APPEALS PANEL DECISION SUMMARIES

(151511 – 152184)

*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*

151511 – C&S, travel, coming and going rule - It was undisputed that the claimant sustained injuries in a motor vehicle accident while driving from his home in (city 1) to the employer’s warehouse in (city 2). The claimant was driving a vehicle that was owned by the company and was issued a company credit card to purchase fuel for that vehicle. The dispute between the parties was whether the injuries sustained by the claimant occurred in the course and scope of his employment. In order for the exceptions to the “coming and going” rule to apply, the claimant must not only show that a specific exception applies, but must show that the injury is of a kind or character that had to do with and originated in the work, business, trade or profession of his employer and was received while he was engaged in or about the furtherance of the affairs or business of his employer. Rather each situation is necessarily dependent on the facts. Proof of origination can come in many forms.

A review of the record reflects that there was no evidence that the claimant was only working at the city 2 warehouse temporarily while awaiting the opening of the city 1 warehouse, but rather had been hired to work at the city 2 warehouse even though he lived in city 1. There was no evidence in the record that the employer was building a warehouse in city 1. The hearing officer applied his legal analysis regarding whether the claimant was injured in the course and scope of employment to inaccurate facts.

151515 – MMI/impairment rating, rating more than the compensable injury – The Designated Doctor explained that the claimant’s future estimated date of MMI would be July 1, 2015, because: *This would allow for adequate time for the surgical procedure to get requested for pre-authorization and get approved, allow [the claimant] to get a medically necessary pre-surgical work-up, which may also require a psychological evaluation, have the surgery performed, allow for a healing (under non-complicated conditions) of the surgical site, and then allow for a reasonable time for post-surgical rehabilitation.* The compensable injury in this case is a lumbar strain. Although the Designated Doctor stated he based his opinion that the claimant has not reached MMI on a lumbar sprain/strain, it is clear from his report that he is considering conditions other than a lumbar strain in determining the claimant has not reached MMI due to the necessity of surgical procedures. None of the other certifications were adoptable.

151527 – MMI/impairment rating, Designated Doctor did not rate the entire injury - The parties stipulated that the self-insured accepted a cervical spine sprain/strain and a lumbar spine sprain/strain. Designated Doctor only rated the cervical sprain/strain. None of the other certifications were adoptable.

151590 – Finality, undiagnosed condition - The hearing officer determined that Dr. F’s certification of MMI/IR dated May 31, 2012, did not become final under Section 408.123(f)(1)(B) because: (1) there was no actual diagnosis of CTS and mere speculation of CTS is not a diagnosis; and (2) CTS was not diagnosed until after Dr. F’s certification of MMI/IR. In evidence is a request for an EMG of the left upper extremity dated March 9, 2012, which states that the doctor suspects the claimant has CTS and needs a diagnostic confirmation. In a medical report dated April 4, 2012, JG referred the claimant to Dr. K for pain and burning sensation in the left wrist. In evidence is a medical report dated June 7, 2012, from Dr. K in which he opines that the claimant’s EMG was significant for CTS of a very mild degree on the left wrist. The initial medical records indicate that the claimant was treated for left wrist pain and the claimant was using a wrist brace. Prior to the date of the first certification of MMI/IR, the claimant’s treating doctor requested an EMG to confirm a diagnosis of left wrist CTS. The claimant was referred to Dr. K and was diagnosed with left wrist CTS prior to the expiration of the 90 days to dispute the first certification of MMI/IR. In APD 080297-s, decided April 11, 2008, the Appeals Panel held that there is no requirement in Section 408.123(f)(1)(B) that the previously undiagnosed medical condition must have been present at the time of the first certification. It appears the hearing officer believed the claimant’s misdiagnosis or previously undiagnosed condition of CTS needed to have been made known prior to the date of the first valid certification of MMI/IR. The AP noted the claimant was diagnosed with left wrist CTS prior to the expiration of the 90 days to dispute the first certification.

151592 – MMI/impairment rating, priority of DDs - Dr. S was initially appointed as the designated doctor for purposes of MMI and IR. A second designated doctor, Dr. Sc was subsequently appointed for purposes of MMI and IR. Because Dr. Sc was the most recently appointed designated doctor for purposes of MMI and IR his certification had presumptive weight. However, the hearing officer determined that the claimant reached MMI on January 14, 2014, with a 5% IR based on the report and certification of Dr. S. Dr. S’ certification only rated the lumbar strain and does not rate the L3-5 disc bulges, right hip fracture, or right hip contusion. Because the certification did not consider and rate the entire compensable injury, it cannot be adopted. **There were at least five certifications by two DDs and none of them rated the entire compensable injury.**

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 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.

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.

151718 – Failure to attend a Designated Doctor exam and suspension of TIBs- A designated doctor examination was scheduled for April 29, 2014, with (Dr. F), and that this examination was rescheduled, at the claimant’s request, to occur on June 3, 2014. Claimant was represented by an attorney. The claimant testified that when she received the Commissioner Order (Order) notifying her of the June 3, 2014, designated doctor examination, she called Mr. C about the appointment. The claimant testified that Mr. C told her not to attend the June 3, 2014, designated doctor examination, and that he would have the claimant seen by other doctors regarding her work-related injury. The claimant then testified that she did not attend the June 3, 2014, appointment on the advice of her attorney. The hearing officer makes clear in his decision that the claimant’s reliance on her attorney’s advice not to attend the June 3, 2014, designated doctor examination constituted good cause for failing to attend that examination. However, bad advice received from one’s own attorney is not an excuse for the failure to comply with Division requirements. Therefore, pursuant to Rule 127.25, the carrier is entitled to suspend TIBs beginning June 3, 2014, when the claimant failed, without good cause, to attend the June 3, 2014, designated doctor examination, through November 4, 2014, the date the claimant submitted to the rescheduled designated doctor examination.

151819 – Hearing officer misread material facts - The hearing officer erred regarding material facts; that is, the claimant’s testimony and undisputed evidence that Mr. M took the claimant to OHS on (date of injury), where he refused to take a drug test, and that the claimant went to JPSH, and took a drug test. Because of this misstatement of material facts of evidence, we reverse the hearing officer’s determinations and remand those issues to the hearing officer.

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.

151857 – Hearing officer misread reports - Both parties correctly note in their appeal that none of the doctors mentioned by the hearing officer in her discussion of the evidence had medical reports in evidence. Further, the diagnoses referenced by the hearing officer were not conditions in dispute at the CCH. Based on the discussion of the evidence, the hearing officer applied her legal analysis regarding the extent of injury of the disputed conditions on inaccurate facts.

151869 – Finality and improperly using the Guides exception - Dr. H assessed a 16% IR based on 3% whole person impairment (WPI) for right thigh atrophy from Table 37 (“Impairment from Leg Muscle Atrophy”) on page 3/77, 5% WPI for right calf atrophy from Table 37, and 8% WPI for loss of range of motion (ROM) for the right knee from Table 41 (“Knee Impairments”) on page 3/78, combined to result in the 16% IR. The hearing officer states in the Discussion portion of the decision that Dr. H assigned an IR for both ROM and atrophy in arriving at a 16% IR, and that “it is clear from the [AMA Guides] that one cannot use both methods to derive an appropriate [IR].” The designated doctor assessed an impairment for the claimant’s compensable injury and it was within his medical judgment on how to rate the claimant’s right knee injury by utilizing more than one Table to arrive at the claimant’s IR. We hold that under the facts of this case, that Dr. H’s assignment of a 16% IR using Table 37 and Table 41 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).

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.”**

152096 – Disability - The hearing officer’s statement that the claimant was assigned to a light-duty position beginning December 17, 2014, is factually incorrect. A review of the record reflects that the claimant testified she returned to work light duty on December 26, 2014. The hearing officer erred regarding material facts, that is, the testimony of both the claimant and the employer’s data analyst, LH, and the claimant’s time sheet that shows that the claimant worked light duty beginning on December 26, 2014. Also, the hearing officer made determinations with conflicting beginning dates of disability.

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.**

152184 – bona fide offer of employment - The claimant argues on appeal that both offers of employment fail to comply with Rule 129.6(c)(4); specifically, the offers merely list the restrictions given by the claimant’s treating doctor rather than state the actual physical and time requirements that the position will entail. The AP agreed. In the instant case neither offer of employment listed the physical and time requirements the offered position would entail, nor do they state the specific job position that was being offered. Instead, both offers of employment listed restrictions of what the job would not entail, which does not meet the requirement listed in Rule 129.6(c)(4).