APPEALS PANEL DECISION SUMMARIES

(142393 – 150510)

*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*

142393 - MMI/impairment rating included non-compensable conditions – CC found Claimant to be not at MMI but included conditions that were not accepted or administratively determined to be compensable. As Dr. N’s opinion that the claimant has not reached MMI is based on conditions that are not compensable, the hearing officer’s determination that the claimant has not reached MMI based on that opinion is not supported by sufficient evidence.

142443 – Hearing officer decide issue beyond scope of certified issue - The issue stated in the Benefit Review Conference (BRC) Report is: “Does the [[Date of Injury]], compensable injury extend to and include right knee Grade III chondromalacia in the medial femoral condyle and patella?” There is no evidence that either party filed a written response to the BRC report. The parties discussed amending the issue to: Does the compensable injury of [Date of Injury], extend to right knee Grade III chondromalacia in the medial femoral condyle and patella after the June 30, 1992, surgery? The claimant requested a continuance if the issue was going to be changed. The carrier was agreeable to the change. On the record the hearing officer stated that they would “save the amendment” of the issue until after the testimony of (Dr. G) was presented by the carrier. Both the claimant and Dr. G testified and the parties presented their closing argument. There was no further discussion on the record regarding amending the issue. The parties did not ever agree to the change, however the hearing officer mistakenly changed the issue and determined it as changed. This exceeded the scope of his certified issue. The case was remanded for the parties to decide the language to be used and to present evidence accordingly.

142451 – Extent of injury opinion and mechanism of injury - In her discussion of the evidence, the hearing officer noted that Dr. G opined that although the claimant may have had some pre-existing degenerative cervical and lumbar conditions, the compensable injury caused or aggravated the disputed conditions. The hearing officer indicated that she discounted Dr. G’s opinion because Dr. G believed the mechanism of injury involved a three car accident, and the hearing officer noted “there was no evidence that the [c]laimant’s vehicle hit another vehicle in front of it.” However, in a second report dated July 31, 2014, Dr. G noted that the claimant “has re-explained the mechanism of injury. [The claimant] indicated that the mechanism of injury on [[Date of Injury]] was not a three car incident but a two car incident where [the claimant] was rear-ended by a car.” Dr. G then explained that the two car incident did not change his opinion regarding the extent of the compensable injury. The case was remanded for the hearing officer to review the evidence.

142477 – Timely contesting compensability of a claim and 60 days - In the Discussion portion of her decision, the hearing officer states that the 60th day following April 25, 2014, is June 23, 2014. However, the 60th day following April 25, 2014, is not June 23, 2014, as indicated by the hearing officer, but June 24, 2014. As the carrier filed a PLN-1 disputing the injury of [Date of Injury], on June 24, 2014, the carrier did not fail to timely contest the injury.

142523 – Headaches and expert medical opinion - In this case it was undisputed that the claimant’s head struck a metal door frame when a patient slammed her head into the door frame with such force that she lost consciousness. Numerous records in evidence from Dr. C from two days after the date of injury onward diagnose the claimant with headaches. 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.

142523 – Extent opinion, hearing officer misread the report - The hearing officer noted in the Discussion portion of the decision the designated doctor who was appointed to determine extent of the compensable injury, concluded that left posterior parietal hematoma was part of the compensable injury “because of [the] [c]laimant’s depression and decreased concentration. . . .” However, Dr. W stated in her report dated May 2, 2014, that left posterior parietal hematoma/contusion was part of the compensable injury because that condition is “documented in the records.” The Appeals Panel reversed the hearing officer’s extent-of-injury determination because he had misread the causation letter in evidence.

142524 – Rating cervical 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. In Appeals Panel Decision (APD) 030091-s, decided March 5, 2003, the Appeals Panel held that the AMA Guides indicate that to find radiculopathy, doctors must look to see if there is a loss of relevant reflexes or unilateral atrophy to find radiculopathy. The Appeals Panel noted that there may be a diagnosis of radiculopathy and/or an administrative determination that the compensable injury extends to radiculopathy; however, in order to rate radiculopathy under the AMA Guides, significant signs are necessary.

142544 – The impairment rating has to rate the entire compensable injury - The parties stipulated that the claimant’s compensable injury consists of sprains/strains to the claimant’s bilateral shoulders, neck, bilateral arms, cervical, thoracic, and lumbar, and an injury to the head. Dr. H failed to consider and rate the claimant’s thoracic sprain/strain, a condition the parties stipulated is a part of the compensable injury. As Dr. H failed to consider and rate the entire compensable injury, his MMI/IR certification cannot be adopted.

142583 – Timely disputing a death claim - Rule 132.17(f)(1) specifically defines the 15-day period in which the carrier shall either begin the payment of death benefits or file a notice of dispute in a case where death benefits are at issue. In the instant case Rule 132.17(f)(1)(C) applies and the carrier had 15 days from the expiration of the 60-day time period provided in Rule 132.17(a) for investigation, to begin the payment of death benefits or file a notice of dispute. The carrier’s liability for death benefits in this case is not due to its failure to dispute or initiate the payment of benefits pursuant to Rule 132.17(f). The carrier is liable for the payment of death benefits is because the decedent sustained a compensable injury on [Date of Injury], resulting in his death.

142592 – Appointment of second Designated Doctor - The hearing officer also determined that the Division should not have appointed Dr. W as designated doctor to evaluate the claimant for the compensable injury of [Date of Injury], to determine the extent of injury. The Division had already appointed a Designated Doctor who had examined Claimant twice before. An order of an administrative body is presumed to be valid and the burden of producing evidence establishing the invalidity of the administrative action is clearly on the party challenging the action. The Division’s appointment of Dr. W to determine the extent of the claimant’s compensable injury is presumed to be valid, and the carrier had the burden of proof to establish that the Division’s appointment of Dr. W was invalid. The record contained no evidence that explained why it would have been improper for the Division to appoint Dr. W as designated doctor to determine the extent of the compensable injury or that the Division did not follow Rule 127.5(d) or any other provision. The carrier did not meet its burden of proof to establish that the Division should not have appointed Dr. W to determine the extent of the claimant’s compensable injury.

142598 – Failure to rate the entire compensable injury – All three doctors who provided impairment ratings failed to rate the actual compensable injury.

142601 – Evidence sent to AP after the CCH – Claimant obtained a letter of causation on extent after the CCH and after the record was held open two weeks for her to get that letter. Documents submitted for the first time on appeal are generally not considered unless they constitute newly discovered evidence. In determining whether new evidence submitted with an appeal or response requires remand for further consideration, the Appeals Panel considers whether the evidence came to the knowledge of the party after the hearing, whether it is cumulative of other evidence of record, whether it was not offered at the hearing due to a lack of diligence, and whether it is so material that it would probably result in a different decision. See APD 051405, decided August 9, 2005. We do not agree that the documents submitted by the claimant for the first time on appeal meet the requirements for newly discovered evidence.

142601 – Visual impairment - Dr. T states in his narrative report that only distant visual acuity measurements are available in this case. For the near visual acuity measurement, Dr. T assumes a similar decrease as the distant visual acuity measurement, but he does not perform actual measurements on the claimant. We further note that Dr. T stated in his report that there are no claimed deficits of either monocular or binocular visual fields or claimed abnormalities of ocular motility or binocular diplopia, but again failed to provide any measurements as required by the AMA Guides and Rule 130.1(c)(3) in rating an impairment of the visual system.

142662 – MMI/impairment rating – No doctors rated the entire compensable injury.

142675 – Failure to rate the entire compensable injury – The Designated Doctor failed to rate the entire compensable injury so his certification could not be adopted. The post-DD RME doctor rated the entire compensable injury so his rating could be adopted. Both doctors had the same MMI date and impairment rating.

142702 – MMI/impairment rating certification – There were internal inconsistencies between what the Designated Doctor wrote and what the hearing officer wrote. The evidence reflected that the Designated Doctor certified that the claimant reached MMI on December 17, 2012, not December 7, 2012. There was no DWC-69 that stated December 07, 2012. The AP rendered a new decision making the findings and conclusions consistent.

142708 – After CCH procedure of sending parties the Designated Doctor report - The claimant contended in her appeal that she only received an unsigned copy of Dr. A’s report, and that she did not receive notice of the date the record closed nor was she given time to file additional arguments, evidence, or objections. However, in evidence is a letter dated October 17, 2014, in which the hearing officer notified the parties that Dr. A had been designated as the designated doctor on re-examination, and that a copy of Dr. A’s MMI/IR certification was attached. The claimant’s mere assertion that she did not receive notice of the date the record closed and that she was not given time to file additional arguments, evidence, or objections is insufficient to establish that she did not receive the hearing officer’s letter dated October 17, 2014, along with Dr. A’s unsigned MMI/IR certification.

142708 – Certifying Doctor has to sign DWC-69 - The hearing officer determined that the claimant reached MMI on June 5, 2013, with a seven percent IR. The evidence does not contain a DWC-69 signed by Dr. A. Rule 130.1(d)(1) provides that a certification of MMI and assignment of an IR for the compensable injury requires the “completion, signing, and submission of the [DWC-69] and a narrative report.” Because the DWC-69 was not signed by Dr. A, it was error for the hearing officer to adopt her certification.

142078 - Certification of no impairment requires narrative – Doctor examined the claimant and certified that the claimant reached and that the claimant did not have any permanent impairment as a result of the compensable injury. However, there is no narrative report from Dr. V regarding his MMI/IR certification. Rule 130.1(d)(1) states that a certification of MMI and assignment of an IR requires completion, signing, and submission of the DWC-69 and a narrative report. See APD 131085, decided June 27, 2013.

142708 – Disability - Treating Doctor released claimant to work without restrictions based on a neck sprain. However, the compensable injury extends to cervical radiculitis, right shoulder impingement syndrome, and a right shoulder rotator cuff tear – not a neck sprain. The Treating Doctor’s DWC-73s show that he only considered a neck sprain when he released the claimant to work without restrictions. Accordingly, the AP reversed that portion of the hearing officer’s determination that the claimant did not have disability from July 11, 2013, through the date of the CCH.

150024 – Rating ankle deficits - 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. The Designated Doctor 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 Designated Doctor was not made in accordance with the AMA Guides, and as such could not be adopted.

150040 – Extent of injury and required expert medical opinion - A radial-oblique tear of the medial meniscus is a condition that requires expert medical evidence to establish causation. None of Designated Doctor 1’s records explain how the compensable injury caused a left knee radial-oblique tear of the medial meniscus. He wrote the claimant’s injury “worsened over a period of time and seen on his second MRI scan.” The appeals panel noted that phrases such as “May have” or “I believe” do not satisfy the requirement for the doctor to explain how the compensable injury caused the disputed condition. There is nothing in the evidence that explained how the compensable injury caused a left knee radial-oblique tear of the medial meniscus.

150072 – Disability - The evidence established that the claimant was unable to work from [Date of Injury], through January 12, 2014, the period in dispute, because of the surgical procedure to his left foot on [Date of Injury]. The surgical procedure was not related to Claimant’s compensable injury. Claimant’s inability to work during the period of [Date of Injury], through January 12, 2014, was not due to the compensable injury,

150098-s – Cancer in fire fighters – Claimant has been employed as a firefighter with the self-insured since August 1994, and that the claimant was diagnosed with a cancer, multiple myeloma, in April 2013. 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.

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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

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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.

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.

In this case there is no dispute claimant met the requirements of Government Code § 607.052.

At issue in this case is the interpretation of Government Code § 607.055, regarding firefighters that develop cancer during the course and scope of their employment. 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. In this case, there is no dispute that the claimant met the first portion of Government Code § 607.055(a)(1)(A).

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.

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.”

Based on the plain language of the statute, the legislative intent, and the hearing officer’s discussion, the evidence supports that the claimant met the threshold presumption as provided in Government Code § 607.055(a)(1) and (2); that is, the claimant is presumed to have developed multiple myeloma during the course and scope of her employment as a firefighter.

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. 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.

150180 – Extent of injury and Designated Doctor appointed on extent - In evidence is a Request for Designated Doctor Examination (DWC-32) from the carrier. The carrier requested a designated doctor to determine whether the compensable injury extended to grade I retrolisthesis of L5 related to S1 with degenerative disc disease and 2mm disc protrusion, contact of S1 nerve root in the lateral recess, HNP at L5-S1, and radiculopathy. Dr. R was appointed to opine on the extent-of-injury issue. Dr. R did not discuss the condition of lumbar disc displacement with intervertebral disc without myelopathy. Dr. S was appointed to opine on this issue. Dr. S examined the claimant on November 13, 2014, and opined that the compensable injury “is a lumbar sprain only” and that “the disputed injuries are not compensable.” The hearing officer found Dr. R opined that the compensable injury extends to lumbar disc displacement with intervertebral disc without myelopathy and rules in Claimant’s favor. This was remanded for the hearing officer to review the evidence and make a determination on lumbar disc displacement with intervertebral disc without myelopathy.

1502014 – MMI/impairment rating and authorized doctor - It was undisputed that although Dr. B 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.

150224 – Extent of injury and causation evidence - In evidence is an undated letter from Treating Doctor in which he stated the following: It is my opinion that [the claimant’s] ongoing symptoms are related to an aggravation of his underlying degenerative condition. He did have bilateral medial meniscus tears, and after surgical treatment he gradually has had some ongoing problems. Therefore, it would appear that the compensable injury did cause an aggravation or primary worsening of his condition. The Treating Doctor did not offer any explanation of how the compensable injury actually caused bilateral medial meniscus tears; rather, he merely stated that the claimant had bilateral medial meniscus tears. Although he stated that the claimant’s ongoing symptoms are related to an aggravation of an underlying degenerative condition, and that surgical treatment resulted in gradual ongoing problems, he did not specify the degenerative conditions to which he was referring, did not refer to an MRI listing those conditions, or offer any explanation of how the compensable injury aggravated those conditions. He did not explain how the compensable injury caused bilateral torn medial menisci, nor did he specify the degenerative changes in the knee or explain how the degenerative changes were aggravated by the compensable injury. His opinion is insufficient to establish causation between the compensable injury and the disputed conditions.

150224 – MMI and MDG – The Designated Doctor based his determination of MMI solely on the MDG. The Appeals Panel has previously held that the MDG cannot be used alone, without considering the claimant’s physical examination and medical records, in determining a claimant’s date of MMI. See APD 130187, decided March 18, 2013, and APD 130191, decided March 13, 2013.

150232 – AP procedures - 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, it 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.

150283 – Impairment rating and radiculopathy – The Designated Doctor examined the claimant placed the claimant in Diagnosis-Related Estimate (DRE) Lumbosacral Category III: Radiculopathy for 10% impairment. The AP noted that the Designated Doctor did not document any significant signs of radiculopathy to rate radiculopathy under the AMA Guides. In his narrative report, the Designated Doctor stated the claimant had signs and symptoms of radiculopathy at statutory MMI and “there were objective signs of mild neurologic impairment” citing to the AMA Guides on page 3/102. In evidence is a medical report from Dr. E, that states that the claimant still has back pain with radiating pain down his legs, right greater than left, that the examination continues to show weakness in the right extensor hallucis longus, and that the claimant has decreased sensation over the dorsum of the right foot. Neither Dr. E’s medical report, nor Designated Doctor’s narrative report show clinical findings to support a rating for radiculopathy. Designated Doctor’s IR certification is not adoptable because the clinical findings do not support a DRE Lumbosacral Category III: Radiculopathy.

150300 – Disability - The appeals panel reformed the hearing officer’s decision to match the disability issue certified in the benefit review conference report.

APD 150341 – 04/24/15 – Extent of Injury, Maximum Medical Improvement, Impairment Rating, and Disability. The appeals panel reversed the hearing officer’s decision and order regarding maximum medical improvement and impairment rating because the certifying doctor did not rate the entire compensable injury. Other certifications were not adoptable because the doctors 1) did not have all of the medical records, or 2) used the Thoracolumbar DRE to rate a lumbar injury. Reversed and remanded as to maximum medical improvement, and impairment rating.

150360 – Extent of Injury, Maximum Medical Improvement, and Impairment Rating - The appeals panel reversed the hearing officer’s decision regarding maximum medical improvement and impairment rating. The appeals panel noted that the certification adopted by the hearing officer did not take into consideration treatment for depression, which was found to be part of the compensable injury. The appeals panel adopted a “not at maximum medical improvement” certification. Reversed and rendered as to maximum medical improvement and impairment rating.

APD 150371 – 04/23/15 – Extent of Injury, Maximum Medical Improvement, and Impairment Rating. The appeals panel reversed the hearing officer’s decision and order regarding extent of injury. Parties stipulated that the claimant suffered a compensable injury including a right knee medial meniscus tear. The carrier failed to argue or present evidence of any other medial meniscus tear, other than the disputed condition at issue – “a tear of the posterior horn of the medial meniscus of the right knee.” Reversed and remanded as to extent of injury, maximum medical improvement, and impairment rating.

APD 150372 – 04/27/15 – Extent of Injury and Disability. The appeals panel affirmed the decision and order of the hearing officer and issued the decision only to clarify a misstatement of the law. The hearing officer believed that a physical therapist’s notes could not be considered for causation because he was not a “physician.” The appeals panel noted that, “a physical therapist’s note should not be discounted as an expert medical opinion on causation merely because the physical therapist is not a physician.” Affirmed.

APD 150395 – 04/10/15 – Extent of Injury, Maximum Medical Improvement, and Impairment Rating. The appeals panel reversed the hearing officer’s decision regarding maximum medical improvement. The appeals panel noted that the designated doctor’s date of maximum medical improvement was three days past the statutory date of maximum medical improvement agreed to by the parties; therefore, the certification could not be adopted. The appeals panel rendered a decision regarding the date of maximum medical improvement, as stipulated to by the parties, and reversed and remanded as to impairment rating.

APD 150399 – 04/27/15 – Extent of Injury, Maximum Medical Improvement, Impairment Rating, and Disability. The appeals panel reversed the hearing officer’s decision and order regarding extent of injury. The appeals panel noted that medical evidence relied upon (surgical report) only listed the diagnosis of labral tear; however, the doctor failed to explain how the compensable injury caused the disputed condition (labral tear). Reversed and remanded as to extent of injury, maximum medical improvement, and impairment rating.

APD 150402 – 04/28/15 – Compensability and Disability. The appeals panel reversed the decision of the hearing officer regarding disability. The hearing officer indicated that no doctor had returned the claimant to work; however, the appeals panel noted two DWC-73s that had released the Claimant to full duty. On remand, the appeals panel indicated the hearing officer could accept or reject the DWC-73 reports. Reversed and remanded as to disability.

APD 150452 – 04/14/15 – Relief of Agreement of the Parties. The appeals panel “set aside” the hearing officer’s decision. At the original contested case hearing in the matter, the claimant was not present; however, the claimant’s attorney and the carrier’s attorney represented they had come to an agreement, which was read into the record. The claimant appealed the agreement set forth in the hearing officer’s decision and order. The matter was remanded by the appeals panel, and the hearing officer issued a decision and order based on the oral agreement recited at the original contested case hearing. The appeals panel found good cause to set aside the oral agreement given that 1) the claimant was not present at the contested case hearing and no explanation of the claimant’s absence was requested by the hearing officer; and 2) the issues of 90-day finality, maximum medical improvement, and impairment rating were imperfectly read into the record. Decision and Order Set Aside.

APD 150457-s – 04/16/15 –90-Day Finality, Maximum Medical Improvement, and Impairment Rating. The appeals panel reversed the hearing officer’s decision regarding 90-day finality, maximum medical improvement, and impairment rating. The appeals panel stated, “[a doctor’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). Reversed and rendered as to 90-day finality, maximum medical improvement, and impairment rating.

APD 150460 – 04/10/15 –Extent of Injury, Maximum Medical Improvement, Impairment Rating, and Disability. The appeals panel reformed the hearing officer’s decision to correct errors.

APD 150498 – 04/10/15 –Extent of Injury, Maximum Medical Improvement, Impairment Rating, and Disability. The appeals panel reformed the hearing officer’s decision to correct errors.

APD 150499-s – 04/29/15 – Supplemental Income Benefits and Carrier’s Waiver of Right to Contest Entitlement to Supplemental Income Benefits. The hearing officer found that the claimant was entitled to supplemental income benefits solely on the basis of carrier waiver. Specifically, the carrier filed a Request for Benefit Review Conference (DWC-45) within 10 days after receiving the application for supplemental income benefits; however, the DWC-45 was denied by the division. The denial by the division was for failure of the carrier to document efforts to resolve disputed issues prior to requesting a benefit review conference. A DRIS note indicated that the DWC-45 did not have any accompanying pages when reviewed, but that the carrier had filed additional pages on the same day it filed the DWC-45 that were scanned into TXComp. The additional pages were emails showing efforts to resolve the disputed issue. The carrier did not file for an expedited contested case hearing to appeal the denial of the DWC-45 (pursuant to Rule 141.1(g) referencing Rule 140.3), but it did file a subsequent DWC-45. The second DWC-45 asserted that the division abused its discretion in denying the first DWC-45. The appeals panel found that filing a DWC-45 to dispute the previous denial of a request for a benefit review conference satisfied the criteria of Rule 141.1(g) referencing Rule 140.3. Reversed and remanded as to carrier’s waiver of right to contest entitlement to supplemental income benefits.

APD 150510 – 04/21/15 – Extent of Injury, Maximum Medical Improvement, Impairment Rating, Bona Fide Offer of Employment, and Disability. The appeals panel found that the hearing officer failed to make findings of fact and conclusions of law regarding a disputed condition that was added by agreement at the contested case hearing. Reversed and remanded as to extent of injury, maximum medical improvement, and impairment rating.