APPEALS PANEL DECISION SUMMARIES- DEC 2014

Don't rely on the summaries for your arguments. Make sure the decision applies to your case. My summaries focus on why the decision was overturned. I don't go into great depth so any decision may say more than what I write/cut/paste from the AP decision. About 90% of what is here is just cut and paste from the decisions. I try to hit the highlights, even if there are other reasons the hearing officer's decision was overturned. I also do not write about typographical errors that may have been made that resulted in a reversal. Ken Wrobel

140402 – The Appeals Panel merely reformed some of the FoFs.

140484 – Evidentiary - Carrier sought to admit a witness statement. Claimant objected on the basis of relevance and an improper attempt to impeach the claimant. The hearing officer admitted the exhibit over the claimant's objection. To obtain a reversal of a judgment based on the hearing officer's abuse of discretion in the admission or exclusion of evidence, an appellant must first show the admission or exclusion was in fact an abuse of discretion, and also that the error was reasonably calculated to cause and probably did cause the rendition of an improper judgment. *Hernandez v. Hernandez*, 611 S.W.2d 732 (Tex. Civ. App.-San Antonio 1981, no writ). In determining whether there has been an abuse of discretion, the Appeals Panel looks to see whether the hearing officer acted without reference to any guiding rules or principles. Appeals Panel Decision (APD) 043000, decided January 12, 2005; APD 121647, decided October 24, 2012; *Morrow v. H.E.B., Inc.*, 714 S.W.2d 297 (Tex. 1986). The AP did not find an abuse of discretion. The hearing officer based her determination that the claimant did not sustain a compensable injury on [date of injury], and that the claimant did not have disability from July 12 through September 8, 2012, in part on Mr. S' statement. However, the hearing officer had misread Mr. S' statement. Mr. S's statement discussed Mr. R, not the Claimant. CCH was remanded.

140505 – MMI/impairment rating - Dr. G considered and rated conditions determined not part of the compensable injury. See Appeals Panel Decision (APD) 132991, decided February 12, 2014. Accordingly, the AP reversed the hearing officer's determinations that the claimant has not reached MMI and that any IR is premature. No other certifications were adoptable.

140601 - Disability – Disability has to be based upon the extent of the injury. It was apparent the hearing officer based her determination the claimant had disability beginning March 5, 2012, through October 24, 2012, on the claimant's extent-of-injury conditions in dispute which she determined, and the Appeals Panel have affirmed, and are not part of the compensable injury of [date of injury]. The Appeals Panel reversed the hearing officer's determination and found claimant did not have disability for that period.

140651 – Extent of injury - The Appeals Panel has, on numerous occasions, rejected the contention that a sprain/strain requires expert medical evidence to establish causation. *See* APD 130160, APD 120383, APD 992946, APD 952129, APD 130808. This was a case where Claimant was claiming an ACL strain.

140712 – Disqualifying association of post-DD RME - The hearing officer made no Findings of Fact, Conclusions of Law, or a Decision as to whether Dr. R had a disqualifying association in accordance with Rule 127.140. (Claimant argues on appeal under Rule 126.5) Because the hearing officer failed to make a determination on this issue, the hearing officer's decision is reversed as being incomplete.

140722 – Failure to timely request an RME and abuse of discretion - In a letter dated February 21, 2014, the hearing officer gave the parties the opportunity to respond to Dr. C's report by March 3, 2014. On March 3, 2014, the self-insured responded and requested additional time so that an RME doctor may be obtained. On March 11, 2014, the hearing officer issued an order denying the carrier's request to hold the record open for an RME report because the self-insured failed to exercise due diligence in seeking and obtaining an alternate IR although the self-insured was fully aware that the designated doctor had not rated the entire compensable injury prior to the CCH. The Appeals Panel found no abuse of discretion in the hearing officer.

140722 – Issue not before the HO - The disputed issue was "[o]n what date is [the self-insured] entitled to reduce the [c]laimant's impairment income benefits [IIBs] based on the Division Order for Contribution dated June 18, 2013." The amount of contribution was not an issue before the hearing officer. A review of the record reflects that the parties did not agree to litigate the amount of contribution. HO determined Carrier was entitled to 36% reduction. The only issue was what date the contribution began. That finding was struck by the AP.

140760 – Disability – The hearing officer states in the Discussion portion of her decision that the "[c]laimant submitted DWC-73s from various medical providers which released him from work duties completely from June 14, 2013, through January 13, 2014, due to the compensable injury." There were no DWC-73s with an end date of January 13, 2014, in evidence. Remanded to get the DWC-73s.

140781 – Affect of DWC-24 on a D&O – After the hearing officer wrote the D&O, the parties signed a DWC-24, which was then signed by the hearing officer. The AP reformed the D&O to reflect what was on the DWC-24.

140790- Designated Doctor and referring for testing – The Designated Doctor was an out-of-state doctor. He suggested testing and a referral but did not do it. He responded in a Letter of Clarification that he did not know it was up to him to request the services. He still did not do it. Dr. P's specific concerns regarding the claimant's right shoulder conditions, as stated in his report and addendum, establish a necessity to refer the claimant for additional testing pursuant to Rule 127.10(c) in order to address the issue before him of whether the compensable injury extends to the right shoulder conditions. The parties at the CCH and on appeal disagree on whether the language to Rule 127.10(c) is mandatory. The plain language of Rule 127.10(c) provides that when additional testing is necessary to resolve the issue in question, the designated doctor shall perform additional testing or if he is not qualified to do so, refer the injured employee to other health care providers to conduct such testing.

140791 – MMI/impairment rating and not rating the entire compensable injury - There was no evidence Dr. W provided an alternate certification that included the right elbow contusion and right elbow lateral epicondylitis. The hearing officer found that Dr. W's certification of MMI and

IR is supported by a preponderance of the evidence. However, Dr. W did not consider and rate the entire compensable injury, and as such his MMI/IR certification cannot be adopted. *See* APD 110463, and APD 101567. Another doctor's certification was adoptable.

140824 – Designated Doctor did not have all of the records - It is clear from Dr. D's narrative report he did not have all of the claimant's medical records as required by Rule 127.10 when he determined the extent of the compensable injury. *See* APD 132258, and APD 140123. "On remand, the hearing officer shall cause to be forwarded to the designated doctor copies of all the claimant's medical records relating to the medical conditions to be evaluated that were not provided to Dr. D, including the February 25, 2013, operative report and medical records from Dr. R."

140840 – Designated Doctor using the Medical Disability Guidelines - Dr. N based his determination of MMI solely on the MDG. Accordingly, the hearing officer's determination of MMI is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust.

140842 – Extent of injury - The hearing officer resolved the disputed issues by deciding that: (1) the [date of injury], compensable injury extends to a left knee tear of the posterior horn of the medial meniscus, a tear of the posterior root of the lateral meniscus, a right knee tear of the medial meniscus with degenerative changes, and a parrot beak tear of the lateral meniscus. Dr. T opined that the compensable injury extended to meniscal tears but did not describe the specific tears in dispute. Further, Dr. T described the mechanism of injury inconsistently and did not explain how the claimant's collapse could cause the disputed meniscal tears.

140962 – Issue actually litigated – The issue did not include biceps tendon rupture but the hearing officer determined that extent was actually litigated. Carrier appealed. The Appeals Panel agreed the hearing officer worked within his discretion because the issue was litigated. However, Claimant also argued his injury included a rotator cuff tear. This extent issue was not addressed. The Appeals Panel sent this back for the hearing officer to add that issue and make a determination on MMI/impairment rating.

140903 – Extent of injury nomenclature - The hearing officer mistakenly identified the issue as internal disc derangement rather than internal disc disruption. The case was remanded.

140916 – Attorney fees – A Carrier is deemed to have received attorney fee orders on the first working day after they are printed and placed into its Austin representative's mail box. A party has 15 days from the date of receipt to dispute the attorney fees. That is calendar days – not working days. That includes Saturdays, Sundays and holidays. The carrier's assertion that it had 15 days excluding Saturdays and Sundays and holidays listed in Section 662.003 to timely request a CCH is without merit.

140926 – Bona fide offer of employment- the hearing officer's determination that the employer made a BFOE to the claimant entitling the carrier to adjust PIE beginning on August 19, 2013, was not appealed and became final. The hearing officer ended the carrier's entitlement to adjust PIE after February 28, 2014, because there were no DWC-73s in evidence dated later than February 28, 2014, and therefore it was unknown if the claimant's restrictions were changed

after that date or if the claimant had been taken off work by the doctor. However, nothing in the Act or Rule 129.6 provides for such a requirement. All of the DWC-73s in evidence restrict the claimant from using his left hand. There was nothing in evidence to indicate a change or worsening in the claimant's condition to establish that the BFOE was no longer valid. The AP rendered a new decision that the carrier is entitled to adjust PIE for the period beginning on August 19, 2013, and continuing through the date of the March 28, 2014, CCH.

140949 – Hearing officer's discretion on continuances – Claimant requested a continuance to wait for the Designated Doctor's report on extent of injury. The Hearing officer denied it but left the record open over three weeks for the parties to get the Designated Doctor report. The hearing officer also said he would leave the record open for any reports refuting the Designated Doctor. The Appeals Panel determined this was within the hearing officer's discretion.

140949 – Extent of injury issues and amending the issue - At the CCH the claimant requested the extent-of-injury issue be amended to include a more specific injury to the left knee in the form of Grade I chondromalacia changes of the anterior and medial joint compartments of the left knee, and an additional injury to the left ankle and left foot, as well as altered gait. The hearing officer stated on the record that he would amend the issue to include the specific conditions related to the knee, but he would not include the left foot and altered gait. Although the hearing officer's decision makes no reference to the left foot, the hearing officer noted the condition of altered gait in the amended issue statement, and made a Finding of Fact, Conclusion of Law, and a Decision that the compensable injury does not extend to altered gait. The hearing officer exceeded the scope of the issue as amended during the CCH.

The hearing officer found in Finding of Fact No. 3 that the claimant "did not sustain an injury to his left knee . . . in the incident of [date of injury]." However, the hearing officer amended the extent-of-injury issue statement from the general condition of "injuries to the left knee" to the more specific conditions of "an injury to the left knee in the form of Grade I chondromalacia changes of the anterior and medial joint compartments of the left knee." By amending the extent-of-injury issue to specific conditions, the hearing officer exceeded the scope of the issue as amended during the CCH in Finding of Fact No. 3. The Appeals Panel reformed the Hearing Officer's FoF, CoL and decision.

140971 – MMI/impairment rating – Remanded to determine the statutory MMI date and because no doctor rated the entire compensable injury.

140981 – Recoupment – There was an agreement on AWW that lowered what Claimant was to be paid. The PLN-11 describing the over-payment was written before that agreement so the amount being disputed was incorrectly calculated. On remand the hearing officer is to make a finding of the AWW that should be used to determine the overpayment made by the carrier, if any, and identify the calculations and relevant time periods utilized to arrive at the amount determined to be overpaid, if any.

140982 – MMI/impairment rating and a prior CCH decision - The hearing officer determined that the claimant reached MMI on December 7, 2012, although a prior Decision and Order dated April 29, 2013, held that the claimant was not at MMI based on a certification by Dr. H dated March 12, 2013. Given that a prior decision held the claimant has not reached MMI based on a

certification from Dr. H dated March 12, 2013, any date prior to March 12, 2013, could not be adopted under the facts of this case.

141030 – Compensability/disability - Claimant testified he injured his back lifting and carrying boxes throughout the day and that he used a dolly to assist him in completing his job of delivering packages. The hearing officer's discussion in her decision describes the mechanism of injury as "jumping out of his delivery truck." The hearing officer mischaracterized and misidentified the description of the claimant's mechanism of injury. The case was remanded.

141040 – MMI/impairment rating and DRE category - Claimant's injury was a lumbar sprain/strain. Designated Doctor incorrectly used the thoracolumbar category, instead of the lumbosacral category. Page 3/95 of the AMA Guides provides that for purposes of the AMA Guides, the thoracic region may be considered to represent the thoracolumbar region, and the lumbar region may be considered to represent the lumbosacral region. The AP reformed the hearing officer's decision by using a different doctor's rating.

141065 – MMI/impairment rating, rounding and MDA - Dr. M did not properly calculate the claimant's right wrist extension under Figure 26 because she failed to properly round the extension ROM to the nearest 10°. Dr. O stated: "[b]ased on [the Medical Disability Advisor, Workplace Guidelines for Disability Duration, excluding all sections and tables relating to rehabilitation published by the Reed Group, Ltd. (MDG)] Internet Version 6, the [claimant] would be at [MMI] on November 3, 2012." The Appeals Panel has previously held that the MDG cannot be used alone, without considering the claimant's physical examination and medical records, in determining a claimant's date of MMI.

141068 – Impairment rating and calculating range of motion of elbow - Dr. S incorrectly assessed a 6% UE impairment for loss of ROM of the right elbow based on his ROM measurements which result in either a 13% or 17% UE for loss of ROM of the right elbow. Rounding the measurements for pronation of the right elbow to derive the correct UE impairment requires medical judgment or discretion, so the AP could not recalculate the correct IR using Dr. S's measurements.

141078 – Disability - The hearing officer misread one or more of the operative reports in evidence when he stated the claimant underwent surgery in July 2013. The hearing officer was mistaken about a material fact which he considered when determining the issue of disability. The case was remanded for the hearing officer to reconsider the dates of disability.

141083 – MMI/impairment rating - Dr. P examined the claimant on March 6, 2014. In his narrative report, Dr. P noted the following impressions: multiple rib fractures; sternal fracture; history of collapsed lung with reconstruction; thoracic compression fracture; and thoracic radiculitis. Dr. P did not mention the claimant's lumbar spine. Dr. P failed to rate the entire compensable injury. Dr. P's MMI/IR certification does not conform with Rule 130.1(c) because Dr. P does not document, analyze, or explain how he derived the 15% IR; Dr. P only mentions that he agreed with Dr. D's 15% IR assessment.

141092 – Extent and attenuation factor - Although he generally discusses chondromalacia and the tears of the meniscus, Designated Doctor Dr. C does not give an opinion regarding the specific conditions at issue in this case, which are a left knee horizontal tear of the posterior horn meniscus and grade 2/3 left patella chondromalacia. Furthermore, Dr. C does not explain how the claimant's fall on [date of injury], would result in the conditions of left knee horizontal tear of the posterior horn meniscus and grade 2/3 left patella chondromalacia that arose in February 2013, which was approximately two years and seven months after the claimant's fall. It was undisputed that there was a gap in treatment from October 2010 to February 2013, and that the conditions at issue were diagnosed in an MRI dated March 29, 2013. There is an attenuation factor in this case. Dr. C does not address the two and a half years the claimant went without treatment between the date of injury and when he again sought treatment for the claimed conditions.

141092 – MMI/impairment rating – Designated Doctor rated conditions not found to be compensable. The Report of Medical Evaluation (DWC-69) in evidence from Dr. B states that Dr. B examined the claimant on [date of injury], and certified that the claimant reached MMI on that same day and that the claimant had no permanent impairment as a result of the compensable injury. However, Dr. B's DWC-69 contains no signature. The reporting requirements of Rule 130.1(d)(1) provide that a certification of MMI and assignment of IR for the current compensable injury requires the "completion, signing and submission of the [DWC-69] and a narrative report." Rule 130.1(d)(1)(A) states that the DWC-69 "must be signed by the certifying doctor." Dr. B's unsigned MMI/IR certification cannot be adopted. The other two certifications form other doctors were also not adoptable.

141129 – Impairment rating – Designated Doctor did not properly round his UE range of motion measurements. He also combined motor and sensory impairments for a peripheral nerve lesion. The AMA Guides provide that if impairment results strictly from a peripheral nerve lesion, the certifying doctor should not combine ROM deficit with section 3.1k, Impairment of the UE Due to Peripheral Nerve Disorders, which includes impairment for both sensory deficit and motor deficit.

141154 – Hearing officer did not address issue - The hearing officer made a conclusion of law and decision that "[a]t the time of [the] [c]laimant's injury on [date of injury][the] [c]laimant was the general employee of [GC] and was the borrowed employee of [H]." The issue agreed to by the parties was "[w]ho was [the] [c]laimant's employer on [date of injury], for purposes of the Texas Workers' Compensation Act?" The hearing officer's decision identifies the claimant as a general employee of GC and a borrowed employee of H on [date of injury]; however, the hearing officer's decision fails to determine the identity of the claimant's employer on the date of injury, [date of injury], for purposes of the Texas Workers' Compensation Act.

141170 – MMI/impairment rating – There were six certifications in evidence. None of them rated the entire compensable injury.

141173 – MMI/impairment rating – Designated Doctor did not rate the entire compensable injury because Carrier did not include the entire compensable injury on the DWC-32. Claimant's doctor rated the entire compensable injury and his certification was used.

141200 – Letter of Clarification/Designated Doctor report responses after the CCH -The hearing officer sent an LOC to the designated doctor and he responded, amending his certification of MMI and IR. The hearing officer admitted the LOC and the doctor's amended response as hearing officer exhibits. Additional correspondence took place after the CCH, between the hearing officer and the attorneys for the claimant and the carrier. Although this correspondence is contained in the appeal file, the hearing officer failed to admit the additional correspondence as hearing officer exhibits.

141200 – MMI/impairment rating – The hearing officer incorrectly stated the parties agreed upon the statutory MMI date. The hearing officer also commented that the Designated Doctor's report was flawed, precluding its adoption, but did not explain how it was flawed.

141205 – Election of remedies - The hearing officer stated, in part, that "[i]n *Valley Forge Ins. Co. v. Austin*, 65 S.W.3d 371 [(Tex. App.-Dallas 2001, pet. denied with per curiam opinion)], the Court of Appeals determined that election of remedies is no longer a viable defense under the 1989 Act." The AP wrote to clarify that although in *Valley Forge Insurance Company v. Austin, supra*, the court of appeals held the election of remedies affirmative defense was abolished by Section 409.009 because it permitted subclaims by insurance carriers and health care providers as a means to prevent double recoveries, the Texas Supreme Court affirmed the underlying decision on the merits for other reasons and stated it left open the question of whether Section 409.009 abolished the election of remedies affirmative defense. *See Valley Forge Insurance Company v. Austin*, 105 S.W.3d 609 (Tex. 2003). *See also* Appeals Panel Decision 030473, decided April 15, 2003.

141226 – Hearing officer failed to make conclusion of law - The hearing officer found that the claimant did not have good cause for not attending the designated doctor examination on August 9, 2012. That finding was not appealed. However, the hearing officer failed to make a conclusion of law or a decision on this issue. The AP reversed the hearing officer's decision as being incomplete and rendered a new decision that the claimant did not have good cause for not attending the August 9, 2012, designated doctor's examination.

141226 – Failure to attend Designated Doctor exam and suspension of TIBs – Complicated fact pattern and good discussion on why Carrier is entitled to suspend TIBs. Of interest is that Claimant called the Division after missing an appointment to get the appointment reset and the Division never rescheduled a Designated Doctor appointment. The AP determined Carrier was entitled to suspend TIBs until Claimant actually went to a Designated Doctor and just because the Division did not reappoint a Designated Doctor and schedule a Designated Doctor exam was not sufficient for Claimant to regain entitlement to TIBs.

141258 – Inadequate interpreter - A review of the record (including the CD record and the Division's own translation) reflects the court interpreter incorrectly translated from English into Spanish for the claimant various terms throughout the CCH including the terms crutches and the place where the claimant described he had fallen. There are also instances of other terminology at the CCH that the interpreter incorrectly translated. Case was remanded for a new hearing with a new interpreter.

141281 – MMI/impairment rating and error between the report and DWC-69 - There is an internal inconsistency between the MMI date Dr. C certified in his narrative report and the MMI date Dr. C certified on the DWC-69. Because the narrative report and DWC-69 list completely different dates regarding when the claimant reached MMI, the AP did not consider that internal inconsistency to be a clerical error that could be corrected.

141299 – MMI/impairment rating and rating the entire compensable injury - Claimant's compensable injury extends to a left leg contusion, facial contusion, cervical strain, lumbar strain, left tooth injury, a left shoulder strain, and disc protrusions at C4-5, C5-6, C6-7, and C7-T1, and pain disorder with psychological factors and a general medical condition and depression. Dr. F did not consider or rate a left leg contusion, facial contusion, and left tooth injury. Since Dr. F's certification of MMI/IR does not rate the entire compensable injury, it cannot be adopted.

141302 – Employer relationship - The issue added at the CCH was as follows: Was [the decedent] an employee of [Employer 1], [Employer 2], or [Employer 3] for the purposes of the Texas Workers' Compensation Act at the time of his death on [date of injury]? The hearing officer made a determination Claimant was not an employee of [Employer 1] but did not make findings or conclusions regarding [Employer 2], or [Employer 3].

141332 – MMI/impairment rating and signed DWC-69 - The hearing officer determined that the claimant reached MMI on June 20, 2013, with a zero percent IR as certified by (Dr. M). However, Dr. M did not sign the DWC-69. Rule 130.1(d)(1) provides that a certification of MMI and assignment of an IR for the compensable injury requires the "completion, signing, and submission of the [DWC-69] and a narrative report." Because the DWC-69 was not signed by Dr. M, it was error for the hearing officer to adopt his certification.

141367 – MMI/IR and rating the entire compensable injury - Although Dr. P mentioned a diagnosis of a head contusion in his narrative report, Dr. P did not otherwise discuss or rate a head contusion. Dr. P failed to consider and rate the entire compensable injury. The hearing officer erred in adopting Dr. P's MMI/IR certification.

141367 – Designated Doctor has to have all the records - The evidence established that Dr. P did not have all of the claimant's necessary medical records for his examination before making a determination on MMI and IR, the issues Dr. P was appointed to determine. Under the facts of this case, this is another reason why Dr. P's MMI/IR certification should not have been adopted. (Designated Doctor also did not properly round his range of motion measurements.)

141367 – Impairment rating and DRE categories - Page 3/95 of the AMA Guides states that for purposes of the AMA Guides, the cervical region may be considered to represent the Cervicothoracic region, and the thoracic region to represent the Thoracolumbar region. DRE Thoracolumbar Category III provides a 15% IR, whereas DRE Lumbosacral Category III provides a 10% IR. Dr. C failed to place the claimant in the correct spinal region for the lumbar compression fractures; therefore, her MMI/IR certification cannot be adopted.

141425 – Decision exceeding scope of issues - The hearing officer mistakenly identified one of the disputed conditions in the extent-of-injury issue as bilateral upper extremity radiculopathy rather than bilateral lower extremity radiculopathy as agreed to by the parties. The AP reversed

the hearing officer's extent-of-injury decision as being incomplete and remanded the issue of whether the compensable injury extends to bilateral lower extremity radiculopathy.

141478 – Extent of injury and sprain/strain – The disputed condition was a sprained talofibular ligament. The AP agreed that since the alleged extent-of-injury condition to the left ankle at issue is specific to a particular ligament, the condition should be diagnosed in the medical records. However, they did not agree that just because the alleged sprain/strain is to a particular ligament that it elevates the condition of a sprain/strain to a level that is so complex that a fact finder lacks the ability from common knowledge to find a causal connection.

141547 – Extent of injury and letters of causation – The letters from the Claimant's doctor did not specifically address the exact issues that were at issue. Although Dr. C explained how the claimant's mechanism of injury causes pressure on the discs in the claimant's neck and lower back, Dr. C did not specifically discuss C3-4, C4-5, or C5-6 disc herniations in his first letter. In the second letter, Dr. C discussed a herniated disc at C3-4 but did not mention any other cervical disc herniation. In both letters, Dr. C referred to a cervical MRI and how this MRI is indicative of a whiplash type injury. However, the MRI was not in evidence. There is no other record in evidence to establish causation between the mechanism of injury and C4-5 and C5-6 disc herniations, nor is there any record in evidence that diagnoses a C4-5 or C5-6 herniation.

141556 – Extent of injury and not needing expert evidence - The claimant was punched in the face several times by an offender and went to the hospital where he received stitches to his lower lip area. The first x-rays were taken of the claimant's nasal bones, six days after the date of injury, and noted that the claimant had a fracture of the tip of the nasal bones. Under the facts of this case, with the described mechanism of injury, we decline to hold expert medical evidence was required to prove a nasal bone fracture. The self-insured accepted a nasal contusion, the medical records document bruising to the bridge of the claimant's nose, and x-rays taken close in time to the date of injury reflect that the claimant had a fracture of the tip of the nasal bones.

141559 – MMI/impairment rating and not rating the entire compensable injury – None of the three certifications rated the entire compensable injury and each included conditions that were not part of the compensable injury. None of the ratings were adoptable.

141598 - MMI/impairment rating and not rating the entire compensable injury – Neither of the two certifications rated the entire compensable injury and included conditions that were not part of the compensable injury. None of the ratings were adoptable.

141626 – Extent of injury and aggravation - The hearing officer specifically found in an unappealed finding of fact that the claimant's right knee had a medial meniscus tear and an osteochondral lesion on the date of her compensable injury but those conditions were enhanced, accelerated or worsened by the work injury. However, the hearing officer determined that the compensable injury does not extend to right knee medial meniscus tear and osteochondral lesion of the medial femoral condyle of the right leg. By definition the aggravation of the right knee medial meniscus tear and osteochondral lesion of the medial femoral condyle of the right leg, is an injury to the right knee medial meniscus tear and osteochondral lesion of the medial femoral condyle of the right leg.

141627 – MMI/impairment rating and not rating the entire compensable injury - The parties stipulated in part that the claimant sustained a compensable injury in the form of a soft tissue injury, jaw contusion, and lip laceration. Dr. F does not mention these conditions in his narrative report. Dr. F failed to consider and rate the entire compensable injury. Neither of the other two certifications rated the entire compensable injury either.

141644 - Unsigned DWC-69 - In evidence is the DWC-69 from Dr. W and it does not contain the certifying doctor's signature. Rule 130.1(d)(1) provides that a certification of MMI and assignment of an IR for the compensable injury requires the "completion, signing, and submission of the [DWC-69] and a narrative report." Because the DWC-69 was not signed by Dr. W, it was error for the hearing officer to adopt his certification.

141650 – Designated Doctor has to have all of the records - 28 TEX. ADMIN. CODE § 127.10(a)(1) (Rule 127.10(a)(1)) provides in part that the treating doctor and insurance carrier shall provide to the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor. *See also* Rules 127.10(a)(3) and 127.10(b). It is clear from Dr. T's narrative report that he did not have all of the claimant's necessary medical records as required by Rule 127.10 when he determined the claimant's IR. That certification was unadoptable.

141688 – Compensable injury and causation for sprain/strains - The hearing officer specifically stated that in this case there is an attenuation factor, given the delay in the manifestation or onset of complaints of 46 days to the thoracic spine, the lumbar spine, and the right knee associated with this injury. The AP did not agree that attenuation factor in and of itself would mandate expert medical evidence of causation to establish compensability of a sprain/strain. To the contrary, a delay in the onset of symptoms was merely a factor for the hearing officer to consider in determining whether the claimant had sustained his burden of proving a causation.

141731 – MMI/impairment rating inconsistency within report - Dr. S states in her narrative report that "[t]he date of [MMI] is May 8, 2013." However, Dr. S's Report of Medical Evaluation (DWC-69) states that she certified the claimant reached clinical MMI on "[May 2, 2013]." There is no DWC-69 in evidence from Dr. S with a May 8, 2013, date of MMI. There is an internal inconsistency between the MMI date Dr. S certified in her narrative report and the MMI date Dr. S certified on the DWC-69. Because the narrative report and DWC-69 list completely different dates regarding when the claimant reached MMI, we do not consider that internal inconsistency to be a clerical error that can be corrected.

141797 – Designated Doctor did not properly address extent - The hearing officer specifically stated that the designated doctor did not provide an opinion regarding the diagnosis of ____, a condition that was specifically listed on the DWC-32 for the designated doctor to address. We note that the designated doctor also failed to provide an opinion regarding the diagnosis of _____. The hearing officer is to send a letter of clarification to the designated doctor to request that he give an opinion, along with an explanation, regarding whether or not the compensable injury sustained on [Date of Injury], extends to the conditions he was asked to address.

141799 – Rating radiculopathy - The AMA Guides do not require, nor have Appeals Panel decisions held, that the absence of relevant reflexes is required to rate radiculopathy. Rather the AMA Guides and Appeals Panel decisions specify that to receive a rating for radiculopathy the claimant must have significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of 2 cm or more above or below the knee, compared to measurements on the contralateral side at the same location. The atrophy or loss of relevant reflex must be spine-injury-related for radiculopathy to be rated.

141822 – Finality and delivery by verifiable means - The 90-day period begins on the day after the written notice is delivered to the party wishing to dispute a certification of MMI or an IR assignment, or both. In evidence is a Notification of [MMI]/First Impairment Income Benefit Payment (PLN-3) dated October 8, 2012, addressed to the claimant. There is no evidence to indicate if the forms were delivered to the claimant. There is no other evidence such as an affidavit, or adjuster notes to show when the forms were mailed or received. In this case, the hearing officer selected October 31, 2012, as the date that the certification of MMI and IR from Dr. S was provided to the claimant by verifiable means. The claimant never testified that she received the documents on October 31, 2012, and there is no evidence that October 31, 2012, is the date of receipt by verifiable means. Claimant acknowledged receipt of the report but equally clearly she did not know or testify to the specific date of receipt nor does the carrier have verifiable proof that the first certification of MMI and IR was delivered. Claimant's testimony in this case, does not constitute an acknowledged receipt by the claimant on a date certain sufficient to begin the 90-day period of Section 408.123(d) and Rule 130.12.

141833 – Hearing officer exceeding scope of hearing - At the CCH the claimant requested the extent-of-injury issue be amended from what was on the BRC report (rotator cuff tear) to include the additional conditions listed in the Designated Doctor Examination Data Report (DWC-68) by Dr. B, the designated doctor, which were: strain of the supraspinatus muscle, strain of the subscapularis muscle, and other joint derangement. The hearing officer stated on the record that he would amend the issue to include: right shoulder rotator cuff tear, strain of the supraspinatus muscle, strain of the subscapularis muscle, and other joint derangement. Hearing officer included rotator cuff tear in his analysis and determination. That condition was not agreed to by the parties. The AP affirmed and reformed the decision, taking out the determination of rotator cuff tear.

141892 – Extent of injury, specific causation analysis - Aggravation of the C5-6 disc displacement and aggravation of degenerative disc disease require expert evidence to establish a causal connection with the compensable injury. The hearing officer relied upon a causation letter dated April 6, 2014, from (Dr. G), the claimant's treating doctor. However, Dr. G did not discuss aggravation of the C5-6 disc displacement or aggravation of degenerative disc disease in this letter. There is no other letter from Dr. G in evidence discussing these conditions, nor is there any letter from any other doctor in evidence that explains how the compensable injury caused these conditions.

141892 – Hearing officer failed to note amended issue - Claimant requested, with no objection from the carrier, that the hearing officer add the condition of an aggravation of cervical disc

disorder/herniation at C6-7 to the claimed conditions. The hearing officer granted the claimant's request. The hearing officer did not include the condition of an aggravation of cervical disc disorder/herniation at C6-7 in the issue statement, nor did the hearing officer discuss or make findings of fact, conclusions of law, or a decision regarding an aggravation of cervical disc disorder/herniation at C6-7.

141892 – Impairment rating and gait derangement - Dr. H found decreased ROM measurements of the claimant's left ankle which resulted in 3% impairment, but noting that the claimant's injury "requires routine use of a short leg brace (ankle-foot orthosis [AFO])," Dr. H assigned a 15% WPI using Table 36 on page 3/76 of the AMA Guides for gait derangement. Page 3/75 of the AMA Guides states under Section 3.2b Gait Derangement that "[t]he lower limb impairment percents shown in Table 36 [relating to gait derangement] should stand alone and should *not* (emphasis original) be combined with those given in other parts of Section 3.2." Dr. H misapplied the AMA Guides in assessing the claimant's IR by improperly combining 15% impairment assigned for gait derangement with 1% impairment assigned for the claimant's partial medical meniscectomy.

141918 – 10-day letter and Claimant's appeal – Claimant was a no show for his CCH and did not respond to a 10-day letter. On appeal, Claimant informed the AP that he was in the hospital for several months and now in hospice in a nursing home; so, he did not get the 10-day letter informing him of the hearing. Claimant requested a hearing and the AP remanded the case for a hearing.

141958 – Disability - The hearing officer determined that the claimant has had disability resulting from the compensable injury of [Date of Injury], from September 9, 2013, through the date of the CCH, August 4, 2014. However, the claimant testified that he began a new job on March 3, 2014, at a higher pay than his pre-injury job. Furthermore, the claimant stated during closing argument that he had disability for the period from September 9, 2013, through March 2, 2014.

141973 – Radiculitis needs expert causation analysis - The condition of lumbar radiculitis is a condition that requires expert evidence to establish a causal connection with the compensable injury. In evidence are records from (Dr. L), the treating doctor, listing an impression of lumbar radiculitis, among other conditions. However, Dr. L did not explain how the compensable injury caused lumbar radiculitis. Also, Dr. C did not specifically discuss lumbar radiculitis, nor did Dr. C explain how the compensable injury caused lumbar radiculitis. The AP reversed that portion of the hearing officer's determination.

141980 – Impairment rating mathematical error - Dr. Mc combined the loss of ROM measurements of the left shoulder which resulted in a four percent UE impairment for left shoulder, he then converted the four percent UE impairment using Table 3 on page 3/20, to a two percent whole person impairment (WPI). The AP noted Dr. Mc listed a four percent IR on the Report of Medical Evaluation (DWC-69), rather than the two percent IR as explained and calculated in his narrative report. The Appeals Panel corrected the error.