 degeneration plus a mildly asymmetrical disc bulge at L3-4. A March 19, 1998, letter from Dr. C indicates equivocation about whether her condition would be bad enough to warrant decompression.

The carrier offered evidence that the Texas Workers' Compensation Commission (Commission) sent Dr. W's report to the carrier on May 2, 1997, which, in turn, notified claimant on May 14, 1997, about the IR in a form letter that described what the results of that IR would mean in terms of benefits and how to dispute it. Claimant contended at the CCH that she wrote the adjuster a letter disputing the IR about a month later. Claimant contended that she waited another two months and then called the adjuster, who told her she did not have the letter and had not received it, but nevertheless it was too late to do anything about it. Claimant did not contend that she wrote or called the Commission with 90 days. The current adjuster on the claim said there were no notes of the reported call or a copy of the letter, which she stated would have been noted or retained if received.

Claimant testified that she was getting progressively worse and might require surgery. However, the latest records in evidence (late 1997) from Dr. P stated his decision

to continue to treat claimant conservatively and there are no reports from Dr. C which recommend surgery.

We first note that we cannot credit an argument raised by the carrier as to the presumptive weight that must be accorded to a designated doctor's report. There was no evidence or assertion at the CCH that Dr. W was a "designated doctor" and the statutes argued by the carrier are thus frankly inapplicable to the dispute here.

Likewise, we cannot agree with claimant that the hearing officer has established any "new standard" of proof in her decision. The hearing officer indicates that she rejects the claimant's contention that there was a "misdiagnosis" by Dr. W in the absence of proof that the L3-4 bulge was in existence at that time. This is neither a new standard nor an egregious burden of proof, but rather a basic element of proof, in our opinion, where the theory of avoiding Rule 130.5(e) is the contention that there was a "misdiagnosis" or that a significant condition was overlooked. The burden is on the person seeking to prove a misdiagnosis to also prove that there was a condition which existed but was overlooked.

However, what is more pertinent to our affirmance is that whether a condition existed at the time of the first IR, or whether it developed later, it must be a significant condition in order to impact finalizing the first IR. We cannot agree that claimant's mild bulge at L3-4 is per se "significant." In this regard, we note that the AMA Guides provide under Table 49 for ratings of regions of the back, not individual discs. Thus, even if Dr. W had noted that bulge, the rating he assigned from Table 49 would not have changed. Likewise, ROM deficits, regardless of whether the underlying cause is one or two herniated discs or bulges, will merit an IR if validity measures are also met. There was no proof as to any significant or material impact on claimant's condition brought about by the L3-4 bulge, over and above what was already present at the time Dr. W certified MMI and IR. In summary, we agree that the hearing officer's fact finding that there were no conditions in existence as a basis for not applying Rule 130.5(e) is sufficiently supported by the evidence.

Likewise, we agree that there is also support for the finding that no timely dispute was made. 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, New Jersey, 508 S.W.2d 701, 702 (Tex. Civ. App.- Amarillo 1974, no writ). She clearly did not believe the claimant's testimony in this regard, and credited the adjuster's testimony concerning the likelihood that a dispute would have been noted in the claims file. She could consider that the claimant had received notice of the report and an instruction to dispute it to the Commission, and yet had not done so.

For these reasons, we affirm the decision and order of the hearing officer.

_____
Susan M. Kelley
Appeals Judge

CONCUR:

_____
Elaine M. Chaney
Appeals Judge

_____
Judy L. Stephens
Appeals Judge