APPEAL NO. 071822
FILED NOVEMBER 26, 2007

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 September 11, 2007. The hearing officer decided that the first certification of maximum medical improvement (MMI) and assigned impairment rating (IR) from (Dr. L) on August 12, 2005, became final under Section 408.123. The appellant (claimant) appealed the hearing officer's determination contending that the MMI/IR certification was not delivered by verifiable means, and that an exception under Section 408.123(f) applied. The respondent (carrier) responded, urging affirmance.

DECISION

Reversed and rendered.

The parties stipulated that: (1) the claimant sustained a compensable injury on _____; (2) Dr. L, the designated doctor, made the first certification of MMI and IR; and (3) Dr. L certified that the claimant reached MMI on August 12, 2005, with a zero percent IR. The evidence indicates that while at work the claimant tripped and fell on the stairs, injuring her face, low back, bilateral hands, and bilateral knees. On August 12, 2005, Dr. L examined the claimant and certified that the claimant reached MMI on that date with a zero percent IR.

Section 408.123(e) provides that except as otherwise provided by Section 408.123, an employee's first valid certification of MMI and first valid assignment of an IR is final if the certification or assignment is not disputed before the 91st day after the date written notification of the certification or assignment is provided to the claimant and the carrier by verifiable means. *See also* 28 TEX. ADMIN. CODE § 130.12 (Rule 130.12). The hearing officer found that the claimant did not dispute Dr. L's certification of MMI/IR within 90 days after the certification was provided to the claimant by verifiable means and that finding is supported by the evidence.

Section 408.123(f) provides that an employee's first certification of MMI or assignment of an IR may be disputed after the period described by subsection (e) if: (1) compelling medical evidence exists of: (A) a significant error by the certifying doctor in applying the appropriate American Medical Association guidelines or in calculating the IR; (B) clearly mistaken diagnosis or a previously undiagnosed medical condition; or (C) improper or inadequate treatment of the injury before the date of the certification or assignment that would render the certification or assignment invalid.

The claimant contends on appeal, as she did at the CCH, that Dr. L's certification did not become final because there was a clearly mistaken diagnosis or a previously undiagnosed medical condition. Among other things, the claimant asserts that Dr. L "under-diagnosed-misdiagnosed" her left knee. The claimant appeals the hearing

officer's finding that no compelling medical evidence exists of a clearly mistaken diagnosis or a previously undiagnosed medical condition.

A report from (Dr. P), a referral doctor, dated April 26, 2005, states that the claimant had left knee pain, and that she had been complaining of left knee pain since her date of injury. Dr. P diagnosed an "Internal derangement of medial meniscus—Left." A MRI of the left knee dated May 4, 2005, revealed a "small Baker's cyst," and "fluid collection in the pes anserinus bursa indicating pes anserinus bursitis. Diffused increased signal (grade 1 signal) is present in the posterior horn of the medial meniscus without a frank tear." In a report dated May 10, 2005, Dr. P diagnosed an "Anserine bursitis" and "Internal derangement of medial meniscus—Left," and recommended physical therapy. The report from the designated doctor, Dr. L, dated August 12, 2005, noted that the claimant fell on steps and injured her face, hands, knees, and low back, and lists the claimant's diagnoses as right knee contusion, right hand contusion, face contusion, and lumbar contusion. There was no diagnosis for the left knee in his report. Dr. L noted range of motion of the right and left knee was performed and he assigned a zero percent IR for the knees. Dr. L stated that no diagnosis related impairment for the bilateral knees would be ratable.

In March 2006, the claimant was referred to an orthopedic surgeon, (Dr. D), who examined the claimant for her left knee pain. An arthrogram of the left knee dated March 27, 2006, showed "[f]raying of the free edge of the medial meniscus posterior horn is demonstrated compatible with posterior horn of the medial meniscus trauma." In part, the findings of the MRI of the left knee post-arthrogram with contrast dated March 27, 2006, "suggests the presence of an intrameniscal closed tear" and "there is a possibility of subtle posterior horn of the lateral meniscus tear." In an April 2006 report, Dr. D states that the arthrogram documented probable tears of the medial and lateral meniscus. In a report dated August 9, 2006, (Dr. H), the required medical examination doctor, opined that the left knee condition was related to the claimant's work injury. An operative report dated October 3, 2006, states that the claimant underwent a left knee arthroscopy and notch abrasion, partial medial meniscectomy, and patellofemoral chondroplasty, and that Dr. D diagnosed "left patellar chondral tearing, left patellofemoral subluxation, left medial meniscus tear, left notch spurring, and cephalad displacement of the intrameniscal ligament." The claimant testified that she did not lose time from work due to her _____, compensable injury until the time of her knee surgery in October 2006.

Based on the CCH record, compelling medical evidence exists of a clearly mistaken diagnosis or a previously undiagnosed condition by the designated doctor, Dr. L, regarding the claimant's left knee as provided under Section 408.123(f)(1)(B). Dr. L's report of August 12, 2005, provides no diagnosis of an injury to the claimant's left knee. The compelling medical evidence establishes that the claimant's left knee conditions are related to her work injury of _____, as diagnosed by Dr. D and Dr. P. The orthopedic surgeon, Dr. D, diagnosed a left patellar chondral tearing, left patellofemoral subluxation, left medial meniscus tear, left notch spurring, and cephalad displacement of the intrameniscal ligament, and Dr. P diagnosed a left knee internal derangement of

medial meniscus. Accordingly, we reverse that portion of the hearing officer's finding that no compelling medical evidence exists of a clearly mistaken diagnoses or previously undiagnosed medical condition because it is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986).

Accordingly, we reverse the hearing officer's determination that the first certification of MMI and IR assigned by Dr. L on August 12, 2005, became final under Section 408.123, and we render a new decision that the first certification of MMI and IR assigned by Dr. L on August 12, 2005, did not become final under Section 408.123.

The true corporate name of the insurance carrier is **ZURICH AMERICAN INSURANCE COMPANY** and the name and address of its registered agent for service of process is

LEO F. MALO
12222 MERIT DRIVE, SUITE 700
DALLAS, TEXAS 75251.

_____
Veronica L. Ruberto
Appeals Judge

CONCUR:

_____
Cynthia A. Brown
Appeals Judge

_____
Thomas A. Knapp
Appeals Judge