APPEALS PANEL DECISION SUMMARIES

(170329 – 170967)

*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 95% of what is here is just cut and paste from the decisions. I try to hit what I think are the highlights, even if there are other reasons the hearing officer’s decision was overturned. My original contributions are limited to the comment giving a summary of the summary. Anything that can be construed as my opinion is just that, my opinion and does not reflect the opinion of the Division. Ken Wrobel*

170329 – Occupational injury, have to be able to identify what the toxic exposure was, no specific chemical or toxic substance was identified - The claimant testified that he was operating a bulldozer moving oil field waste material comprised, in part, of oil, water and chemicals, from one side to another side of a mound of waste material 60-90 feet tall and covering an area of 17 acres. He further testified that while working he was overcome by fumes, became nauseated, threw up and may have lost consciousness briefly. He left the jobsite and sought medical attention with his primary care physician who refused to see him due to noxious odors which had permeated his clothing and who told him to go to the emergency room (ER). The claimant did so and reported his complaints as nausea, vomiting, lightheadedness and weakness. The ER records dated (date of injury), list a diagnosis of “exposure to gaseous substance” and “toxic effect of gas exposure.” The claimant relies upon the reports of his treating physician, (Dr. B) and pulmonary specialists, (Dr. N) and (Dr. D), to establish the requisite causal connection between the claimed toxic exposure inhalation injury on (date of injury), and the alleged resultant conditions suffered by the claimant. In his Decision and Order, the hearing officer stated that the reports of these physicians were persuasive evidence that the claimant sustained a compensable injury in the form of an occupational disease on (date of injury).

The fact that the proof of causation may be difficult does not relieve the claimant of the burden of proof. APD 93665. The medical records in evidence do contain diagnoses of exposure to gaseous substance, toxic effect of unspecified substance, exposure to toxic fumes, shortness of breath, chronic bronchial inflammation with chronic bronchitis and bronchiolitis following fume exposure, and toxic inhalation lung injury but no specific chemical or toxic substance was identified and none of the medical records in evidence contain an explanation concerning how exposure to or inhalation of any substance the claimant may have encountered at work caused his symptoms. There is insufficient evidence to relate any injury or condition the claimant may have to inhalation of toxic fumes or gaseous substance while at work on (date of injury).

170345 – SIBs waiver - In evidence is the claimant’s DWC-52 for the second quarter signed by the claimant on July 24, 2015. In Finding of Fact No. 5 the hearing officer found that the self-insured received the claimant’s DWC-52 for the second quarter on July 24, 2015. However, that same document shows that the self-insured actually received the DWC-52 for the second quarter on July 28, 2015. In evidence is a DWC-45 from the self-insured filed on August 4, 2015, disputing the claimant’s entitlement to second quarter SIBs. Also in evidence is the self-insured’s determination of non-entitlement to second quarter SIBs dated August 4, 2015. As discussed above, the evidence established that the self-insured received the DWC-52 for the second quarter on July 28, 2015. The 10th day after July 28, 2015, is Friday, August 7, 2015. The self-insured in the case met the requirements to timely dispute the claimant’s entitlement to second quarter SIBs. Additionally, we note that the evidence does not establish that quarter one was actively under dispute on the date the self-insured received the claimant’s DWC-52 for the second quarter. Therefore, the self-insured was not required to file a DWC-45 within 10 days of receiving the claimant’s DWC-52 for the second quarter. *See* Appeals Panel Decision No. 051130-s, decided July 12, 2005, et.al.

170415 – Timely filing for death benefits by a minor - Pursuant to Section 409.007(a), a DWC-42 must be filed by the first anniversary of the decedent’s death, which in this case was June 11, 2013. However, the evidence established that as of the first anniversary of the decedent’s death, claimant beneficiary 2 and claimant beneficiary 3 were both minor children and pursuant to Section 409.007(b), their failure to file a DWC-42 not later than the first anniversary date of the decedent’s death does not bar their claims.

170518 – MMI/impairment rating must be based upon the compensable injury only - Dr. B examined the claimant on April 19, 2016, certified the claimant reached MMI on January 15, 2016, and assigned a one percent IR. Dr. B noted in his attached narrative report that the compensable diagnosis was a left knee contusion. Dr. B also noted that the claimant underwent an arthroscopic synovectomy, chondroplasty of the patellofemoral joint, and left knee partial medial meniscectomy on October 12, 2015.

Dr. B assigned the claimant a one percent IR based on Table 64 on page 3/85 of the AMA Guides for the left knee partial meniscectomy. The hearing officer determined compensable injury does not extend to depression, patellar tendonitis, or a meniscus tear of the left knee. The compensable injury in this case, as stipulated by the parties, is a left knee contusion. The evidence did not establish that the October 12, 2015, left knee surgery was treatment for the claimant’s left knee contusion. Dr. B’s MMI/IR certification considers treatment for conditions that have been determined not to be part of the compensable injury. Accordingly, we reverse the hearing officer’s determinations that the claimant reached MMI on January 15, 2016, and that the claimant’s IR is one percent.

170558 – Hearing Officer exceeded scope of certified issues; adding an issue after the BRC - The Benefit Review Conference (BRC) Report lists the issue in dispute as follows: “[i]s the [c]laimant entitled to [LIBs] from [October 29, 2016] through the present based on a physically traumatic injury to the brain resulting in incurable imbecility in accordance with [Section 408.161]?” On the claimant’s motion without objection from the self-insured at the CCH and upon a finding of good cause, the issue was amended regarding the date of entitlement: “[i]s [the] [c]laimant entitled to [LIBs] from September 20, 2016, based on a physically traumatic injury to the brain resulting in incurable imbecility in accordance with [Section 408.161]?” The hearing officer found in Finding of Fact No. 3 that the claimant does not suffer from imbecility as a naturally flowing result of his (date of injury), traumatic brain injury. Finding of Fact No. 3 is supported by sufficient evidence. However, the hearing officer determined the claimant is entitled to LIBs from September 20, 2016, because he found that the claimant has the permanent and total loss of use of both feet at or above the ankle as a result of the compensable injury. Section 410.151(b) and 28 TEX ADMIN. CODE § 142.7 (Rule 142.7) essentially provide that issues not considered at a BRC may only be added by consent of the parties or upon a showing of good cause. While consent may be inferred if the parties actually litigated an issue not otherwise identified, the record in this case does not establish that the parties litigated that the claimant is entitled to LIBs based upon the total and permanent loss of use of both feet at or above the ankle. The specific issue before the hearing officer as certified and amended at the CCH was whether the claimant is entitled to LIBs from September 20, 2016, based on a physically traumatic injury to the brain resulting in incurable imbecility. The hearing officer’s determination that the claimant is entitled to LIBs from September 20, 2016, based upon the total and permanent loss of use of both feet at or above the ankle exceeded the scope of the issue before him. We note this decision does not preclude the claimant from filing a claim for LIBs based upon a different theory of entitlement contained in Section 408.161.

170585 – Existence of employment relationship - It is undisputed that the claimant was injured in a motor vehicle accident, after beginning travel from Texas to Indiana when the vehicle in which he was riding sustained a blowout and was involved in a rollover accident near Georgetown, Texas. Where the claimant attended a recruitment meeting on May 31, 2014, for which he was to be paid; that he completed all pre-employment paper work on May 31, 2014, and had his employment eligibility verified electronically, which the self-insured’s policy dictates must be completed after a job offer is accepted by the employee but no later than the first day of employment, and given that, as in years past, upon arrival in Indiana and prior to beginning work in the fields, the claimant was to be paid “arrival pay” and a housing stipend from which payroll deductions would be withheld, we hold that the hearing officer’s decision that the self-insured was not the claimant’s employer for purposes of the 1989 Act is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust.

170606 – Headaches do not need an expert - In the Discussion section of her decision the hearing officer stated: As to the corneal opacity and headaches, the mere fact that the conditions are identified in a medical report is insufficient to show that these conditions are related to the work injury within a reasonable medical probability. By requiring that the claimant show that headaches are related to the work injury to a reasonable medical probability the hearing officer is, in fact, requiring expert evidence to establish a causal connection between such condition and the compensable injury.

170659 – Designated Doctor has to be qualified - In evidence is a physician profile prepared by the Texas Medical Board which indicates that Dr. P holds ABMS board certifications in emergency and family medicine, but he is not listed as being board certified in any of the specialties enumerated in Rule 127.130(b)(8)(A). We hold that under the facts of this case, the parties should receive the benefit of an impartial examination by a qualified designated doctor as contemplated by Sections 408.0041 and 408.0043 and Rule 127.130(b)(8)(A).

170666 – Date of injury and whether it was an issue or not - In evidence at the CCH was the Benefit Review Conference (BRC) Report which reflected that the parties agreed that the date of injury is (date of injury). No stipulation was made regarding the date of the injury at the CCH. We note that the issue regarding compensability in the Decision and Order incorrectly listed the date of injury as (date), rather than (date of injury), the date of injury listed in the BRC Report and agreed to by the parties as part of the issue. The hearing officer states in her discussion that the claimant testified that he became aware that he could file a claim in January 2015, subsequent to changes in Texas law. The hearing officer did not add the date of injury as a disputed issue. However, in Finding of Fact No. 9 the hearing officer found that on January 26, 2015, the claimant knew or should have known that the condition may be related to the employment. Accordingly, we reverse the hearing officer’s decision and remand to the hearing officer to add the date of injury as a disputed issue or have the parties stipulate as to the date of injury. The AP noted how this affected the issues of timely notice to employer, timely filing a claim with the Division, and whether the firefighter cancer presumption applies.

170747 – SIBs, requirement of Carrier to send DWC-52 - Rule 130.104(b) provides, in part, that a carrier is required to send a DWC-52 for a subsequent quarter with either the first payment for a quarter of SIBs to which the claimant is determined to be entitled or with the carrier’s determination of nonentitlement for that quarter. *See* Appeals Panel Decision (APD) 021776, decided August 28, 2002. The duty of a carrier to send the application arises only with either the first payment of SIBs or a determination of nonentitlement for any quarter. *See* APD 020047, decided February 21, 2002. It is undisputed that the Division determined the claimant was not entitled to SIBs for the first quarter. Nevertheless, the hearing officer clearly based her determination that the claimant was entitled to SIBs for the second quarter upon her finding that the carrier failed to comply with its obligation under Rule 130.104(b) to provide the claimant with a DWC-52 containing accurate information regarding the dates of the qualifying period and her further finding that the claimant performed the required number of work search contacts after he received the second DWC-52 on June 27, 2016, containing the correct dates of the qualifying period at issue. We disagree and hold that the hearing officer erred, as a matter of law, in basing her decision on the carrier’s failure to send a DWC-52 form for the second quarter as required by Rule 130.104(b), because no such obligation was triggered under Rule 130.104(b), since the carrier never sent a monthly payment for a SIBs quarter nor did it make a determination of nonentitlement after the Division’s initial nonentitlement determination for the first quarter.

170773 – Employer’s right to appeal - Section 409.011(b)(4) provides that an employer has the right to contest the compensability of an injury if the insurance carrier accepts liability for the payment of benefits. As noted above, the issues in this case were extent of the compensable injury, MMI, and IR. The employer does not have standing to appeal the issues in this case because the employer did not become a party to the CCH.

170774 – Medical records noted complaints at beginning of claim - In the Discussion section of her decision, the hearing officer stated: The medical records from [Dr. W] indicate that [the] [c]laimant’s initial complaints were limited to the left shoulder. There was no mention of any neck complaints. . . . [Dr. W] does not explain the 6-month delay between the date of injury and the initial complaints of cervical pain. In evidence, however, are Dr. W’s medical records which reflect that on October 7, 2015, the day following the date of the compensable injury, the claimant listed neck pain on the Patient Questionnaire. In his report of the office visit on October 7, 2015, Dr. W noted complaints of neck pain in his discussion of the history of the claimant’s injury of ((date of injury)), and obtained X-rays of the claimant’s cervical spine. Given a review of the evidence admitted, the hearing officer’s statement indicating that the claimant did not complain of cervical pain for 6 months following the date of injury constitutes a material misstatement of fact.

170819 – Failure to timely raise extent issue - The claimant sought to add an extent-of-injury issue. The request to add this issue was denied. The issue was not raised at the benefit review conference, the parties did not consent to adding the issue, and the hearing officer did not find good cause to add the issue. Under these circumstances, we perceive no abuse of discretion on the part of the hearing officer in denying the request to add an issue.

170835 – Good cause for failure to attend CCH – A CCH was held on February 28, 2017, to decide the disputed issue of extent of injury. The claimant did not appear at the CCH and a 10-day letter dated February 28, 2017, was sent to the claimant at his last known address. The claimant failed to respond to the 10-day letter and the hearing officer closed the record on March 15, 2017. The hearing officer issued a decision on March 23, 2017, that was unfavorable to the claimant. On appeal, the claimant states he was admitted to the hospital on February 27, 2017, for chest pains and was diagnosed with the flu. The claimant contends he was not aware of the 10-day letter. The claimant contends he was not physically able to attend the CCH. In the instant case, the claimant makes factual allegations that, if true, could constitute a basis for good cause for the claimant’s failure to attend the CCH on February 28, 2017, or respond to the 10-day letter dated February 28, 2017.

170849 – Properly appointed Designated Doctor under Rule 127.130(b)(8)(B) - The claimant sustained a compensable injury on (date of injury), when she tripped on a rug and fell onto her right hip and buttocks. She eventually developed cauda equina-like symptoms which were determined to be related to the disputed thoracic disc herniations with nerve root irritation. The Division of Workers’ Compensation (Division) appointed Dr. G who examined the claimant on November 1, 2016. Rule 127.130(b)(8)(B) provides, in part, as follows: To examine spinal cord injuries . . . a designated doctor must be board certified in neurological surgery, neurology, physical medicine and rehabilitation, orthopaedic surgery, or occupational medicine by the [American Board of Medical Specialties (ABMS)] or board certified in neurological surgery, neurology, physical medicine and rehabilitation, orthopaedic surgery, preventative medicine/occupational-environmental medicine, or preventative medicine/occupational by the [American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS)]. A review of the record reveals that Dr. G is a doctor of chiropractic and there was no evidence that he is board certified in any of the specialties enumerated in Rule 127.130(b)(8)(B).

170858 – Good cause for failure to attend CCH - A second setting of the CCH was held on February 21, 2017, to decide the disputed issues of extent of injury, disability, MMI and IR. The claimant did not appear at the CCH and a 10-day letter dated February 22, 2017, was sent to the claimant. The claimant failed to respond to the 10-day letter and the hearing officer closed the record on March 9, 2017. The hearing officer issued a decision on March 9, 2017, that was unfavorable to the claimant on all of the issues before her. In her discussion of the case in the decision and order the hearing officer stated that she mailed a 10-day letter to both the claimant and subclaimant on that date. We note that there is no evidence in the appeal file that a subclaimant was involved in this case. A 10-day letter dated February 22, 2017, is in evidence that was mailed to the claimant at the following address: (address 1), (city), Texas 79114-8707. The decision and order was mailed to the claimant at the following address: (address 2), (city), Texas 78234-2565. In his appeal the claimant contends that he was physically unable to attend the February 21, 2017, setting and the 10-day letter was sent to an incorrect address and stated his correct address was (address 2), (city), Texas 78234. This same address was listed as the claimant’s address on the sign-in sheet for the January 12, 2017, CCH. In the instant case, the claimant makes factual allegations that, if true, could constitute a basis for good cause for the claimant’s failure to attend the CCH on February 21, 2017, or respond to the 10-day letter dated February 22, 2017.

170862 – Intoxication - A post-accident urine sample was taken from the claimant and a drug test was performed and showed the claimant tested positive for cocaine and MDMA. The same report shows that the claimant testified negative for marijuana metabolites. The hearing officer both in her discussion and in Finding of Fact No. 4 states a urine sample was taken of the claimant which tested positive for marijuana. The hearing officer’s Finding of Fact No. 4 as it pertains to the claimant testing positive for marijuana is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust.

170893 – Designated Doctor failed to properly rate the compensable injury - Dr. K placed the claimant in Diagnosis-Related Estimate (DRE) Cervicothoracic Category II: Minor Impairment for 5% for the cervical spine. This certification only considered a cervical sprain/strain. As previously noted the parties stipulated that on (date of injury), the claimant sustained a compensable injury in the form of a cervical sprain/strain and C5-6 disc protrusion. This certification could not be adopted. Subsequently, Dr. K re-examined the claimant on October 21, 2016, and certified that the claimant was not at MMI considering the conditions of a neck strain and cervical disc disorder with radiculopathy. After the CCH, the hearing officer sent a presiding officer’s directive to order a designated doctor examination to Dr. K and requested that he provide a certification of MMI/IR that considered only a cervical sprain/strain and C5-6 disc protrusion. Dr. K examined the claimant again on December 23, 2016, and certified that the claimant reached MMI statutorily on November 24, 2016, and assigned a 19% IR using the AMA Guides. Dr. K placed the claimant in DRE Cervicothoracic Category II: Minor Impairment for 5% and further assessed 15% whole person impairment for motor and sensory loss of the median nerve below the forearm. The hearing officer correctly noted in her decision that Dr. K did not provide any explanation as to why he provided a rating for sensory and motor deficits in the upper extremity, considering the compensable injury he was asked to rate did not include any upper extremity conditions. However, no other doctor correctly rated only the compensable injury.

170967 – Inconsistency in the Designated Doctor report - In his Report of Medical Evaluation (DWC-69) and in his accompanying narrative report, Dr. J assigned a zero percent IR for the claimant’s head contusion, left knee sprain/strain and cervical strain; however, in the narrative report, Dr. J also stated, with regard to the left knee, that “[a] full physical examination with range of motion [ROM] was performed and resulted in [four percent] whole person impairment, per Table 41.” Dr. J gave no explanation for his failure to include an IR on the DWC-69 dated March 29, 2016, or in his narrative report reflecting the claimant’s measured ROM loss of the left knee. Therefore there is an internal inconsistency between the IR assigned on the DWC-69 and narrative report and the result of ROM testing observed and noted in Dr. J’s IR narrative.