WORKERS’ COMPENSATION UPDATE
Workers’ Compensation Section Program
Hot Topics and Updates

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10:15 a.m. – 10:45 a.m.
As a shareholder of Downs Stanford, Mr. Colburn opened the Austin, Texas, office and manages the TDI - Texas Department of Insurance, Division of Workers’ Compensation Austin board representation services. He is board certified in Workers’ Compensation Law by the Texas Board of Legal Specialization. Mr. Colburn is the firm’s representative at Division meetings. He is also a certified lobbyist and attends all Legislative meetings and hearings. Mr. Colburn has extensive experience in all phases of dispute resolution before the Division of Worker’s Compensation and in district courts across the state. He is extremely active in the education of both adjusters and employers for workers’ compensation and bad faith allegations and is certified by the Texas Department of Insurance as a continuing education provider. Mr. Colburn is the founder and past chair of the State Bar of Texas Workers’ Compensation Section. He also serves as the Course Director for numerous programs including the Texas State Bar’s Advanced Workers’ Compensation Seminar and Texas Workers’ Compensation Forum. He serves on the Executive Committee of the Lexis Nexis advisory board for Larson’s on Workers’ Compensation. He is also on the Advisory Board of Employers Texas Workers’ Comp Alert. A sought-after speaker, Mr. Colburn has delivered over five hundred speeches regarding Workers’ Compensation.
Case Law and Appeals Panel Review
By: Stuart D. Colburn

INTRODUCTION

The Legislature passed major reforms to worker’s compensation law in 2005. The newly created Division of Worker’s Compensation assumed the task of implementing the reforms and adopting new rules. A summary of these changes was provided in 2007 and 2008. Significant changes were proposed in 2009. However, the voter ID issue disposed many of those bills. (In fact, a special session was necessary to reauthorize Texas Department of Insurance from Sunset).

Most stakeholders believe the worker’s compensation climate has improved. Lingering concerns include: (1) adequacy of benefits; (2) improved return to work outcomes; (3) access to medical care; (4) delivery of medical care; and a possible legislative response to Entergy v. Summers (see below).

The DWC is currently studying a closed formulary in response to national statistics that Texas is considered a “high cost” state. “Bad faith” litigation dominates conversation and disagreement within the bar even before a Bexar County jury awarded 70 million in damages on denied benefits of $9,800. The Texas Supreme Court just heard oral arguments in Texas Mutual Insurance Company v. Ruttiger, 2008 WL 184240 (Tex.App.—Hous. (1 Dist.))

Stakeholders can only speculate on whether the Texas Supreme Court will overturn worker’s compensation bad faith; narrow its application; or leave it alone.

Case law provided the most interesting changes in the last twelve months. Below is a review of some of the most interesting cases.

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I.

CASE LAW REVIEW

A. Exclusivity Bar

Entergy Gulf Store, Inc. v. Summers, 282 SW 3d 433 (Tex. 2009)
Issue: Exclusivity Bar

The Texas Supreme Court holds that a premises owner can be considered a general contractor for purposes of the exclusivity provisions of the Workers’ Compensation Act. The premises owner enjoys the exclusivity bar and is shielded from 3rd party lawsuits if it provides workers’ compensation insurance for all the subcontractor employees. The Texas Supreme Court’s decision sparked immediate controversy and a response from the Legislature. Both political parties seemed united in their resolve to legislatively overturn the decision.

H.C. Beck, Ltd. v Wise, 284 S.W.3d 349 (Tex. 2009)
Issue: Exclusivity Bar

The property owner operated an Owner Controlled Insurance Program (OCIP). The Texas Supreme Court believed the OCIP protected the owner, the general contractor, and all subcontractors. As such, the owner and the general contractor were entitled to the exclusivity bar.

B. Waiver

Issue: Waiver

The Supreme Court overturned Continental Casualty v. Downs, 81 S.W. 3d 803 (Tex. 2002) and held a carrier cannot waive its right to dispute a case within the first 60 days.

SORM v. Lawton 295 S.W.3d 646 (Tex. 2009)
Issue: Waiver

The Texas Supreme Court held the carrier cannot waive extent of injury. The decision ended the five year Appeals Panel creation of a “waiver period” where a carrier could waive all diagnoses, if not sufficiently disputed, including those conditions it never received notice or conditions the claimant specifically denied. The court held the Appeals Panel could not apply the 60 day deadline governing compensability to extent of injury disputes. Rule 124.3(e), stating that waiver does not apply to extent of injury disputes, and the preamble to the rule make clear the compensability dispute deadline
does not apply to extent of injury disputes. The Court’s dicta stating the carrier has 45 days from receipt of a medical bill to dispute extent of injury probably does not create another waiver period but may lead to additional litigation.

**Issue:** Waiver

The claimant sustained a right forearm scratch on June 25, 2001. The carrier did not dispute the injury. The claimant underwent a comprehensive health screening at his employer’s office in October and tested negative for Hepatitis C. On February 22, 2002, the claimant tested positive for Hepatitis C. DWC and trial court found the carrier waived its right to dispute Hepatitis C because no dispute was filed within seven days following written notice of the original injury even though the claimant did not test positive for Hepatitis C for another 8 months. The court distinguished between the claimant’s original specific injury and the new occupational disease, Hepatitis C. The occupational disease claim started a new 60 day clock to pay or dispute pursuant to *Mitchell*.

**C. Expert Medical Evidence**

**Issue:** Expert Evidence

The claimant sustained a compensable injury to his knee and ankle when he threw carpet in a dumpster. He alleged the injury extended to the lumbar spine (herniations and radiculopathy) and Complex Regional Pain Syndrome (CRPS) (also known as Reflex Sympathetic Dystrophy (RSD)). The trial court found in favor of the injured worker and the City of Laredo appealed on grounds the plaintiff’s claims required expert evidence to establish causation. Expert evidence is required to prove causation unless the injuries (1) are within the common knowledge and experience of lay persons; (2) they did not exist before the accident; and (3) appeared after and in close time to the accident. In this case, the claimant did not report back pain or injury to either the adjuster or the treating doctor for over four months. The treating doctor testified he would expect an injured worker to complain of pain within one week of a specific injury causing herniations. Without expert medical evidence, the appellate court found insufficient evidence the injury extended to the spinal injuries and CRPS.

### Issue: Expert Medical Evidence

The claimant alleged typing 65% - 90% of the day caused a repetitive trauma claim to his upper extremities. The parties did not individually list the diagnosis claimed or disputed as part of the alleged compensable injury. Instead, the issue was whether the claimant sustained a compensable repetitive trauma claim. DWC held for the claimant but the jury found for SORM. The court held repetitive trauma claims were beyond the scope of knowledge for a lay person. Therefore, the party with the burden of proof (in this case, SORM) must present expert evidence the claimant did not sustain a repetitive trauma injury. The injured worker's expert testified to trigger finger, carpal tunnel syndrome (CTS), tendonitis, and tenosynovitis. SORM's expert only negated CTS (and to some extent tendonitis). The court held the carrier failed to provide sufficient expert evidence to establish its burden that each diagnosis (namely tenosynovitis and tendonitis) was not related. Thus, the claimant prevailed on the issue of a compensable repetitive trauma claim.

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### Issue: Expert Medical Evidence

An injured worker sued her health care providers for medical malpractice, and her employer intervened. After surgery, the claimant was instructed to perform knee-to-chest exercises. She alleged immediate onset of pain and a subsequent MRI demonstrated a recurrent herniation requiring a second spinal surgery. The jury found for the injured worker. The Court of Appeals reversed finding the plaintiff did not present expert evidence establishing causation with reasonable medical probability as opposed to speculation, conjecture, surmise or possibility. Plaintiff's expert testimony only rose to the level of possibility. The court writes, “Here, Smith was suffering from a pre-existing condition. Additionally, the testimony established that the timing of the onset of pain that Smith experienced did not mean that the disc herniated at the moment Gallardo administered the knee-to-chest exercise; rather, the only inference that could be drawn was that the disc contacted the nerve at that point in time. The disc itself may well have herniated before then. “The court explained the expert need not use magic words but the substance of his opinion must be based on reasonable medical probability.” The court concludes, “Similarly, although an expert may use the phrase "reasonable probability," his testimony may still be insufficient to establish the same when the substance of his testimony raised only mere possibilities, speculation, and surmise."
D. Compensability


**Issue: Dual Purpose Doctrine**

The Court of Appeals established that a claimant must satisfy both prongs of Texas Labor Code §401.011(12)(B) for an injury to be compensable under the Dual Purpose Doctrine. The Dual Purpose Doctrine requires (1) travel to the place of injury occurrence would have been made even had there been no personal or private affairs of the employee to be furthered by the travel and (2) the travel would not have been made had there been no affairs or business of the employer to be furthered by the travel. The court requires the plaintiff satisfy the Dual Purpose Doctrine test even if a §401.011(12)(A) exception applies (including transportation furnished or under the control of the employer or the Special Mission Doctrine). In this case, the claimant is a pharmaceutical sales representative who worked out of her house. She was driving from a work event to a storage facility where she kept business materials. Therefore, she was not on her way home at the time of the accident. Plaintiff contends that even if she was on her way “home” she is still entitled to workers’ compensation benefits since she offices out of her apartment.


**Issue: Personal Comfort Doctrine**

The claimant was injured picking up his own garbage in the employer-provided drilling crew house approximately 10 hours after his shift ended. The court of appeals reversed the jury finding in favor of the injured worker noting the Personal Comfort and Convenience doctrine allows small and insignificant deviations from employment but you must actually be in the course and scope of employment prior to providing for your own personal comfort and convenience. The court did not discuss the application of the Continuous Coverage Principle (allowing 24/7 coverage when an employee’s work requires travel away from home).

E. Lifetime Income Benefits


**Issue: Lifetime Income Benefits**

The claimant sustained an injury to the spine but no injury to the claimant’s feet or right hand. The court of appeals determined the injuries to the neck, shoulder, low back, and
hips affected the condition of one hand and one foot satisfying the statute. Therefore, the injured worker is entitled to lifetime income benefits for the permanent loss of use of one foot and/or one hand despite the fact there was no injury to the hand or foot.

F. Attorney Fees

*Discovery, Property & Casualty Insurance Co. v. Tate*, 298 S.W.3d 249 (Tex.App.-San Antonio, 2009)

**Issue: Attorney Fees**

At trial, the claimant prevailed on two quarters of supplemental income benefits (an amount less than $10,000). The court awarded attorney’s fees in excess of $100,000 and additional attorney fees for the pursuit of attorney fees. The majority held the carrier was entitled to a jury issue and determination on the amount of reasonable and necessary attorney fees. The dissent believed Discovery had a right to a plenary hearing on the attorney fees but no jury question. The court also held an attorney may not secure additional attorney fees in pursuit of attorney fees.

G. Stop/Loss

*Texas Mutual Insurance Co. v. Vista Community Medical Center, LLP*, 275 S.W.3d 538 (Tex.App.—Austin, 2008, pet. filed)

**Issue: Stop loss**

The court of appeals determined hospitals may not use the $40,000 stop/loss threshold (the carrier owes 75% reimbursement of all audited charges that exceed $40,000) unless the provider established the audited charges exceeded $40,000 and the services provided were unusually costly or extensive.

H. Bad Faith


**Issue: Bad Faith**

The claimant sustained an injury in 2000. The carrier was not aware of any disability or medical treatment for two years until the claimant sought emergency spinal surgery in 2003. Plaintiff’s expert asserted the carrier must conduct a three point contact in 2003 when they became aware of the need for emergency surgery. The adjuster filed a denial after speaking with the claimant’s former employer. The adjuster did not speak with the claimant, treating doctor, or the surgeon. Plaintiff’s expert also testified the carrier must consider the aggravation theory (carrier must pay if the claimed injury is just a “1%” cause of the need for surgery). The court of appeals accepted the plaintiff’s
expert opinions (three point contact three years after the initial investigation and the 1% aggravation standard) in its reasoning upholding a finding of bad faith.

**Cunningham Lindsey Claims Management Inc. v. Snyder, 291 S.W.3d 472 (Tex.App.-Houston [14th Dist.], 2009)**

**Issue: Bad Faith**

The jury found “bad faith” and awarded 4.3 million dollars in damages. However, the court of appeals reversed, finding the plaintiff did not exhaust his administrative remedies. The carrier originally denied both the original injury and the first request for surgery. The claimant prevailed on compensability at a Contested Case Hearing. The claimant did not pursue medical dispute resolution of the spinal surgery denial. The doctors filed a second request for spinal surgery that was approved by the carrier. The court of appeals held the claimant was essentially pursuing a denial of the claimant’s surgery, not a denial of compensability. Since the first denial of surgery was never pursued, the claimant did not exhaust his administrative remedies.

II. **Appeals Panel Decisions**

A. **Compensability**

**APD 091309**

**Issue: Intoxication**

The decedent’s post mortem blood and urinalysis showed marijuana. Based upon the positive test, the claimant is presumed intoxicated. To overcome the presumption and satisfy the burden of proof, the claimant presented evidence from a doctor citing a text book on forensic pathology that “Drug levels and post mortem exams is totally invalid when testing for cannabis, (THC) and its metabolites due to the rapid redistribution from storage issues such as fat in the body.” The Appeals Panel reversed holding that the decedent’s expert only challenged the drug screen itself but did not present any evidence the claimant did have the normal use of his mental or physical faculties at the time of the incident. There was no other evidence the claimant had the normal use of his mental or physical faculties. The injury itself was caused when the claimant was driving a motor vehicle and drifted into an oncoming lane. The Hearing Officer’s finding that the injury was compensable is reversed and rendered.
B. Extent

APD 090633
Issue: Extent

The Hearing Officer found the claimant sustained a compensable injury which extended to and included MRSA. The Appeals Panel reversed the finding of MRSA noting there was “no expert medical evidence presented to establish the claimant was infected with MRSA at the workplace or due to a sticking/bite incident.”

APD 091367
Issue: Psychological

Claimant sustained a compensable injury in the course and scope of employment. The treating doctor believed the claimant appeared to have situational reactive depression issues. He recommended a psychological evaluation before surgery. The Hearing Officer found the claimant had a reactive depression related to the compensable injury. Appeals Panel noted there is not a diagnosis of psychological disease or disorder. Further, there is no evidence the claimant was treated for reactive depression or any statement from any doctor that the compensable injury was a cause of the reactive depression. The designated doctor did not mention or rate any psychological problems. Therefore, the Appeals Panel reversed and held the compensable injury does not extend to and includes psychological problems.

APD 091423
Issue: Extent of Injury

At a Benefit Review Conference, the Hearing Officer indicated she would write a letter of clarification. Subsequently, she personally spoke with the designated doctor who agreed the injury was only a sprain/strain. Therefore, no letter of clarification was drafted. The Appeals Panel stated, “The Hearing Officer erred by failing to allow the parties an opportunity to see or hear exactly what additional information was given to the doctor and exactly how, or if, the designated doctor reconciled his conflicting opinions.” Therefore, the Appeals Panel reversed and remanded to the Hearing Officer to write a written letter of clarification.

APD 091640
Issue: Follow-on Injury

The claimant sustained a compensable injury in the course and scope of his employment. Thereafter, the claimant dislocated his right shoulder when he reached behind the backseat to separate his two children from each other while driving. The Hearing Officer found the compensable injury extended to and included the dislocated
right shoulder because the original injury reduced his resistance and increased the risk of a re-dislocation. The Appeals Panel reversed. A follow-on injury must naturally flow from the compensable injury. The Hearing Officer must consider “whether there is a distinct, non work-related activity involved in the subsequent injury, whether a distinct different body part was injured, the length of time between the injuries, whether there was only a degree of weakening or lower resistance, and whether there was medical evidence to establish causation. APD 00594.”

C. Disability/TIBS

APD 090558
Issue: Disability

Claimant sustained a right ankle injury and was placed on restrictions. No doctor released claimant back to work full duty. However, she was able to return back to work with her employer the remainder of her contract term. After her contract ended, she began searching for other work. The Hearing Officer found the claimant did not have disability. The Appeals Panel disagreed holding that no medical record reflected the claimant was able to return to work full duty and therefore the Hearing Officer must find disability as a matter of law.

APD 091194
Issue: Disability

The Hearing Officer found disability beginning on March 29, 2009 through the date of the Contested Case Hearing (CCH). However, the claimant worked in a light duty position from February 9 to February 17, 2009. She went to her treating doctor on February 17, 2009 who took her completely off work and referred her to an orthopedic surgeon. The Appeals Panel found the claimant suffered disability beginning on February 18, 2009 through the date of the CCH, stating that a claimant is disabled if there is a medical report indicating anything other than a full duty return to work.

APD 091260
Issue: Disability

The Hearing Officer found disability ended. Allegedly, the employer told the claimant they could no longer accommodate his restrictions. The Appeals Panel held a light duty release is evidence that disability continues. Because the claimant testified that he was unable to reform his regular duties during the disputed period, the Appeals Panel found the claimant is presumed to be entitled to temporary income benefits.

APD 091511
Issue: Disability
The Appeals Panel affirmed the decision that the claimant’s compensable injury extended to and included a disc protrusion at L4-5 but not lumbar radiculopathy or a disc protrusion at L5-S1. The claimant's doctor returned the claimant to regular work. Subsequently, the doctors took the claimant off work for the non-compensable lumbar radiculopathy and surgery at L5-S1. Therefore, the Appeals Panel reversed the disability determination finding no medical evidence to support the claimant was unable to obtain or retain employment due to the compensable injury at L4-5.

**APD 091807**  
**Issue: TIBS**

At the first Contested Case Hearing, the parties stipulated the average weekly wage was $677.38. The Hearing Officer found the post injury earnings (PIE) pursuant to the bona fide job offer (BFOE) were $440 a week. This finding was not appealed and therefore became final. The carrier argued the post injury earnings (PIE) should be the BFOE amount of $440.00 per week. However, the claimant did not actually work nor was paid at $440.00 a week for every week in consideration. The Appeals Panel writes, “The evidence indicates that the claimant was not able to work 40 hours per week for various reasons including weather conditions and economic conditions that affected the employer.” The Appeals Panel recalculated the benefits owed. Even though the carrier appealed the amount of TIBS owed ($5,032.96), the Appeals Panel reversed and ordered the carrier to pay more money to the injured worker: $5,239.85. Therefore, the amount of the BFOE is not considered PIE when the claimant actually worked. If the claimant did not work the full hours pursuant to the bona fide job offer due to weather and conditions affecting the employer’s financial health.

**D. MMI/IR**

**APD 090639**  
**Issue: IR**

Radiculitis is not radiculopathy for purposes of calculating a proper impairment rating.

**APD 091039**  
**Issue: Maximum Medical Improvement**

The Hearing Officer sent the designated doctor a letter of clarification indicating the claimant reached statutory MMI. The designated doctor issued a report with the given statutory MMI date and rendered a 17% impairment rating. The Appeals Panel believed the designated doctor did not certify statutory MMI based on his medical opinion but rather by the instructions given by the Hearing Officer. Thus, they reversed the findings of maximum medical improvement.
APD 091210
Issue: Disqualifying Association

The designated doctor was associated with an organization (SWS). A peer review report was authored by a doctor which had the same street address, suite number, telephone number, and fax number as the designated doctor. The peer review report supported the designated doctor's opinions and the designated doctor failed to change his opinion in three letters of clarification. Claimant's attorney called himself as a witness and testified that both the designated doctor and the peer review doctor came from SWS. The claimant’s attorney also testified the carrier used SWS for its required medical examination physician although the address was different. The Appeals Panel relied on the definition of disqualifying association found in Rule 180.21 and Appeals Panel Decision 960569 to hold there is a disqualifying association between the peer review physician and the designated doctor based on their shared office space, telephone number, and fax number.

APD 091354
Issue: Impairment Rating

The Hearing Officer found in accordance with the treating doctor’s report. However, the Appeals Panel reversed based on Rule 130.1(d)(1)(B) because the treating doctor's DWC-69 was not accompanied by a narrative report that provided: (1) an explanation of the analysis performed to determine MMI; (2) a narrative history of the medical condition that outlines the course of the injury and correlates the injury to the medical treatment; and (3) the specific body parts considered by the treating doctor and certifying MMI and assessing an impairment rating. The Appeals Panel further noted the doctor does not describe how the clinical findings are related to and compared with the applicable criteria the AMA Guidelines pursuant to Rule 130.1. Therefore, the Appeals Panel adopted the RME’s report.

APD 091375
Issue: Impairment Rating

The Hearing Officer found certain conditions related to the compensable injury and certain conditions were not related. However, none of the impairment ratings offered by any of the doctors either rated the entire compensable injury or rated conditions that were not part of the compensable injury. Therefore, the case was remanded for the Hearing Officer to contact the designated doctor and seek an opinion as to the proper impairment rating for the compensable injury as of the date of maximum medical improvement.

APD 091437
Issue: Impairment Rating
The designated doctor felt claimant gave poor effort in range of motion exercises but also felt loss of strength was attributable to decreased use of the right wrist. However, the designated doctor improperly calculated the impairment by combining the upper extremity impairment with the right wrist impairment. The Appeals Panel felt they could calculate the impairment rating without need of a letter of clarification since it was simply a mathematical formula. Therefore, the range of motion for the upper extremity is combined with the wrist extremity and then using the combined value chart to arrive at a 21% impairment rating (which is more than 20% found by the Hearing Officer and argued by the claimant). Thus, carrier’s appeal increased the impairment rating.

**APD 091660**  
**Issue: Designated Doctor: Disqualifying Association**

The claimant’s attorney called himself as a witness to testify the Designated Doctor and Required Medical Examination (RME) doctor share the same office space, record keeping, billing, collection, and 100% clerical support. They are both also employed by a certain healthcare provider. The Appeals Panel noted that Rule 180.21(a)(2) defines a qualifying association as “any association that may reasonably be perceived as having potential to influence conduct or decision of a doctor.” The Appeals Panel believes this definition includes any agreement for space, personnel services, or any other services related to the management of a doctor’s practice.

**APD 091787**  
**Issue: Extension of MMI, and Impairment Rating**

The Appeals Panel reversed the Hearing Officer’s findings and remanded further action with specific instructions. Those instructions include determining a date for an extension of MMI date due to spinal surgery. The Hearing Officer is then to inform the designated doctor of the new MMI date, provide all medical records including those records of the claimant’s alleged major depressive disorder and cervical spine, and seek an opinion as to the proper impairment rating possibly using alternate certifications for anxiety and cervical spine.
APD 091820
Issue: Impairment Rating

The designated doctor awarded a 4% impairment rating though the claimant underwent shoulder surgery. Table 27 (AMA Guides) provides an impairment rating for arthroplasty and range of motion loss. Failing to give an impairment rating for both is a failure to rate the entire injury.

APD 091822
Issue: Impairment Rating

The second designated doctor awarded a 10% impairment rating based on Table 75 using the ROM model. Citing Appeals Panel 061529-5, the Appeals Panel found the designated doctor did not explain why the DRE model was not used. The record also did not include a DWC-69.

APD 091960
Issue: Maximum Medical Improvement

The treating doctor certified maximum medical improvement with a 1% impairment rating. The designated doctor believed the claimant’s injury extended to and included a tibial collateral ligament which the claimant had not yet been treated. He changed the MMI date from May 12, 2008 to August 12, 2008. However, he did not complete a DWC-69. The Division held that Rule 130.1 requires a certification of maximum medical improvement and determination of an impairment rating requires completion, signing, and submission of a DWC-69 and narrative report. Because the designated doctor did not issue or sign a DWC-69, the certification of maximum medical improvement and impairment rating is invalid. The treating doctor’s certification of MMI and IR is overcome by the designated doctor even though there is no DWC-69 since the designated doctor did not believe the claimant reached maximum medical improvement on May 12, 2008. Moreover, the designated doctor felt the claimant required additional treatment for the collateral ligament.

E. 90 Day Finality

APD 091106
Issue: 90 Day Provisions

The Hearing Officer found the carrier did not send the PLN-3 and DWC-69 by verifiable means. The evidence included a United States Postal Service tracking confirmation indicating the envelope had been delivered and the adjuster notes indicating a DWC-69 and DWC PLN-3 was sent to the claimant by certified and regular mail referencing the United States Postal Service tracking form. There is no evidence that either the certified or regular mail was returned undeliverable. Citing Appeals Panel Decision...
070533-S, the DWC found the carrier submitted the first certification of maximum medical improvement and impairment rating to the claimant by certified mail which showed delivery to the claimant who did not dispute within 90 days.

**APD 091827**  
**Issue: 90 Day Finality**

The Appeals Panel found reports from three separate doctors (including the carrier’s RME) compelling medical evidence of inadequate medical treatment to the elbow and low back. The reports state the claimant needed a referral to an elbow specialist. Thus, the first certification was not final.

**APD 092051**  
**Issue: 90 day rule**

The Hearing Officer found that the first certification of maximum medical improvement and impairment rating did not become final. The doctor who assigned the first impairment rating examined the claimant and reviewed the medical reports including an MRI. The narrative report found no objective findings or significant signs of radiculopathy. At that time, no doctor diagnosed radiculopathy and the claimant had returned back to work lifting approximately 50 lbs. Thereafter, the claimant underwent additional testing including an EMG/NCV showing acute L5 radiculopathy. The doctors diagnosed clinical signs of radiculopathy and the claimant underwent lumbar surgery at L5-S1. Citing Appeals Panel Decision No. 052666-S, the Appeals Panel states that “just because there is subsequent surgery or treatment which proves beneficial to the patient does not automatically, or in this case, amount to inadequate treatment.” Applying the rationale of APD 052666-S, the Appeals Panel writes, “In this case, there is no compelling medical evidence that any of the claimant’s treatment prior to Dr. G’s certification on March 18, 2008, was improper or inadequate.” The Appeals Panel noted the lack of any medical evidence the claimant received improper or inadequate treatment for his injury, or the failure to perform spinal surgery earlier amounted to improper and inadequate treatment.

**F. SIBS**

**APD 091146**  
**Issue: Supplemental Income Benefits Waiver**

The Division held the claimant was not entitled to the first quarter of supplemental income benefits (SIBs). The claimant’s attorney submitted an application for the second quarter to the carrier who did not dispute that quarter within ten days. The carrier relied upon Appeals Panel Decisions stating that it was not required to dispute subsequent quarters of supplemental income benefits when the Division denied the first quarter. The Appeals Panel held that if the previous quarter is “actively in dispute” at the time the
carrier receives the application for the second quarter, the carrier must dispute that quarter by requesting a Benefit Review Conference (BRC) within 10 days or it waives its right to dispute that quarter.

APD 091318
Issue: Supplemental Income Benefits

The physician’s assistant believed the claimant could not return to any full duty work for at least six months. The Appeals Panel held that the physician’s assistant is not a doctor and therefore the report is not a narrative report consistent with Rule 130.102(d)(4).

APD 091318
Issue: Supplemental Income Benefits

The treating doctor felt his twenty-five years of experience and role as a designated doctor supported his opinion the claimant is entitled to supplemental income benefits. The Appeals Panel found that such report does not explain why the claimant’s medical condition caused a total inability to work.

APD 092043
Issue: SIBS

The Hearing Officer found the claimant was entitled to the 2nd and 3rd quarter of supplemental income benefits. The claimant did not make an active work search effort documented by job applications during the two qualifying periods. However, the DWC-52 applications have attached sheets showing job contacts through the Texas Workforce Commission (TWC). However, the claimant only began working with TWC in the middle of the third quarter. The claimant cannot testify to additional job searches that were not documented on the initial SIBS application, citing Appeals Panel Decision No. 000505. The Appeals Panel writes, “We have held that the documentation requirement of Rule 130.102(e) is mandatory and undocumented employment contacts may not be considered in arriving at the good faith determination.” Therefore, the claimant was not entitled to supplemental income benefits for the 2nd and 3rd quarters.

G. Misc

APD 090991
Issue: Issues Reported Out of a BRC

The issue before the Hearing Officer was whether the claimant’s compensable injury extended to and included spondylolysis. The Hearing Officer found the compensable injury did extend to and include spondylolysis, degenerative disk disease, and trochanteric bursitis. The Appeals Panel found that the diagnoses of degenerative disk
disease and trochanteric bursitis were not found in the issue certified at the Benefit Review Conference and therefore struck that portion of the Hearing Officer’s determination as surplusage.

APD 091039  
Issue: Res Judicata

In a previous Contested Case Hearing, the Hearing Officer found the claimant did not sustain a compensable injury but the carrier waived its right to dispute the injury. In the background information, the Hearing Officer found the claimant’s compensable injury was to her low back and right knee. In the instant Contested Case Hearing, the issue is whether a compensable injury extended to and included other conditions including the left knee. A self-insured argued that the doctrine of res judicata prevented the Hearing Officer from finding that the compensable injury extended to and included the left knee. The Appeals Panel agreed and limited the compensable injuries to the low back and right knee.

APD 091047  
Issue: Adding an Issue

The issue before the Hearing Officer was whether the claimant’s compensable injury extended to include lumbar instability. However, the Hearing Officer also found that a five millimeter retrolisthesis was not related to the compensable injury. The Benefit Review Conference report did not list retrolisthesis as an extent of injury issue. The Appeals Panel noted that parties may consent to add an issue. Consent can be inferred by parties actually litigating the issue. In this case, the parties did not discuss, argue or otherwise litigate retrolisthesis. Furthermore, the Appeals Panel noted there was no discussion how retrolisthesis either differed from or was similar to instability.

APD 091229  
Issue: Judicial Notice

The Hearing Officer found the carrier waived its right to dispute the claim. The carrier initially began making temporary income benefits when it received notice of the injury. The Appeals Panel found that the carrier received notice at least by July 19, 2007 (as evidenced by the PLN-1 indicating it received notice on that day). The carrier’s PLN-1 was signed on August 14, 2007 but was not date stamped. The carrier asked the Hearing Officer to take judicial notice of when the PLN-1 was filed with the Division. The Hearing Officer found waiver. Citing the Appeals Panel Decisions 050833 and 030295, the Appeals Panel reversed and asked the Hearing Officer to take judicial notice of the PLN-1 filing date and determine if the carrier timely disputed compensability.

APD 091328
Issue: Request for Continuance and Admission of Evidence

After the Benefit Review Conference, the claimant filed a motion for continuance so the claimant could be examined by a designated doctor and then offered the designated doctor’s examination report into evidence over the carrier’s objections. The Appeals Panel found that the Hearing Officer’s granting of the motion for continuance and the admittance into evidence of the designated doctor’s report was not an abuse of discretion. The Appeals Panel also noted the Hearing Officer had a duty to fully develop the record.

APD 091513
Issue: Contested Case Hearing Procedures

The claimant provided rebuttal testimony. The Hearing Officer did not allow the carrier an opportunity to cross examine the claimant on this additional testimony. The claimant’s testimony was a “significant consideration in the resolution of the disputed issues of compensability and disability before the Hearing Officer.” Therefore, the Appeals Panel held the Hearing Officer committed error by allowing the claimant to present additional rebuttal testimony without providing the self-insured an opportunity to cross examine the claimant regarding the additional testimony.

APD 091728
Issue: Issues Reported at BRC

The issue reported out of the BRC was whether the compensable injury extended to the medial meniscal tear. The Hearing Officer made a finding of fact the injury extended to a right knee internal derangement. The parties did not actually litigate the issue. The Appeals Panel overturned this finding of fact.

APD 091971
Issue: DWC-41 Claim for Compensation Form

The claimant stepped on a sharp object aggravating his pre-existing diabetes and underwent a partial amputation of his left foot. The claimant filed a DWC-41 with the Division of Workers’ Compensation more than one year after the date of injury. The employer was not notified of the claimed injury until after the DWC-41 was filed with the Division. The Hearing Officer found the claimant’s obligation to file a DWC-41 within one year was tolled pursuant to Texas Labor Code section 409.008. The Appeals Panel writes, “In the instant case, the employer was not required to file a DWC-1 pursuant to Section 409.005 before the claimant was required to file his DWC-41 because the employer did not have notice or knowledge of the claimed injury until after the claimant filed his claim on April 28, 2009.” Thus, the tolling provisions do not apply unless there is a duty to file the DWC-1. Since there was no duty to file the DWC-1 by
the employer, the claimant still had the obligation of filing the DWC-41 within one year. Because he failed to do so, the tolling provisions did not attach.

H. Waiver

APD 090644
Issue: Claimant Waiver

The Hearing Officer found claimant waived his right to activate a dispute or challenge the carrier’s denial of certain extent of injury issues relying upon Appeals Panel Decision 951494. The Appeals Panel reversed holding “to hold otherwise would deprive claimants of rights specifically afforded to them under the 1989 Act.” The claimant correctly noted in his appeal there is no statutory authority for a timeframe for the claimant to pursue an extent of injury dispute.

APD 091260
Issue: Waiver

The Hearing Officer found the self-insured waived its right to dispute certain extent of injury diagnoses. However, the self-insured filed a timely denial disputing the entire claim. The Appeals Panel stated, “Because the self-insured timely disputed that any injury occurred, there could be no waiver under §409.021 regarding an injury that was later determined through dispute resolution to be compensable.”

The court reversed both the summary judgment and the order for sanctions. The Appeals Panel reversed the following cases of waiver based on the SORM v. Lawton decision:

APD 091106
APD 091156
APD 091188
APD 091210
APD 091230
APD 091242
APD 091292
APD 091344
APD 091380