APPEAL NO. 000620

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 25, 2000. The issues at the CCH were: is Dr. HS the respondent=s (claimant) initial choice of treating doctor, did the Texas Workers= Compensation Commission (Commission) abuse its discretion in approving Dr. P as an alternate treating doctor, and did the appellant (carrier) waive its right to contest the change of treating doctors by not contesting the change within 10 days after receiving the Commission=s order. The hearing officer determined that the Commission did not abuse its discretion in approving an alternate doctor and that the carrier waived its right to contest the change of treating doctors by not timely contesting the change. The carrier appealed. It urged that the hearing officer erred in determining that the Commission did not abuse its discretion in approving Dr. P as an alternate treating doctor and in determining that the carrier waived its right to contest the change of treating doctors. The carrier also contended that the hearing officer erred and abused her discretion in failing to acknowledge, discuss, and/or rule upon its requested relief under Section 408.024 and Tex. W.C. Comm=n, 28 TEX. ADMIN. CODE ' 126.9(h) (Rule 126.9(h)). The carrier requested that the Appeals Panel reverse the decision of the hearing officer and render a decision in its favor, or, in the alternative, reverse the decision of the hearing officer and remand the case to her. The claimant responded, urged that the hearing officer did not commit error, and requested that her decision be affirmed.

DECISION

We affirm in part and reverse and render in part.

The claimant sustained a compensable injury to her shoulder on _____. She testified that she had been treated by Dr. HS as her family doctor for about nine years; that she went to him, used health insurance that she has because of her husband's job, and did not tell Dr. HS that she was hurt at work. Dr. HS referred the claimant to Dr. AS. She saw Dr. AS in July 1998, and Dr. AS performed surgery on the claimant=s shoulder in October 1998. The claimant testified that after the surgery she received therapy and was referred to a pain management doctor, that the doctor gave her injections, and that the injections made things worse and she could not turn her neck. At the request of the carrier, the claimant was seen by Dr. K. In a Report of Medical Evaluation (TWCC-69) dated April 12, 1999, Dr. K reported that the claimant reached maximum medical improvement (MMI) on that day with an eight percent impairment rating (IR). With a letter dated April 27, 1999, the Commission advised the claimant of the MMI date and IR assigned by Dr. K and advised her of her rights related to disputing the report of Dr. K. The claimant said that she received a copy of the report of Dr. K; saw Dr. AS on May 6, 1999; that Dr. AS had a copy of the report of Dr. K; that the report said that it was time for her to start working again; that Dr. AS said that there was nothing else that he could do for her; that she did not recall Dr. AS saying that he agreed with the report of Dr. K; and that she wanted to go to a doctor who could give her appropriate treatment. A note in the

claimant=s medical records of Dr. AS dated May 5, 1999, states that he agrees with the MMI and would have claimant measured for a disability rating for her neck and shoulder.

In an Employee=s Request to Change Treating Doctors (TWCC-53) dated May 17, 1999, the claimant requested that her treating doctor be changed from Dr. AS to Dr. P. The reason given is:

> I have been treating with [Dr. AS]. I don=t feel that I=ve received appropriate medical care. I=ve tried to discuss this but I=m not getting anywhere with that. I need a doctor who understands the system, who can help me obtain appropriate care and help me get well.

The TWCC-53 was completed in handwriting. The claimant testified that she signed the TWCC-53, said that she does not write in English, and agreed that the other handwriting was done by two other persons. A letter from the law firm representing the claimant to the Commission dated May 18, 1999, states that the firm represents the claimant. On May 21, 1999, a Commission employee approved the request to change treating doctors. It appears that the carrier=s Austin representative received a copy of the approval of the request to change treating doctors on May 28, 1999. In a Payment of Compensation or Notice of Refused/Disputed Claim (TWCC-21) dated June 2, 1999, the carrier stated that it "disputes claimant=s request to change treating doctors" and provided its reasons. In a Request for Benefit Review Conference [BRC] (TWCC-45) dated September 24, 1999, the carrier stated that it maintained that it timely filed its dispute of the approval to change treating doctors and had been informed that a BRC would be set.

We first address the contention that the hearing officer erred in determining that the carrier did not timely contest the Commission=s approval of the claimant=s request to change treating doctors. First, the carrier argued that Rule 140.1 defines a benefit dispute as "a disputed issue arising under the [1989 Act] in a workers= compensation claim regarding compensability or eligibility for, or the amount of, income or death benefits" and that the issue of changing treating doctors is not a benefit dispute that should be handled under the benefit dispute provisions of the 1989 Act and Commission rules. However, Rule 126.9 is entitled Choice of Treating Doctor and Liability for Payment and subsection (g) provides:

> With good cause, the injured employee or carrier may dispute the order regarding a change to an alternate treating doctor within 10 days after receiving the order. That dispute will be handled through the dispute resolution process described in Chapters 140 through 143 of this title (relating to Dispute Resolution/General Provisions, [BRC], Benefit [CCH], and Review by the Appeals Panel).

The effective date of Rule 140.1 is May 24, 1991, and the effective date of Rule 126.9 is July 1, 1993. Rule 126.9, stating the dispute resolution process to be used in resolving disputes concerning change of treating doctors, is dated after the general definition rule and indicates

that the process in Rules 140 through 143, rather than the process in the Administrative Procedure Act that is used for some medical disputes, should be used resolving disputes concerning approval or denial of a request to change treating doctors. The issue was properly before the hearing officer.

The carrier also contends that the filing of a TWCC-21 before the 10-day period expired was sufficient to contest the approval of the request to change treating doctors. In previous decisions, the Appeals Panel has generally required that a TWCC-45 be filed within the 10-day period to timely contest the approval or denial of a request to change treating doctors. In Texas Workers= Compensation Commission Appeal No. 991715, decided September 22, 1999, the Appeals Panel recognized that Commission rules permit an unrepresented claimant to request a BRC in any manner and stated that it was not holding that a dispute of a Commission order regarding a change to an alternate doctor may never be made orally. In Texas Workers= Compensation Commission Appeal No. 971957, decided November 3, 1997, the Appeals Panel wrote:

> The carrier asserts that there is no 10 day or other time requirement to dispute a change of treating doctor contained in Rule 126.9(g), nor is there any requirement that it be in writing. While it is true that Rule 126.9(g) does not specifically state a writing is required, the rule does specifically provide a 10-day time frame and states that "[t]hat dispute will be handled through the dispute resolution process . . . ." Clearly, the dispute resolution process as set forth in Section 410.021 and Rule 141.1 provides that a BRC is the initial vehicle to mediate and possibly resolve disputed issues and that a request for a BRC shall be made on a form TWCC-45. Rule 102.7 mandates that a request to be considered timely must be received on or before the last permissible day of filing. That requirement was not met here. As was held in Texas Workers= Compensation Commission Appeal No. 951264, decided September 8, 1995, a case concerning the timely filing of a request for a BRC in a supplemental income benefits [SIBs] case, the request had to be received by the Commission within 10 days and not just mailed within 10 days. *See also* Texas Workers= Compensation Commission Appeal No. 962426, decided January 8, 1997.

Rule 130.108 requires that a carrier that wishes to dispute a Commission finding of entitlement to or the amount of SIBs do so by requesting a BRC as provided by Rule 141.1 within 10 days of receiving the Commission determination of entitlement. Rule 126.9 states that a claimant or a carrier may dispute an order regarding a change to an alternate doctor within 10 days after receiving the order. Rule 126.9 goes on to state that the dispute will be handled through the dispute resolution process in Chapters 140 through 143 of the Commission=s rules. It does not require the use of a specific form as does the rule concerning SIBs. If a carrier contests the compensability of a claimed injury contending that the claimant was not injured in the course and scope of employment or that the injury does not extend to a specific injury or body part, the standard practice is for the carrier to use a TWCC-21 to contest compensability. Later, a TWCC-45 may be filed. If so, the BRC, CCH, and Appeals

Panel dispute resolution process will be used to resolve the dispute. The TWCC-21 was published by the Commission in February 1991, prior to Rule 126.9 being adopted, and contains:

> Notice of Refused or Disputed Claim
>
> PAYMENT REFUSED OR DISPUTED FOR THE FOLLOWING REASONS: (Art. 8308-5.21(B)(C)).

The TWCC has a space to state the reasons and then says:

> MEDICAL PAYMENT DISPUTES. (Art. 8308-4.68(d)). If an Insurance Carrier disputes the amount of payment for medical services or the entitlement to payment for medical services, the carrier must report its position on Form TWCC-62 REPORT OF MEDICAL PAYMENT DISPUTE [NOTICE OF MEDICAL PAYMENT DISPUTE].

In the case before us, the carrier filed a TWCC-21 disputing the approval of the request to change treating doctors within 10 days of receiving it and later filed a request for a BRC. While filing a TWCC-45 may be the preferred way to dispute an order concerning change of treating doctors and should result in a BRC being rapidly set to start the dispute resolution process in Rules 140 through 143, that is not the only way that such a dispute may be made. The carrier timely disputed the Commission=s order approving the request to change treating doctors when it filed the TWCC-21 within 10 days of receiving the order approving the request to change treating doctors. We reverse the determination that the carrier did not timely dispute the order approving the request to change treating doctors and render a decision that the carrier timely disputed the order approving the request to change to an alternate treating doctor.

We next address the determination that the Commission did not abuse its discretion approving the request to change treating doctors. The carrier did not contend that the hearing officer erred in considering only the information available to the Commission at the time that the request was approved.[1] The record indicates that the Commission had information that the report of Dr. K had been sent to the claimant before she requested the change of treating doctors. The carrier argued that the Commission knew from an entry in the records of Dr. AS that she knew that he agreed with Dr. K that she had reached MMI. However, Commission rules do not require that medical records be sent to the Commission and the copy of the note of Dr. AS concerning his agreement that the claimant had reached MMI that is in the record in no way indicates that it had been received by the Commission. The record does not indicate

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[1] *See* Texas Workers= Compensation Commission Appeal No. 992447, decided December 22, 1999, for a case concerning what may be considered when fraud is involved in obtaining approval of a request to change treating doctors.

that when the Commission approved the request to change treating doctors, it had information that Dr. AS agreed that the claimant had reached MMI and that he was going to have tests performed so that an IR could be assigned to the claimant.

The burden was on the carrier to prove that the Commission abused its discretion when it approved the claimant=s request to change treating doctors. The hearing officer is the trier of fact and is the sole judge of the relevance and materiality of the evidence and of the weight and credibility to be given to the evidence. Section 410.165(a). An appeals level body is not a fact finder, and it does not normally substitute its own judgment for that of the trier of fact even if the evidence would support a different result. National Union Fire Insurance Company of Pittsburgh, Pennsylvania v. Soto, 819 S.W.2d 619, 620 (Tex. App.-El Paso 1991, writ denied). The hearing officer=s determination that the Commission did not abuse its discretion in approving the request to change treating doctors is not so against the great weight and preponderance of the evidence as to be clearly wrong or unjust and is affirmed. In re King=s Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 715 S.W.2d 629, 635 (Tex. 1986).

The carrier also contended that the hearing officer erred in not making a determination that the carrier was relieved of liability for health care provided by Dr. P. Section 408.024 provides that the Commission may relieve a carrier of liability for health care that is furnished by a health care provider selected in a manner inconsistent with the provisions of the 1989 Act for obtaining medical benefits. In the absence of a determination that the Commission abused its discretion in approving the request of the claimant to change treating doctors to Dr. P, the hearing officer was not required to render a decision or issue an order that the carrier is relieved of liability for health care provided by Dr. P.

We reverse the part of the hearing officer=s decision that the carrier did not timely dispute the Commission=s order approving the claimant=s request to change treating doctors and render a decision that it did. We affirm the part of the hearing officer=s decision that the Commission did not abuse its discretion when it approved the claimant=s request to change treating doctors.

Tommy W. Lueders
Appeals Judge

CONCUR:

Gary L. Kilgore
Appeals Judge

Dorian E. Ramirez
Appeals Judge