APPEALS PANEL DECISION SUMMARIES

(152167 – 160494)

*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*

150283 – Impairment rating and radiculopathy - Dr. W did not document any significant signs of radiculopathy to rate radiculopathy under the AMA Guides. See Appeals Panel Decision (APD) 072220-s, decided February 5, 2008, in which the Appeals Panel held that to receive a rating for radiculopathy the claimant must have significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of 2 cm or more above or below the knee, compared to measurements on the contralateral side at the same location.

151207 – Extent of injury, sprain/strain does not need an expert - The hearing officer found that the compensable injury of (date of injury), does not extend to Grade I strain/tear of the infraspinatus muscle. The hearing officer is requiring expert evidence of causation with regard to the Grade I strain/tear of the infraspinatus muscle to establish causation. Although the hearing officer could accept or reject in whole or in part the claimant’s testimony or other evidence, the hearing officer is requiring a higher standard than is required under the law, as cited in this decision, to establish causation. In APD 130808, decided May 20, 2013, the Appeals Panel held that Grade II cervical sprain/strain and Grade II lumbar sprain/strain do not require expert medical evidence. *See* APD 130915, decided May 20, 2013. *See also* APD 120383, decided April 20, 2012, where the Appeals Panel rejected the contention that a cervical strain requires expert medical evidence; 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.

151219 – Impairment rating, total knee replacement – How to rate a total knee replacement using the point system.

151371 – Claimant was a no-show, 10-day letter - The claimant did not attend the June 4, 2015, CCH, or respond to the 10-day letter that was sent to the claimant by the hearing officer after the CCH to the claimant’s address of record. The hearing officer closed the record on June 29, 2015. The hearing officer determined that the claimant did not have good cause for his failure to appear for the CCH of June 4, 2015. The Appeals Panel did not remand this for a rehearing after agreeing Claimant did not have good cause for not appearing at the CCH.

151511 - Course and scope/travel - There is no bright line rule for determining whether the employee travel originated in the employer’s business. Rather each situation is necessarily dependent on the facts. Proof of origination can come in many forms. *See Zurich American Ins. Co. v. McVey*, 339 S.W.3d 724 (Tex. App.-Austin 2011, pet. denied). The hearing officer stated that the claimant was hired and was in training to be a warehouse technician for the to-be-opened city 1 warehouse, but was needed temporarily to work on site at the city 2 warehouse. 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.

151803 – Impairment rating of the upper extremity – Although Dr. B did not specifically state in his narrative report that he assigned a 1% impairment for 70 degrees of internal rotation, Dr. B clearly included this impairment in his UE impairment: 3% impairment for flexion + 0% impairment for extension + 0% impairment for adduction + 3% impairment for abduction + 1% impairment for internal rotation + 0% impairment for external rotation = 7% UE impairment. As discussed above these are the ROM measurements and impairments contained in Dr. KM’s narrative report and worksheet, which Dr. B used in making his IR determination. Although he did not specifically state in his narrative report that he assigned a 1% impairment for 70 degrees of internal rotation, Dr. B clearly included this impairment in his 7% UE impairment.

151899 – Disability “To” v. “Through” - The hearing officer in Finding of Fact No. 4, Conclusion of Law No. 4, and his decision determined the claimant had disability from December 10, 2014, through February 2, 2015. This determination includes disability of February 2, 2015, which was not at issue before the hearing officer. Accordingly, we reform the description of the disability period in the hearing officer’s Finding of Fact No. 4, Conclusion of Law No. 4, and decision to include “to” rather than “through” to conform to the evidence and the issue in dispute.

151923 – Attorney fees, justification - Respondent 1 (attorney) requested the fees in Order 1. Division records show that hearing officer 2 reduced the above requested fees for attendance of the September 29, 2014, BRC and November 20, 2014, CCH based on the actual length of the BRC and CCH as documented in Division records. Division records also show hearing officer 2 reduced the other requested fees because the attorney did not provide written justification to exceed other guidelines. In Order 2, the attorney attached a detailed justification text regarding the requested fees, and on September 1, 2015, hearing officer 1 approved all of the above fees requested by the attorney in Order 2, for a total of 9.50 hours (1.00 + 3.50 + .75 + 4.25). As noted above, Order 1 awarded a total of 6 hours for fees related to the November 20, 2014, CCH, which is the maximum amount allowed under Rule 152.4 (2 hours for the actual time of the CCH plus 4 hours). 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*

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. Also, the employer’s data analyst testified that she supervised the light-duty work schedules and that the claimant’s light-duty work assignment began on December 26, 2014, as reflected in the claimant’s time sheet.

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.

151841 – Bona fide offer of employment - In Appeals Panel Decision (APD) 010110-s, decided February 28, 2001, 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." “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’s review of the evidence - 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.

151896 – Finality - The carrier mailed Dr. H’s certification of MMI and IR to the claimant on January 2, 2015, and filed a Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC) (DWC-45) on April 6, 2015. We note that the hearing officer did not make a finding of when the carrier received the first valid certification of MMI and IR; however, given the hearing officer’s discussion and the evidence presented at the CCH, the carrier had receipt of Dr. H’s certification of MMI and IR by January 2, 2015, the date the carrier mailed Dr. H’s certification to the claimant. Therefore January 2, 2015, was the beginning of the 90-day period for the carrier to dispute the certification of MMI and IR. Also, we note that the hearing officer finds that the carrier filed the DWC-45 on April 3, 2015; however, in evidence is a copy of the carrier’s DWC-45 dated April 3, 2015, showing the DWC-45 was hand-delivered to the Texas Department of Insurance, Division of Workers’ Compensation and filed on April 6, 2015. The hearing officer’s discussion and the evidence indicates that the carrier did not timely dispute the first valid certification of MMI and IR within 90-days after the carrier’s receipt of Dr. H’s certification of MMI and 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 (atrophy) and Table 41 (knee impairments) 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).

152167 – Finality and exchange considered date for verifiable means - The first certification of MMI and assigned IR from Dr. G on September 10, 2014, was exchanged by the self-insured to the claimant on October 6, 2014, and by the claimant to the self-insured on December 10, 2014. The exchange of information constitutes acknowledged receipt of the first certification of MMI and IR by the claimant. We note the expiration of 90 days from October 6, 2014, is January 1, 2015, and from December 10, 2014, it is March 10, 2015. The claimant disputed the first valid certification of MMI and IR on March 27, 2015, as evidenced by the DRIS notes and determined by the hearing officer. The claimant’s filing of a DWC-45 on March 27, 2015, was not timely considering either October 6, 2014, or December 10, 2014, because it was filed after the expiration of the 90-day period to dispute first valid certification.

152184 – Good cause for not attending a CCH - The hearing officer’s finding that the claimant had good cause for his failure to appear at the July 16, 2015, CCH is supported by sufficient evidence. However, the hearing officer failed to make a conclusion of law or decision on the disputed good cause issue.

152184 – Bona fide offer of employment - 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).

152250 – Hearing officer has to address each condition as certified or agreed - The extent-of-injury issue before the hearing officer as added upon the agreement of the parties included the condition of a “left shoulder supraspinatus tendon tear.” The hearing officer made clear in the Discussion portion of the decision that he found the compensable injury extended to a left shoulder supraspinatus tendon tear. However, the Decision and Order section, Finding of Fact No. 3, Conclusion of Law No. 3, and the Decision all reference a left shoulder supraspinatus tendon and omit “tear.” The extent-of-injury issue also included the condition of an aggravation of degenerative changes to the lumbar spine. Although the hearing officer discussed this condition in the Discussion portion of the decision, the hearing officer made no findings of fact, conclusions of law, or a decision as to whether the compensable injury of (date of injury), extends to an aggravation of degenerative changes to the lumbar spine. Because the hearing officer failed to make a determination on this condition that was properly before him to determine, the hearing officer’s decision is reversed as being incomplete. *See* Appeals Panel Decision (APD) 131684.

152290 – Impairment rating and consistency between the form and narrative - Dr. C listed an IR of five percent on her Report of Medical Evaluation (DWC-69) dated March 2, 2015; however, Dr. C’s narrative report lists an IR of six percent. Because there is an internal inconsistency between the IRs assigned by Dr. C on the DWC-69 and in her attached narrative report, her assignment of IR is not adoptable.

152331 – Jurisdiction - Section 410.205(b) provides that a decision of the Appeals Panel is binding during the pendency of an appeal under Subchapter F or G of the 1989 Act (pertaining to judicial review). Section 410.207 provides that during judicial review of an Appeals Panel decision, the Division retains jurisdiction of all other issues related to the claim. *See* Appeals Panel Decision 001126, decided June 30, 2000. Because the carrier sought judicial review of the decision dated November 20, 2014, on the issues of MMI and impairment rating (where Claimant was found to be not at MMI), we affirm the hearing officer’s decision that the Division did not have jurisdiction at the time of the CCH on October 26, 2015, to determine the issues of MMI and IR.

152346 – Decision requirements - In his Conclusion of Law No. 4, the hearing officer determined that the self-insured is not relieved from liability under Section 409.004 because of the decedent’s failure to timely file a claim for compensation with the Division within one year as required by Section 409.003; however, no findings of fact concerning the issue of good cause for failure to file were made by the hearing officer. In his Conclusion of Law No. 5, the hearing officer determined that the self-insured’s defenses to compensability were limited to those listed in its PLN-1 filed on November 23, 2011, but again, no findings of fact concerning the issue are included in the decision.

152374 – Finality and verifiable means - In support of her finding that Dr. H’s certification was provided to the claimant by verifiable means on August 8, 2014, the hearing officer relies on Dispute Resolution Information System (DRIS) note No. 31 of that date which states, in part:

*“[Injured Employee (IE)] stated his attorney and workers’ compensation doctor is disputing the RME report and sending him to another doctor for an evaluation. Reviewed DRIS notes and TXCOMP. Informed IE that there is no DWC-45 on file at this time. [Provided IE a DWC-45 for attorney to complete]. . . .”*

While a review of the record reveals conflicting evidence concerning the date the claimant may have received a copy of Dr. H’s certification, the hearing officer relied upon DRIS note No. 31 to find that the claimant was provided written notice of Dr. H’s certification by verifiable means on August 8, 2014. The DRIS note, which indicates only that the claimant’s attorney and doctor are disputing Dr. H’s report, does not constitute reasonable confirmation of delivery of written notice to the claimant on that date.

152445 – MMI/impairment rating, have to rate the entire compensable injury - The only certification of MMI on March 29, 2014, in evidence is that of Dr. S dated June 23, 2015, which certification fails to rate the entire compensable injury by failing to rate the cervical sprain/strain, right shoulder contusion and right elbow contusion. Accordingly, the hearing officer’s determination that the claimant reached MMI on March 29, 2014, with a zero percent IR is reversed.

152464 – MMI/impairment rating, the AP can correct a mathematical error - Dr. C mistakenly assigned 0% impairment for 25° of extension of the left hip. Table 40, page 3/78 provides moderate impairment, 4% WP impairment, for ROM measured 20°-29°. The Appeals Panel can recalculate the correct IR from the figures provided in the certifying doctor’s report and render a new decision as to the correct IR. *See* APD 121194; APD 041413; APD 100111; and APD 101949. Under the facts of this case, the certifying doctor’s assigned IR can be mathematically corrected based on the documented measurements for the left hip.

152489 – Attorney fees, time for attending a proceeding - The Order for Sequence No. 4, awards an attorney’s fee to the claimant’s attorney for 2.00 hours service for attendance at a CCH. Division records indicate that a CCH was held in Houston, Texas, lasted 85 minutes. Given the discrepancy between the length of the CCH reflected in Division records and the length of time for which fees were approved by the hearing officer for the attorney’s attendance at the CCH, we reverse that portion of the Order awarding an attorney’s fee for 2.00 hours at $150.00 per hour for attending the CCH and remand the Order to the hearing officer for a hearing regarding these requested fees.

152492 – LIBs and traumatic brain injury, imbecility - The claimant argues that he is entitled to LIBs due to his traumatic brain injury which has resulted in severe cognitive dysfunction which affects his personal, non-vocational life and has rendered him permanently unemployable. In the case on appeal, the hearing officer determined that the claimant’s injury resulted in neither incurable insanity nor imbecility. In the Discussion section of her decision the hearing officer stated:

*As for the issue of whether or not [the] [c]laimant is entitled to LIBs because of “imbecility,” the standard that will be used in our case is that of a mentally deficient person, especially a feebleminded person having a mental age of three to seven years and requiring supervision in the performance of [routine] daily tasks or caring for himself.*

We noted in that decision, the hearing officer considered the evidence in light of several factors including the definitions of imbecility contained in BLACK’S LAW DICTIONARY 749 (6th ed. 1990), DORLAND’S ILLUSTRATED MEDICAL DICTIONARY 105 (28th ed. 1994), and WEBSTER’S NINTH NEW COLLEGIATE DICTIONARY (1991). The hearing officer did not discuss any factors in reaching her decision regarding entitlement to LIBs for incurable imbecility other than the definition of imbecility contained in WEBSTER’S,

The court of appeals, first district, citing *Lumbermen’s Reciprocal Ass’n v. Gilmore,* 258 S.W. 268, 269 (Tex. Civ. App.–Texarkana 1924), stated the term “imbecility” has been in use in the Labor Code for almost a century, always without an assigned definition. The court went on to state that dictionary entries published closer in time to the enactment of the legislation would be more instructive. The court specifically referenced the following definition of imbecility from the 1910 edition of BLACK’S LAW DICTIONARY:

*A more or less advanced decay and feebleness of the intellectual faculties; that weakness of mind which, without depriving the person entirely of the use of his reason, leaves only the faculty of conceiving the most common and ordinary ideas and such as relate almost always to the physical wants and habits . . . the test of legal capacity in this condition, is the stage to which the weakness of mind has advanced, as measured by the degree of reason, judgment, and memory remaining.*

*See Chamul v. Amerisure Mutual Ins. Co*., 2016 Tex. App. LEXIS 1263 (Tex. Civ. App.–Houston [1st Dist.] 2016 no writ history).

The court further noted that attaching a narrow definition to limit a benefit without statutory text to support that interpretation violates the rule of liberal construction and would result in the exclusion of claimants having a mental age of less than three years from receiving LIBs. *See Barchus v. State Farm Fire & Cas. Co*., 167 S.W.3d 575 (Tex. App.–Houston [14th Dist.] 2005, pet. denied).

We hold that the hearing officer erred in linking her analysis of the claimant’s entitlement to LIBs for a physically traumatic injury to the brain resulting in incurable imbecility solely to a single factor rather than considering additional factors such as those discussed in APD 121131-s, *supra,* and *Chamul*, *supra*.

152531 – Admitting/excluding evidence and continuance requests, abuse of discretion standard - The carrier argued that the hearing officer abused her discretion in denying the carrier’s request for a continuance to allow the completion of a peer review report, and in admitting Claimant’s Exhibit 4 into evidence, which is a report dated June 9, 2015, from the claimant’s surgeon. The hearing officer denied the carrier’s request for continuance and admitted Claimant’s Exhibit 4, having found good cause for the untimely exchange of that exhibit. The hearing officer held the record open to allow the carrier to admit the peer review report into evidence. The peer review report, dated June 30, 2015, was admitted into evidence, and specifically addresses the June 9, 2015, surgeon’s report admitted as Claimant’s Exhibit 4. We hold that under the circumstances of this case the hearing officer did not abuse her discretion in denying the carrier’s request for continuance, nor did she abuse her discretion in admitting Claimant’s Exhibit 4.

152531 – Extent of injury, specific opinion for specific conditions - The hearing officer stated the following in her Discussion:

*. . . the neurosurgeon persuasively explained that the mechanism of injury was consistent with the MRI findings of the lumbar spine taken on September 25, 2013, which resulted in surgery to the lumbar spine in January of 2014.*

However, (Dr. S), the claimant’s surgeon, does not in any of his reports in evidence reference or discuss a small midline annulus tear at L4-5 or the September 25, 2013, MRI. Instead, Dr. S discusses a herniated disc at L4-5, and opined that the producing cause of that herniation was the lifting, holding, and squatting with a 50-pound load at work. There were no medical reports in evidence, including those from Dr. S, that explain how the compensable injury caused a small midline annulus tear at L4-5.

152535 – Finality, delivery by verifiable means on a date certain and exceptions - The hearing officer also found in Finding of Fact No. 5 that “[Dr. S’s] first valid certification of MMI and assignment of no impairment was provided to [the] [c]laimant by verifiable means.” However, the hearing officer failed to find a specific date on which the claimant received written notice of Dr. S’s first valid MMI/IR certification through verifiable means. Without a date specific, the hearing officer cannot determine whether a timely dispute was filed.

At the CCH and on appeal the claimant specifically argued that he met all three exceptions to finality found in Section 408.123(f). The hearing officer failed to discuss or make any findings of fact, conclusions of law, or a decision as to whether there was compelling medical evidence to establish any of the three exceptions to finality found in Section 408.123(f).

152636 – Claimant Attorney fees for SIBs - The Division’s Attorney Fee Processing System reflects that the attorney provided a justification text for the fees requested stating that “[t]hese hours were to obtain benefits for the [third quarter] of SIBs. We prevailed at a CCH.” Division records reflect, however, that the issues in dispute at the benefit review conference (BRC) on June 25, 2015, were entitlement to SIBs for the first and second quarters and that the claimant did not prevail of either of those quarters. Accordingly, hours devoted to preparation for and attending that BRC are not payable by the carrier pursuant to Rule 152.1(f). Furthermore, the issues in dispute at the CCH on July 29, 2015, included entitlement to SIBs for the first, second and third quarters. We are not able to determine from the record before us which of the attorney’s fees covered by the fee order in Sequence No. 60 are attributable to services performed for the third and, possibly, the fourth quarters and which were for services performed for the first and second quarters.

160055 – Finality, delivery by verifiable means on a date certain - The hearing officer made a finding that the claimant did not dispute the first valid certification by Dr. N within 90 days after the date the rating was provided to her by verifiable means. However, the hearing officer failed to make a specific finding about the date the DWC-69 was delivered to the claimant by verifiable means. We note that there is evidence in the record that indicates the DWC-45 was faxed to and received by the Division on March 20, 2015. The hearing officer did not discuss the March 20, 2015, date in her discussion but rather concluded the claimant did not timely dispute Dr. N’s certification of MMI/IR based on the date the Division “approved” the request.

160057 – MMI determination cannot be based on treatment for non-compensable conditions - In an attached narrative report Dr. K gave the following rationale for his MMI opinion regarding the lumbar sprain/strain:

*. . . it is my impression that [the claimant] most likely would benefit from an SI injection on the left. Also, he could possibly benefit from a repeat L4-5 injection.*

*\*\*\*\*\*\**

*If [the claimant] doesn’t benefit from the injections then in my opinion he is obviously at MMI. . . .*

Although Dr. K noted in his narrative report that his first DWC-69 is based on a lumbar sprain/strain, Dr. K makes clear that he believes the claimant had not reached MMI for either a lumbar sprain/strain or the SI joint on the left and disc bulges at L4-5 and L5-S1 because he would benefit from injections to the SI joint on the left, as well as an injection at L4-5. However, the parties neither stipulated to nor actually litigated an SI joint condition, and the hearing officer’s determination that the compensable injury does not extend to disc bulges at L4-5 and L5-S1 has not been appealed and has become final. There was no evidence establishing that the recommended injections are treatment for the lumbar sprain/strain. Although Dr. K stated that his first MMI/IR certification that the claimant has not reached MMI is based on a lumbar sprain/strain, Dr. K opines that the claimant has not reached MMI based on recommended injections for conditions that have not been determined to be part of the compensable injury.

Dr. B makes clear in his narrative report that he based this MMI/IR certification on the lumbar sprain/strain. Dr. B’s second MMI/IR certification that the claimant reached MMI on January 23, 2015, with a five percent IR considers and rates the compensable injury and is supported by the evidence.

160074 – Witness list exchange within 15 days (Rule 142.13(c)(1)(D)) - The claimant asserts that the hearing officer erred in allowing Dr. H to testify at the CCH because the identity of that witness was not exchanged by the carrier as required by 28 TEX. ADMIN. CODE § 142.13(c)(1)(D) (Rule 142.13(c)(1)(D)). Rule 142.13(c)(1)(D) requires, in part, that no later than 15 days after the benefit review conference (BRC), parties shall exchange the identity and location of any witness known to have knowledge of the relevant facts. The claimant asserted that the carrier exchanged Dr. H’s identity, along with the identities of 43 other potential witnesses, via facsimile transmission at 10:00 p.m. on October 20, 2015, the 15th day following the date of the BRC on October 5, 2015.

We note that Rule 102.3(d) provides that “[a]ny written or telephonic communications received other than during normal business hours on working days are considered received at the beginning of normal business hours on the next working day.” Further, Rule 102.3(c) establishes that “[n]ormal business hours in the Texas workers’ compensation system are 8:00 a.m. to 5:00 p.m. Central Standard Time with the exception of the [Texas Department of Insurance, Division of Workers’ Compensation’s (Division)] El Paso field office whose normal business hours are 8:00 a.m. to 5:00 p.m. Mountain Standard Time.” The preamble to Rule 102.3 comments that subsection (d) establishes the date communications are deemed received outside of normal business hours on working days. The preamble goes on to state “[t]his subsection applies to communications received by **any participant** in the Texas workers' compensation system. [Emphasis added.] Because the carrier’s exchange of information was received by the claimant after normal business hours on October 20, 2015, the claimant did not receive the exchange until October 21, 2015, a date more than 15 days after the BRC.

The claimant objected to the testimony of Dr. H and argued that the carrier had not exchanged the identity of the witness within 15 days after the BRC. The hearing officer did not discuss the reasons for the late exchange nor did she make any determination of good cause, but summarily overruled the claimant’s objection and allowed Dr. H to testify at the CCH concerning extent of the compensable injury. The hearing officer additionally denied the claimant’s request that the CCH record be held open so that the treating doctor could respond to Dr. H’s testimony.

To obtain reversal of a decision based upon error in the admission or exclusion of evidence, an appellant must show that the evidentiary ruling was in fact error, and that the error was reasonably calculated to cause, and probably did cause, the rendition of an improper decision. Appeals Panel Decision (APD) 051705, decided September 1, 2005. Because the identity of the carrier’s witness was not timely exchanged, and the hearing officer overruled the claimant’s objection and allowed the testimony of Dr. H without a finding of good cause for the carrier’s untimely exchange of information, we find the hearing officer’s evidentiary ruling was, in fact, error. We further note that the hearing officer stated in her decision that:

*The testimony provided by the peer reviewer was persuasive and thorough. Therefore, the [c]laimant failed to establish that the remaining diagnoses were also caused, accelerated, worsened or enhanced as a result of the compensable injury.*

Accordingly, the hearing officer based her decision regarding extent of the compensable injury on the testimony of Dr. H which was reasonably calculated to cause, and probably did cause, the rendition of an improper decision.

160079 – Finality, exceptions (undiagnosed conditions) - It is not disputed that Dr. W’s is the first valid certification of MMI and assignment of IR or that the claimant received a copy of Dr. W’s certification on October 17, 2014, and did not dispute the same within 90 days of receiving it through verifiable means. On February 20, 2014, the claimant underwent arthroscopic repair of a right shoulder anterior labral Bankart tear secondary to dislocation. The claimant underwent a second surgical procedure on May 19, 2015, a right shoulder arthroscopy with revision of anterior labral repair. In his operative report, Dr. B stated that the “more superior portion [of the anterior labrum] had not healed and he had a recurrent tear.” In this case, the hearing officer determined that the surgically repaired labral tear had not healed by the date of Dr. W’s October 1, 2014, certification of MMI/IR and stated in his findings of fact that:

*4. The right shoulder dislocation and labral tear that existed after September 26, 2014, was a non-healing surgically repaired labral tear that represented an undiagnosed condition that arose out of or naturally flowed from the (date of injury), compensable injury and surgery the for that injury.*

We disagree that the claimant’s non-healing surgically repaired labral tear constituted an undiagnosed medical condition meeting the exception under Section 408.123(f)(1)(B). The claimant’s first certification of MMI and assignment of IR became final because the repeat surgery performed on May 19, 2015, was treatment for a condition that was essentially a continuation of the original medical condition for which MMI had been certified and an IR assigned.

160108 – Claimant Attorney fees, SIBs fees need to be separated - The hearing officer’s determination that attorney fees in the amount of $975.00 are reasonable and necessary for services rendered from June 2 through June 26, 2015, in Sequence No. 22 is reversed and remanded to the hearing officer to await the determination on the first and second quarters of SIBs. The application for attorney fees should designate the fees for services rendered for SIBs by specific quarter and the services rendered for the other issues which are subject to the provisions of Rule 152.1(c) and the guidelines in Rule 152.4.

160115 – Disability - The hearing officer found that during the period at issue (September 9, 2014, through the date of the CCH), the claimant was unable to obtain and retain employment at wages equivalent to her pre-injury wage as a result of the compensable injury, and therefore determined the claimant had disability from September 9, 2014, through the date of the CCH. However, the claimant testified that her last day of work for the employer was October 30, 2014, and that she worked as a janitor for the employer before and after the date of injury. The claimant did not offer any evidence to establish she was unable to obtain and retain employment at wages equivalent to her pre-injury wage as a result of the compensable injury from September 9 through October 30, 2014, the last day she worked for the employer.

160131 – Disability and DWC-73s - The disability period in dispute is July 29, 2015, through the date of the CCH, December 15, 2015. In the Discussion portion of her decision, the hearing officer stated that “[the] [c]laimant presented [DWC-73s] from various doctors which released him to work with restrictions from May 27, 2015, through June 11, 2015, July 15, 2015, through August 15, 2015, October 6, 2015, through October 27, 2015, and from November 24, 2015, through December 22, 2015.” We note that the periods of disability found by the hearing officer match the periods covered by the DWC-73s identified in her decision. There is another DWC-73 in evidence which was not described or discussed by the hearing officer in her decision. This DWC-73 is dated October 27, 2015, and was issued and signed by (Dr. P) releasing the claimant to restricted duty from October 27, through November 17, 2015. The hearing officer determined that the claimant had no disability during the period covered by Dr. P’s DWC-73. However, she failed to explain why she found the other DWC-73s in evidence to be “objective credible evidence” of disability but found Dr. P’s October 27, 2015, DWC-73 not to be similarly persuasive. We note further that the hearing officer provides no rationale for her determination that the compensable injury was not a cause of the claimant’s inability to obtain and retain employment for the time periods not covered by the DWC-73s mentioned in her decision.

160228 – Appointment of a new Designated Doctor, abuse of discretion - The hearing officer stated that he ordered the appointment of a second designated doctor because following the CCH on August 20, 2015, he determined that the preponderance of the evidence was contrary to Dr. RL’s determination of EOI and that:

*Rather than ask the Division to re-appoint Dr. [RL] to do the re-examination, based on the [h]earing [o]fficer’s finding on the [EOI], the [h]earing [o]fficer exercised his discretion and requested that a different [designated doctor] be appointed. . . . The [h]earing [o]fficer requested a different [designated doctor] because he was concerned that Dr. [RL] might take umbrage in being instructed that his opinion of extent was rejected. . . .*

Because the hearing officer’s reason for ordering the appointment of a new designated doctor is not one of those authorized by Rules 127.5(d) and 127.130, we reverse the hearing officer’s decision that the Division properly designated Dr. JL as its designated doctor to perform the EOI examination and determine MMI and IR and render a new decision that Dr. JL was not properly appointed as designated doctor in accordance with Rule 127.1.

160229 – MMI/impairment rating, MMI date based on the records and properly rating the entire compensable injury - We note from a review of the record that the claimant received physical therapy treatment after May 7, 2013, the date Dr. J determined she had reached MMI. We note further that the AMA Guides provide specific instructions on pages 3/52 and 3/53 and under Table 14, page 3/52 for rating brachial plexus-related impairments; however, Dr. J chose instead to provide a rating under Table 15, page 3/54 of the Guides for peripheral nerve impairment, a condition not determined to be part of the compensable injury. Because Dr. J failed to rate the compensable brachial plexus to the right shoulder, right arm, right wrist, and right hand as instructed by the AMA Guides or to provide an explanation for his decision to instead provide an IR for peripheral nerve deficit, we reverse the hearing officer’s determination that the claimant reached MMI on May 7, 2013, with a 13% IR.

160249 – Compensability and Carrier waiver - Carrier contested compensability of the claimed injury in the July 8, 2015, PLN-11, which was within the 60-day period. However, just as in APD 982975, the carrier then filed a PLN-11 accepting the claim. We hold in this case, as we did in APD 982975, that by accepting liability in the PLN-11 filed on August 3, 2015, the carrier effectively withdrew its prior July 8, 2015, dispute. As noted above, the 60-day period in this case was May 15 through July 14, 2015. There is no other PLN in evidence from the carrier denying compensability within the 60-day period.

160307 – Disqualifying association - The carrier noted in its appeal that the hearing officer failed to make a conclusion of law regarding the issue of a disqualifying association. The issue of disqualifying association was added at the CCH by the hearing officer because it was actually litigated. The hearing officer in Finding of Fact No. 5 found that both Dr. G, the designated doctor, and (Dr. W), a doctor with whom the claimant treated, shared a business address and phone and fax numbers through Genesis, a scheduling company. There is sufficient evidence to support this finding of fact. *See* Appeals Panel Decision 131335, decided July 15, 2013.

160325 – Finality and significant error in applying the Guides - Dr. L examined the claimant on March 3, 2015, and certified that the claimant reached MMI on March 2, 2015, and assigned a 15% IR including 10% impairment for the lumbar spine based on DRE Category III: Radiculopathy for the lumbar spine. Dr. L noted patellar and Achilles reflexes are 2+ bilaterally, equal and normal. The physical examination findings did not document measurements which would relate to atrophy.

The AMA Guides and Appeals Panel decisions specify that to receive a rating for radiculopathy the claimant must have significant signs of radiculopathy, such as loss of relevant reflexes, or measured unilateral atrophy of 2 cm or more above or below the knee, compared to measurements on the contralateral side at the same location. The atrophy or loss of relevant reflex must be spine-injury-related for radiculopathy to be rated. Dr. L assessed a rating for radiculopathy but did not document significant signs of radiculopathy or note significant signs of radiculopathy in the medical records he reviewed. Accordingly, we hold that in this case there is compelling medical evidence of a significant error by Dr. L in calculating the claimant’s IR pursuant to Section 408.123(f)(1)(A).

160332 – MMI/impairment rating, DWC-69 requirements - The hearing officer noted in the Discussion portion of the decision that the claimant died from an unrelated illness prior to attending the designated doctor examination scheduled subsequent to the September 22, 2015, CCH. All copies of Dr. S’s DWC-69s in evidence reveal that he did not provide a date of MMI on his DWC-69. As noted above, Rule 130.12(c) requires that for an MMI/IR certification on a DWC-69 to be valid there must be an MMI date that is not prospective. Because none of Dr. S’s DWC-69s in evidence contain a date of MMI, his MMI/IR certification failed to meet the requirements of a valid certification. The only MMI/IR certification in evidence is from Dr. S, and as previously noted there is no DWC-69 from Dr. S in evidence that provides the date that Dr. S placed the claimant at MMI. In his attached narrative report Dr. S did not specify a date of MMI; rather, Dr. S opined that “[the claimant] is, by definition, at clinical MMI.” In evidence is an EES-60 Request for Statistical Information Regarding an Incomplete DWC Form-069 signed by Dr. S in July 2014. In this document the Division notified Dr. S that he had indicated in his DWC-69 that MMI was reached but failed to provide a specific date of MMI. Dr. S indicated on the form that the date of MMI was June 23, 2014. We note that the form also specifically states that the “completing of this information does not modify, amend, or perfect any deficiencies in the above-referenced report.” The EES-60 cannot be used to determine the date of MMI. *See generally* Rule 130.12.

160363 – Admission of evidence not timely exchanged and good cause - In support of her position, the claimant beneficiary offered excerpts from the deposition of CN which was taken on October 2, 2014, in the probate matter of the estate of the decedent. The carrier objected to the admission of the deposition excerpts into evidence on the grounds that such testimony had not been timely exchanged. In this case, the BRC was held on November 5, 2015. The exchange deadline pursuant to Rule 142.13(c)(1) was November 25, 2015. As noted above, the deposition of CN was taken on October 2, 2014. Counsel for the claimant beneficiary replied that the deposition had been in the possession of the claimant beneficiary’s probate attorney, “an attorney that’s not a party to the [w]orkers’ [c]ompensation claim” and that it was provided to counsel for the carrier as soon as it was made available to the attorney representing the claimant beneficiary. The AP disagreed with his ruling that good cause for the late exchange of relevant documentary evidence exists where such evidence is obtained by the opposing party through additional discovery processes as authorized by Rule 142.13(f). Because excerpts from the deposition of CN were not timely exchanged, and the hearing officer overruled the carrier’s objection and admitted the deposition excerpts without a showing of good cause for the claimant beneficiary’s untimely exchange, we find the hearing officer’s evidentiary ruling was in fact error.

160494 - At the CCH the parties agreed to modify the disability in dispute to read as follows: “Did the claimant have disability resulting from the claimed injury beginning on November 17, 2014, and continuing through February 13, 2015?” In Finding of Fact No. 5, the hearing officer found that: “During the period at issue [the] [c]laimant was unable to obtain and retain employment at his pre-injury wages beginning on (date of injury), and continuing through February 13, 2015.” The hearing officer’s finding of fact beginning disability on (date of injury), exceeds the scope of the disability issue as modified.