APPEALS PANEL DECISION SUMMARIES
(March 29, 2013 – May 31, 2013) (122195 – 130915)
http://www.tdi.texas.gov/appeals/2013cases

Don't rely on the summaries for your arguments. Make sure the decision applies to your case. Ken Wrobel

121951 - The "special mission" exception arises where the employee is directed in his employment to proceed from one place to another. Generally, an employee on a special mission does not go into and out of the course and scope of employment while on that special mission. This is sometimes referred to as the principle of "continuous coverage.

122262 - The requirements of Rule 126.11(g) provide that a dispute of an order denying the extension of statutory MMI date must be filed no later than 10 days after receiving the Division order. A claimant's attempt to request a BRC on the issue of extending the date of MMI prior to receiving a Division order would not be a dispute of the Division order.

122314 – Make sure all necessary parties have notice of the CCH.

122326 - Rule 130.12(b)(1) provides that filing a DWC-32 will dispute a first valid certification of MMI/IR only if a designated doctor has not previously been appointed. The party could only dispute the Treating doctor's first valid certification of MMI/IR by filing a DWC-45 because a designated doctor had previously been appointed.

122347 – An exception to the 90-day rule – an undiagnosed condition.

122353 - There was no evidence or testimony that listhesis is the same or synonymous with spondylolisthesis although the parties treated the terms as being synonymous. The doctors found different diagnoses than the one certified at the BRC. Doctors did not identify specific lumbar levels.

122358 – Doctors did not rate the entire injury. Rating of a thoracic spinal fracture.

122377 – Doctors did not rate the entire compensable injury.

122459 – Claimant appealed a D&O based on her nonappearance. Claimant informed the AP she was homeless and did not have a good address. The AP remanded to allow the Claimant to participate. If she did not appear for that CCH, the hearing officer was to send another 10-day letter.

122474 - The mere recitation of the claimed conditions in the medical records without attendant explanation how those conditions may be related to the compensable injury does not establish those conditions are related to the compensable injury within a reasonable degree of medical probability.

122475 – Designated Doctor did not document significant signs of cervical radiculopathy but rated Claimant in DRE Category III.

122485 - Adjustments under Section 2.2 page 2/9 of the AMA Guides provide for additional impairment in cases where: (1) treatment of an illness results in apparent remission of symptoms but the patient has not regained his prior good health; and (2) pharmaceuticals themselves may lead to impairment.

122488 - Once it has been determined a claimant was not entitled to SIBs for a period of four consecutive quarters, the claimant permanently loses entitlement to SIBs on either the merits or by waiver.

122502 - Section 3.2e entitled '[ROM],' page 3/77, of the AMA Guides, provides that '[e]valuating permanent impairment of the lower extremity according to its [ROM] is a suitable method.' Section 3.2e does not require that a certifying doctor must only use the most severe impairment for an individual direction of motion within the same table [Tables 40 through 43]." Claimant had a bilateral hip injury and the Designated Doctor compared the injured sides to calculate the impairment rating. Also, the Designated Doctor did not rate the entire injury.

122545 – Designated Doctor did not rate the entire compensable injury.

122580 – Designated Doctor included an impairment rating for depression but depression was not part of the compensable injury. However, pain disorder associated with both psychological factors and general medical condition is part of the compensable injury and was not rated as such.

122611 – Designated Doctor did not rate the entire compensable injury.

122617 - With respect to whether the claimant sustained a repetitive trauma type injury or a specific type injury, the AP noted the strict rules of pleading do not apply and alternative theories may be advanced if they are not contradictory or mutually exclusive. There must be a proper analysis of all of the evidence as to the sufficiency of the medical evidence to causally link the claimed injury to the work injury, whether specific or repetitive trauma injury with a date of injury sustained by the claimant.

122627 - A finding of MMI does not mean that there will not be a need for some future medical treatment, and the need for such additional treatment does not mean that MMI was not reached at the time it was certified.

122649 - The hearing officer made no findings regarding when the carrier received the first written report of injury, which is required under Section 409.021. Pursuant to Section 409.021, the carrier has 60 days from the date on which it is notified of the injury to contest the compensability of an injury. Section 409.022(a) provides that an insurance carrier's notice of refusal to pay benefits under Section 409.021 must specify the grounds for refusal and pursuant to Section 409.022(b) the grounds for the refusal specified in the notice constitute the only basis for the insurance carrier's defense on the issue of compensability in a subsequent proceeding, unless the defense is based on newly discovered evidence that could not reasonably have been discovered at an earlier date. Without a date certain on which the carrier received written notice of the claimant's injury, it cannot be determined when the 60-day period the carrier had to dispute the claim begins.

130022 - The Appeals Panel has held the market value of an apartment may be included in calculating the AWW.

130032 - The evidence established the claimant received an offer for work in the first week of the 12th quarter qualifying period but did not accept that offer until the second week of the 12th quarter qualifying period. The evidence also established that the claimant did not begin working until the sixth week of the 12th quarter qualifying period. The claimant did not meet the requirements of an active effort to obtain employment as set forth in Rule 130.102(d).

130036 – For purposes of impairment rating finality, evidence of attempted delivery and the date notification was attempted can constitute written notice through verifiable means.

130061 – Doctors did not properly rate the entire compensable injury. One doctor added impairment for medications Claimant was taking. There was no evidence that the claimant was taking medication which resulted in apparent total remission of his condition, nor any evidence establishing that the medications taken by the claimant have caused impairment.

130123 – Self-employment income qualifies as wages. A CCH is not the proper forum to determine fraudulent intent based upon Section 415.008.

130135 - Where the certifying doctor's report provides the component parts of the rating that are to be combined and the act of combining those numbers is a mathematical correction which does not involve medical judgment or discretion, the Appeals Panel can recalculate the correct IR from the figures provided in the certifying doctor's report and render a new decision as to the correct IR.

130157 – The certification improperly included 3% impairment for Adjustments for Effects of Treatment or Lack of Treatment and did not rate the entire compensable injury.

130160 – The hearing officer improperly found the compensable injury did not include several sprain/strains but the Designated Doctor rated the entire compensable injury, including the sprain/strains so the Appeals Panel only reversed and rendered the decision to include the sprain/strains.

130164 - The doctor evaluating permanent impairment must consider the entire compensable injury.

130185 – The AMA Guides has no provision for using ROM of the contralateral joint and it is in the discretion of the certifying doctor to do so or not. Because the entire compensable injury was not rated, the doctor's certification of MMI and IR cannot be adopted.

130187 - It was undisputed the Designated Doctor based the MMI date on records not previously available to him, and that he did not physically reexamine the claimant prior to changing his MMI date. The Appeals Panel has held that an amended certification of MMI/IR done without a medical examination is a violation of Rules 130.1(b)(4)(B) and 130.1(c)(3), which require the certifying doctor to perform a complete medical examination of the injured employee for the explicit purpose of determining MMI/IR.

130191 – The Designated Doctor determined the date of MMI not by specifically considering the claimant's physical examination and medical records but simply applied based on his opinion of the claimant's job classification the maximum number of days which someone with a knee and ankle sprain should have been able to return to work as provided in the MDA.

130200 - In Conclusion of Law No. 4 and the Decision portion of the hearing officer's decision and order, the hearing officer added the condition of "L4-5 herniated disc with annular tear." This was not one of the certified extent of injury diagnoses. "L4-5 herniated disc with extrusion" was the certified diagnosis. The Designated Doctor failed to rate the entire compensable injury.

130228 - The parties stipulated that the compensable injury was a lumbar contusion not a lumbar sprain/strain. The Designated Doctor rated a lumbar sprain/strain. The Designated Doctor did not rate the cervical sprain/strain; a right shoulder sprain/strain; or a concussion without loss of consciousness. A 2nd doctor did not specifically state that the concussion was resolved nor did he provide any impairment, such as including zero percent for the concussion.

130235 – The AP determined Claimant's injury included the staph infection. Because there were two certifications of MMI and IR in evidence that rated the entire compensable injury, the AP did not consider it appropriate to simply render a decision regarding the claimant's MMI and IR.

130238 - There were no DWC-69s in evidence with the correct statutory MMI date as agreed to by the parties. A letter from the doctor was not sufficient to correct the date of MMI.

130301 - The Division records indicate that the 10-day letter was sent to the claimant at the wrong address. The DRIS notes attached to the claimant's appeal constitute newly discovered evidence pertaining to why the claimant did not attend the CCH. The DRIS notes indicate Claimant called the Division with a new address. The 10-day letter was sent to the old address.

130309 - The hearing officer did not make a conclusion of law or decision about the entire time period in the disputed disability issue.

130318 - The [self-insured] presented no evidence that the wage supplementation was provided to by the [claimant], on the written request or agreement of the [claimant]. Because the [self-insured] failed to do so, the employer may not be reimbursed solely under Section 408.003. To be a payment "made under Section 408.003" the payment must meet the criteria of Section 408.003.

130341 –The doctor's failure to properly apply his ROM figures to the AMA Guides constitutes compelling medical evidence of a significant error in calculating the impairment rating that would render the certification or assignment invalid.

130342 - If an impairment results strictly from a peripheral nerve lesion, the physician should not apply impairment percents from Sections 3.1f through 3.1j ([pages 3/24 through

3/45]) of this chapter [Figures 26 and 29 included], and this section [3.1k Impairment of the (UE) Due to Peripheral Nerve Disorders (Table 16 included)], because a duplication and an unwarranted increase in the impairment percent would result.

130350 – Designated Doctor's narrative report contains an inconsistency between the ROM measurements of ulnar deviation and radial deviation in the claimant's right wrist, noting different measurement on page 4 and page 5. The AP determined one of the other certifications was valid so it was not remanded to the hearing officer to send an Letter of Clarification..

130361 – Parking lot case. The claimant testified her vehicle was very close to where she was working and that she had to get in the vehicle to roll down the windows because it was so hot. The parties agree that as the claimant exited her vehicle she twisted her right ankle. The Appeals Panel held that an act which is reasonably anticipated to be performed by an employee, performed while on the premises, and which does not deviate from the course of employment to the extent that an intent to abandon employment can be inferred, remains within the course and scope of employment. This case followed APD 001700.

130377 - The parties agreed that the date of MMI is the statutory date of July 30, 2010. The hearing officer mistakenly noted August 1, 2010. This resulted in the AP finding a new MMI date and impairment rating.

130386 - This case presents one of those few circumstances where the party has provided newly discovered evidence on appeal which warrants a remand based on that evidence. An agreement on attorney fees made in district court was made after the claimant's attorney requested fees from the Division.

130399 – The Designated Doctor did not properly rate atrophy in the leg where a claimant had a knee injury. He used Table 37, Impairments from Leg Muscle Atrophy, page 3/77 of the Guides. He measured the thigh and calf but only included the thigh in the impairment rating, where the calf should have been combined with the thigh atrophy rating.

130472 - The evidence established that as of the first anniversary of the decedent's death, minor claimant beneficiary 7 was a minor, and that she would be a minor until January 13, 2014. Therefore, pursuant to Section 409.007(b), claimant beneficiary 7's failure to file a DWC-42 does not bar her claim. Further both parties stipulated that minor claimant beneficiary 7 is a proper legal beneficiary. The evidence reflected that both LP, as the next friend of minor claimant beneficiary 7, and minor claimant beneficiary 7 are necessary parties to this proceeding and entitled to present evidence.

130484 - This case presents one of those few circumstances where the carrier has provided newly discovered evidence on appeal which warrants a remand based on that evidence. In this case, the carrier was not made aware of the claimant's employment with the chiropractic clinic until after the CCH. One of the issues was disability so the newly discovered evidence was relevant.

130489 – Claimant was a no show. The issue was MMI and impairment rating. The hearing officer made a clerical error on MMI and was reversed.

130499 - The hearing officer in reading the extent-of-injury issue before the parties at the CCH and in reducing the extent-of-injury issue to writing in his decision and order misidentified the condition described at the L4-5 spinal level and left out entirely the condition described for the L5-S1 level. This was remanded for the hearing officer to make a decision on the extent of injury issues identified in the BRC report.

130515 – The Designated Doctor's IR rated an injury not determined to be a part of the compensable injury, and as such it could not be adopted. There was no other rating in evidence that rated the entire compensable injury.

130572 – Claimant had a cervical spinal cord stimulator implanted that worked for three weeks. CRPS is accepted as part of the injury. Two doctors found Claimant to be at MMI before the implant. The hearing officer used one of those ratings. The AP rendered a new decision agreeing with the Designated Doctor that Claimant did not reach MMI until the statutory MMI date.

130611 – The hearing officer overlooked making a determination on the L5/S1 disc that was part of the certified issue. Because the extent issue was remanded, the AP also remanded the MMI, impairment rating and finality issues.

130633 – The Designated Doctor used Table 16 for entrapment neuropathy. Page 3/56 describes the impairment as due to mild residual carpal tunnel syndrome. The hearing officer thought Table 156 could not be used to rate carpal tunnel syndrome. The AP noted that both the quoted language of the AMA Guides and APD 111965 apply when impairment based on loss of ROM is assessed in addition to impairment assessed under Section 3.1k, which includes Table 16. In this case the designated doctor did not combine impairment assessed under Table 16 with any other impairment but rather rated the claimant's bilateral CTS solely on Table 16. This is an acceptable alternate means of rating carpal tunnel syndrome.

130643 – AWW to be based on fair, just and reasonable means. The hearing officer commented that "[the claimant's] testimony was credible, persuasive, and consistent with the limited documentary evidence that was available on this claim." However, there is no evidence that the claimant's hourly wage was what he said it was.

130648 - Because the Designated Doctor considered degenerative joint disease of the right knee, which has not been determined to be part of the compensable injury, and did not consider the entire compensable injury, his certification that the claimant has not reached MMI could not be adopted. There were no other adoptable ratings in evidence.

130668 - The Appeals Panel reversed a hearing officer's determination that the first certification of MMI and assigned IR became final and rendered a new decision that the first certification did not become final. The certifying doctor failed to rate the entire compensable injury which had been administratively determined. The case makes clear that the failure to rate the entire compensable injury constitutes compelling medical evidence of a significant error by the certifying doctor in applying the appropriate AMA Guides.

130723 – The AP noted that in Guevara evidence of an injury followed closely by the manifestation of or treatment for conditions that did not appear prior to the injury may be

combined with other causation evidence to be probative in determining causation. "[W]hen combined with other causation evidence, evidence that conditions exhibited themselves or were diagnosed shortly after an event may be probative in determining causation." Guevara v. Ferrer, 247 S.W.3d 662 (Tex. 2007). The hearing officer misread the Treating Doctor's causation letter. MMI/impairment rating did not become final and since extent had not been determined, the issues of MMI and impairment rating had to be remanded also.

130739 – Designated Doctor's narrative report dated February 17, 2012, states that he examined the claimant on January 28, 2012, and certified that the claimant reached clinical MMI on "12-05-2012." Designated Doctor's narrative report references a date of December 5, 2011; however, that date relates to the beginning date of the claimant's disability, not the date the claimant reached MMI. Designated Doctor wrote on this DWC-69 Claimant was MMI as of January 28, 2012. The narrative report and DWC-69 list completely different dates regarding when the claimant reached MMI. This was not an internal inconsistency that could be corrected by the AP.

130746 - The hearing officer specifically references "three" DWC-73s describing them by date. However, there were four DWC-73s in evidence.

130837 - It is undisputed that the 8th quarter of SIBs was actively in dispute on June 14, 2012, and there was no evidence that the carrier timely filed a request for a BRC to dispute entitlement to the 9th quarter of SIBs. Consequently, the carrier waived the right to contest entitlement to SIBs for the 9th quarter.

130848 – The Treating Doctor identified the disputed diagnoses as: right ankle, osteochondral lesion of the talus and left posterior tibialis tenosynovitis. Because the hearing officer misidentified the conditions in dispute for the extent of the compensable injury by treating the two separate conditions as one (tenosynovitis of the osteochondral talar lesion of the right ankle), we reverse the hearing officer's decision that the compensable injury does extend to "the tenosynovitis of the osteochondral talar lesion of the right ankle" and remand the extent-of-injury issue.

130915 – Sprain/strains do not need expert medical evidence to be considered compensable. The Claimant's doctors do not need to provide an analysis of the differential diagnoses to establish causation of the extent of injury diagnoses in dispute. See Appeals Panel Decision 120311-s.