APPEALS PANEL DECISION SUMMARIES
(December 13, 2012 – February 19, 2013 (122109))
http://www.tdi.texas.gov/appeals/2012cases

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

121133 - The amended certification did not include an accompanying narrative that documented any clinical findings of a physical examination nor did the Designated Doctor indicate that he re-examined the claimant prior to his amended certification. Because the designated doctor did not re-examine the claimant prior to his amended DWC-69 and did not have the operative report and additional medical records since the date of his March 4, 2011, examination of the claimant, the hearing officer erred in her determination that the MMI date is January 22, 2012.

121194 – Impairment rating - How to correctly calculate bilateral shoulder impairments. Also, the AP has previously stated that, 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 impairment rating from the figures provided in the certifying doctor's report and render a new decision as to the correct impairment rating.

121194 – SIBs - Because a new impairment rating has been rendered, the dates of the qualifying periods and SIBs quarters will change. The AP remanded the SIBs issues in dispute to the hearing officer to examine the evidence and make a determination regarding entitlement to SIBs based on the correct dates. Also, the issues of whether the carrier was relieved of liability because of the claimant's failure to timely file a DWC-52 for the second and third quarters were remanded to examine the evidence and make a determination regarding these issues based on the correct dates.

121200 – The hearing officer incorrectly read the Designated Doctor's description of his opinion of the compensable injury from the Letter of Clarification responses. The AP reversed the decision to be consistent with the Designated Doctor's opinion.

121215 – To the question of finality, failure to rate the entire compensable injury constitutes compelling medical evidence of a significant error in applying the appropriate AMA Guides or in calculating the impairment rating. Even if the certifying doctor rated the lumbar spine, the failure to consider and rate the administratively determined lumbar disc bulges at L3-4, L4-5, and L5-S1 is compelling medical evidence of a significant error by the certifying doctor.

121249 - The claimant had the burden to prove that he filed his claim of injury within one year of the date of his injury pursuant to Section 409.003, or had good cause for not timely filing.

121269 – The AP holds that 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.

121272 - A designated doctor had already been appointed so the party could only dispute the first certification by requesting and setting a BRC.

121272 - The "validity" of a certification of MMI and/or impairment rating is determined as provided in Rule 130.12(c). Rule 130.12(c) provides that the report must be on a Report of Medical Evaluation (DWC-69) and this certification is valid if: (1) the MMI date is not prospective; (2) there is impairment determination of either no impairment or a percentage of [IR] assigned; and (3) the report is signed by the certifying doctor who is authorized under Rule 130.1(a) to make the impairment determination. The question then becomes whether the report contains an exception under Section 408.123(f).

121300 - A review of the medical records in evidence did not establish an attendant explanation of how COPD (or an aggravation of pre-existing COPD) was causally related to the work injury.

121311 – Designated Doctor did not certify an MMI date based on the claimant's condition or rate the entire compensable injury because he failed to consider, document, and analyze an impairment (which could include 0% IR) for the entire compensable injury.

121315 – Thirteen beneficiaries. Some got notice of the CCH. Some did not. Some should have gotten notice sent to their next of friend because they were minors. Decedent had at least two marriages with children from each. The same concepts of fairness and judicial economy that underlie Rule 39 and case law concerning necessary parties should be applied in these death benefit proceedings, especially where the beneficiary status of a minor child is concerned.

121363 - The issue before the hearing officer was, "[d]id [the] [c]arrier have good cause for failing to meet the requirements of Rule 141.1?" There is no DRIS entry in evidence or any other evidence that establishes that any DWC-45 was filed with the Division on October 17, 2011. Accordingly, the hearing officer's finding concerning a DWC-45 filed on October 17, 2011, is not supported by the evidence. With regard to whether the carrier had good cause for failing to meet the requirements of Rule 141.1, the hearing officer does not have in evidence before him the DWC-45 that was filed with the Division on October 25, 2011. The hearing officer erred by not taking official notice of the Division's records with regard to the filing of the DWC-45 with the Division. The AP remand the "good cause for failing to meet the requirements of Rule 141.1" issue.

121465 - That trauma could cause these diagnoses states no more than a possibility and is not enough to establish a causal connection.

121472 - In determining whether new evidence submitted with an appeal or response requires remand for further consideration, the Appeals Panel considers whether the evidence came to the knowledge of the party after the hearing, whether it is cumulative of other evidence of record, whether it was not offered at the hearing due to a lack of diligence, and whether it is so material that it would probably result in a different decision. This was a very odd case with two dockets – an AM and PM case. The hearing officer found Claimant did not have a repetitive trauma injury in the morning but found she did have a repetitive trauma in the afternoon. This is a very unique case.

121474 - The hearing officer did not abandon his role as an impartial decision maker. The AP perceived no error in the denial of the Motion to Recuse Hearing Officer.

121547 - The claimant was recommended for further surgery for the compensable cervical injury and further material recovery could reasonably be anticipated. The hearing officer's decision Claimant was not at MMI was upheld. Claimant's doctor's office notes did not establish within a reasonable medical probability causation of the conditions in dispute and in fact indicate the claimant's shoulder problems may originate in the cervical spine. There was insufficient expert medical evidence linking the claimed shoulder extent-of-injury conditions to the compensable injury.

121559 – Claimant's doctors did not relate how the compensable fall down some stairs would cause, or aggravate, the depression, anxiety and/or gastroenteritis or that there was a causal connection between those conditions and the compensable injury within a reasonable medical probability. The diagnoses were found in his daily notes. There was insufficient expert medical evidence that the claimed conditions of anxiety and gastroenteritis were causally related to the compensable injury.

121581 – Self-insured did not show for the first scheduled hearing. A ten day letter was sent and the self-insured responded. The hearing officer held a show cause hearing and, in the Background Information, stated he found the self-insured did not have good cause for its failure to appear at the May 11, 2012, CCH. However, the hearing officer did not make a finding of fact on no good cause. In the decision on remand, the hearing officer was to make a finding of fact whether the self-insured had good cause for its failure to appear at the first CCH.

121581 - The hearing officer's determination did not specifically conform to the disputed extent issue. The opinion given by the Designated Doctor did not establish causation, particularly as it was conclusory. The hearing officer erred in stating that the Designated Doctor's opinion established *prima facie* evidence of causation between the compensable injury and the conditions at issue.

121647 - Rule 142.13(c)(3) provides that the hearing officer shall make a determination whether good cause exists for a party not having previously exchanged information or documents to introduce evidence at the hearing. A causation letter was not timely exchanged despite being written four days before the BRC. There was insufficient discussion or evidence presented of what good cause may have existed and there is no finding of fact on good cause. Because that letter was the only expert medical evidence of causation, the AP reversed the hearing officer's determination that the compensable injury of extended to include the disputed injury.

121672 - When an injury is asserted to have occurred by way of an aggravation of a pre-existing condition, there must be evidence that there was a pre-existing condition and there was some enhancement, acceleration, or worsening of the underlying condition. The Designated Doctor's review of the medical records was not consistent with what the actual records stated.

121695 – Claimant had a severe ankle injury requiring the use of a short ankle-foot orthosis. The Designated Doctor correctly documented in his narrative report that the AMA Guides state that impairment for gait derangement should stand alone and not be combined with any other method

of impairment. The Designated Doctor additionally stated that when an individual qualifies for more than one impairment, the evaluator should choose the higher of the two. The AMA Guides specifically provide gait derangement as a method for assessing impairment for lower extremity injuries.

121709 - The evidence established the claimant was not given notice that Dr. W was appointed as the designated doctor for the purposes of MMI/impairment rating. Therefore, Dr. W. was improperly appointed as the Designated Doctor to address MMI/impairment rating.

121740 – This was an affirmed case under Section 410.204(a)(1). The Designated Doctor certified the claimant had not yet reached MMI and therefore assigned no IR. The post-Designated Doctor RME doctor examined Claimant and found him to be at MMI. The evidence reflected the post-Designated Doctor RME doctor's certification was the first valid certification of MMI/IR. Claimant did not properly dispute that rating by requesting a BRC within 90 days because a Designated Doctor had already been appointed.

121761 – The Findings of Fact were inconsistent so the decision was remanded for corrections.

121772 – The doctor did not properly rate the eye injuries.

121786 – The AP held that 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. Extent was found against the Claimant and the case was reversed for a proper impairment rating certification.

121797 - The Findings of Fact and Conclusions of Law were inconsistent so the decision was remanded for corrections.

121823 – The hearing officer had to pick a second Designated Doctor because the first Designated Doctor would not provide the required information. The second Designated Doctor did not correctly rate the compensable injury and there were no other adoptable ratings in evidence. Dr. R was the treating doctor who did not request Dr. S to perform an IR evaluation. Rule 130.12(c)(3) provides that for a certification of MMI and/or IR to be valid it must be signed by a certifying doctor who is authorized by the Division under Rule 130.1(a) to make the assigned impairment determination. Dr. S's certification was not a valid certification pursuant to Rule 130.12. Consequently, Dr. S was not an authorized doctor pursuant to Rule 130.1(a) and his certification of MMI and IR could be adopted.

121826 – Inadequate expert medical evidence linking the extent of injury to the compensable injury.

121876 - The record does not reflect that the Designated Doctor considered the entire compensable injury. Good decision on how to rate a median nerve injury.

121893 - Workers' compensation coverage for volunteer reserve deputy constables. The self-insured is a political subdivision. Because the self-insured is a political subdivision, the applicable statute is Section 504.001 et seq. Section 504.001(2) defines employee as (A) a person

in the service of a political subdivision who has been employed as provided by law; or (B) a person for whom optional coverage is provided under Section 504.012 or 504.013. Section 504.012(a) provides that a political subdivision may cover volunteer fire fighters, police officers, emergency medical personnel, and other volunteers that are specifically named. No evidence was presented at the CCH to establish that [Employer] had agreed to provide optional coverage for reserve deputy constables pursuant to Section 504.012.

121900 – Extremely complicated impairment rating certification of the wrist.

121909 - When an injury is asserted to have occurred by way of aggravation of a pre-existing condition, there must be evidence that there was a pre-existing condition and there was some enhancement, acceleration, or worsening of the underlying condition. The Treating Doctor did not explain how the fall would result in a right shoulder full thickness tear of the supraspinatus tendon or how that condition might go without medical documentation for 21 months.

121927 - In this case, none of the letters/reports from the doctors specifically link the cervical disc herniation at C5-6 and cervical radiculitis to the mechanism of injury or establish causation within a reasonable medical probability.

121983 – LIBS - The claimant contended he was entitled to LIBs based on an aggravation of a personality disorder that resulted in an inability to obtain or retain employment. Section 408.161 specifies the criteria for which entitlement to LIBs can be established. The aggravation of a personality disorder is not one of the specified conditions for which LIBs is payable. EXTENSION OF STAT MMI DUE TO SPINAL SURGERY - Section 408.104(a) provides that on application by either the claimant or the carrier, the Commissioner may extend the 104-week period if the claimant had spinal surgery, or has been approved for spinal surgery under Section 408.026 and the Commissioner rules within 12 weeks before the expiration of the 104-week period. Claimant applied for the extension almost 8 years after the stat MMI date. JURISDICTION TO DETERMINE MMI - Because a prior determination of MMI had been made, the hearing officer in the instant case determined that the Division does not have jurisdiction to determine the date of MMI. SIBS AND CARRIER WAIVER - The claimant failed to provide evidence to establish the date the carrier received the SIBs applications. Section 408.083 provides that an employee's eligibility for TIBs, IIBs, and SIBs terminates on the expiration of 401 weeks after the date of injury. Claimant filed her applications more than 7 days after the expiration of the 401 weeks.

122022 - No medical provider specifically diagnosed an "L4-5 HNP" nor opined that an L4-5 HNP was causally related to the work injury. There was not an adoptable impairment rating certification in evidence.

122027 – When an injury is asserted to have occurred by way of aggravation of a pre-existing condition, there must be evidence that there was a pre-existing condition and there was some enhancement, acceleration, or worsening of the underlying condition.

122064 - There was no medical provider causally linking the claimed right elbow extensor tendon tear to the work injury or to the treatment of the compensable injury.