APPEALS PANEL DECISION SUMMARIES

(160495 – 161283)

*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*

160495 – Bona fide offer of employment - The employer’s written offer of modified duty dated September 8, 2015, was based upon activity restrictions contained in the DWC-73 issued by (Dr. N) on August 31, 2015, and directed that the claimant notify the employer by September 21, 2015, if he wished to accept the offer. The DWC-73 dated August 31, 2015; however, was superseded by revised DWC-73s issued by Dr. N and dated September 10, 2015, and September 17, 2015. The September 10, 2015, DWC-73 imposed additional restrictions of no lifting/carrying objects weighing more than five pounds and reduced the number of hours the claimant was allowed to work to four per day. The employer’s written offer of modified duty was not based upon the claimant’s activity restrictions effective on September 21, 2015,

160541 – SIBs, no ability to work - The claimant’s theory of entitlement to SIBs for the fourth quarter is based on a total inability to work. In APD 012286, decided November 14, 2001, the Appeals Panel “held that the narrative report from the doctor must specifically explain how the compensable injury causes a total inability to work.” Claimant’s Treating Doctor wrote , “Based on medical information provided, it is my opinion that the claimant’s medical condition worsened enough during the identified qualifying period . . . to have his work status listed as off work due to non-healing wounds that required extensive and serial treatment. Although Dr. KR’s report states that the claimant’s work status is listed as off work, it does not state that the claimant has a total inability to work. None of the medical reports in evidence constitute a narrative report from a doctor which specifically explains how the compensable injury caused a total inability to work in any capacity.

160575 – Timely appeal of D&O - Section 410.202(c) provides, “A request for appeal or a response must clearly and concisely rebut or support the decision of the hearing officer on each issue on which review is sought.” *See also* 28 TEX. ADMIN. CODE § 143.3(a)(2) (Rule 143.3(a)(2)). On March 24, 2016, the appellant (claimant) filed with the Division the information brochure published by the Division entitled “Appeal Rights and Procedures” (brochure) and signed the brochure in the sample certificate of service contained in that brochure. The Appeals Panel has held that the filing of that brochure with the Division is insufficient to constitute a request for appeal because it does not tell us how or why a claimant disagrees with a hearing officer’s decision. *See* Appeals Panel Decision (APD) 94973, decided September 1, 1994; and APD 052351, decided November 30, 2005.

160580 – Decision requires Finding of Fact, must address each element of an issue - Section 409.021(c) provides that if an insurance carrier does not contest the compensability of an injury on or before the 60th day after the date on which the insurance carrier is notified of the injury, the insurance carrier waives the right to contest compensability. However, the hearing officer made no findings of fact or any discussion as to when the carrier received first written notice of the injury. The claimant has the burden to prove when the carrier received the first written notice of injury and, once that is done, the burden shifts to the carrier to prove that it timely filed a dispute. *See* Appeals Panel Decision (APD) 051656, decided September 14, 2005. Without a finding as to when the 60-day period began, it cannot be determined whether or not the carrier timely contested compensability of the injury in accordance with Section 409.021.

160587 – Decision requires Finding of Fact, every extent condition must be resolved - The hearing officer resolved the disputed issue by deciding that the compensable injury sustained on (date of injury), does not extend to an injury to the head, both hands, trigger finger to the bilateral index and middle fingers, an injury to the left shoulder, vision loss to both eyes, an injury to both heels, a bone spur in the left heel, bilateral elbow strains, bilateral carpal tunnel syndrome, chronic low back pain syndrome, lumbar stenosis, lumbar spondylosis, lumbar spondylolisthesis, degenerative arthritic changes at L5-S1, lordosis of the spine, degenerative disc disease of the cervical and lumbar spine or enthesopathy. The hearing officer failed to make a finding of fact, conclusion of law, or decision on whether the compensable injury of (date of injury), extends to a thoracic strain or thoracic muscle strain.

160590 – SIBs and total inability to work - The claimant relied upon the medical report of the Division-appointed designated doctor to establish his inability to work during the qualifying period in accordance with Rule 130.102(d)(1)(E) above. The hearing officer found that the claimant provided a narrative report from the Designated Doctor which specifically explained how the injury caused a total inability to work. In a narrative dated July 28, 2015, Dr. S stated the following: *The question then becomes can he work in ANY capacity. My answer could be a conditional yes. Theoretically, a sheltered workshop with structure and supervision could potentially be a setting where the examinee could participate. He would need to be mostly sitting and also supervised closely for safety purposes. This is not to be confused with a competitive work setting with the ability to earn a meaningful wage. While it is arguable that the work injury sequela are not the main reasons for his not working, they clearly are contributing significantly to his present dysfunction. The dizziness and degree of cognitive dysfunction seem to be related primarily to the work injury. Frankly, I cannot envision any job this man, with his age and health history, could safely perform well enough to satisfy a potential employer.* Dr. S describes circumstances in which the claimant could work and does not specifically explain how the compensable injury causes the claimant to be unable to work in any capacity.

160591 – Impairment rating finality per Rule 130.102(h) - Rule 130.102(h) provides that if there is no pending dispute regarding the date of MMI or the IR prior to the expiration of the first quarter SIBs, the date of MMI and IR shall be final and binding. Once the IR became final pursuant to Rule 130.102(h), what was included in the underlying compensable injury was established. In both its opening and closing argument, the self-insured argued that the 15% IR certified from the designated doctor, Dr. J, became final pursuant to Rule 130.102(h) without objection from the claimant. Under the facts of this case we hold that the issue of whether the IR assessed by Dr. J became final pursuant to Rule 130.102(h) was actually litigated and it was error for the hearing officer to fail to make findings of fact, conclusions of law, and a decision on this issue.

160596 – MMI/impairment rating has to be consistent in report and DWC-69 - There is an internal inconsistency between the MMI date Dr. I certified in his narrative report and the MMI date Dr. I certified on the DWC-69. Because the narrative report and DWC-69 list different dates regarding when the claimant reached MMI, we do not consider that internal inconsistency to be a clerical error that can be corrected. *See* Appeals Panel Decision (APD) 130739, decided May 7, 2013. Furthermore, we note the hearing officer in his discussion specifically discounted Dr. I’s first MMI/IR certification certifying that the claimant reached MMI on October 10, 2014, with a 10% IR because the claimant’s ROM measurements were significantly inconsistent with any other examination findings, and because the video surveillance in evidence shows that the claimant has significantly more use of his left arm than what the subjective complaints in the medical records would indicate. Despite noting these inconsistencies, the hearing officer adopted Dr. I’s second MMI/IR certification, which is based on the same ROM measurements the hearing officer found inconsistent and initially rejected.

160618 – Admitting evidence by Hearing Officer that was not exchanged -

The carrier contends that the hearing officer improperly reopened the record to admit evidence after the CCH that was never exchanged with the carrier. A letter in the hearing file from the hearing officer dated February 16, 2016, to the carrier’s adjuster states in part the following: *As a [h]earing [o]fficer, I have the responsibility and duty to fully develop the record in each case that comes before me. I have, therefore, reopened the record in [the case on appeal], and directed the ombudsman for [the claimant] to provide me with the examination reports from (Dr. M).* Another letter in the hearing file from the hearing officer dated February 18, 2016, to the carrier’s adjuster stated that all of the reports from Dr. M obtained from the ombudsman were included and admitted as Hearing Officer Exhibit 3. Section 410.163(b) provides that a hearing officer “shall ensure the preservation of the rights of the parties and the full development of facts required for the determination to be made.” The Appeals Panel noted that Section 410.163(b) does not grant the hearing officer the right to become a “surrogate party at the CCH,” and that a hearing officer is not to become an advocate for either party. The Appeals Panel further stated that “it is the parties themselves who are primarily responsible for presenting their case and protecting their own interests,” and held that it was “improper for the hearing officer to shore up the claimant’s case under the guise of ensuring a full development of the record.” The records from Dr. M admitted by the hearing officer after the CCH consist of Dr. M’s diagnosis of PTSD and a discussion of psychological testing administered to the claimant dated April 29, 2014, and progress notes dating from May 2014 through May 2015. A review of the record reveals that neither party sought the admittance of Dr. M’s records dated April 29, 2014, through May 2015, that the hearing officer admitted into evidence after the CCH; instead, the hearing officer unilaterally reopened the record to direct the ombudsman to provide him with medical records from Dr. M, and upon receipt of those documents admitted them into evidence.

160629 – Finality and delivery by verifiable means - Rule 130.12(b) provides, in part, that the first MMI/IR certification must be disputed within 90 days of delivery of written notice through verifiable means. The hearing officer stated that “(Dr. J)] noted in his report that the Division received a [RME Notice or Request for Order Form (DWC-22)] on July 10, 2015; therefore the request for a post-DD RME exam establishes a reasonable expectation that [the] [C]arrier] received the DD report before this date.” The AP disagreed. The carrier’s request for a post-DD RME may suggest that the carrier had actual knowledge of Dr. W’s certification and assignment but no evidence was presented that reasonably confirms delivery or that written notification was provided to the carrier by verifiable means.

160634 – Timely reporting and counting days on the calendar - The hearing officer determined that the claimant did not timely report her work injury to the employer because August 31, 2015, is more than 30 days from the claimed injury and that because the claimant did not timely report her injury, the self-insured is relieved of liability under Section 409.002. We conclude that the hearing officer erred in determining that the claimant did not timely report her injury because the 30th day after (date of injury), was Sunday, August 30, 2015, and the claimant gave notice on the next day, Monday, August 31, 2015.

160636 – Prospective MMI date - A date of MMI becomes prospective if it is projected to occur at some time after the certification of MMI is made. The Appeals Panel has stated that “[t]he key consideration is that the date of MMI was not after the date of certification, that is, signature of the certifying doctor, on the [Report of Medical Evaluation (DWC-69)].” *See* APD 100636-s, decided July 16, 2010; APD 100766, decided August 16, 2010. Dr. C noted on his December 13, 2015, DWC-69 an April 29, 2014, date of examination, which as noted above was for extent of injury, and certified the claimant reached MMI on May 8, 2014. Dr. C signed the DWC-69 on December 13, 2015. Dr. C’s amended May 8, 2014, date of MMI is not after his December 13, 2015, MMI/IR certification; therefore, his December 13, 2015, MMI/IR certification does not contain a prospective date of MMI.

160721 – Subclaimant is a party - The Subclaimant, a healthcare provider, is a Subclaimant under Section 409.009. 28 TEX. ADMIN. CODE § 140.1(4) (Rule 140.1(4)) defines a “party to a proceeding” as a person entitled to take part in a proceeding because of a direct legal interest in the outcome. The hearing officer erred in failing to allow the Subclaimant, a party in this case, to participate in the CCH.

160730 – Disability is based only on compensable conditions - Although Dr. D opined that the claimant could only return to work in a sedentary or light-duty position, it is clear Dr. D believed the claimant had such restrictions due to his pre-existing condition and not due to the compensable injury.

160742 – Impairment rating for the upper extremity - In his attached worksheet Dr. P noted 40 degrees of flexion and assigned a 4% impairment for ROM deficits in the claimant’s right wrist. Figure 26 on page 36 of the AMA Guides provides that 40 degrees of flexion results in 3% impairment, not 4% as assigned by Dr. P.

160787 – Admitting evidence by Hearing Officer - The carrier contends that the hearing officer improperly and unilaterally reopened the record to obtain and admit evidence regarding disability that had not been exchanged with the carrier. In evidence is Hearing Officer’s Exhibit 9, which is a letter dated March 16, 2016, from the hearing officer to the claimant, the claimant’s ombudsman, and the carrier’s attorney. The letter states the following: *As the [h]earing [o]fficer, it is my obligation and duty to fully develop the record. After reviewing the exhibits in this case, it was clear that I had no evidence on which to base a determination of disability… Consequently, I asked the ombudsman assisting the claimant to obtain whatever records of [Dr. W’s] she was able to get. I have re-opened the record, and those records, which are attached, will be admitted as Hearing Officer Exhibits 3-6.* A review of the record reveals that neither party sought the admittance of these records; instead, the hearing officer unilaterally reopened the record to direct the ombudsman to provide him with medical records from Dr. W, and upon his receipt of those documents admitted them into evidence.

160840 – Decision has to address every extent condition - The parties agreed at the CCH that the conditions of C5-6 disc bulge and L4-5 posterior disc bulging were part of the extent-of-injury issue to be determined at the CCH. As previously noted both the carrier and the claimant on appeal agree that the hearing officer erred in failing to resolve whether the compensable injury of (date of injury), extends to a C5-6 disc bulge and L4-5 posterior disc bulging.

160846 – Impairment rating must rate every compensable condition - Dr. Y discusses neither an MMI date nor an IR for the compensable tibial fracture and laceration of the tibial artery and vein. Neither does he explain in his report that impairment for these compensable conditions is properly addressed under the AMA Guides by his assignment of an IR for right ankle ROM loss or that the correct MMI date for these conditions is January 9, 2015.

160850 – Hearing Office inaccurately reflected parties’ agreement - The parties stipulated at the CCH that the compensable injury does not extend to herniated nucleus pulposus at C4-5, C5-6, L4-5, and L5-S1. The hearing officer mistakenly determined that the compensable injury does extend to herniated nucleus pulposus at C4-5, C5-6, L4-5, and L5-S1. A review of the record reflects that the parties actually agreed at the CCH that the compensable injury does not extend to the conditions listed in the extent-of-injury issue.

160851 – Distal clavicle resection - Dr. A did not include a 10% UE IR for a distal clavicle resection under Table 27 on page 3/61 of the AMA Guides. It was undisputed by the parties that the claimant underwent a distal clavicle resection on January 29, 2014, for repair of his torn left rotator cuff. The Appeals Panel has previously held that impairment for a distal clavicle resection that was received as treatment for the compensable injury results in 10% UE impairment under Table 27 of the AMA Guides, which is then combined with ROM impairment, if any, as provided by the AMA Guides.

160876 – Impairment rating for upper extremities gets rounded to nearest tenth - Dr. F incorrectly applied Figure 29 on page 3/38 of the AMA Guides in assessing impairment for radial deviation. Dr. F found 15° of radial deviation for which he assigned 1% UE impairment, and 20° ulnar deviation for 2% UE impairment. Figure 29 uses increments of 5°, whereas the general directions on page 3/37 state to round the measurements of radial deviation to the nearest 10°.

160935 – A sprain/strain does not need expert causation - At issue was also whether the compensable injury of (date of injury), includes a sacroiliac sprain/strain. In her discussion the hearing officer stated that in this case the disputed conditions/diagnoses require expert evidence to establish a causal connection with the compensable injury. The hearing officer is requiring expert evidence of causation with regard to the sacroiliac sprain/strain 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.

160937 – Designated Doctor has to provide range of motion measurements - Dr. L also assessed zero percent impairment for the claimant’s right elbow, and four percent upper extremity impairment for the claimant’s right wrist, which using Table 3 on page 3/20 of the AMA Guides converts to two percent whole person impairment. The narrative report does not contain any ROM measurements taken of the claimant’s right wrist, which was the basis of Dr. L’s two percent IR. Dr. L’s narrative accompanying his DWC-69 does not document clinical findings from an examination of the claimant’s right wrist that was used to assess impairment.

160953 – Course and scope deviation - As the claimant was traveling to the office a motor vehicle accident occurred directly in front of him. Although he was not involved in the accident, the claimant exited his vehicle to assist in removing an unconscious woman from one of the motor vehicles involved in the accident. After the police arrived on the scene, the claimant made a U-turn and proceeded to the office using an alternate route as the road on which he had been travelling was still blocked as a result of the accident. The hearing officer determined that the claimant sustained a compensable injury, finding that the claimant’s knee injury occurred while he was in the course and scope of his employment. In reaching his decision, the hearing officer relied on Texas Employers’ Ins. Ass’n v. Thomas, 415 S.W.2d 18 (Tex. Civ. App.-Fort Worth 1967, no writ) and stated in the Discussion section of his decision that in the instant case, as in Thomas, “the conduct subsequent to the accident, including the act of assisting with the accident and resultant emergency stemming therefrom, was a part of clearing the road so [the claimant] could proceed with his [e]mployer’s business.” In *Thomas, supra*, the court held that "[a] servant does not cease to be in the course of his employment merely because he is not actually engaged in doing what is specifically prescribed to him, if in the course of his employment an emergency arises, and, without deserting his employment, he does what he thinks necessary for the purpose of advancing the work in which he is engaged in the interest of his employer."

The AP disagreed with the hearing officer that Thomas is applicable to the facts of this case. Although an emergency situation did arise, there was no evidence that the claimant was performing any action that he thought was necessary for the purpose of advancing the employer’s interest. On the contrary, the claimant testified that after law enforcement authorities arrived at the accident scene, he made a U-turn and traveled back to the office via an alternate route. His action in assisting the accident victim was not action calculated to clear the road so that he could proceed back to the office and was not necessary for the purpose of advancing the work in which the claimant was engaged in the interest of the employer.

160959 – Impairment rating has to be based on compensable injuries only - Because the carrier denied the requests for surgery, Dr. H referred the claimant for a MMI evaluation on June 23, 2015, indicating that no further treatment was available through the workers’ compensation system and that the claimant would pursue the recommended surgical intervention through his private health care insurance. Dr. R’s certified MMI date is not based upon the earliest date after which further material recovery from or lasting improvement to the compensable injuries. Rather Dr. R’s MMI date is the date the claimant’s surgeon determined not to further pursue left elbow arthroscopy, a procedure recommended for treatment of conditions determined by the hearing officer not to be compensable. Finally Dr. R listed the claimant’s diagnoses as left elbow sprain/strain and osteoarthrosis of the medial and lateral elbow compartments, a condition not part of the compensable injury, and considered such condition in assigning IR. Because Dr. R considered conditions determined by the hearing officer not to be compensable in certifying MMI and assigning an IR, his certification cannot be adopted.

161017 – Finality and compelling medical evidence of a significant error in using the Guides – The Appeals Panel discussed several errors made by the Designated Doctor in rating the upper extremity. The worksheet and the narrative give different numbers for the ROM measurement of the flexion of the right shoulder. In the worksheet Dr. E assigned 5% UE impairment for flexion of the right shoulder based on rounding the 113 degrees stated measurement of flexion to 110 degrees. The narrative noted the flexion measurement “average” for the right shoulder was 133 degrees which when rounded to either 130 degrees or 140 degrees would result in 3% UE impairment. The AP held hold in this case there is compelling medical evidence of a significant error by Dr. E in calculating the claimant’s IR.

161082 – Impairment rating has to rate every compensable condition - Dr. C failed to provide an IR for the compensable left thumb DeQuervain’s syndrome and tenosynovitis, and in certifying MMI and assigning an IR, considered radial and median nerve conditions that are not part of the compensable injury. For such reason, neither of Dr. C’s certifications of MMI and assignment of IR can be adopted.

161123 – Range of motion measurements were inconsistent between report and worksheet - In his narrative report, Dr. F indicated that, upon examination, the claimant had right shoulder extension of 40°; however, on the worksheets attached to his report, Dr. F indicated the claimant’s right shoulder extension was 50°. Dr. F’s calculation of 11% loss of ROM of the right shoulder is obtained by using the 50° of extension which, pursuant to Figure 38 of the AMA Guides, yields a 0% UE impairment. An extension of 40°, on the other hand, yields a 1% UE impairment which, when combined with Dr. F’s other ROM measurements would yield a total UE impairment of 16% which converts to a whole person impairment of 10% rather than the 9% assigned by Dr. F. Because there is an internal inconsistency between the measurements recorded by Dr. F in his narrative report and those recorded in his worksheets and because the measurements noted in the narrative report yield a different IR than that entered on Dr. F’s Report of Medical Evaluation (DWC-69), his assignment of IR is not adoptable.

161129 – Hearing officer misread the evidence - The claimant testified the 1109 S. Fairgrounds location is about one mile north of I-20, and to leave that yard to go to 7700 East I-20 one turns south onto FM 715, then turns right onto I-20, and continues east on I-20 to 7700 East I-20. The hearing officer stated in the Background Information section of the decision that the claimant “was heading South on I-20” when he lost consciousness and drove onto the median, and that the claimant’s collision “occurred 400 feet off the route to the 7700 I-20 yard location.” The hearing officer has misread the evidence in this case regarding the route on which the claimant was traveling and the distance from the route on which the accident occurred, which we view as a misstatement of material facts in evidence.

161158 – Hearing officer overlooked one of the conditions in dispute - The extent-of-injury issue reported from the benefit review conference (BRC) included the condition of rotator cuff tear. The parties agreed when the hearing officer read the extent-of-injury issue from the BRC report that the rotator cuff tear was one of the conditions in dispute. On the first page of her decision and order, the hearing officer determined that the compensable injury sustained on (date of injury), does extend to a rotator cuff tear. However, the hearing officer left out the condition of rotator cuff tear when listing the extent-of-injury issue in the Statement of the Case. Additionally, the hearing officer failed to make a finding of fact, conclusion of law, or decision on the condition of rotator cuff tear.

161280 – Extent of injury legal sufficiency of expert opinion - In the case on appeal, radial nerve entrapment, re-current right wrist de Quervain’s tenosynovitis and neuroma of the right superficial sensory branch of the radial nerve are conditions outside the common knowledge and experience of the fact finder, and consequently, require expert medical evidence to establish causation. The causation narrative report relied upon by the hearing officer dated July 17, 2015, from (Dr. D) indicates that the doctor “suspects” a neuroma of the right superficial sensory branch of the radial nerve and states further that when patients complain of radial wrist pain after a de Quervain’s release, “one should suspect inadequate release of the 1st dorsal compartment secondary to persistent septum.” Dr. D’s narrative does not relate these suspected conditions to a reasonable degree of medical probability, to the mechanism of the compensable injury. None of the records in evidence from the numerous other doctors who have examined or treated the claimant or who have examined the claimant’s medical records contain an adequate expert causation explanation of how the compensable injury caused the disputed conditions and in fact, the claimant’s current treating doctor wrote in her causation letter that “[t]here is an overwhelming body of documents and reports by board certified hand surgeons that do not support a causation of [the claimant’s] current status to be directly caused by the reported injury of 9/18/07.”

161283 – Hearing officer determined issue not raised, exceeding authority - The claimant objected to Carrier’s Exhibit B, a report from Dr. S, on the basis that Dr. S was not properly appointed by the Division as a post-designated doctor required medical examination (RME) doctor under 28 TEX. ADMIN. CODE § 126.5 (Rule 126.5). It was uncontested that Carrier’s Exhibit B was timely exchanged prior to the CCH. The carrier argued at the CCH that the claimant waived its right to object to Dr. S’s report because the issue of whether Dr. S was properly appointed as the RME pursuant to Rule 126.5 was not certified as an issue prior to the CCH. The hearing officer issued a post-hearing “Order Excluding Report of [Dr. S],” ordering that Dr. S’s report was excluded because “[t]he RME by [Dr. S] was not approved in accordance with Division [r]ules and the [Act],” and “[p]ursuant to Rule 126.5(b), the Division shall not consider a report of an RME doctor that was not approved or obtained in accordance with Division [r]ules.”

Section 410.151(b) provides that an issue that was not raised at a BRC may not be considered unless the parties consent or the Division determines that good cause existed for not raising the issue at the BRC. It is undisputed that there was no response to the benefit review officer’s report and that the carrier did not consent to add the issue of whether Dr. S was properly appointed as the RME pursuant to Rule 126.5. There is no evidence that the claimant requested an additional dispute be included in the statement of disputes prior to the beginning of the May 9, 2016, CCH.

The hearing officer excluded Dr. S’s report on the basis that he was not properly appointed by the Division as the RME pursuant to Rule 126.5, an issue that was not before him to decide. Section 410.165(b) provides that the hearing officer shall accept all written reports signed by a healthcare provider, which includes Dr. S.