APPEALS PANEL DECISION SUMMARIES

(150372 - 150589)

<http://www.tdi.texas.gov/appeals/2015cases>

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

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 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.

150378 – Designated Doctor does not apply contribution – Designated Doctor placed Claimant in DRE Category II with a 5% but said Claimant was already rated at 5% for a prior injury, so he certified Claimant at 0%. It is clear from his narrative report that Designated Doctor took into consideration an IR from a prior workers’ compensation injury to determine the claimant’s IR for the [date of injury], compensable injury. The AP noted the amount of contribution from a prior compensable injury was not in dispute and was not actually litigated by the parties. Because the Designated Doctor applied an analysis of contribution in assigning an IR for the claimant it was error for the hearing officer to adopt the IR assigned by Dr. D. Accordingly, they reversed the hearing officer’s determination that the claimant’s IR is zero percent.

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. The hearing officer determined that the claimant reached MMI on December 26, 2013, but there is no certification from Dr. H in evidence that the claimant reached MMI on December 26, 2013.

150399 – Extent of injury needs expert medical explanation, needs more than recitation in records - The hearing officer determined that the compensable injury of [Date of Injury], extends to a labral tear. The hearing officer stated that the claimant points to surgeon’s operative report to establish the causal link between the compensable injury and the labral tear. The hearing officer explained the surgeon found a labral tear during the right shoulder surgery which was not visible in the MRI of the right shoulder on November 26, 2013. The operative report first mentions that the “labrum” was debrided and lists as a post-operative diagnosis a labral tear. The operative report and subsequent medical reports dated October 16, 2014, and October 30, 2014, from the surgeon do not explain how the compensable injury caused the claimant’s labral tear. Under the facts of this case, a labral tear is a condition that is a matter beyond common knowledge or experience and requires expert medical evidence. In this case, none of the medical reports, including the surgeon’s, causally link the labral tear to the compensable injury.

150402 – Disability - The hearing officer noted that “[n]o doctor has returned [the] [c]laimant to full duty work.” However, in evidence are two Work Status Reports (DWC-73) from (Dr. RC), the claimant’s treating doctor. In the first DWC-73, which is dated November 4, 2014, Dr. RC released the claimant to return to work as of November 4, 2014, without restrictions. In an attached office note dated November 4, 2014, (Dr. S) noted that he was releasing the claimant from care, and that the claimant was to return to full work without restrictions as of November 4, 2014. In the second DWC-73, which is dated November 6, 2014, Dr. RC again released the claimant to return to work as of November 4, 2014, without restrictions. Although the hearing officer in this case could accept or reject in whole, or in part, the opinion of Dr. RC, Dr. S, or any other evidence, the hearing officer misread the evidence regarding a doctor’s release to return to work full duty without restrictions.

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.

150457-s – Finality/90-day Rule – The hearing officer also found in Finding of Fact No. 5 that the claimant did not dispute Dr. S’s January 16, 2014, MMI/IR certification “within 91 days” after the date the certification was provided to her by verifiable means. Section 408.123(e) provides that except as otherwise provided by Section 408.123, an employee’s first valid certification of MMI and first valid assignment of an IR is final if the certification or assignment is not disputed before the 91st day after the date written notification of the certification or assignment is provided to the employee and the carrier by verifiable means. Section 408.123(e) does not provide that an employee or a carrier has 91 days to dispute a first valid MMI/IR certification; rather, that provision states that the first valid MMI/IR certification has to be disputed before the 91st day after the date written notification of the MMI/IR certification is provided by verifiable means. Also noted above, Rule 130.12(b) provides, in part, that the first MMI/IR certification must be disputed within 90 days of delivery of written notice through verifiable means. Neither the Act nor Rules provide that a party disputing the first valid MMI/IR certification has 91 days after the date the certification was provided to the party by verifiable means to dispute that certification.

150457-s – Finality/exceptions and failure to rate the stipulated accepted injuries - The hearing officer stated that Dr. S’s failure to rate the conditions stipulated to by the parties constitutes compelling evidence of a significant error in applying the appropriate AMA Guides in calculating the claimant’s IR. In Appeals Panel Decision No. 132594-s, The Appeals Panel noted that “there is no provision in either Section 408.123 or Rule 130.12 that provides that the exclusion of a condition in an assignment of IR constitutes an exception for finality,” and declined to read any such interpretation in those provisions and declined to follow any prior cases that may have read such an interpretation. In APD 132117, as in the instant case, the extent of the claimant’s compensable injury was not at issue. The hearing officer in that case determined that the first assigned IR did not become final because there was compelling medical evidence of a significant error by the certifying doctor in calculating the claimant’s IR because the certifying doctor included a condition that was not determined to be a part of the compensable injury. The Appeals Panel noted, as it did in APD 132594-s, supra, that “[t]here is no provision in either Section 408.123 or Rule 130.12 that states that the mere inclusion of a condition in an assignment of IR constitutes an exception for finality.” In this case, Dr. S’s failure to rate a medical condition to which the parties have stipulated at the CCH to be included in the compensable injury does not, by itself, constitute compelling medical evidence of a significant error in applying the appropriate AMA Guides under Section 408.123(f)(1)(A).

150499-s – SIBs and Carrier waiver - The hearing officer determined that the claimant is entitled to 11th quarter SIBs solely on the basis of carrier waiver. The hearing officer stated in the Discussion portion of the decision that the Division’s denial of the carrier’s DWC-45 noted that the documentation of efforts to resolve the disputed issues prior to requesting a BRC was insufficient. The hearing officer stated that because the carrier’s DWC-45 was denied and a complete DWC-45 was not filed within 10 days after receiving the claimant’s application for 11th quarter SIBs, the carrier waived its right to contest the claimant’s entitlement to SIBs for the 11th quarter by failing to timely request a BRC, and therefore the claimant is entitled to 11th quarter SIBs.

The carrier contended that it presented evidence establishing that it filed a DWC-45 on July 25, 2014, disputing the claimant’s entitlement to 11th quarter SIBs, and that it attached to the DWC-45 e-mails between the claimant’s attorney and the carrier’s adjuster as documentation of its efforts to resolve the disputed issue. We note that in evidence are e-mails from (Ms. J) from the carrier to (Ms. H) with the claimant’s attorney’s office that are date stamped as received by the Division on July 25, 2014, which is the same date the carrier filed the DWC-45. Also in evidence is a DRIS note dated September 4, 2014, Sequence Number 183 from a Division employee noting that she had “denied the [DWC-45] based on the fact that I [received] only two pages, which was the DWC-45 and no attachments. After reviewing TxComp, I see that the supportive documentation was scanned in and date stamped on the same day just not noticed that they were (sic) should be together. . . .”

In evidence is a second DWC-45 filed by the carrier on September 3, 2014, in which the carrier described the disputed issue as follows:

[The] [c]arrier asserts that the [Division] abused its discretion in denying the BRC requested [on July 25, 2014] based on [Rule] 141.1. The [c]arrier included with the [July 25, 2014] DWC-45 its attempts to resolve the issue through documentation showing the date the claims adjuster contacted the claimant’s attorney and the representation that counsel would not agree that her client is not entitled to [SIBs]. The communications between the claims adjuster and the claimant’s attorney are memorialized in e-mail communications attached to the DWC-45. All documents reflect hand delivery to the [Division] on July 25, 2014.

A BRC was held on October 3, 2014. The BRC report in evidence shows that the two issues unresolved after the BRC were whether the claimant is entitled to 11th quarter SIBs, and whether the carrier waived its right to contest the claimant’s entitlement to 11th quarter SIBs by failing to timely request a BRC. The BRC report notes that the carrier’s position at the BRC was that it did not waive the right to dispute 11th quarter SIBs because it timely filed a DWC-45 on July 25, 2014, along with documentation showing the carrier’s attempts to resolve the issue with the claimant’s attorney, and that the Division abused its discretion by denying the July 25, 2014, DWC-45. The carrier argued the same position at the CCH. The evidence in this case shows that the carrier pursued an administrative appeal of the Division’s denial of the carrier’s July 25, 2014, DWC-45 under Chapter 142 relating to Dispute Resolution, which is one of the two methods listed in Rule 141.1(g) under which a party may challenge a Division denial of an incomplete DWC-45.

As noted above the carrier in the instant case filed a DWC-45 asserting that the Division abused its discretion in denying the carrier’s July 25, 2014, DWC-45, because the carrier did file a complete DWC-45 under Rule 141.1(d). The carrier argued this position at both the BRC and the CCH. Therefore, we find the facts in the instant case distinguishable from those in APD 111189-s, and we hold that the carrier in the instant case appealed the Division’s denial of its July 25, 2014, DWC-45 under Rule 141.1(g).

150503 – MMI/impairment rating must rate the entire compensable injury and not include non-compensable conditions – The AP affirmed the hearing officer’s determination that the compensable injury of February 16, 2013, does not extend to a cervical disc protrusion at C5-6 and bilateral shoulders sprain/strains. Dr. L considered and rated bilateral shoulder sprain/strains, a condition which has been determined to not be part of the compensable injury. Additionally, although Dr. F diagnosed low back pain and mentioned a lumbar sprain in his narrative report, Dr. F did not provide a specific impairment for the claimant’s lumbar spine.

150510 – Hearing officer must address each condition - Upon the claimant’s request and a finding of good cause by the hearing officer, the following condition was added to the extent-of-injury issue: nonunion of the anterior C1 arch left of midline and of the C1 lamina in the midline. Although the hearing officer noted in the discussion portion of the decision that he added this condition to the extent-of-injury issue, the hearing officer made no findings of fact, conclusions of law, or a decision as to whether the compensable injury extends to nonunion of the anterior C1 arch left of midline and of the C1 lamina in the midline. Because the hearing officer failed to make a determination on this condition, which was properly before him to determine, the hearing officer’s decision is reversed as being incomplete.

150558 – Post-concussion headaches may not need expert medical evidence for causation -The hearing officer determined that the compensable injury does not extend to post-concussion headaches. The hearing officer explained in the discussion portion of the decision that the claimant failed to produce sufficient expert medical evidence to establish compensability of post-concussion headaches. In this case the claimant was injured in an explosion that threw him back approximately five feet, which resulted in an injury to his head. The parties stipulated in part that the compensable injury includes at least a post-concussion syndrome. 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 post-concussion headaches.

150575 – MMI/impairment rating – The hearing officer resolved the disputed issues by deciding that the appellant (claimant) reached maximum medical improvement (MMI) on October 14, 2014, and the claimant’s impairment rating (IR) is 13%. The Designated Doctor explained the claimant had reached MMI on September 9, 2013, the date of her last visit with any physician. Furthermore, he explained that the claimant reached MMI because she had been provided with all potential reasonable care for her injuries, she was not a candidate for further physical therapy or surgery, and if she were to undergo pain management procedures, it would not provide further material recovery from or lasting improvement to her injury. In a medical report dated January 30, 2014, the treating doctor states that he disagrees with the Designated Doctor certification of MMI/IR because the claimant was approved for a work hardening program on October 29, 2013, and she began the program on November 4, 2013. In a medical report dated April 7, 2014, the Treating Doctor notes that the claimant had injections on her last visit which have helped resolve her pain for a few weeks, but it has returned and is the same. He notes that the claimant has had conservative care with medication, rest, injections, and therapy which have all failed, and a request for surgery at this time is medically necessary for the claimant to resolve ongoing pain in her right shoulder. An operative report dated July 8, 2014, from Dr. K shows that the claimant underwent a right shoulder arthroscopy. Designated Doctor’s narrative report indicates that he considered the claimant’s July 8, 2014, right shoulder surgery and physical therapy. Also, he noted that although the claimant “has [2] more therapy visits, these are due to be completed this week and as such, there is no anticipation of further material recovery from or lasting improvement over where she is currently.” Furthermore, Dr. F states that no proposed treatment has been recommended or has been scheduled by attending providers. At the December 19, 2014, CCH the claimant argued that she was not at MMI because she was preauthorized for additional right shoulder surgery scheduled on December 23, 2014. In evidence is a notification letter from the carrier dated November 11, 2014, preauthorizing right shoulder surgery.

In discussing the preauthorization for surgery and the claimant’s testimony, the hearing officer states that:

The problem with [the November 11, 2014, preauthorization letter] and the claimant’s testimony is that they are no guarantee that the claimant will actually undergo the surgery. This [h]earing [o]fficer is cognizant of the fact that surgeries are often preauthorized and scheduled, but then cancelled at the last minute because of a last minute extent-of-injury dispute or because the claimant opts not to have the surgery. In light of this fact, the preauthorization letter and the claimant’s testimony are not persuasive on the issue of MMI.

The hearing officer included a footnote in his decision that the claimant did not request that the record be held open, pending performance of the surgery and receipt of the operative report. In this case, the hearing officer clearly states in his decision that he based his MMI determination on his belief that there is “no guarantee that the claimant will actually undergo the surgery” rather than on the statutory definition that the date of MMI is the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated. The hearing officer applied the wrong legal standard in determining MMI.

150589 - MMI/impairment rating cannot include non-compensable conditions - The hearing officer adopted Dr. H’s alternate August 29, 2014, DWC-69 and determined that the claimant reached MMI on July 25, 2014, with a zero percent IR. However, Dr. H’s alternate DWC-69 considers and rates cervical radiculopathy and disc herniations at C3-6. We have affirmed the hearing officer’s determination that the compensable injury does not extend to cervical radiculopathy and disc herniations at C3-6. Dr. H’s alternate MMI/IR certification considers and rates conditions that have been determined to not be part of the compensable injury.