STATE BAR of TEXAS
WORKERS' COMPENSATION Section Newsletter
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Two months into 2016 the workers' compensation section of the State Bar of Texas has flourished and has been working to prepare for another advanced continuing legal education course.

Mark your calendars now – our **Advanced Workers' Compensation** course will be held in Austin, Texas on **August 11–12, 2016** at the Radisson Hotel and Suites. More information to come. Options are being explored as to where our pro-bono social event will take place on Thursday, August 11, 2016 evening. Sponsorships are available for the informal reception after the course on Thursday; and for the "big event" on Thursday evening. Contact Margaret Knott or Lea Buffington or myself to help get the ball rolling.

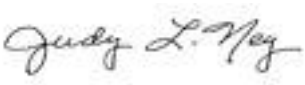
Distributions from the proceeds of last year's casino party have been made for a total of $6,339.25. The groups who received the contributions were:

American Heart Association	In memory of W.J. "Bill" Morris
Madeline Anderson Middle School Library-St. Francis	In memory of Madeline Anderson
Adam's Angels Ministry	In memory of Paul Coleman
Youth Ministry at White Rock Community Church	In memory of Charles T. Cole
Caleb Midkiff Scholarship Fund-Plaza Theater	In memory Caleb Midkiff

The Section is embarking in a new pro bono endeavor called Kids Chance of Texas. This is a non-profit organization that provides college scholarships to children of catastrophically injured or deceased workers. What a wonderful way to support our fellow workers. For additional information please contact Jane Linscomb Stone.

I am very grateful to Hearing Officer Kenneth Wrobel for all the time and effort spent on our Section's list-serve and newsletter. Thank you for keeping our members connected to current events in the world of workers' compensation in Texas. Please provide Judge Wrobel with any news about current events, speaking engagements, and life-cycle happenings so our members can network and stay informed. All articles and legal trends are always welcomed.

Sincerely,



Letter From The Editor

I'M BAAAAACCCKKKK. So, it's been awhile and the first thing I need to do is send out a special thank you to the attorneys who have sent me articles so that I actually had a newsletter to put together. I keep saying without input from you, I am nothing. At least not a newsletter editor. Thank you very much.

The second thing I need to do is to say "Hi" and "Bye" to a lot of people since the last newsletter. We've lost a lot of great hearing officers but have added a whole crew of new hearing officers. I've included our latest personnel chart (thank you, Jennifer Hopens) so you can see all the new names of benefit review officers and hearing officers around that state you will run into. My suggestion – when you're in their neighborhood, introduce yourself. As you know and have heard countless times, know your hearing officer and what she or he likes before you present your case. No matter how much turnover we get, that truism will never change.

The third thing I need to say is, "Wow! There is a lot in this newsletter!" Like any good newspaper or conference, you should be able to find a nugget or two in here that will apply to your practice and help you represent your clients. The rest of it you can put into your paperless, virtual bird cage.

I think this newsletter will have a lot of relevant information for you. There are a lot of AP decisions that are really important and will affect your everyday practice. There was, in my opinion, a huge AP decision that addressed the written verification you send to the Division to justify your fees that are outside the guidelines. When we look at your attorney fee applications and review your justifications, we have been instructed by the AP for you to have more specific information as to why you did what you did. Canned language may not be sufficient anymore. Read the summary and then the decision and adjust your applications accordingly. Another AP decision, which is not on the website as of today, reversed the hearing officer because the hearing officer approved Claimant's attorney requested 2.0 hours of time for a CCH, when the CCH ran only 85 minutes.

Let's not be strangers. I will try to put another one of these together in May/June. That way the newsletter won't be so "UUGE". Send me anything at any time. I'll save it in my May 2016 folder, which will give me an incentive to make another run at one of these. Thanks for your help and your support.

On a personal note, we are having to say good-bye to one of our cornerstones. Cheryl Dean retired on April 08, 2016. My first CCH was with Cheryl. When we were done and everyone left the room, I actually asked her how I did and what did I need to work on. Of course she politely said I did fine. I obviously didn't know much about *ex parte* communications. From there, we got talking more about theater and other stuff. We have maintained that relationship since that time. For 21 years, Cheryl has been my hearing officer, coworker, supervisor and true friend, and it will take me a while to get used to not being able to walk down to her office to get advice or just vent. Thank you, Cheryl. I miss you already.

Ken Wrobel

Surveillance Video Casewatch

By Gary A. Thornton, Jackson Walker L.L.P.

Great effort is made and much money is often spent in personal injury cases to obtain surveillance video of claimants. According to the Houston Court of Appeals (1st Dist.), however, "… no Texas case addresses, as a specific point on appeal, the admissibility and propriety of this evidence." *Diamond Offshore Services v. Willie David Williams*, 2015 Tex. App.—Houston [1st Dist.] LEXIS 7480 Case No. 01-13-01068-CV (July 21, 2015). In that case a surveillance video was offered into evidence by Diamond numerous times but the trial court consistently refused to allow it.

> The jury verdict against Diamond: "… the total sum of $8,512,068 … less an offset of $197,293 …" *Id*. at 19.

Facts: Williams was attempting to repair an "elevator" (a piece of machinery that lowers pipes into the drilling hole) and allegedly injured his back. Doctors performed micro discectomy and eventually fusion surgeries. Several doctors provided a variety of different medical opinions affecting future work, the lack of the Plaintiff's physical capabilities, etc. Diamond attempted to admit into evidence a post-incident surveillance video showing Williams nearly five years after his injury occurred,

> "showing him driving and walking in several locations … performing various repairs on his 4-wheeler vehicle, operating his mini excavator … and certain activities involving some bending and lifting …" *Id*. at 17.

Diamond contended that the surveillance video countered some of the physicians' testimony but Williams argued that the video had no impeachment value because he never asserted that he could not do the activities depicted in the video. The trial court ruled "that Diamond Offshore can keep [the video] in your reserve bank for impeachment, and that's it. So, if [Williams] opens the door, then we'll take a look at it." *Id*. at 18. On several occasions during the trial, Diamond requested that the trial court revisit the ruling, but the trial court refused to admit the surveillance video.

On appeal, the Court of Appeals ruled primarily that "a trial court does not abuse its discretion simply because the appellate court would have ruled differently … We uphold the trial court's evidentiary ruling if there is any ground for doing so, even if the trial court did not rely upon the proper ground and even if the defendant did not assert a proper ground for excluding the evidence." *Id*. at 20 citing to *K.J. v. USA Water Polo, Inc.*, 383 S.W.3d 593 (Tex. App.—Houston [14th Dist.] 2012, pet. denied). The appeals court pointed out the Plaintiff "acknowledged that he could perform the activities depicted … [but] that he would be in pain after engaging in these activities." *Id*. at 29.

Interestingly, a dissenting Court of Appeals justice, Evelyn V. Keys, stated, "I urge the Texas Supreme Court to take this case to establish the criteria for exclusion of a surveillance video in Texas …" *Id*. at 51. Justice Keys, in her dissent, pointed out that Williams contends that, "as a result of his injury on the Diamond Offshore rig, he is totally disabled and unable to return to work … [and that Diamond offered the video] both as impeachment evidence and as substantive evidence …" *Id*. at 54-5. Justice Keys also said that in view of Williams' testimony "that he would be unable to work in any capacity in the future" and "the video depicting Williams performing various activities outside his house over three consecutive days … would have allowed the jury to judge for itself the credibility of Williams and his friends and family members' testimony …" and the extent of claimed damages. *Id*. at 67. As to the claim that the video was cumulative, Justice Keys countered, "Without the video … there was nothing to show that Williams could, in fact, perform the tasks the video showed him performing." *Id*. at 79.

Late in 2015, Diamond filed its "Motion for En Banc Reconsideration" claiming that the "jury's verdict would have probably been different if the defendant had been permitted to use its best evidence." In the same motion, Diamond points out that the court was "divided sharply" over their ruling and asked "… did it [the Court of Appeals majority opinion] pave the way for the

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A Network is Not a Netwon't

By Caldwell Fletcher

I was surprised that Carriers would take the position that only medical records generated from a network provider are admissible or probative in BR or CCH proceedings. Not only is such "outside medical" direct evidence of extent of injury and aggravation issues, both the regulations, the network statute and the medical standard of care, require working with and consideration of such records by network providers. Finally, causation standards extant in TDI/DWC proceedings emphasize the reductive reasoning required by providers to determine the nature and extent of injuries and their source.

It is axiomatic that in Texas, an injury includes both the effects of that discrete injury, and the natural progression of those effects on pre-existing conditions. The Statute, and the rule, define "medical records" to include "…other health care records **from each health care practitioner** who provides care to an injured employee".[1] (emphasis added). The network practitioner who attempts to evaluate and treat a comp-only injury would do a disservice to their patients to attempt such an artificial delineation.

Such an attempt, whether bolstered by a misguided attempt to object to the admissibility of such records, or medical autocracy, would also run counter to the *Crump* analysis required of all physicians in our system:

> The Supreme Court recognized that differential diagnosis is "a clinical process whereby a doctor determines which of several potential diseases or injuries is causing the patient's symptoms by ruling out possible causes—by comparing the patient's symptoms to symptoms associated with known diseases, conducting physical examinations, collecting data on the patient's history and illness, and analyzing that data—until a final diagnosis for proper treatment is reached."[2]

Taking a patient's history is the most important skill in medicine; it would be a travesty if that skill was minimized or eroded by a misunderstanding of the role of work comp networks and the admissibility of the other health care records.

1 Tex. Ins. Cd. 1305.004(14) and 28 Tex. Adm. Cd. Sec. 10.2(16).

2 APPEAL NO. 120311-s *citing Transcon. Ins. Co. v. Crump*, 330 S.W.3d 211(Tex. 2010).

Ode to Judge David Wagner

By Mike Donovan

I saw your request for articles for the next newsletter and I have just recently been told that Judge David Wagner is retiring this month, so I thought it would be a good time to pass this on to you.

Some years back, I woke up one morning in San Angelo, and got in my car to travel to Midland for a contested case hearing at 10:00 a.m. When I was within 45 minutes of Midland, or the halfway point, I realized the hearing was not in fact in Midland, as I pieced together what office I was in for the BRC and determined I was originally in the right city, San Angelo. I immediately turned around and was reaching 100 miles an hour on roads that I have no business traveling at that speed, especially considering the oil trucks I was having to compete for lane space. I realized I was not going to make the scheduled 10:00 a.m. time, so I called Judge Wagner on the phone.

I told him I was not going to make the hearing, as I thought the hearing was in Midland and was trying my best to get there, but his options were probably going to be to either wait for me for a good 30 to 45 minutes before starting the hearing or have me participate by phone. Judge Wagner's response to me was, "Well Donovan, there is another problem and that is the hearing is in freakin' Abilene!" We then discussed the options and he decided to cancel the hearing and just reschedule for a later date and inform the ombudsman and claimant the hearing was not going to happen due to "events beyond the carrier's control." At the end of the conversation I said to Judge Wagner, "Judge, you are going to have to do me one more favor and that is you can't tell anyone about this, because it will be too embarrassing." His response was, "Donovan, you are asking a lot of me because this would be a damn good story", but I was finally able to convince him to keep it under his hat.

Being a man of his word, I never heard from any third party any indication Judge Wagner had said a peep about my royal screw-up. Although, every time I had a hearing in front of him after that he would always make some little utterance, just low enough in his raspy voice that I would hear but the others in the room would not be entirely sure of what he was talking about. It would usually go something like, "Well Mr. Donovan, I am happy to see you here on time. Not that I wouldn't think you would be on time. I just assumed you would be on time in some other office." I would have to acknowledge his remark with a little smile and we would then get on with the hearing.

I am hopeful that sometime when he is sitting in his rocking chair, he will remember the day the insurance carrier's attorney couldn't figure out the difference between Midland, Abilene and San Angelo and that will make his day. Or at least he would have a story to swap with the fellow old times over early morning coffee at the local convenience store where the topic of the day was idiot lawyers.

Opt Out Plans in Texas and Elsewhere

By Robert Greenlaw, Associate of Stone Loughlin & Swanson, LLP

Michael Grabell of ProPublica and Howard Berkes of NPR published an online article, *Inside Corporate America's Campaign to Ditch Workers' Comp* (October 14, 2015), detailing "Opt Out" plans for employers in Texas and elsewhere. The article should be of interest to any workers' comp practitioner in Texas. What follows is a brief summary.

Opting out of workers' compensation coverage has always been available to employers in Texas, which, until recently, was the only state that allowed for such an option. Nevertheless, a majority of employers traditionally availed themselves of the protections provided by the Texas Workers' Compensation Act, primarily the insulation from lawsuits under the exclusive remedy provision.

However, Texas employers have increasingly begun re-evaluating the benefit of subscribing to a workers' compensation policy versus the cost. Many have concluded that compensation under plans of their own devise (and the expense of the occasional lawsuit) is cheaper in the aggregate than what is to be saved by adhering to the regulations set forth under the state system.

The epicenter of opt-out planning in Texas, and the focus of the ProPublica investigation, is Dallas attorney Bill Minick and his consulting firm, PartnerSource. It is Minick himself who writes a great number of the plans Texas non-subscribers have substituted for standard workers' compensation policies. PartnerSource's declared goal is to provide better—not reduced—benefits to workers while lowering companies' expenses by devising unique compensatory plans for them.

The rationale for choosing to opt out is that the considerable savings a company realizes under such a plan will minimize disputes over treatment and avoid contentious arguments that imperil the employer/employee relationship. In theory, a company with an opt-out plan employs workers who are more fully aware of benefits & available medical treatment should they sustain an injury at work. For the employer, it produces greater awareness of an employee's recovery process and readiness to return to work.

However, in practice, the ProPublica investigation suggests a more precarious path awaits workers whose employers depart from the traditional workers' compensation system. Grabell and Berkes raise doubt as to whether both of the purported goals behind opt-out plans—better benefits for employee at a lower cost to employers—are being achieved. While it can be said that non-subscribing companies are more engaged in the process of handling their employees' work injury claims, the journalists posit that opt-out plans often result in excessive control over an injured employee's treatment.

Some plans are said to penalize a worker for tardiness to a doctor's appointment by terminating further benefits. Others allegedly exclude occupational diseases and repetitive stress injuries from what the employer considers a work injury. Some companies have apparently rejected the no-fault premise of workers' compensation claims under the state system by including safety violations as a reason to deny worker benefits. Procedurally, an employee who has been denied benefits in the state system can request a hearing and present evidence to an impartial Hearing Officer. But a worker subject to an opt-out plan has only a committee set up by the employer to evaluate the legitimacy of such a denial.

The article points out also that non-subscribing employers, whose plans are not submitted to any state agency with oversight authority, are free to limit medical benefits as they wish. In contrast to the lifetime medical benefits guaranteed under the Labor Code, and in order to offset the potentially costly litigation that non-subscription exposes them to, employers routinely cap duration of medical benefits, usually at two years.

Oklahoma, in an effort to lower insurance rates, passed the Employee Injury Benefit Act in 2013, making it only the second state to permit qualified employers from opting out of the state workers' comp system. Oklahoma employers who choose not to subscribe to a workers' compensation policy must nevertheless provide a minimum level of benefits corresponding to state law. However, unlike Texas, employers with opt-out plans in Oklahoma maintain protection from lawsuits.

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The Structure of the TDI/DWC Hearings Department

By Jennifer Hopens

	Kerry Sullivan Deputy Commission	
Dispute Processing	Presiding Officers Southern & Coastal	Presiding Officers Northern & Western

		Presiding Officers Southern & Coastal Allen Craddock, Director		
Kenneth Huchton Coastal Region Team Lead (Tyler)		Barbara McWilliams (Austin) Old Law	Carol Fougerat Southern Region Team Lead (San Antonio)	
Marilyn Allen (Houston West)	David "Alan" Stanley Liaison (Beaumont)		Jeff Carothers (San Antonio)	Chris Vega Liaison
Robin Burgess (Houston West)	Nora Astorga (Houston East)		Carolyn Cheu Mobley (Austin)	Robert Eichelbaum (San Antonio)
Jacquelyn Coleman (Houston East)	Aura Garzon-O'Brien (Houston East)		Julio Gomez, Jr. (Weslaco)	Yolanda Gutierrez (San Antonio)
Jacqueline Harrison (Houston West)	Bonnie Lopez (Houston East)		Virginia Gomez (Corpus Christi)	Alice Orta (San Antonio)
Early Moye (Houston East)	Leo Montano (Houston West)		David Northup (San Antonio)	Margaret Mery-Cisneros (San Antonio)
Judy Ney (Houston East)	Bich Pham (Houston West)			
Francisca Okonkwo (Houston West)	Abimbola "Abby" Sotomi (Houston West)			
William Routon (Tyler)	Lora "Olivia" Tyler (Tyler)			
Patrice Squirewell Jean (Houston East)				

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The Structure of the TDI/DWC Hearings Department

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		Presiding Officers Northern & Western Jennifer Hopens, Director		
Northern Region (Fort Worth)			Teresa Hartley Western Region Team Lead (El Paso)	
Amanda Barlow (Dallas)	Carole Doughman Liaison (Dallas)	Mayson Pearson (Traveling hearing officer)	Travis Dupree (Midland)	Lori Reyna Liaison (Abilene)
John Bell (Dallas)	Larry Beckham (Fort Worth)	Dee Marlo Chico (Traveling hearing officer)	Teresa Boone (Lubbock)	Anita Flores (Midland)
Phillip Brown (Fort Worth)	Emily Flores (Fort Worth)			Leticia Medrono (El Paso)
Britt Clark (Fort Worth)	Donna Forster (Dallas)			Stephen Rincon (Lubbock)
Warren Hancock, Jr. (Denton)	Amparo Ilustre (Fort Worth)			
Thomas Hight, Jr. (Dallas)	Esmeralda Jimenez (Fort Worth)			
Marilyn "Katie" Kidd (Dallas)	Cheryl Kilpatrick (Dallas)			
Kara Squier (Waco)	Marilyn McBee (Denton)			
Gerri-Lyn Thomas (Dallas)	Catherine Ripley (Waco)			
Ken Wrobel (Fort Worth)				

Appeals Panel Decisions

The summaries I have provided in the past are up to date and can be found on our section website. These are just a few miscellaneous decisions over the past year (or more) that we should all be aware of. Most of the extent of injury cases of note are in the Appeals Panel Decision Manual article.

142524 – Rating radiculopathy – Dr. B only stated that the neurologic exam reveals equal deep tendon reflexes in the upper extremities, but she did not describe any decrease in the upper extremity reflexes. Dr. B concluded that the claimant's rating was obtained using a diagnosis of cervicothoracic radiculopathy. There is no documentation by Dr. B of loss of relevant reflexes or unilateral atrophy in any of her narrative reports. *To clarify, we note that there may be a diagnosis of radiculopathy and/or an administrative determination by the Division that the compensable injury extends to radiculopathy; however, in order to rate radiculopathy under the AMA Guides, it is necessary for the certifying doctor to identify and document the "significant signs of radiculopathy" as provided in the appropriate category and as provided in Table 71 on page 3/109, such as loss of relevant reflexes and/or unilateral atrophy of 2 cm or greater.*

150024 – Rating partial motor and sensory loss – The AMA Guides provide on page 3/88 that all estimates listed in Table 68 are for complete motor or sensory loss for the named peripheral nerve. Dr. M modified the estimates for partial sensory deficit involving the medial and lateral plantar nerves as listed in Table 68 using Table 11. The specific provisions of the AMA Guides do not prohibit using Table 11 to rate the value of a partial sensory deficit using Table 68. The AMA Guides state on page 3/88 that "[p]artial motor loss should be estimated on the basis of strength testing" under Section 3.2d on page 3/76. Dr. M found a partial motor deficit involving the medial and lateral plantar nerves, and used Table 68 and Table 12 to determine those nerves' impairment. According to the AMA Guides, any impairment for a partial motor deficit should be estimated on the basis of strength testing under Section 3.2d rather than Table 68. Therefore, the 10% IR assessed by Dr. M was not made in accordance with the AMA Guides, and as such could not be adopted.

150201 – Certifying doctor has to have the proper credentials – The Designated Doctor incorrectly rated Claimant's injured hand. It was undisputed that although the required medical examination doctor at one time had been certified by the Division to assign IRs, at the time of his examination of the claimant, his certification had lapsed. Rule 130.1(a)(1) provides only an authorized doctor may certify MMI, determine whether there is permanent impairment, and assign an IR if there is permanent impairment. Because the Division's certification of Dr. B had lapsed, he was no longer an authorized doctor to certify MMI and assign an IR. Accordingly, the certification from Dr. B was not adoptable.

150252 – Appeals Panel can only remand a case once – Pursuant to Section 410.203(c), the AP may not remand a case more than once. Since it previously remanded this case for reconstruction of the record, they affirmed as reformed the hearing officer's decision to include an omitted finding of fact and conclusion of law with regard to the extent-of-injury conditions in dispute. The AP then reformed the hearing officer's decision.

150341 – The certifying doctor has to have all the records – Rules 130.1(b)(4)(A) and 130.1(c)(3) specifically require that the certifying doctor, including the designated doctor, review the medical records before certifying an MMI date and assigning an IR. In Appeals Panel Decision (APD) 062068, decided December 4, 2006, the Appeals Panel held that the 1989 Act and the Division rules require that the designated doctor conduct an examination of the claimant and review the claimant's medical records. 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. In this case the Designated Doctor did not have all the medical records to determine the date that the claimant reached MMI. Therefore, that certification that the claimant reached MMI on March 28, 2014, is contrary to the preponderance of the evidence and cannot be adopted.

150372 – Physical therapist can render an expert medical opinion – Although a physical therapist is not listed under the definition of "doctor" in Section 401.011(17), medical evidence may be generated by a number of sources other than by individuals who

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Appeals Panel Decisions – Extent of Injury

Extent of injury – Expert medical evidence
(This is taken directly out of the Appeals Panel Decision Manual. If you are not familiar with it, this is a very good resource for most of our most common issues. A link is provided under Work Comp Websites.)

Proof of causation must be established to a reasonable medical probability by expert evidence where the subject is so complex that a fact finder lacks the ability from common knowledge to find a causal connection. Appeals Panel Decision (APD) 022301, decided October 23, 2002. *See also Guevara v. Ferrer*, 247 S.W.3d 662 (Tex. 2007). To be probative, expert testimony must be based on reasonable medical probability. *City of Laredo v. Garza*, 293 S.W.3d 625 (Tex. App.-San Antonio 2009, no pet.) citing *Insurance Company of North America v. Meyers*, 411 S.W.2d 710, 713 (Tex. 1966). 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. APD 110054, decided March 21, 2011.

Insufficient expert medical evidence to establish causation. The IW injured her right shoulder while lifting clothing from a pallet and hanging them overhead. The IW alleged the compensable injury includes right shoulder impingement. An MRI performed included an impression of significant impingement. The AP noted the evidence reflects that no doctor diagnosed the IW with right shoulder impingement. The doctors only listed the MRI findings under tests performed. The AP further noted that there is no medical evidence explaining how a right shoulder impingement is related to the compensable injury. The AP reversed the HO's determination that the compensable injury extended to right shoulder impingement because the finding in the MRI of impingement without attendant explanation how this condition may be related to the compensable injury does not establish the condition is related to the compensable injury within a reasonable degree of medical probability. APD 101323-s

The IW injured her lumbar spine when she slipped and fell at work. The HO determined that the compensable injury extends to an L4-5 disc protrusion with central stenosis, among other conditions. The AP found that although the designated doctor diagnosed the conditions at issue and then stated that the compensable injury should extend to those conditions, the AP noted that there was nothing in evidence that provides an explanation of how the mechanism of injury caused the L4-5 disc protrusion with central stenosis. APD 132953, *see also* APD 150750

The IW testified that he injured his back while attempting to straighten a part of the production line that was bent. The HO found that the compensable injury extends to stenosis at L4-S1, disc protrusion at L5-S1 on the left, facet hypertrophy at L4-5, and S1 radiculopathy based on a letter of causation from the treating doctor. However, the AP noted that the treating doctor did not identify the specific findings he is referencing nor did he refer to a diagnostic test which would identify the specific conditions. The AP reversed the HO's determination that the compensable injury extends to the conditions in dispute. APD 132180

Sufficient expert medical evidence to establish causation. The IW was injured when she fell and fractured her left ankle. The HO determined that the compensable injury did not include a stress fracture of the left second metatarsal, because the causation opinion in evidence failed to rule out other possible causes of the stress fracture. The AP noted that an analysis of other possible causes of an injury or illness is a factor to consider when determining causation, however, the Supreme Court in Crump did not hold that the only method to establish expert medical causation is by differential diagnosis. The AP reversed and remanded the HO's determination because the HO misinterpreted and misapplied the law by requiring a differential diagnosis. APD 120311-s

The IW was injured when she stepped in a crack and rolled her right ankle. The HO determined that the compensable injury does not extend to plantar fasciitis and complex fasciitis, and complex regional pain syndrome/reflex sympathetic dystrophy (CRPS/RSD) of the right lower extremity. The HO found that the letter of causation in evidence from the

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Appeals Panel Decision Regarding Firefighters and Cancer

(This is not much of a summary because I was not sure what to cut. I think this is important enough to get its own space. – Ken Wrobel)

150098-s – Cancer in firefighters and presumption – It is undisputed that the claimant has been employed as a firefighter with the self-insured since August 1994, and that the claimant was diagnosed with a cancer, multiple myeloma1, in April 2013. We note that this case involves an amendment to Chapter 607 of the Government Code, by adding Subchapter B, Disease or Illnesses Suffered by Firefighters and Emergency Medical Technicians, effective September 1, 2005. *See* Senate Bill (S.B.) 310 of the 79th Leg., R.S. (2005).

Under the facts of this case, the relevant statutes under the Government Code are as follows:

> Government Code § 607.052. APPLICABILITY.
> (a) Notwithstanding any other law, this subchapter applies only to a firefighter or emergency medical technician who:
> (1) on becoming employed or during employment as a firefighter or emergency medical technician, received a physical examination that failed to reveal evidence of the illness or disease for which benefits or compensation are sought using a presumption established by this subchapter;
> (2) is employed for 5 or more years as a firefighter or emergency medical technician; and
> (3) seeks benefits or compensation for a disease or illness covered by this subchapter that is discovered during employment as a firefighter or emergency medical technician.
>
> Government Code § 607.055. CANCER.
> (a) A firefighter or emergency medical technician who suffers from cancer resulting in death or total or partial disability is presumed to have developed the cancer during the course and scope of employment as a firefighter or emergency medical technician if:
> (1) the firefighter or emergency medical technician:
> (A) regularly responded on the scene to calls involving fires or fire fighting; or
> (B) regularly responded to an event involving the documented release of radiation or a known or suspected carcinogen while the person was employed as a firefighter or emergency medical technician; and
> (2) the cancer is known to be associated with firefighting or exposure to heat, smoke, radiation, or a known or suspected carcinogen, as described by Subsection (b).
> (b) This section applies only to a type of cancer that may be caused by exposure to heat, smoke, radiation, or a known or suspected carcinogen as determined by the International Agency for Research on Cancer.
>
> Government Code § 607.057. EFFECT OF PRESUMPTION.
> Except as provided by Section 607.052(b), a presumption established under this subchapter applies to a determination of whether a firefighter's or emergency medical technician's disability or death resulted from a disease or illness contracted in the course and scope of employment for purposes of benefits or compensation provided under another employee benefit, law, or plan, including a pension plan.
> Sec. 3, eff. September 1, 2005.
>
> Government Code § 607.058. PRESUMPTION REBUTTABLE.
> A presumption under Section 607.053, 607.054, 607.055, or 607.056 may be rebutted through a showing by a preponderance of the evidence that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter or emergency medical technician caused the individual's disease or illness.

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Appeals Panel Decisions Specifically Related to Your Practice

150452 – Oral agreement – At the January 28, 2015, CCH the claimant was not present, the claimant's attorney was present, and the respondent's (self-insured) attorney appeared by telephone. The claimant's attorney and the self-insured's attorney represented to the hearing officer that they had come to an agreement on the disputed issues on remand. On appeal the claimant is not represented by an attorney and has filed a pro se appeal requesting review of the hearing officer's finality, MMI, IR and disability determinations arguing that he disagrees with the hearing officer's decision because he was not present at the January 28, 2015, CCH, when the oral agreement was read into the record. The claimant specifically argues that the adoption of Dr. B's certification of MMI and IR "was done without the [c]laimant being present at the remand [CCH] on January 28, 2015.

Rule 147.4(d) provides, in part, that a signed written agreement, or one made orally is binding on: (1) the carrier and a claimant represented by an attorney through the final conclusion of all matters relating to the claim, whether before the Texas Department of Insurance, Division of Workers' Compensation (Division) or in court, unless set aside by the Division or court on a finding of fraud, newly discovered evidence, or other good and sufficient cause; and (2) a claimant not represented by an attorney through the final conclusion of all matters relating to the claim while the claim is pending before the Division, unless set aside by the Division for good cause.

At the CCH, there was no explanation requested by the hearing officer or provided by the claimant's attorney why the claimant was not present at the CCH. The Appeals Panel has held that an oral agreement reached during a CCH, which is preserved on the record, is effective and binding on the parties on the date made in the same manner as a signed written agreement, subject to the provisions of Section 147.4(c). However, the Appeals Panel has also held that even where the parties make an agreement on the record at a CCH, a hearing officer may not permit an agreement to be made that is contrary to the 1989 Act and the rules. We agree with the claimant's assertion that there is good and sufficient cause to set aside the oral agreement made at the January 28, 2015, CCH, given that the claimant was not present at the CCH and no explanation of the claimant's absence at the CCH was requested by the hearing officer or provided by the claimant's attorney on the record.

151112 – Admission of evidence/testimony – To obtain a reversal for the admission of evidence, the appellant must demonstrate that the evidence was actually erroneously admitted and that "the error was reasonably calculated to cause and probably did cause rendition of an improper judgment." It has also been held that reversible error is not ordinarily shown in connection with rulings on questions of evidence unless the whole case turns on the particular evidence admitted or excluded. In the present case, after listening to the arguments of the parties, the hearing officer found good cause for allowing Dr. O to testify. Under the facts of this case, the hearing officer's admission of the complained-of evidence does not constitute reversible error.

151382 – Claimant's attorney fees in SIBs case – The Texas Department of Insurance, Division of Workers' Compensation (Division) Order for Sequence No. 77, dated May 14, 2015, grants attorney's fees to the claimant's attorney for travel time and attendance at a BRC held on September 10, 2013. The standard for review in an attorney's fees case is abuse of discretion. Division records indicate that a BRC was held in Corpus Christi, Texas, on September 9, 2013, and lasted 45 minutes. Division records do not indicate that a BRC was held in this case on September 10, 2013. Additionally, the carrier attached to its appeal, a Order for Sequence No. 60 dated December 11, 2014, which reflects that the same attorney previously requested time for travel time to and attendance at a BRC on September 10, 2013, which was approved by a hearing officer. Given the discrepancy between the date of the BRC reflected in Division records and the date of service requested for attendance and travel to the BRC by the claimant's attorney and the duplication of requested fees as reflected in the Order for Sequence No. 60, we remand the Order to the hearing officer for a hearing regarding these requested fees.

151390 – Claimant's attorney fees in SIBs case – The carrier contends that the fees submitted included 5.0 hours for travel time, which is the amount consistently billed by this office for round trip travel from San Antonio to Corpus Christi, Texas. The carrier contends that 5.0 hours does not reflect the actual travel time by the attorney to the contested case hearing. Additionally, the

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MEMO

Insurance Carrier Claim Adjusting and Plain Language Notices

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) reminds system participants that the Texas Workers' Compensation Act and related rules contain several provisions regarding an insurance carrier's duty to reasonably adjust claims, including completing and filing plain language notices (PLNs). Timely filing notices helps ensure injured employees are notified of actions taken on their claims, including the reasons for such actions.

These notices also provide injured employees with important information about their rights to request a benefit review conference (BRC) to dispute any denial or refusal to pay benefits. Insurance carriers are required to file the *PLN-01, Notice of Denial of Compensability/Liability and Refusal to Pay,* and PLN-11, *Notice of Disputed Issue(s) and Refusal to Pay Benefits* in accordance with agency rules. Notices must provide full and complete statements in plain language that clearly explain the denial or dispute. Generic statements without a clear explanation of reasons for the action are not sufficient. Examples of statements that do not meet the requirements can be found in 28 Texas Administrative Code (TAC) §124.2(f) and (h). Insurance carriers must file the PLN-1 or PLN-11 timely in accordance with 28 TAC §124.3(a) and (e), and §132.17(b).

TDI-DWC also reminds system participants that parties in dispute resolution proceedings are required to exchange pertinent information with the opposing party before BRCs and contested case hearings (CCHs). Pertinent information is all information relevant to the resolution of the disputed issue or issues to be addressed at the BRC, and examples of pertinent information are available on the TDI website at www.tdi.texas.gov/wc/idr/brc_info_ic.html. 28 TAC §141.4.

The PLN-1 and PLN-11 are considered pertinent information and must be exchanged with the opposing party and sent to TDI-DWC before the scheduled BRC or CCH.

28 TAC §141.4(e) and §142.13(b) and (c).

Pursuant to Labor Code §415.002(a)(11) it is an administrative violation for an insurance carrier or its representative to fail to process claims promptly in a reasonable and prudent manner. It is also an administrative violation for an insurance carrier or its representative to violate a commissioner rule or fail to comply with a provision of the Act. Labor Code §415.002(a)(20) and (22). In addition, insurance carriers are specifically reminded of the following administrative violations:

- Labor Code §415.002(a)(2) – Terminating or reducing benefits without substantiating evidence that the action is reasonable and authorized by law;
- Labor Code §415.002(a)(5) – Failing to tender promptly full death benefits if a legitimate dispute does not exist as to the liability of the insurance carrier;
- Labor Code §415.002(a)(12) – Failing to initiate or reinitiate benefits when due if a legitimate dispute does not exist as to the liability of the insurance carrier; and
- Labor Code §415.002(a)(18) – Controverts a claim if the evidence clearly indicates liability.

Copies of the PLN-1 and PLN-11 are available on the TDI website at www.tdi.texas.gov/forms/form20plain.html.

MEMO

Adjusted Gross Annual Payroll Requirements Determined for Coverage of Seasonal Workers

The Division of Workers' Compensation (DWC) has determined, pursuant to the authority and direction given under the Texas Workers' Compensation Act (Texas Labor Code, Section 406.162), the adjusted annual payroll requirement of an employer for the coverage of seasonal workers has increased from $54,229 to $54,359. This is an increase of .24 percent based on the inflation rate calculated by the Texas Comptroller of Public Accounts. This gross payroll amount will be used in year 2016 to apply against an agricultural employer's year 2015 gross payroll, and to determine whether a farm or ranch worker is covered by workers' compensation.

For more information about the adjusted gross annual payroll requirement for coverage of seasonal workers, contact Dylan McCoy, Texas Department of Insurance, Financial Services, at (512) 676-6195.

MEMO

Amended 28 Tac §110.108 and §110.110 Regarding Required Notices of Coverage

On November 17, 2015, Commissioner of Workers' Compensation Ryan Brannan adopted amended 28 Texas Administrative Code §110.108 and §110.110, regarding required notices of coverage. The adoption was filed with the Office of the Secretary of State on November 24, 2015. The adoption will be published in the December 11, 2015 issue of the *Texas Register* and may be viewed on the Secretary of State website http://www.sos.state.tx.us/texreg/index.shtml. A courtesy copy of the adoption is available on the Texas Department of Insurance website at http://www.tdi.texas.gov/wc/rules/adopted/index.html.

Amended 28 TAC §110.108 and §110.110:

- updates the TDI-DWC telephone number employees use to report possible exposure to communicable diseases or HIV and to inquire about, verify, or report the lack of employer coverage at construction project sites;
- reflects the current agency name by deleting "Texas Workers' Compensation Commission" and adding "Division of Workers' Compensation," and updating "commission" to "division";
- includes the division website address on the required notice in Figure §110.110(d)(7); and,
- amends the form names in §110.110(a)(1), (a)(5), and Figure (c)(7) to conform to current agency style.

MEMO

Adopted Rule: Amendments Regarding Amount of Temporary Income Benefits

On February 08, 2016, Commissioner of Workers' Compensation Ryan Brannan adopted amendments to 28 Texas Administrative Code (TAC) §129.3 and §129.11. The adoption was filed with the Office of the Secretary of State on February 8, 2016. The adoption will be published in the February 19, 2016 issue of the *Texas Register* and may be viewed on the Secretary of State website at http://www.sos.state.tx.us/texreg/index.shtml. A courtesy copy of the adoption is available on the Texas Department of Insurance website at the link below:

http://www.tdi.texas.gov/wc/rules/adopted/index.html.

Amendments to 28 TAC §129.3 and §129.11:

- increase the hourly wage that qualifies an injured employee to be paid at the higher TIBs rate of 75% of the employee's pre-injury average weekly wage for the first 26 weeks of disability from less than $8.50 an hour to less than $10 an hour for workers' compensation claims with a date of injury on or after September 1, 2015;
- clarify that the qualifying pre-injury average weekly wage of less than $8.50 an hour still applies to workers' compensation claims with a date of injury before September 1, 2015; and
- delete the applicability date for agreements for monthly payments of TIBs because it is no longer relevant.

Amendments to 28 TAC §129.3 and §129.11 are effective March 2, 2016.

MEMO

Commissioner's Bulletin No. B-0029-15 Annual Change to Medical Fee Guideline Conversion Factors

Commissioner Bulletin No. B-0029-15 has been posted to the TDI website to inform workers' compensation system participants of the annual change to the Medical Fee Guideline conversion factors as established in 28 TAC §134.203. Under Labor Code §413.011(a), fee guidelines adopted by the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) for non-network services and approved out-of-network services are based on the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services.

To provide predictability and reflect changes in medical service delivery costs to system participants, TDI-DWC established a conversion factor and an annual update as part of 28 TAC §134.203(c). The annual update is based on the Medicare Economic Index (MEI), which is a weighted average of price changes for goods and services used to deliver physician services. The MEI for 2016 reflects an increase of 1.1 percent.

More information on 2016 Medical Fee Guideline conversion factors and a table containing conversion factors from 2008 through 2016 is available on the TDI website.

MEMO

Medical Records and Designated Doctor Examinations

The Division of Workers' Compensation (DWC) reminds all system participants that 28 Texas Administrative Code § 127.10(a)(3) requires treating doctors and insurance carriers to provide all required medical records and any analyses to the designated doctor no later than three business days prior to a designated doctor examination. Additionally, if the required medical records are not received within one business day prior to an examination, the designated doctor shall reschedule the exam to occur no later than 21 days after receipt of the records. A new e-mail address for system participants to request assistance with medical records is listed at the end of this memorandum.

Failure to provide medical records in accordance with the agency rule is an administrative violation and prevents the designated doctor from completing a certifying examination of the injured employee. Rescheduled examinations may result in unnecessary delays when processing a claim and bring increased cost to the system.

Designated doctors are encouraged to reach out to the DWC for assistance obtaining medical records prior to examinations. DWC staff may contact treating doctors and insurance carriers that have not yet provided a complete set of required medical records to the designated doctor at any time before a scheduled examination, and will take necessary action to ensure all required medical records are received. The DWC asks all insurance carriers and treating doctors for full cooperation when contacted for assistance in obtaining medical records.

MEMO

New DWC Form-154, Workers' Compensation Complaint Form

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) has finalized new DWC Form-154, *Workers' Compensation Complaint Form*.

Title 28 Texas Administrative Code §180.2(a) states that any person may submit a complaint to TDI-DWC for alleged administrative violations. Labor Code §402.023(c) states, in part, that TDI-DWC shall develop and post on its website a simple, standardized form for filing complaints. New DWC-Form-154 provides a simple, standardized form for the filing of workers' compensation complaints and may be submitted via email, fax, or mail. A person may also submit a complaint without using the form through TDI-DWC's website, email, fax, written correspondence, or in person.

An informal draft of DWC Form-154 was posted on the TDI-DWC website on December 11, 2015, with an informal comment period ending on January 4, 2016. The finalized DWC Form-154 is available in English and Spanish on the TDI-DWC website at http://www.tdi.texas.gov/forms/form20numeric.html, and is effective March 1, 2016.

MEMO

Texas Announces 2016 Workers' Compensation Education Conferences

AUSTIN, TX — The Division of Workers' Compensation (DWC) will host two Workers' Compensation Education Conferences for 2016 in Austin and Dallas. The Austin conference will be September 19-20 at the Crowne Plaza Austin Hotel, and the Dallas conference will be October 24-25 at the Renaissance Dallas-Richardson Hotel. The conferences will provide valuable information and resources to health care providers, medical office staff, employers, employee organizations, workers' compensation insurance carriers, third party administrators, and other Texas workers' compensation system participants.

"The Division of Workers' Compensation is committed to maintaining an effective and stable workers' compensation system in Texas," said Workers' Compensation Commissioner Ryan Brannan, "And educating our workers' compensation professionals, health care providers, and employers is an essential part of maintaining that balance."

Each conference will feature general and breakout sessions presented by subject matter experts that focus on the Texas Workers' Compensation Act and rules, agency programs and initiatives, and other important issues facing the Texas workers' compensation system.

Conference registration will be available in Spring 2016. Participants may be eligible for continuing education credits and applications will be made for the following:

- Texas CLE credit for attorneys
- TDI continuing education credit for insurance adjusters
- HRCI credit for human resources professionals
- CRC, CDMS, and CCM credits for rehabilitation providers

Additional information on the 2016 Workers' Compensation Education Conferences is available on the Texas Department of Insurance website at http://www.tdi.texas.gov/wc/events/edconference.html.

MEMO

Workers' Compensation Weekly Benefit Rates Set for October 1, 2015, through September 30, 2016

AUSTIN — The workers' compensation state average weekly wage for dates of injury from October 1, 2015, through September 30, 2016, is set at $895.08. The maximum weekly benefit rates for workers' compensation income benefits is set at $895 and the minimum weekly benefit rate is set at $134 for that period.

The maximum and minimum weekly benefit rates for dates of injury from October 1, 2014, through September 30, 2015, were $861 and $129 respectively.

In accordance with Texas Labor Code (TLC) §408.047, the workers' compensation state average weekly wage is equal to 88 percent of the average weekly wage in covered employment as computed each year by the Texas Workforce Commission under TLC §207.002(c).

A table showing maximum and minimum weekly benefit amounts for injuries that occurred on or after January 1, 1991, is available on the Texas Department of Insurance website at www.tdi.texas.gov/wc/employee/maxminbens.html.

MEMO

Finalize DWC Form-048, Request for Travel Reimbursement

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) finalizes revisions to DWC Form-048, *Request for Travel Reimbursement*.

DWC Form-048 incorporates amendments to 28 Texas Administrative Code §134.110(a), effective March 30, 2014, that permit injured employees to request reimbursement from an insurance carrier for travel expenses to attend a designated doctor examination, required medical examination, or post-designated doctor examination. The revisions create a separate Spanish form, add plain language, update the format and style for consistency with other TDI-DWC forms, and add a "Things to Know" section to provide additional information about travel reimbursement.

An injured employee may request reimbursement from an insurance carrier for travel expenses incurred either while seeking medical treatment for a compensable injury not reasonably available within 30 miles one way from where the injured employee lives or while traveling to attend certain examinations if the distance traveled is greater than 30 miles one way. An injured employee must use DWC Form-048 to request travel reimbursement. If the insurance carrier denies or partially denies the request, the insurance carrier must send a plain language explanation to the injured employee explaining the reasons for the denial or partial denial.

TDI-DWC posted an informal working draft of DWC Form-048 to its website on May 18, 2015, with an informal comment period ending on June 1, 2015. To show revisions made after the first comment period, TDI-DWC posted a second informal working draft of DWC Form-048 to its website on December 14, 2015, with an informal comment period ending on December 28, 2015. The finalized DWC Form-048 is available on the TDI-DWC website at http://www.tdi.texas.gov/forms/form20employee.html, and is effective April 11, 2016.

Injured employees and insurance carriers may continue to use the existing DWC Form-048 until the effective date of revised DWC Form-048.

Governor Abbott Reappoints Brannan Commissioner of Workers' Compensation

Governor Greg Abbott has reappointed Ryan Brannan of Austin Commissioner of Workers' Compensation at the Texas Department of Insurance (TDI) for a term to expire February 1, 2017. TDI's Division of Workers' Compensation regulates the workers' compensation system in Texas, ensuring injured workers receive the necessary benefits to quickly return to work, and that workers' compensation costs are kept at a reasonable level for Texas employers.

FAX NUMBER FOR HEARINGS – 512-804-4011

The Division of Workers' Compensation (DWC) has reorganized Hearings section staff into two regional docketing workgroups, North Western and South Coastal, to improve both formal and informal dispute resolution proceedings docket scheduling and management. Staff assigned to the new docket workgroups are responsible for the scheduling or rescheduling of dispute proceedings, assisting with docket management, as well as communication to system participants regarding scheduled proceedings and pending actions.

Included with this memo is a Regional Docketing chart, which provides system participants with single points of contact for proceedings management at each field office location. Additionally, there are now two dedicated fax lines for proceedings documents:

– **(512) 804-4011** is for all proceeding-related documents including motions, subpoenas, and other related documents pertaining to the dispute resolution process.

– **(512) 804-4021** will continue to be used for requests for a review from the Appeals Panel and other requests related to the Appeals Panel process.

For any other questions or additional information regarding the dispute resolution process, please contact the Hearings Customer Line at (512) 804-4010, which is available from 8 a.m. to 5 p.m., Monday through Friday.

For questions or more information regarding the new DWC regional docketing procedure, please contact Tiffany Duarte, Chief Clerk of Proceedings at (512) 804-4055.

Surveillance Video Casewatch

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routine exclusion of surveillance videos in civil cases?" Most recently, in a brief entitled "Appellant's Reply in Support of Motion for En Banc Reconsideration" Diamond argues that "the majority's holding blesses unbridled discretion."

Both the majority and the dissent discuss the Fifth Circuit case of *Chiasson v. Zapata Gulf Marine Corp.*, 988 F.2d 513 (5th Cir. 1993), involving a post-accident surveillance video and the issue of whether it constituted substantive and/or impeachment evidence. In that case, the trial court allowed the jury to view the video. The Fifth Circuit, however, held that the evidence was substantive evidence and should have been excluded because all substantive evidence had to be disclosed before trial under a local rule of the Eastern District of Louisiana. The Fifth Circuit ruled that the trial court committed reversible error because "the tape is of some impeachment value [but was] also of a substantive nature … at the very least in part substantive" and therefore should have been disclosed prior to trial. *Id.* at 517-518. The Fifth Circuit went on to point out that the value of the evidence was "obvious" and both sides conceded that the case would, in all probability, have settled if Chiasson had known about the video." *Id.* In the *Diamond v. Williams* case, however, Diamond did in fact properly disclose the evidence timely which was even the subject of "a pre-trial hearing …" *Id.* at 15.

In post-submission briefing, counsel for the Claimant/Plaintiff/Appellee says that Diamond simply does not like the result. Diamond's attorney, however, asserts that the Court of Appeals majority opinion is the first civil case in Texas fully addressing the admissibility of a surveillance video and it parts ways with Texas criminal courts, the Fifth Circuit, and the high courts of several states.

It should be noted that the very same Houston appeals court ruled similarly but with different facts, one year earlier. *Houston v. UPS Inc.*, 434 S.W.3d 630 (Tex. App.—Houston [1st Dist.] 2014, pet. denied). There, the trial court admitted surveillance video which showed that, despite the medical issues plaintiff claimed, she was "able to move around normally." The appeals court concluded "…that the jury resolved the conflicting evidence in favor of UPS and that the jury's award of zero damages for loss of future earning capacity was not against the great weight and preponderance of the evidence." *Id.* at 30.

Other courts had dealt with surveillance videos, but different issues. The Amarillo Court of Appeals in 2003 held that a surveillance video had not been properly authenticated but that Appellant waived their argument as to any prejudicial affect. *See Dunn v. Bank–Tec S.*, 134 S.W.3d 315 (Tex. App.—Amarillo 2003, no pet.). Still earlier, the El Paso Court of Appeals also considered a surveillance video but, again, plaintiff did not challenge the admissibility. *Home Insurance Company v. Garcia*, 74 S.W.3d 52 (Tex. App.—El Paso 2002, no pet.).

Until the Houston Court of Appeals' decision in *Diamond v. Williams* either becomes final or the Texas Supreme Court reviews it, consider the following: disclose the existence of surveillance video, assume it as both impeachment and substantive evidence, and the party challenging admissibility should utilize every conceivable ground to do so.

Opt Out Plans in Texas and Elsewhere

Continued from page 7.

States, of course, have long been permitted to determine their own workers' compensation systems, but with regulatory agencies and administrative penalties for non-compliance functioning as safeguards. As interest in employer-driven benefits programs expands nationally (Tennessee and South Carolina are currently contemplating reforms to their workers' compensation laws to permit the practice), it is natural to wonder whether the proliferation of opt-out plans will prompt the federal government to intervene in order to divert any newly incurred costs away from government programs like Social Security disability, Medicare, and Medicaid.

Appeals Panel Decisions

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are defined as "doctors" in Section 401.011(17). That medical evidence may be in the form of physical therapist's reports and notes, and by any number of other health care providers. See Appeals Panel Decision (APD) 970845, decided June 23, 1997, citing APD 970730, decided June 9, 1997. See also APD 990803, decided June 2, 1999, and APD 041849, decided September 20, 2004. The weight to be given such medical evidence is in the province of the hearing officer. APD 990803. A written decision is issued in this case to clarify that a physical therapist's note should not be discounted as an expert medical opinion on causation merely because a physical therapist is not a physician.

150395 – Certification must have the correct date of stat MMI – Dr. H mistakenly believed that the date of statutory MMI was December 29, 2013, rather than December 26, 2013, as stipulated by the parties. However, the parties stipulated that the claimant reached statutory MMI on December 26, 2013. While it is clear Dr. H intended to certify the claimant reached MMI on the statutory date both his narrative and his DWC-69 state the claimant reached statutory MMI on December 29, 2013.

150662 – CCH must have the proper parties – Hearing officer found a date of injury for a repetitive trauma case based on trivialization. That date was different than the date of injury on the BRC report. The date on the BRC report had one insurance carrier. The date the hearing officer found had a different insurance carrier who was not at the first CCH. The case was remanded for the second insurance carrier to be able to participate. In Houston Gen. Ins. Co. v. Association Cas. Ins. Co., 977 S.W.2d 634 (Tex. App.-Tyler 1998, no writ), the Tyler Court of Appeals held that workers' compensation coverage may not be extended by waiver or estoppel.

150720 – Extent of injury, temporal proximity a factor – The claimant in this case offered evidence that the acute tear of the lateral meniscus was diagnosed shortly after the date of injury and treatment was administered for the tear of lateral meniscus. The letter from Dr. S provides an explanation of how an acute tear of the lateral meniscus was caused by the mechanism of injury. Furthermore Dr. E, the designated doctor, opined that the acute tear of the lateral meniscus was part of the compensable injury based on the mechanism of injury and the MRI of the right knee which indicated an acute tear of the lateral meniscus was part of the compensable injury. We note that in *Guevara, supra*, 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. We further note that there was no medical evidence that an acute tear of the lateral meniscus was caused by something other than the mechanism of injury.

150797 – SIBs and attending school and reasonable grounds – The claimant testified that he was in compliance with his Individualized Plan for Employment (IPE) by attending school full-time, and that his IPE did not require him to look for work. The claimant testified that at the end of the fall semester, he studied math and registered for the spring semester. The claimant's theory of entitlement to SIBs for the sixth quarter is active participation in a vocational rehabilitation program (VRP). The IPEs dated December 3, 2014, and January 14, 2015, encompass the qualifying period in dispute. The claimant's responsibilities were to maintain and complete a full-time course load, and obtain and maintain employment after earning a bachelor's degree. The record reflects that the claimant did not attend school during the winter break from December 22, 2014, through January 2, 2015, which encompasses weeks 12 and 13 of the qualifying period for the sixth quarter. The claimant testified that during weeks 12 and 13, he used that time to study and register for the next semester. Rule 130.102 provides that an injured employee demonstrates an active effort to obtain employment by meeting at least one or any combination of the specified work search requirements each week during the entire qualifying period. The hearing officer made a specific written finding regarding whether the claimant had reasonable grounds for failing to make five or more job contacts during each week of the qualifying period for the sixth quarter of SIBs. The claimant did not look for work during weeks 12 and 13 and no evidence was offered that the claimant performed any other activity in connection with his IPE for weeks 12 and 13 of the qualifying period in dispute. Furthermore, the claimant presented no evidence of any other active efforts during weeks 12 and 13 to meet the work search requirements of Rule 130.102(d)(1). The AP reversed the hearing officer's determination that the claimant is entitled to SIBs for the sixth quarter.

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Appeals Panel Decisions

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151158-s –Impairment rating/Distal clavicle resection – The language on page 3/62 clearly provides that impairment for arthroplasty procedures is to be derived by combining loss of ROM, if any, with arthroplasty impairment under Table 27. The language contained on page 3/58 is ambiguous, whereas the language on page 3/62 provides more clear instruction regarding the rating of arthroplasty procedures. Therefore, we hold that impairment for a distal clavicle resection arthroplasty that was received as treatment for the compensable injury results in 10% UE impairment under Table 27, which is then combined with ROM impairment, if any, as provided by the AMA Guides. We note that the manner of assessing loss of ROM, including but not limited to whether or not loss of ROM should be invalidated or the comparison of ROM of a contralateral joint, remains within the discretion of the certifying doctor.

151639 – Extent of injury, "could" is not sufficient – While Dr. S acknowledged the compensable injury "could have" aggravated the arthritis, Dr. S did not provide any explanation of how the compensable injury caused chondromalacia of the patella of the left knee, and there was no other record in evidence providing the necessary explanation.

151841 – Bona fide offer of employment – In Appeals Panel Decision (APD) 010110-s, the Appeals Panel noted that the language in Rule 129.6 is "clear and unambiguous" and that the rule "contains no exceptions for failing to strictly comply with its requirements." In evidence is the employer's BFOE, which states in part the following: "Your work schedule will be as follows: Full-time; 30 hrs a week/5 days a week." In this case, the letter fails to comply with the requirement of Rule 129.6(c)(2) because it does not disclose the specific days the claimant is scheduled to work or time the claimant is scheduled to start and end each work day.

152145 – Identification of service agent – the hearing officer failed to include in the decision a separate paragraph stating the true corporate name of the insurance carrier and the name and address of its registered agent for service of process. See Section 410.164(c). Section 410.204(d) provides that each final decision of the Appeals Panel shall conclude with a separate paragraph stating the true corporate name of the insurance carrier and the name and address of its registered agent for service of process. **It is important to note, this was an attorney fee case where this information has traditionally not been included.**

152167 – Finality, receipt by verifiable means with BRC exchange – In evidence is a letter dated October 6, 2014, from the self-insured addressed to the claimant and claimant's attorney referencing the self-insured's exchange of information which includes Dr. G's DWC-69 and narrative report. Also, a letter dated December 10, 2014, from the claimant's attorney addressed to the carrier's attorney referencing the claimant's exchange of information which includes Dr. G's report. Claimant did not dispute the certification until March 27, 2015. This case is similar to Appeals Panel Decision 081248-s, decided October 3, 2008, in which the evidence established that the first valid certification of MMI and IR was exchanged by the claimant to the self-insured at a BRC. The Appeals Panel held that the claimant was in the possession of the first valid certification at the time of the exchange at the BRC which constituted acknowledged receipt by the claimant.

Appeals Panel Decisions – Extent of Injury

Continued from page 11

treating doctor in regard to those conditions was conclusory because it merely recited the MRI findings, CRPS diagnosis, and a statement that they are related to the compensable injury. However, the AP noted that the causation letter additionally discussed the claimant's mechanism of injury and how the torqueing forces caused the disputed conditions. The AP reversed the HO's determination because the HO misread the causation letter and considered it as though there was no sufficient expert medical evidence regarding causation of the disputed conditions. The extent-of-injury issue was remanded for the HO to fully consider the causation letter and give it proper weight. APD 130723

The IW testified that he injured his back while moving boxes at work and contended that the compensable injury extends to a 4 mm broad-based disc bulge at L5-S1, lumbar radiculopathy at L5-S1, or Grade I spondylolisthesis (approx. 6-7 mm of anterior displacement of L5). The HO determined that the IW did not meet his burden of proof on the issue because the designated doctor, whose opinion the IW relied on, did not provide a causation analysis. However, the AP noted that the designated doctor stated in part that the 4 mm broad-based disc bulge and L5-S1 radiculopathy were caused by the injury, that the IW had Grade I spondylolisthesis on x-rays and stated the mechanism of lifting and twisting has resulted in the disc bulge and resulting spondylolisthesis, which in turn resulted in the nerve root injury. The AP reversed the HO's extent-of-injury determination because the designated doctor did provide some analysis for his opinion that the conditions in dispute were part of the compensable injury. The HO misread the designated doctor's causation opinion. The issue was remanded to the HO to consider the opinion. APD 142257

The IW injured her left knee and ankle when she tripped over the leg of a passenger as she was pulling a cart down the aisle of an airplane. The HO determined in part that the compensable injury extends to medial and lateral meniscus tears of the left knee, chondromalacia of the patellar femoral joint including femoral trochlea of the left knee, and Piriformis syndrome. However, in the Discussion portion of the decision, the HO noted that the IW's physical therapist provided an explanation of how the Piriformis syndrome resulted from the compensable injury. The HO stated that the physical therapist's opinion is not considered an expert medical opinion on causation because it is not from a physician. The HO went on to find sufficient causation evidence from the designated doctor to determine the compensability of the Piriformis syndrome. The AP affirmed the HO's extent-of-injury determination, but explained that the HO erred in failing to consider the physical therapist's opinion. Although a physical therapist is not listed under the definition of "doctor" in Section 401.011(17), medical evidence may be generated by a number of sources other than by individuals who are defined as "doctors" in Section 401.011(17). That medical evidence may be in the form of a physical therapist's reports and notes, and by any number of other health care providers. APD 150372

Expert medical evidence is not required. Conditions that are within the common knowledge and experience of the fact finder do not require expert medical evidence to establish causation.

The Appeals Panel has long held expert medical evidence is not required for strains. *See* Appeals Panel Decision (APD) 120383, decided April 20, 2012, where the Appeals Panel rejected the contention that a cervical strain requires expert medical evidence, and APD 992946, decided February 14, 2000, where the Appeals Panel declined to hold expert medical evidence was required to prove a shoulder strain, and APD 952129, decided January 31, 1996, where the Appeals Panel declined to hold expert medical evidence was required to prove a back strain.

The IW testified he was injured when he fell from a ladder while painting. The HO determined in part that the compensable injury extends to a left knee injury in the form of a sprain, but does not extend to Grade II cervical sprain/strain at C3-4 and Grade II lumbar sprain/strain at L2-3, L3-4, and L4-5. The HO stated in the Discussion section of the decision that the disputed conditions appear to be called sprains/strains, but include a Grade II degree of those sprains/strains and are further classified as being tied to various disc levels as would be disc pathology in the nature of a herniation or protrusion. The HO further stated that the disputed conditions would go beyond the accepted condition of sprains of the cervical and lumbar spine and would require expert testimony in order to determine the nature of the injury as described in the disputed issue. The AP disagreed that the disputed conditions go beyond the cervical sprain/strain and

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lumbar sprain/strain accepted by the carrier, especially in light of the fact that medical records in evidence use the same diagnosis codes interchangeably for cervical and lumbar sprain/strain and Grade II cervical and lumbar sprain/strain. The HO's extent-of-injury determination was reversed and rendered in favor of the IW. APD 130808

The IW was injured when she stepped on an air conditioning vent in the floor that gave way. The HO determined in part that the compensable injury does not extend to a herniation at L4-5 with nerve root irritation [sciatica], sprained talofibular ligament, and fibromyalgia. The HO stated in part that the sprained talofibular ligament was beyond common knowledge and that an expert medical opinion was required for a specific ligament despite the accepted ankle sprain/strain. The AP noted 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, the AP further noted that it cannot 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. The issue of extent to the sprained talofibular ligament was remanded to the HO because a higher standard than is required under the law to establish causation was required. APD 141478

The IW sustained a compensable injury in the form of at least a right ankle sprain and a left shin contusion. The HO determined that the compensable injury does not extend to a thoracic sprain/strain, a lumbar sprain/strain, and a right knee sprain/strain. The HO noted that there is an attenuation factor in this case and specifically stated that as such, expert medical causation evidence was necessary to establish a causal link between the claimed conditions and the compensable injury. The AP disagreed that an attenuation factor in and of itself would mandate expert medical evidence of causation to establish compensability of a sprain/strain. The AP stated that a delay in the onset of symptoms was merely a factor for the HO to consider in determining whether the IW had sustained his burden of proving a causation connection between the disputed extent-of-injury conditions and the compensable injury. The HO's determination was reversed and the issue of extent was remanded to the HO to consider the evidence and apply the proper evidentiary standard of causation. APD 141688

The IW was injured when she was assaulted by a patient which resulted in loss of consciousness when her head hit a metal seclusion door frame. The HO determined in part that the compensable injury extends to concussion and impaired concentration but does not extend to post-concussion syndrome, left posterior parietal hematoma/contusion, post-traumatic stress disorder, headaches, and depression. Regarding the condition of headaches, the AP noted that it was undisputed that the claimant's head struck a metal door frame with such force that she lost consciousness and numerous records in evidence from two days after the date of injury onward diagnose the claimant with headaches. The AP stated that under the facts of this case and with the described mechanism of injury, we decline to hold that expert medical evidence was required to prove headaches. That portion of the HO's extent determination that the compensable injury does not extend to headaches was reversed and rendered as being against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. APD 142523

The IW was injured while he was working as a prison guard and was assaulted by an inmate on the date of injury. The stipulated compensable injuries were a nasal contusion, lip laceration, and cervical strain. The HO determined in part that the compensable injury does not extend to the diagnoses of cervical disc bulges at C2-3, C3-4, C4-5, C5-6, and C6-7, disc protrusion/herniation at C5-6, nasal bone fracture, concussion, traumatic brain injury with post-concussion syndrome/seizure disorder—epilepsy. Regarding the nasal fracture, the AP noted that the IW was punched to the face several times by an offender and went to the hospital where he received stitches to his lower lip area. Additionally, the first x-rays were taken of the IW's nasal bones, six days after the date of injury, and noted that the IW had a fracture of the tip of the nasal bones. The AP stated that 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 HO's determination that the compensable injury does not extend to a nasal bone fracture was reversed and rendered as being against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. APD 141556

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The claimant contends that even though a statutory presumption has been established in her favor, she additionally introduced expert medical evidence to corroborate that statutory presumption. In evidence is a medical report dated April 18, 2013, that lists the claimant's diagnosis as multiple myeloma and subsequent reports that show the claimant has undergone treatment for her cancer. A medical report from (Dr. C) dated September 23, 2013, states the claimant's occupational exposure and years of service as a firefighter to be the major factor in the claimant acquiring multiple myeloma. In this case there is no dispute that the claimant has met the requirements of Government Code § 607.052 which is the applicability of Subchapter B.

The key dispute in this case is whether the claimant met the second requirement under Government Code § 607.055(a)(2) which provides that "the cancer is known to be associated with firefighting or exposure to heat, smoke, radiation, or a known or suspected carcinogen, as described by Subsection (b)." Subsection (b) states that "this section applies only to a type of cancer that may be caused by exposure to heat, smoke, radiation, or a known or suspected carcinogen as determined by the International Agency for Research on Cancer." Both parties dispute as to how the presumption is established and which party has the burden of proof as provided in Government Code § 607.055.

The claimant argued that the presumption under Government Code § 607.055(a)(2) is established by showing that she was diagnosed with multiple myeloma during the course and scope of her employment as a firefighter, and therefore the burden of proof is then shifted to the self-insured to rebut that presumption. The self-insured argued that the presumption under Government Code § 607.055(a)(2) is established if the claimant presents evidence of causation that multiple myeloma is shown to be associated with firefighting or exposure to heat, smoke, radiation, or a known or suspected carcinogen as determined by the International Agency for Research on Cancer. In effect, the self-insured argued that the claimant has the burden of proof to establish that the International Agency for Research on Cancer has determined that multiple myeloma may be caused by heat, smoke, radiation, or a known or suspected carcinogen.

The House Research Organization (HRO) Bill Analysis for S.B. 310 states that the subject of the bill was to create a presumption about certain illnesses among emergency workers and that the medical conditions covered by the bill would include cancer and "presumption could be rebutted by showing through a preponderance of the evidence that the medical condition resulted from some factor not related to an individual's service as a firefighter or emergency medical technician." HRO Bill Analysis, Tex. S.B. 310, 79th Leg. R.S. (2005). Furthermore, the HRO Bill Analysis states that supporters of S.B. 310 emphasize that:

[S.B. 310] would improve firefighter and emergency personnel benefit security and shift the burden of proof away from the employee to the local government or risk pool in determining whether an employee's illness was caused by the performance of duties. Firefighters and emergency personnel often face hazardous situations and sustain injuries, illness, and death in their efforts to save lives and property. To receive medical coverage and workers' compensation, they must document when and where they sustained injury and illness. Because of the nature of their work, determining the origin of disease exposure or injury can be impossible to prove, yet the burden of proof currently lies with the employee. This bill appropriately would create a presumption in favor of the employee for diseases, such as certain cancers and respiratory illnesses, which typically are associated with the performance of emergency personnel duties. . . . By allowing for the rebuttal of presumption in specific situations, it would not create barriers to receiving benefits in unrelated situations. HRO Bill Analysis, Tex. S.B. 310, 79th Leg. R.S. (2005).

Additionally, the Senate Research Center (SRC) Bill Analysis for S.B. 310 states the author's/sponsor's statement of intent was to explain that:

Current Texas law provides that public safety personnel who contract certain occupational diseases may receive benefits if the person can prove that the disease was caused by an exposure in the line of duty, and if a specific exposure is documented in a timely manner. There is a lack of available benefits to those who do not show the effects of a disease that they contracted in the line of duty until later. S.B. 310 provides a rebuttal presumption for firefighters and emergency medical technicians for certain diseases, including . . . cancer. State Affairs, SRC Bill Analysis, Tex. S.B. 310, 79th Leg. R.S. (2005).

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It is clear that the legislative intent was to shift the burden of proof from the claimant to the employer by creating a presumption of causation in favor of the firefighter or emergency medical technician. We note that the Texas Supreme Court has explained that a presumption's "effect is to shift the burden of producing evidence to the party against whom it operates." *See Gen. Motors Corp. v. Saenz*, 873 S.W.2d 353, 359 (Tex. 1993).

The hearing officer has failed to properly apply the statutory presumption to facts of this case by requiring direct and unequivocal evidence that multiple myeloma is caused by heat, smoke, radiation or a known or suspected carcinogen of which the claimant was exposed during the course and scope of her employment as a firefighter. As discussed above, the legislative intent was to create a presumption in favor of the employee and to allow for the employer to rebut that presumption by a preponderance of the evidence. Government Code § 607.058 provides that a presumption under Section 607.055 may be rebutted through a showing by a preponderance of the evidence that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter or emergency medical technician caused the individual's disease or illness. Once the presumption is established, the burden of proof is shifted to the self-insured to rebut that presumption.

151156 – Cancer in firefighters and presumption - The decedent was diagnosed with pancreatic cancer while employed as a firefighter. The decedent passed away on May 6, 2011. In evidence is a certificate of death listing the decedent's immediate cause of death as "metastatic pancreatic undifferentiated carcinoma." This case involves the application of Chapter 607 of the Government Code, Subchapter B, Disease or Illnesses Suffered by Firefighters and Emergency Medical Technicians, effective September 1, 2005. See Senate Bill (S.B.) 310 of the 79th Leg., R.S. (2005). Also, we note House Bill (H.B.) 1388 of the 84th Leg., R.S. (2015), amended Government Code § 607.058, Presumption Rebuttal which was signed by the Governor on May 29, 2015.

Under the facts of this case, the relevant statutes under the Government Code are as follows:

> Government Code § 607.052. APPLICABILITY.
> (a) Notwithstanding any other law, this subchapter applies only to a firefighter or emergency medical technician who:
> (1) on becoming employed or during employment as a firefighter or emergency medical technician, received a physical examination that failed to reveal evidence of the illness or disease for which benefits or compensation are sought using a presumption established by this subchapter;
> (2) is employed for 5 or more years as a firefighter or emergency medical technician; and
> (3) seeks benefits or compensation for a disease or illness covered by this subchapter that is discovered during employment as a firefighter or emergency medical technician.
>
> Government Code § 607.055. CANCER.
> (a) A firefighter or emergency medical technician who suffers from cancer resulting in death or total or partial disability is presumed to have developed the cancer during the course and scope of employment as a firefighter or emergency medical technician if:
> (1) the firefighter or emergency medical technician:
>
> (A) regularly responded on the scene to calls involving fires or fire fighting; or
> (B) regularly responded to an event involving the documented release of radiation or a known or suspected carcinogen while the person was employed as a firefighter or emergency medical technician; and
> (2) the cancer is known to be associated with firefighting or exposure to heat, smoke, radiation, or a known or suspected carcinogen, as described by Subsection (b).
>
> (b) This section applies only to a type of cancer that may be caused by exposure to heat, smoke, radiation, or a known or suspected carcinogen as determined by the International Agency for Research on Cancer [(IARC)].

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> Government Code § 607.057. EFFECT OF PRESUMPTION.
> Except as provided by Section 607.052(b), a presumption established under this subchapter applies to a determination of whether a firefighter's or emergency medical technician's disability or death resulted from a disease or illness contracted in the course and scope of employment for purposes of benefits or compensation provided under another employee benefit, law, or plan, including a pension plan.
>
> Government Code § 607.058. PRESUMPTION REBUTTABLE.
> A presumption under Section 607.053, 607.054, 607.055, or 607.056 may be rebutted through a showing by a preponderance of the evidence that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter or emergency medical technician caused the individual's disease or illness.

The hearing officer states in the Discussion section of the decision that "[a] plain reading of [Government Code] § 607.055 indicates that both portions of Government Code § 607.055(a) (1) and (2) must be satisfied in order for a presumption to be established that the firefighter developed cancer during the course and scope of employment." The hearing officer discusses in the decision that the decedent met the requirements of Government Code § 607.055(a) (1), however the decedent did not meet the requirements of Government Code § 607.055(a) (2) and (b) based on the written opinion and testimony of (Dr. K).

In Appeals Panel Decision (APD) 150098-s, decided March 9, 2015, the Appeals Panel held that the hearing officer failed to properly apply the statutory presumption to the facts of the case because the hearing officer required direct and unequivocal evidence that the injured worker's multiple myeloma was caused by heat, smoke, radiation or a known or suspected carcinogen of which the claimant was exposed during the course and scope of her employment as a firefighter. In that case, the Appeals Panel determined that the hearing officer applied the wrong legal standard and reversed and remanded the case back to the hearing officer to apply the proper legal standard. The Appeals Panel discussed the statutory presumption found in Government Code § 607.055(a) (2) and the legislative intent to create a presumption for firefighters that would include cancer. The Appeals Panel stated that it is clear that the legislative intent was to shift the burden of proof from the claimant to the employer by creating a presumption of causation in favor of the firefighter or emergency medical technician. The Appeals Panel noted that the Texas Supreme Court explained that a presumption's "effect is to shift the burden of producing evidence to the party against whom it operates." *See Gen. Motors Corp. v. Saenz*, 873 S.W.2d 353, 359 (Tex. 1993).

In this case, in evidence is a publication by the IARC, entitled "IARC Monographs on the Evaluation of Carcinogenic Risks to Humans, Volume 98, Painting, Firefighting, and Shiftwork," (2010). That publication contains a section on Firefighting, pages 397-525, that discusses exposure of carcinogens found in smoke at fires under the title of Exposure Data. Also, that publication references evidence-based medicine on firefighters developing types of cancer, including pancreatic cancer, under the title of "Studies of Cancer in Humans."

Government Code § 607.055(b) states that the presumption found in section 607.055 applies "only to a type of cancer that **may be** caused by exposure to heat, smoke, radiation, or a known or suspected carcinogen as determined by the [IARC]." (Emphasis added). In this case, the evidence is sufficient to establish that the decedent met the statutory presumption that the decedent's cancer is known to be associated with firefighting or exposure to heat, smoke, radiation, or a known or suspected carcinogen, and that pancreatic cancer is a type that may be caused by exposure to heat, smoke, radiation, or a known or suspected carcinogen as determined by the IARC.

The hearing officer erred in finding that pancreatic cancer is not known to be associated with firefighting or exposure to heat, smoke, radiation, or a known or suspected carcinogen, as determined by the IARC, because the hearing officer failed to properly apply the statutory presumption to the facts and evidence. Furthermore, the hearing officer misplaced the burden of proof on the claimant beneficiaries to show causation, and by doing so applied the wrong legal standard to determine whether the decedent sustained a compensable injury in the form of an occupational disease with a date of injury of (date of injury), resulting in his death.

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carrier contends that the claimant's attorney submitted a different amount of time for attending the BRC than the attorney who represented the carrier at the same BRC. Neither the respondent 1 (claimant) nor the respondent 2 (atty) responded. Division records indicate that a BRC was held on November 10, 2014, and was continued after 20 minutes. The amount of time requested by the claimant's attorney was 45 minutes. Given the discrepancy between the actual time of the BRC reflected in Division records and the amount of time requested for attendance by the claimant's attorney at the same proceeding, we remand the Order to the hearing officer for a hearing regarding these requested fees.

151401 – Claimant's attorney fees in SIBs case - Division records indicate that a CCH was held on July 23, 2012, and was concluded on the same date, lasting 100 minutes. The amount of time requested by the claimant's attorney was 105 minutes. Given the discrepancy between the actual time of the CCH reflected in Division records and the amount of time requested for attendance by the claimant's attorney at the same proceeding, we remand the Order to the hearing officer for a hearing regarding these requested fees.

151634 – Relief from a DWC-24 and newly discovered evidence - On November 25, 2014, the carrier requested subpoenas duces tecum stating in that request that the carrier's investigation had revealed that the claimant received medical treatment prior to the claimed date of injury. Also, the carrier states that medical records requested from various healthcare providers would assist in determining whether these healthcare providers rendered pre-injury treatment to the claimant's right knee. On December 4, 2014, the Division granted the carrier's request and issued the subpoenas. On December 19, 2014, the post-Designated Doctor required medical examination doctor examined the claimant and opined that the compensable injury included right knee contusion, right knee strain, right medial meniscus tear, signal inhomogeneity along the ACL, and distal patellar and quadriceps tendinopathy. On January 15, 2015, a day prior to the scheduled CCH of January 16, 2015, the parties, both of which were represented by attorneys, signed a DWC-24 resolving the disputed issues of extent, bona fide offer of employment (BFOE), and disability. The DWC-24 states that the parties agreed that: (1) the (date of injury), compensable injury extends to and includes a right knee medial meniscus tear, right ACL sprain, and patellar tendinopathy; On February 10, 2015, the carrier received some subpoenaed medical records, including progress notes and medication reports, which show that the claimant had a prior right knee injury in 2003, while in military service, and had complaints of right knee pain in 2011, 2012, 2013, and 2014. Also, the subpoenaed progress notes in evidence indicate that the claimant received prescriptions for pain medication from various healthcare providers. On March 16, 2015, the carrier filed a DWC-45 stating the disputed issue as "[r]elief from DWC-24 [a]greement based on fraud."

Section 410.030 provides that a written agreement is binding on the insurance carrier absent a finding of fraud, newly discovered evidence or other good and sufficient cause to relieve the insurance carrier of the effect of the agreement. Rule 147.4(d) provides, in part, that a signed written agreement is binding on: (1) a carrier and a claimant represented by an attorney through the final conclusion of all matters relating to the claim, whether before the Division or in court, unless set aside by the Division or court on a finding of fraud, newly discovered evidence, or other good and sufficient cause.

The hearing officer determined good cause exists to relieve the carrier from the effects of the DWC-24 signed on January 15, 2015. The hearing officer's Finding of Fact No. 3 states: "[n]ewly discovered evidence from the [c]laimant's previous healthcare providers he saw before this date of injury [(date of injury)] and other good and sufficient cause exist for relieving the parties of the effects of the agreement." The hearing officer states that "[t]he medical records clearly show these conditions are not new and [t]he [c]laimant had been treating for them within weeks [prior to] the date of injury. Newly discovered evidence and other good and sufficient cause exist for relieving the parties of the effects of the agreement."

In this case, the carrier may not have been aware of the contents of records documenting the claimant's previous healthcare treatment, but it certainly was aware that the claimant had previously received treatment from a number of healthcare providers and was further aware, as reflected in the carrier's request for subpoenas, that it needed to determine whether these healthcare

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providers had provided pre-injury treatment to the claimant's right knee. The fact that the carrier had not received records of the claimant's prior healthcare treatment at the time it signed the DWC-24 is not, by itself, enough to constitute newly discovered evidence or other good and sufficient cause to relieve the carrier from the effects of the agreement.

Although the hearing officer did not make a finding of fact on fraud, the carrier's allegation on fraud is based on the medical records the carrier received after the DWC-24 was signed. We have determined based on the evidence that the medical records are not newly discovered evidence because the carrier did not exercise due diligence in obtaining the records.

151923 – Attorney fees – The attorney provided the following written justification for exceeding the guidelines regarding the CCH, "[November 6, 2014] Additional time was spent with claimant due to a much complicated mechanism of injury and causation issues involved [November 19, 2014] Updated CCH direct [November 20, 2014] Met with claimant after CCH to discuss next step" **The AP wrote, "Division records do not establish that the extent-of-injury issue at the November 20, 2014, CCH was so complicated to warrant justification to exceed the guidelines provided in Rule 152.4. Accordingly, we hold that the attorney's written justification is not sufficient to exceed the guidelines provided in Rule 152.4."**

I will have a proof to you tomorrow morning

IMPORTANT WORKERS' COMPENSATION WEBSITES AND LINKS

Workers' Compensation Section Website
http://www.texasworkerscompensationsection.com/index.php

Texas Department of Insurance (note the change in the domain to .gov. All state agencies will be making this change.)
http://www.tdi.texas.gov/

TDI-Division of Workers' Compensation
http://www.tdi.texas.gov/wc/index.html

Administrative decisions including AP decisions and medical contested case decisions
http://www.tdi.texas.gov/wc/admindecisions.html

Advisories and bulletins
http://www.tdi.texas.gov/wc/news/advisories/index.html
http://www.tdi.texas.gov/bulletins/index.html

Appeals Panel Decision Manuel
http://www.tdi.texas.gov/wc/idr/apdmtoc.html

Medical Contested Case Hearing Manuel
http://www.tdi.texas.gov/wc/idr/mddmtoc.html

Medical Fee Dispute Resolution
http://www.tdi.texas.gov/wc/mfdr/

Workers' compensation forms
http://www.tdi.texas.gov/forms/form20.html

Requests for a Letter of Clarification (LOC) of a Designated Doctor's Report
http://www.tdi.texas.gov/wc/loc/index.html

Carrier's Interrogatories to Claimant
http://www.tdi.texas.gov/wc/rules/documents/carinterrcla.pdf

Claimant's Interrogatories to Carrier
http://www.tdi.texas.gov/wc/rules/documents/clainterrcar.pdf

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Important Worker's Compensation Websites and Links

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Proposed Rules
http://www.tdi.texas.gov/wc/rules/proposedrules/index.html

Informal Working Drafts
http://www.tdi.texas.gov/wc/rules/drafts.html

TxComp
https://txcomp.tdi.state.tx.us/twccprovidersolution/homehtml

Information on Networks
http://www.tdi.texas.gov/wc/wcnet/indexinjured.html

Texas Board of Legal Specialization
http://www.tbls.org/Default.aspx

Rule book supplements
http://www.tdi.texas.gov/wc/rules/supplements.html

Designated Doctor Outreach & Oversight
Telephone: 512-804-4765
Fax: 512-804-4769
E-mail: DesDoc.Education@tdi.texas.go

Designated Doctor Certification Training Schedule and Events
http://www.tdi.texas.gov/alert/event/dd.html

ICD-10 codes
https://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx