APPEALS PANEL DECISION SUMMARIES
(January 07, 2014, -- *140246*)
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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. I try to hit the highlight, 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

132383 – Finality - Dr. B's December 14, 2012, DWC-69 is a valid certification of MMI/IR pursuant to Rule 130.12(c) because it does not contain a prospective date of MMI, the DWC-69 is signed by Dr. B, and Dr. B certified that the claimant does not have any permanent impairment as a result of the compensable injury. Dr. B's December 14, 2012, MMI/IR certification meets the requirements of Rule 130.12(c) and is a valid certification. Even thought there was no narrative, Dr. B's certification that the claimant reached MMI on December 14, 2012, with no permanent impairment became final.

123423 – MMI/impairment rating without a Designated Doctor - No Designated Doctor was appointed to address MMI and impairment rating. In APD 020385, the Appeals Panel stated that "[u]nder the provisions of Section 408.125, no determination can be made regarding the claimant's IR because there is no report from a designated doctor."

132541 – MMI/impairment rating, Designated Doctor's discretion - The Designated Doctor placed Claimant into DRE II when the medical evidence supported placing Claimant in DRE III. The AP stated Dr. A's placement of the claimant in DRE Category II was in his discretion as a matter of medical judgment and they disagreed that this constituted compelling medical evidence of a significant error by the certifying doctor in applying the appropriate AMA Guides or in calculating the IR per Section 408.123(f)(1)(A).

132544 – Disability - There were inconsistencies between the hearing officer's discussion of the DWC-73s and the record so the case was remanded to determined disability.

132574 – MMI/impairment rating. Doctor did not rate compensable injury - Hearing loss was found to not to be part of the compensable injury. Dr. E noted that Dr. K assessed a zero percent impairment for the claimant's hearing problems. Based on examination findings and previous EMGs, Dr. E assessed zero percent impairment for the claimant's cervical and lumbar spine. Dr. E certified that the claimant reached clinical MMI on that same date with a zero percent IR. Even though the final result was zero percent impairment rating, the AP remanded the case because the doctor did not rate the compensable injury. Dr. E assigned impairment for a condition that has been determined to be noncompensable and as such his IR cannot be adopted.

132318 – Extent. Lack of causation opinion - The hearing officer noted Dr. M's and Dr. R's opinions to be based upon an accurate understanding of the mechanism of injury and reasonable

medical probability and were more persuasive on the extent of the claimant's injury. However those doctors did not specifically mention the disputed lumbar IVD diagnosis. Dr. R opined that the compensable injury extended to lumbar IVD but he did not provide any explanation of causation between the compensable injury and lumbar IVD. The AP rendered a new decision that the compensable injury of did not extend to lumbar IVD.

132594-s – Finality - The AP noted the preamble to Rule 130.12, states "[a] party that wishes to dispute the certification or any of the ratings should not wait until after the extent-of-injury dispute is resolved as this resolution may occur after the 90-day period expires and the certification may have already become final." The hearing officer found that a certifying doctor's failure to rate the entire compensable injury constituted an exception under Section 408.123(f)(1)(A). The AP found there is no provision in either Section 408.123 or Rule 130.12 that provides the exclusion of a condition in an assignment of IR constitutes an exception to finality.

132643 - Extent. Lack of causation opinion - AP affirmed hearing officer decision that compensable injury extends to a ganglion cyst but reversed and rendered hearing officer decision the compensable injury extends to left volar carpi radialis tenosynovitis due to insufficient medical evidence of causation.

132734 – MMI/impairment rating. Designated Doctor's discretion - The hearing officer applied a mathematical correction to Dr. C's 8% IR because he believed the ROM loss for the different angles of loss of ROM for the claimant's right knee must be combined. Using table 41 of the Guides, DD assessed 4% for flexion and 8% for extension/flexion contracture for a whole person IR of 8%. However, there is no specific provision in the AMA Guides in the Lower Extremity section that requires ROM deficits in multiple directions be combined to increase the impairment for a single joint, and it was within Dr. C's discretion as a matter of medical judgment to not combine the different angles of loss of ROM for the claimant's right knee.

132760 – Extent. Diagnoses listed but lack of causation analysis - None of the medical records, including those of Dr. H, Dr. D, Dr. C, and Dr. Hu, causally link otalgia and TMJ to the compensable injury. Although Dr. D noted diagnoses of right wrist and forearm sprain, the extent-of-injury condition was not specific to those conditions, and those conditions were not litigated at the CCH. Claimant had radicular complaints but no injury to the right wrist and forearm. As there was no MMI/IR certification in evidence that could be adopted, the AP remanded the issues of MMI and IR to the hearing officer.

132783 – MMI/impairment rating. Rounding error - Hearing officer adopted DD's 4% impairment rating for right wrist strain and triangular fibrocartilage tear. AP found DD failed to round measurements of extension and remanded to the hearing officer to request that the DD rate the injury, rounding range of motion figures as required by the Guides.

132794 – MMI/impairment rating. Rounding error - Hearing officer found compensable injury does not include right shoulder capsultitis and that impairment rating is 2% as certified by the DD. AP found that, as part of his calculations, the DD improperly assessed a 1% UE impairment based on 15º for radial deviation of the right wrist when page 3/37 of the Guides directs that

radial deviation measurements must be rounded to the nearest 10º. None of the other certifications in evidence could be adopted. Remanded for the HO to instruct the DD to assess impairment rating in accordance with the Guides.

132795 - Salary continuation - The evidence reflects that the claimant has worked for the employer in some capacity during the claimed period of disability. As the claimant has worked for the employer in some capacity and continued to draw his preinjury wage, the AP rendered a new decision that the claimant did not have disability.

132801 – Incorrect Carrier Information Form - The Appeals Panel remanded the case to the hearing officer to determine who the correct carrier is for the date of injury because the Carrier Information Form listed a different Carrier name than what the parties announced and stipulated.

132816 – Extent of injury - AP reversed and remanded due to inconsistent findings re: extent. On remand, hearing officer is to make a decision concerning extent which is consistent and supported by the evidence, advise the DD and obtain DD's opinion re: MMI and impairment rating.

132838 – MMI/impairment rating. DD rated non-compensable conditions. Treating Doctor didn't rate entire injury. In explaining his determination that the claimant has not reached MMI, Designated Doctor stated that " It is my opinion that she has reached MMI in all other areas, but not in the area of the cervical spine." This was based in part on the cervical EMG that indicated cervical radiculopathy. Cervical radiculopathy was found not to be part of the compensable injury. Dr. W examined the claimant on September 25, 2012, and determined the claimant had not yet reached MMI, but was expected to do so on December 25, 2012, because she was still being evaluated for the patellar fracture and a therapy program had been recommended. Dr. W listed the following conditions under "clinical impression": contusion of the face (resolving), right patella fracture, right ankle sprain, cervical strain (resolved), lumbar strain (resolved), left wrist strain (resolved), left thumb strain (resolved), and left hip strain (resolved). However, Dr. W failed to rate the compensable condition of a single episode of depression. Dr. W's certification could not be adopted.

132839 – Hearing officer added extent issue without agreement - Hearing officer adopted Treating Doctor referral certification of 11% impairment rating and rejected the RME certification, in part, because it did not include Claimant's alleged lumbar injury, a condition in support of which Claimant submitted evidence at the CCH. AP remanded because there was no stipulation by the parties or determination by the Division that the alleged lumbar sprain/strain was part of the compensable injury. On remand, hearing officer is to add the extent issue, make a determination re: the lumbar injury, advise the DD re: the extent of injury and obtain a rating from the DD for the entire compensable injury.

132849 – Extent is a threshold issue - Whenever the issue is IR and there is a dispute regarding the extent of the injury, the extent issue must be resolved first.

132851 – Designated Doctor did not have all the records - The evidence established the Designated Doctor did not have all of the claimant's medical records for his examination before

making a determination on MMI and IR. *See* APD 132258. See Rule 127.10 and Section 408.0041(c). On remand, the hearing officer should ensure that the treating doctor and the carrier shall send to the designated doctor all of the claimant's medical records that are in their possession relating to the issues to be evaluated by the designated doctor.

132853 – Extent of injury, lack of explanation – Designated Doctor did not discuss how the compensable injury caused C5 and C6 right sided and left sided radiculopathy. As the evidence did not contain an explanation of how the compensable injury caused this condition, the AP reversed the hearing officer's determination

132857 – MMI/impairment rating. Certification included non-compensable conditions - Hearing officer determined that compensable cervical sprain injury does not extend to aggravation of disc disease at C5-6 and C6-7 or C7 radiculopathy and adopted DD's certification of MMI on 3/9/12 with a 0% impairment rating. AP reversed and remanded with regard to MMI/impairment rating because the DD's certification considers disc disease and radiculopathy, conditions found by the hearing officer not to be compensable. The only other certification in the file could not be adopted because it appears to consider surgery performed to address those conditions found not to be compensable. Remanded for hearing officer to obtain DD certification of compensable cervical sprain only.

132865 – Finality - Hearing officer found 1st certification did not become final because the same was not provided by Carrier by verifiable means and further that compelling medical evidence exists of a significant error in applying the Guides. Hearing officer adopted RME certification. AP affirmed but found that Carrier's PLN-3 referencing 1st certification established acknowledged receipt of the same and, for such reason; hearing officer's finding that first impairment rating was not provided Carrier was reversed.

132905 – Question of who was the correct employer.

132911 – MMI/impairment rating – Hearing officer found a date of MMI. The AP agreed. The AP reversed only on the issue of impairment rating. The Designated Doctor miscalculated his range of motion measurements and used the range of motion model for a single level fusion. The AP said the range of motion model could not be used just because someone had spinal surgery.

132913 – Setting aside a stipulation and wrong employer identified - The parties in this case stipulated on the record that on [incorrect date of injury], the claimant was the employee of [AHI]. The AP noted that Finding of Fact No. 1.B. identifies the date as [date of injury], which, although is the correct date of injury, that is not the date the parties stipulated to on the record. The carrier contended that the employer identified in Finding of Fact No. 1.B. is incorrect. The carrier stated that it discovered after the CCH that the correct employer in this case is [HCT], not [AHI], as stated in the decision. The case was remanded to see if there was good cause to set aside the stipulation and to determine who was the correct employer.

132919 – Employer providing network information - Insurance Code Section 1305.451(a) states that an insurance carrier that establishes or contracts with a network shall provide to employers, and the employer shall provide to its employees, an accurate written description of the terms and

conditions for obtaining health care within the network's service area. The evidence showed that an electronic link to the provider list is provided to the claimant on page two of the information packet. Furthermore, 28 TEX. ADMIN. CODE § 10.60(c)(3) (Rule 10.60(c)(3)) provides that the notice of network requirements may be in an electronic format provided a paper version is available upon request.

132926 – Stipulations - A review of the record shows that the parties stipulated at the July 23, 2013, CCH that the carrier accepted bilateral shoulder rotator cuff tears. Although the carrier stated at the November 5, 2013, CCH that it would not stipulate that it has accepted bilateral shoulder rotator cuff tears, the carrier had already so stipulated at the July 23, 2013, CCH. Section 410.166 and 28 TEX. ADMIN. CODE § 147.4(c) (Rule 147.4(c)) provide, in part, that an oral stipulation or agreement of the parties that is preserved in the record is final and binding on the date made.

132926 – Designated Doctor did not have all of the records - In both his October 16, 2012, and August 22, 2013, narrative reports, Dr. B stated that there was no operative report for review regarding a left shoulder surgery. Dr. B's October 16, 2012, date of MMI is based on the claimant being three months post-operative for a left shoulder surgery; however, Dr. B did not have the left shoulder surgery operative report. Section 408.0041(c) provides in pertinent part that the treating doctor and the insurance carrier are both responsible for sending to the designated doctor all of the injured employee's medical records relating to the issue to be evaluated by the designated doctor that are in their possession.

132926 – MMI/impairment rating certification - Several certifications were in evidence. The Designated Doctor did not have all the records and did not rate the entire compensable injury (because he did not believe the compensable injury was compensable). One doctor gave an MMI date after the stat MMI date. One doctor said Claimant was not at MMI but the CCH was held after the stat MMI date. The Appeals Panel has held that it is legal error to determine a claimant has not reached MMI in a decision and order dated after the date of statutory MMI. *See* APD 131554.

132953 – Extent of injury – The doctors did not explain how the mechanism of injury caused the disputed condition.

132991 – MMI/impairment rating – No doctor rated the entire compensable injury.

140002 – Res judicata – At the November 12, 2013 CCH, the issue was "Does the compensable injury extend to include bilateral [CTS], bilateral trigger finger and tendonitis of both hands?" In the January 19, 2012, CCH, the hearing officer made a specific finding regarding the bilateral CTS and bilateral trigger finger but did not make a finding regarding tendonitis in both hands. Under these circumstances, the AP agreed the bilateral CTS and bilateral trigger finger was barred under res judicata but the issue of extent of injury as to the alleged condition of tendonitis in both hands is not barred under the doctrine of res judicata.

140034 – Extent of injury – "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." See Appeals Panel Decision 110054.

140039 – SIBs - The preamble to Rule 130.104 states adopted Rule 130.104(b) "requires the insurance carrier to advise the injured employee of the number of work search contacts required when it sends out the [DWC-52] prior to the beginning of a qualifying period." Neither the fourth or fifth quarter DWC-52s provide the minimum number of work search efforts required by Rule 130.102(d)(1) and (f). The claimant testified that she was led to believe she was doing "the correct thing" because the carrier had paid her for the other two quarters and her husband had spoken with the carrier's adjuster, who told him the claimant was doing everything correctly. Claimant relied on Carrier's past performance of paying SIBs for the 2nd and 3rd quarters when Claimant was making only three job searches per week when she should have been making five. The AP reversed the hearing officer who found Claimant had not made five job searches per week as required for her county based upon the Carrier not fulfilling its requirements.

140053 – Extent of injury - There is nothing in evidence, including the reports of Dr. O, Dr. B, and Dr. K, that provides an explanation of how the [date of injury], mechanism of injury caused a right wrist scapholunate ligament tear. All doctors agreed Claimant had the condition.

140111 – First certification/verifiable delivery – Carrier presented a green card dated March 23, 2013, to show delivery of the DWC-69 and report. Claimant's appointment with the Designated Doctor was not until March 26, 2013, and the report was dated April 03, 2013. Carrier got the signed green card back on April 25, 2013. Claimant argued he did not get the report and could not have with a green card dated before the Designated Doctor appointment. Carrier argued Claimant misdated the green card. AP said it was a fact issue for the hearing officer.

140114 – Exception to 90 day rule - As noted in APD 132594-s, supra, a subsequent resolution of the extent of the compensable injury may be an element of one of the three exceptions contained in Section 408.123(f). Hearing officer based the finality finding on the failure of the certifying doctor to include the L5-S1 herniation in the conditions rated. The AP noted this was legally incorrect under APD 132594-s. AP affirmed hearing officer, however, because the herniated disc was a previously undiagnosed medical condition under §408.123(f)(1)(B).

140123 – Extent – Hearing officer found compensable injury does not extend to include lumbar radiculopathy, chronic pain syndrome, and additional lumbar conditions. AP found that it was clear from the Designated Doctor's report concerning extent that he did not have all of Claimant's medical records as required by Rule 127.10. Reversed and remanded for hearing officer to cause all of Claimant's medical records not previously provided to be forwarded to Designated Doctor.

140142 - Extent, MMI, impairment rating – Hearing officer found the compensable injury does not extend to and include a strain/sprain and medial meniscus tear of the left knee and that Claimant reached MMI with a 0% impairment rating as certified by the DD for left knee "injury/strain" and "left partial tear medial hamstring". AP affirmed extent determination but reversed hearing officer on MMI/impairment rating because the DD rated left knee strain which hearing officer found was not part of the compensable injury.

140166 - Extent, MMI, impairment rating - Hearing officer determined the compensable injury extended to include thoracic strain/sprain, headaches, cervical spine (right side) and thoracic spine; that Claimant reached MMI with a 10% IR as certified by the 2d DD. AP affirmed extent findings but reversed MMI/impairment rating determination because the adopted certification did not rate headaches or the thoracic spine and the DD refused to rate those conditions even after having been requested to do so through an LOC.

140234 - Extent, MMI, impairment rating - Hearing officer added issue of whether or not compensable injury included cauda equina lesion and found compensable injury extended to include urinary and fecal incontinence (cauda equina lesion) and that Claimant reached MMI with a 23% impairment rating as determined by the RME doctor. The AP found that the issue of cauda equina lesion was neither certified by the BRC report nor was the issue tried by consent. For such reason, AP struck the issue and references to cauda equina lesion from D&O. Multiple doctors diagnosed Claimant with urinary and fecal incontinence resulting from the compensable injury but none sufficiently explained how the mechanism of injury caused these conditions. AP rendered that the compensable injury does not include urinary and fecal incontinence. AP reversed hearing officer's determination of MMI and impairment rating and remanded to determine whether there is an adoptable certification in the file and, if not, obtain a new certification from the DD.

140246 - Extent, MMI, impairment rating, disability - Hearing officer found the compensable injury extended to disc bulges at L4-5 and L5-S1 and lumbar radiculopathy; that Claimant has not reached MMI and Claimant had disability. AP affirmed determination re: disability, MMI and disc bulges but reversed and rendered a decision that the compensable injury does not include radiculopathy because there was no explanation in evidence of how the compensable injury caused that condition.