

TEXAS WORKERS' COMPENSATION APPEALS PANEL DECISIONS DIGEST



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TEXAS WORKERS' COMPENSATION APPEALS PANEL DECISIONS DIGEST

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The *Texas Workers' Compensation Appeals Panel Decisions Digest* (APD Digest) is published by the Insurance Council of Texas as a benefit to our member companies and associate members. The APD Digest decision summaries have been prepared by the Austin-based insurance defense law firm Burns Anderson Jury & Brenner, L.L.P. (BAJB). The manual is also available to the clients of BAJB as a client benefit. ICT and BAJB update this manual on a quarterly basis.

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Editor's Note: Readers can navigate to different pages of the manual and to Division of Workers' Compensation Appeals Panel decisions by "left clicking" on the page numbers of the table of contents and text with a hyperlink. Readers may also navigate to different pages and sections of the manual by accessing the manual book marks.

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About Burns Anderson Jury & Brenner, L.L.P.

Firm History

Burns Anderson Jury & Brenner, LLP (BAJB) is a partnership based on shared expertise and a shared vision. Its principal office is located in Austin, Texas. The law firm was created as a place where professionalism and ethics are a priority, ingenuity and know-how are respected, and clients are as welcome and comfortable as those who work there.

The firm has a diverse practice, representing clients from the conference room to the courthouse. Experienced in mediation, administrative hearings, appellate work and litigation, BAJB attorneys and staff serve clients from business formation and deal-making to dispute resolution. It handles all matters pertaining to Texas workers' compensation from the administrative level through the state and federal courts. The firm's client base consists of a full range of individuals, professionals, businesses and entrepreneurs, including insurance carriers, railroads and manufacturers, who count on BAJB for guidance toward superior results throughout the continued life of their business.

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ABOUT THE LEGAL EDITORS



Joe R. Anderson
Chief Legal Editor

Since the "old law" days of the workers' compensation system, [Joe Anderson](#) has used his sharp wit and attention to detail to win cases, often salvaging unpromising situations for his insured clients.

Since the inception of "new law" in 1991, Joe has been expanding the scope of his expertise to include representing insurance carriers before the Texas Department of Insurance Division of Workers' Compensation Commission (DWC), and providing training to adjusters, employers and DWC ombudsmen across Texas. He has also proposed and drafted legislation for his clients.

As a founding partner of the firm, he enjoys the continued fast pace of fast pace of attending to the details of leading and mentoring his team of "comp" attorneys as they solve their clients workers' compensation issues.

Certification

Texas Workers' Compensation Law - Texas Board of Legal Specialization

Practice Areas

[Insurance Coverage](#), [Toxic Exposure](#) and [Workers' Compensation](#)

Joe also provides the following legal and consultation services to his clients:

- bad faith prevention
- benefit dispute resolution representation
- claims management issues
- compliance and enforcement defense
- claims management issues
- Benefit Contest Case Hearing (BCCH) representation
- Benefit Review Conference (BRC) representation
- DWC appeals and responses
- medical dispute resolution representation
- legislative consultation

Additional information regarding Joe can be found at the following hyperlinks:

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Robert "Bob" Graves
Senior Legal Editor

[Bob Graves's](#) leadership and legal experience made him a perfect fit when he joined Burns Anderson Jury & Brenner, L.L.P. (BAJB) in November 2000. From his early days as a Pathfinder with the 82nd Airborne Division, to Willamette University College of Law's Law Review, to representing the largest workers' compensation carrier in Texas, he has consistently proven that hard work can accomplish great feats.

Before joining BAJB, he was in-house counsel for Texas' largest workers' compensation insurance company, representing it in administrative and court proceedings and eventually managed a subrogation department. He returned to private practice at BAJB, where he engages in the complex interplay between legislative, governmental and regulatory forces.

Bob has practiced insurance defense, focusing on workers' compensation since 1995. He has extensive experience in all aspects of the Texas workers' compensation system, including medical disputes, compliance and practice matters, benefit disputes and subrogation.

On January 1, 2008, BAJB proudly named Bob a junior partner in the firm.

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Mark Sickles
Legal Editor

[Mark Sickles](#) joined BAJB in 2008 but has been practicing workers' compensation since 1999. Throughout his years practicing workers' compensation, he has handled cases through administrative hearings, medical disputes at the DWC and State Office of Administrative Hearings, compliance and practice matters, subrogation claims.

Mark has also successfully represented and defended clients in jury trials throughout Texas.

Mark spends his free time away from work with his family and three children. His children are active in little league sports, and Mark thoroughly enjoys coaching the little league teams.

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Bob also provides the following legal and consultation services to his clients:

- bad faith prevention
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- claims management issues
- compliance and enforcement defense
- claims management issues
- Benefit Contest Case Hearing (BCCH) representation
- Benefit Review Conference (BRC) representation
- DWC appeals and responses
- medical dispute resolution representation
- legislative consultation

Additional information regarding Joe can be found at the following hyperlinks:

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Anna Russell
Legal Editor

[Anna Russell](#) hails from Marshall, Texas, famous for its pottery and the Wonderland of Lights. Despite being an Aggie, she fell in love with Austin and joined the BAJB team in 2007, fresh out of law school and anxiously awaiting her bar results. The results were in, favorably, and she has been with the firm ever since.

Anna focuses on workers' compensation and insurance defense. She finds the ever changing legal horizon of both these areas of the law intriguing and a perfect fit for her desire to become a passionate advocate for her clients.

Anna attended and graduated from Texas A&M University with a B.B.A. Business Degree. She earned her Doctor of Jurisprudence degree from Baylor University School of Law in 2006.

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Burns Anderson Jury & Brenner's representative clients list can be found on the firm's website at: <http://www.bajb.com/clients.html>.

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I. HISTORY OF THE TEXAS WORKERS' COMPENSATION SYSTEM

Before Texas enacted workers' compensation legislation in 1913, employers could defend against injured employees' negligence claims by invoking the complete defenses of assumption of the risk and fellow servant. As part of a nationwide workers' compensation movement, Texas created the Employers' Liability Act of 1913 to compensate for medical costs and loss of wage earning capacity caused by a work-related injury. The Act essentially replaced the common law negligence remedy with limited but more certain benefits for injured workers. Under the Act, employees injured in the course and scope of employment could recover compensation without proving fault by the employer and without regard to their or their coworkers' negligence. At the same time, the Act substantially limited the employer's total liability for an injury. An employer's election to opt out of this system barred the employer from asserting any traditional common law defenses.

Although modified on numerous occasions over the years, the Act's basic structure never changed. As of 1989, totally incapacitated employees could recover two-thirds of their average weekly wage for up to 401 weeks. Partially incapacitated employees could recover two-thirds of the difference between their average weekly wage and their post-injury weekly earning capacity for up to 300 weeks, subject to an aggregate maximum of 401 weeks for periods of total and partial incapacity. Disability from injury was generally referred to as either "temporary" or "permanent," depending on whether it was likely to persist beyond the maximum benefit period. Thus, an injury causing complete incapacity for at least 401 weeks was the functional equivalent of "permanent total" disability, while an injury causing partial incapacity for at least 300 weeks was the functional equivalent of "permanent partial" disability. Conversely, an injury that totally incapacitated a worker for less than 401 weeks was a "temporary total" disability. The former act also provided lifetime benefits for certain injuries conclusively presumed to be totally and permanently incapacitating, such as loss of both feet or both hands, and long-term death benefits for the beneficiaries of a fatally-injured employee. For certain other "specific injuries," the Act mandated specific compensation in lieu of all other wage-loss benefits. Today, Texas is the only state that allows employers to choose whether or not to provide workers' compensation, although public employers and employers that enter into a building or construction contract with a governmental entity must provide workers' compensation.

The Industrial Accident Board

The Industrial Accident Board, created in 1917, was a three-member panel appointed by the Governor, which administered the former workers' compensation system. The Board and its staff monitored work-place injuries, seeking to resolve disputes between claimants and insurers. The adjudicative process began with a "prehearing conference," an informal meeting of the parties presided over by a prehearing officer. Witnesses were not sworn and no record was made, and no matter occurring during, or fact developed in, a pre-hearing conference could be deemed as admissions, evidence or impeachment against the association, employee, or the subscriber in any other proceedings except before the Board. Under the prehearing officer's guidance, the parties attempted to mutually resolve the disputed issues. If successful, they could enter into binding settlement agreements, subject to Board approval. For claims not settled, the prehearing officer prepared a report stating the officer's recommendations and bases for the award, if any. These

claims then proceeded to the Board for formal hearing. Although the parties could appear and give sworn testimony, in most cases the Board simply reviewed its claim file, usually approving the prehearing officer's recommended award. Any party dissatisfied with the Board decision could appeal to court. All issues were subject to *de novo* review under the normal rules of procedure, including the right to a jury trial, on disputed factual issues. Settlements were subject to court approval, as was the claimant's attorney's fee, which could not exceed twenty-five percent of the recovery. At trial, the Board award was inadmissible.

The Texas Workers' Compensation Commission (TWCC)

It is generally believed that participants' satisfaction with the former workers' compensation system was low. Loss of confidence in the system reached crisis proportions in the 1980s. In 1983, the percentage of claims with indemnity payments increased dramatically, along with the proportion of indemnity claims with payments for permanent disability. Medical costs for injured workers also increased at a much higher rate than medical costs outside the compensation system. Consequently, workers' compensation insurance premiums doubled between 1984 and 1988. By 1988, the cost of workers' compensation to Texas employers was among the highest in the nation. Businesses began to locate operations elsewhere and many small businesses ceased operations or opted out of coverage. The system was simultaneously perceived as unfair to injured workers. So in July 1987, the Legislature created the Joint Select Committee on Workers' Compensation Insurance to study the system and propose changes. After numerous public hearings and meetings, the Committee identified several inequitable features of the former Act. The Committee made numerous recommendations, namely to: 1) make the system more objective by awarding benefits, at least in part, on the basis of physical impairment rather than loss of wage earning capacity; 2) utilize a neutral doctor to resolve disputes; 3) prohibit the settlement of medical benefits; 4) increase the statutory maximum; 5) extend the duration of permanent disability payments; and 6) vest the Board with authority to render binding findings, subject to judicial review only under the substantial evidence rule.

In December 1989, the Legislature passed the new Act, which became effective January 1, 1991. Like the former law, it compensated for all medical costs flowing from a compensable injury, with no limit as to amount or time. It also mandated four levels of income benefits: temporary income benefits (TIBs), impairment income benefits (IIBs), supplemental income benefits (SIBs), and lifetime income benefits (LIBs). TIBs compensated for lost wages while an injured employee was convalescing. They accrued when the employee suffered a disability and continued until "maximum medical improvement." "Disability" meant the "inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage," and thus resulted from any reduction in wage earning capacity. "Maximum medical improvement" was the point when further material recovery or lasting improvement could no longer be reasonably anticipated, or two years after income benefits began to accrue, whichever was sooner. TIBs were paid weekly at the rate of either seventy or seventy-five percent of the difference between the claimant's average weekly wage and the post-injury weekly earnings, subject to the statutory maximum and minimum. The "average weekly wage" was generally based on the wages from the thirteen weeks preceding injury.

A claimant who remained impaired after reaching maximum medical improvement became

eligible for IIBs. Impairment was any anatomic or functional abnormality or loss existing after maximum medical improvement that resulted from a compensable injury and was reasonably presumed to be permanent. The claimant's "impairment rating," which is the percentage of permanent impairment of the whole body, was determined by a physician utilizing the American Medical Association's Guides to the Evaluation of Permanent Impairment. A designated doctor's rating carried presumptive weight and was only overcome if the great weight of the other medical evidence was to the contrary, in which case the Commission must adopt the impairment rating of one of the other doctors. IIBs were paid at the rate of seventy percent of the claimant's average weekly wage, subject to the statutory maximum and minimum. Benefits began the day after maximum medical improvement and continued for three weeks for every percentage point of impairment. Impairment income benefits were intended to compensate for the impairment itself and, thus, were payable without regard to post-injury wages or wage earning capacity.

SIBs provided long-term disability compensation. They became payable upon termination of IIBs, but only if the claimant had an impairment rating of fifteen percent or more and was earning less than eighty percent of his or her preinjury average weekly wage as a direct result of the injury. These benefits, which were recalculated every quarter, were paid at the weekly rate of 80 percent of the difference between eighty percent of the preinjury average weekly wage and the weekly wage earned during the quarterly reporting period. A claimant remained eligible for SIBs until 401 weeks after the date of injury.

LIBs were payable for certain severe injuries, such as loss of both feet or both hands, at the rate of seventy-five percent of the preinjury average weekly wage, subject to the statutory maximum. The Act also provided death benefits at the same rate as lifetime benefits.

Disputed claims proceeded through a three-stage hearing process: the benefit review conference, the contested case hearing, and the administrative appeal. The benefit review conference, like the former prehearing conference, was an informal proceeding aimed at resolving the disputed issues by mutual agreement. The presiding benefit review officer (BRO) informed all parties of their rights and responsibilities and attempted to mediate the dispute. The BRO could direct questions to the parties, but did not take testimony or make a formal record. The BRO prepared a written report detailing each issue not settled at the conference, along with each party's position, and the BRO's recommendation for resolution on each issue. The parties then proceeded to a benefit contested case hearing, a formal evidentiary proceeding with sworn testimony and prehearing discovery procedures. The hearing officer decided the disputed issues by written decision containing factual and legal findings, awarding benefits if due. The hearing officer's decision was binding during the pendency of an administrative appeal and was final in the absence of appeal. Any party could appeal the hearing officer's decision to the Commission Appeals Panel. After considering these briefs and the record from the benefit contested case hearing, the Appeals Panel could affirm the decision of the hearing officer, reverse and render a new decision, or remand no more than one time to the hearing officer for further consideration and development of the record. If the Appeals Panel did not decide the case within thirty days after the response was filed, the decision of the hearing officer became final and was deemed to constitute the Appeals Panel's final decision, and the final decision of the Commission. The Commission's final decision could be appealed to district court under modified *de novo* review. For issues regarding compensability of the injury and eligibility for and the amount of income and death

benefits, there was a right to trial by jury. The appealing party bore the burden of proof by a preponderance of the evidence. The jury, although informed of the Commission's decision, was not required to accord it any particular weight. The opinion of the designated doctor regarding impairment was accorded no special weight. In determining the extent of impairment, however, the jury was required to adopt the specific rating of one of the physicians in the case. Evidence of the extent of impairment was limited to that presented to the Commission unless the court made a threshold finding that the claimant's condition had substantially changed, in which case new impairment evidence could be introduced. If the parties disputed whether the claimant's condition had substantially changed, the court had to hear from the designated doctor, whose opinion was controlling on this issue "unless the preponderance of the other medical evidence is to the contrary." The court's finding of substantial change of condition could not be revealed to the jury. The Commission record was admissible to the extent allowable under the Texas Rules of Civil Evidence. Issues other than compensability of the injury and eligibility for and the amount of income and death benefits were reviewed by a Travis County district court under the substantial evidence rule.

The Division of Workers' Compensation (Division)

During the 1990s, the Legislature passed additional laws designed to make the workers' compensation system run more efficiently. In 2004, the Senate Select Interim Committee on Workers' Compensation was directed to examine the benefits of existing, regional health care networks to treat injured workers and to assess the potential impact of full-scale networks in the system. The committee also was directed to examine measures undertaken and proposed to regulate medical costs for treating worker injuries. The Senate Select Interim Committee concluded that health care networks should become part of the workers' compensation system and that treatment guidelines should be developed to direct the types of care given to injured workers. At the same time, the House Business and Industry Committee prepared an interim study on the workers' compensation system that also endorsed health care networks to treat injured workers. In addition to these legislative interim studies, the TWCC underwent review by the Texas Sunset Advisory Commission. The Sunset Commission recommended the abolition of TWCC, the addition of health care networks for injured workers, and the creation of an Office of Injured Employee Counsel (OIEC). Other recommendations included improvement of return-to-work outcomes and measures to control medical costs.

In 2005, the Legislature enacted House Bill 7 to reform the administration of the workers' compensation system and implement major changes in the delivery of benefits to injured workers. The Texas Department of Insurance (TDI) assumed the responsibilities of the Texas Workers' Compensation Commission, forming a new division of TDI—the Division of Workers' Compensation (Division). The Governor appointed a Commissioner to oversee the Division. The bill also established a new state agency, the Office of Injured Employee Counsel (OIEC), to be administered by a Public Counsel appointed by the Governor. The Public Counsel represents injured workers in rulemaking proceedings and coordinates ombudsman assistance for injured workers in administrative dispute proceedings. Health care networks, similar to those found in group health insurance, first came to the Texas workers' compensation system under the bill. Insurance carriers can provide medical benefits to injured employees through certified Workers' Compensation Health Care Networks. If the insured employer selects a carrier who offers a

XII. LEGISLATIVE MODIFICATIONS

Even after the House Bill 7 reformation, the Texas Workers' Compensation system continues to evolve. While largely intact, as it has been for years, the Legislature routinely modifies the Act:

A. 2007

- [House Bill 34](#) imposed an administrative violation on an insurance adjuster, case manager, or other person if that person offers to pay, pays, solicits, or receives an improper inducement relating to the delivery of benefits to an injured employee or improperly attempts to influence the delivery of benefits to an injured employee, including through the making of improper threats.
- [House Bill 472](#) amended the definition of administrator to include persons collecting premiums or adjusting or settling claims for workers' compensation benefits, and expands the regulatory requirements for administrators.
- [House Bill 473](#) allowed for deviation from fee guidelines by "informal or voluntary" workers' compensation health care networks. It further requires these networks to be certified by January 1, 2011.
- [House Bill 724](#) provided that a dissatisfied party to a medical fee or medical necessity dispute is entitled to an administrative review through a contested case hearing (CCH) if the review concerns a health care provider fee dispute where the reimbursement amount in dispute is under \$2,000; if the appeal is of an independent review organization (IRO) decision regarding the retrospective medical necessity of a health care service under \$3,000; or where the review concerns an IRO decision concerning the concurrent or prospective medical necessity for health care services. A benefit review conference is not a prerequisite to the CCH under this change. It also provided for the payment of death benefits to surviving eligible parents of the deceased. A payment of death benefits made under this subsection may not exceed one payment per household and may not exceed 104 weeks.
- [House Bill 886](#) required the Commissioner of Workers' Compensation to establish an optional preauthorization plan for eligible employers who participate in the return-to-work pilot program for small employers. To participate in the preauthorization plan, an employer must submit a proposal to the Division that describes the workplace modifications the employer would make to accommodate an injured employee's return to work. It further required the Division to guarantee that an approved employer would be reimbursed from the workers' compensation return-to-work account for the expenses incurred in implementing the modifications, up to the account's \$2,500 reimbursement limit, unless the Division determines that the modifications differ materially from the employer's proposal.
- [House Bill 888](#) required a health care provider, on the written request of an ombudsman for the OIEC, to provide copies of the injured employee's medical records to the ombudsman at no cost. It further required the workers' compensation insurance carrier to

reimburse the provider for the cost of the copies, prohibited the carrier from deducting that cost from any benefit to which the employee is entitled, and provided that the cost be the amount prescribed by Commissioner of Workers' Compensation rules for copying medical records.

- [House Bill 1003](#) required that an IRO that uses doctors to perform reviews of health care services may only use doctors licensed to practice in this state. Further, it provided that the definition for IRO as used in Texas Labor Code is the same as in Insurance Code Chapter 1305.
- [House Bill 1005](#) clarified that a healthcare provider who fails to submit a medical bill within 95 days after the services are provided to the injured employee, as required by statute, does not forfeit the right to reimbursement if 1) the provider submits proof that the bill was timely filed with a group accident and health insurer, an HMO that issues coverage under which the injured employee is covered, or a workers' compensation carrier other than the carrier liable for payment; or 2) the Commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the provider's normal business operations. The provider is required to submit the claim to the correct insurer within ninety-five days of being notified of the erroneous submission.
- [House Bill 1006](#) required that URAs and insurance carriers use doctors licensed to practice in Texas for performing utilization review or review conducted under the Workers' Compensation Act or Insurance Code. It further provided that the definitions for "credentialing" and "retrospective review" in Texas Labor Code Chapter 401 are the same as in Insurance Code 1305, and that the definitions for "utilization review" and "utilization review agent" are the same as in Insurance Code 4201.
- [House Bill 2004](#) required that doctors performing peer review, utilization review, independent review, required medical examination, or as a designated doctor must be certified in the specialty appropriate to the care the injured employee is receiving. It further required that providers reviewing dental or chiropractic services must be licensed in these specific areas.
- [Senate Bill 458](#) amended the Texas Labor Code to define "orthotic device" and "prosthetic device" and to include the provision and fitting of, change or repair to, and training in the use of such devices within the meaning of "health care" as the term relates to workers' compensation benefits.
- [Senate Bill 471](#) required the Commissioner of Insurance to establish by rule the information that must be reported on workers' compensation claims and the reporting requirements for insurance companies relating to those claims, and removed provisions specifying such information and requirements. It further authorized the Commissioner to reduce or eliminate reporting requirements for insurance companies whose workers' compensation insurance business falls below a specific minimum premium volume established by the commissioner.

- [Senate Bill 1169](#) required reimbursement from the Subsequent Injury Fund to an insurance carrier for any overpayment of workers' compensation benefits made by the insurance carrier based on an opinion by a designated doctor if that opinion is reversed or modified by a final arbitration award or a final order or decision of the Commissioner of Workers' Compensation or a court. It further specified that an insurance carrier is entitled to reimbursement from the Subsequent Injury Fund for the amount of death benefits as well as income benefits paid to a worker with multiple employments that are based on employment other than that during which the compensable injury occurred.

B. 2009

- [House Bill 1058](#) extended death benefits to non-dependent parents who do not receive burial benefits and clarified that a failure to file a claim for death benefits in the time required bars the claim unless good cause exists for the failure to file a claim under this section. Previously, the standard for failing to file for these benefits within the statutory timeframe required a "compelling reason."
- [House Bill 2547](#) allowed a treating doctor to request job description information from an injured worker's employer and requires the Commissioner of Workers' Compensation to prescribe a form to be used to identify the scope and functions the worker performed prior to the injury as well as a contact person for the employer. The purpose of this legislation is to facilitate communication between employers and treating doctors regarding the availability of alternate duty or other return-to-work options for the injured worker. The legislation applies to employees of an employer with ten or more employees.
- [House Bill 3625](#) changes the timeframe for an insurance carrier to respond to a request for preauthorization from three calendar days to three working days, which conforms the preauthorization timeframes for network and non-network claims.
- [House Bill 4545](#) changed the timeframe for a party to dispute a decision by the Division Appeals Panel to district court. The effect of the bill is to change the current forty days to essentially fifty days from the date the decision was filed with the Division. The actual language in the bill requires a request for judicial review to be filed not later than the forty-fifth day after the date the decision was mailed by the Division to the party; however, additional language was added that for the purposes of this section, the mailing date is considered to be the fifth day after the date the decision of the appeals panel was filed with the Division, giving a party up to fifty days, rather than forty days to seek judicial review.
- [Senate Bill 1814](#) extends a pilot program that was created by House Bill 7 in the 79th Legislative Session to allow small employers to be reimbursed for making workplace modifications to help return an injured employee to work. The bill increases those reimbursements to up to \$5,000 annually and allows the Commissioner of Workers' Compensation to extend these reimbursements to other categories of employers as needed. Additionally, this bill clarifies an insurance carrier's statutory responsibility to provide return-to-work coordination services on an ongoing basis when an employer's injured employee begins to lose time away from work and requires insurance carriers to

4. An injured worker suffers from a spine injury that has resulted in permanent but partial paralysis of his legs. However, because of the partial paralysis, he is no longer able to get and keep employment that requires use of his legs. However, he was retrained and is doing work that does not require use of his legs. Is he entitled to LIBs?

Yes, because he meets the second prong of the test in that he cannot return to work that requires use of his legs. He need not meet both prongs.

Accrual of Benefits:

Mid-Century Ins. Co., 187 S.W.3d 754, effectively repealed Rule 131.1 regarding when LIBs were to be initiated. (The Rule was formally repealed on January 9, 2008.) The court explained that in many of the LIBs qualifying compensable injuries, the date of LIBs eligibility and disability are the same, such as when an employee loses an eye and the loss impacts his or her earning capacity. In these situations, LIBs accrue on the eighth day of disability.

Other injuries, however, worsen over months and years before the injured employee would be determined to be entitled to LIBs. In applying Texas Labor Code section [408.161](#), the court assumed the Legislature contemplated the prospect of slower-developing but ultimately LIBs-qualifying conditions when drafting the statute. The court held:

An employee is eligible to receive LIBs on the date that employee suffers from one of the conditions specified in section [408.161](#). Section [408.161](#) does not permit payment of LIBs prior to that date. Once an employee is adjudicated eligible to receive LIBs, however, LIBs should be paid retroactively to the date the employee first became eligible.

Stated differently, once LIBs eligibility is judicially or administratively determined, the employee would be entitled to such benefits from the date at which the injurious condition first entitled the employee to LIBs.

XIV. DISPUTE RESOLUTION PROCESS UNDER THE TEXAS LABOR CODE

A. Adjudication of Disputes

1. Benefit Review Conference (BRC)

Texas Labor Code Overview

A BRC is a non-adversarial informal dispute resolution proceeding, which is designed to explain the rights of (1) the respective parties regarding a workers' compensation claim; (2) procedures necessary to protect such rights; (3) the facts of a claim; (4) review information necessary to evaluate a claim; (5) delineate disputed issues; and (6) mediate and resolve the disputed issues with the agreement of the parties. TEX. LAB. CODE ANN. § [410.021](#).

XV. SIGNIFICANT APPEALS PANEL DECISIONS

COURSE AND SCOPE

010163-S – No File Date Given

Whether worker is given permission to perform something personal on work hours is not determinative of whether he was in the course and scope of employment when injured. Likewise, the fact that employer allowed employees to purchase goods at a slight markup is not dispositive of the work-relatedness of a purchasing mission.

002546-S – No File Date Given

The fact that claimant was driving a police car to work at the time he was injured in a motor vehicle accident and the fact that self-insured's police department had a policy of permitting certain police officers to drive police cars to and from work, operated to place claimant in the course and scope of employment at the time of the accident.

012376-S – Filed November 14, 2001

Workers' compensation law is not tort law; employee need not prove that employer was in some way negligent, or the premises defective, in order to recover for injuries that are encountered in the course and scope of employment or arise from that employment, while the business of employer is being furthered. The Appeals Panel rejects the notion that “an injury arising from an activity that could also be experienced outside of work is, per se, noncompensable for that fact alone.”

031900-S – Filed September 8, 2003

Claimant was in the course and scope of his employment while driving a company car and furthering the affairs of his employer by talking on a company cell phone with a supervisor regarding a problem at work at the time of the accident.

042922-S – Filed January 6, 2005

Claimant's deviation leaving employer's premises ends when claimant returns to employer's premises rather than when claimant returns to claimant's workstation.

042922-S – Filed January 6, 2005

“Course and scope of employment” means, in pertinent part, an activity of any kind or character that has to do with and originates in the work, business, trade, or profession of employer and that is performed by an employee while engaged in or about the furtherance of the affairs or business of employer.

051610-S – Filed August 26, 2005

Where injuries resulted from claimant's impact with the ground after an idiopathic fall, and where claimant's employment conditions placed claimant in the vicinity of that ground, claimant's injuries are compensable as a matter of law even though employer did not control that ground.

for his pleasure and entertainment. The Appeals Panel overturned the hearing officer's decision that the decedent was in the course and scope of employment when involved in a fatal motor vehicle accident. They stated that the choice made by the decedent that evening to eat, drink, play pool, and watch television in city C, 35 to 45 miles away from his accommodations, was made due to his personal pleasure and recreation and was not an incident of his employment.

COMPENSABILITY

[031055-S](#) – Filed June 19, 2003

Claimant's mistaken belief that he gave timely notice of injury to his employer can never constitute good cause for failure to timely report an injury.

[042922-S](#) – Filed January 6, 2005

Claimant has the burden to prove by a preponderance of the evidence that she sustained a compensable injury in the course and scope of her employment. A "compensable injury" means "an injury that arises out of and in the course and scope of employment for which compensation is payable under this subtitle."

[060631-S](#) – Filed May 30, 2006

Carrier is not relieved of liability under [Tex. Lab. Code 409.004](#) where carrier waived the right to contest based on failure to file a claim within one year under [409.022\(b\)](#).

[081665-S](#) – Filed January 29, 2009

[Rule 124.3](#) covers both carrier's liability for accrued benefits for failure to dispute by the 15th day after receiving first written notice of the claimed injury as well as carrier's waiver of the right to contest compensability of the claimed injury if not disputed on or before the 60th day after receiving first written notice of the claimed injury pursuant to [Section 124.3\(b\)](#).

COVERAGE

[050018-S](#) – Filed February 22, 2005

Carrier that is given notice of an alleged date of injury not within its policy period cannot waive its right to contest the compensability of the injury. Carrier is only required to dispute an injury once it is provided notice of a date of injury within its policy period.

EMPLOYEE

[061764-S](#) – Filed October 31, 2006

Where claimant was employed by co-employers at time of injury, all carriers with coverage of the co-employers are equally liable for a proportionate share of workers' compensation benefits.

DEATH BENEFITS/BENEFICIARIES

[061381-S](#) – Filed August 16, 2006

A court order does not bind DWC as to whether a purported common law spouse is a common law spouse due to lack of privity on carrier's part.

[071277-S](#) – Filed October 18, 2007

Legal beneficiaries have an independent cause of action separate from claimant and claimant can take no action that would negatively affect the rights of his beneficiaries to collect benefits by reason of claimant's death.

DD

[061328-S](#) – Filed August 21, 2006

A party cannot waive its right to object to a DD who is unqualified or inappropriately selected by failing to object until after the appointment.

[061713-S](#) – Filed October 20, 2006

There are no rules or authority for the appointment of a successor DD based upon an agreement by the parties.

[100705-s](#) – Filed August 12, 2010

The issue to be resolved was whether the designated doctor was properly appointed to determine MMI and IR in accordance with section [408.0041](#) and Rule 130.5. In this case, carrier had filed a PLN-1 denying compensability of this case on March 21, 2005. On July 16, 2007, carrier filed a request for a designated doctor ([DWC-32](#)) to determine the claimant's MMI, IR, and extent of injury. Carrier now contends at the CCH that the appointment of a designated doctor by the Division was improper because compensability of the claimed injury was in dispute. The hearing officer determined Dr. X. was not properly appointed as a designated doctor based on memorandum dated June 18, 2007, from the Division's policy advisor, to workers' compensation system participants, entitled "Guidance on Requesting Designated Doctor Examinations." The memorandum states, in part, that with regard to compensability issues:

There are two components to compensability: (1) Medical – Is there an injury resulting from the claimed incident; and (2) Legal – Did the injury occur in the course and scope of employment. When the compensability of the injury has been denied/disputed the Division will not schedule a designated doctor to address the legal issue. The Division will only schedule a designated doctor to address the medical issue of whether there is an injury related to the claimed incident, and if so, the extent of the injury.

The Appeals Panel disagreed with the hearing officer's rational that the acceptance or adjudication of a compensable injury must be determined before a designated doctor is appointed. The Appeals Panel noted the June 18, 2007 memorandum is correct since the Division will not schedule a designated doctor examination to address a legal issue, but rather will schedule a designated doctor examination to address a medical issue. Thus, the Division did

DISABILITY

010110-S – No File Date Given

An employer's offer of employment constitutes a bona fide offer of employment under [Rule 129.6\(c\)](#). A bona fide offer of employment must conform to the doctor's restrictions, is communicated to the employee in writing, and meets the requirements of [Rule 129.6\(c\)](#).

030027-S – Filed February 19, 2003

[Tex. Lab. Code 401.011\(16\)](#) defines disability as "the inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage." A claimant need not prove that the injury was the sole cause, as opposed to a cause, of the disability. [406.092](#) specifically provides that a resident or nonresident alien employee is entitled to compensation. In [Appeal No. 022258-S](#), an illegal alien was not prevented from receiving workers' compensation benefits solely because an illegal alien could not legally enter into an employment contract.

052243-S – Filed November 29, 2005

The fact that employer paid claimant salary continuation for a period of time while she was off work due to her compensable injury does not exclude that period of time from the calculation of statutory MMI when [Tex. Lab. Code 408.003\(f\)](#) is applied.

052864-S – Filed February 21, 2006

Claimant has the burden to document any wages from concurrent employment. Where claimant's claim for disability arises solely from his non-claim employer, and where claimant has failed to establish his average weekly wage from that employer, he has failed to establish the elements of disability.

071087-S – Filed August 10, 2007

A hearing officer commits error applying the Medical Disability Advisor to the claimed period of disability when: (1) the MDA was not in evidence; (2) no notice is given to the parties that the MDA would be considered; and (3) the entire period of disability at issue is prior to the May 1, 2007 effective date of DWC [Rule 137.10](#).

071108-S – Filed August 15, 2007

Where the beginning date of disability is prior to the effective date of the adoption of the MDA by DWC, where part of the claimed disability period is after May 1, 2007, it is not error for the hearing officer to consider the MDA in making the disability determination. But the report of the DD on the issue of the ability to return to work is given presumptive weight as is the MDA. The DD must therefore utilize the disability duration values in the current issue of the MDA or explain why they do not apply to the particular claimant. Because the MDA requires knowledge of the specific condition that is part of the compensable injury, resolution of the disability issue cannot proceed until the threshold issue is either resolved by the parties or the hearing officer even if not expressly raised by the parties. But diagnoses evolve over time and claimants may claim additional injuries or conditions are compensable if the particular conditions were not resolved in conjunction with the disability determination.

IMPAIRMENT INCOME BENEFITS

[070871-S](#) – Filed July 2, 2007

No reduction of IIBs allowed where employer's payments do not meet the criteria to be a payment made under [Section 408.003](#).

LIFETIME INCOME BENEFITS

[070063-S](#) – Filed March 22, 2007

Entitlement may be found based upon total and permanent loss of use of the legs and/or feet where the injury was to the spine. Total loss of use of the leg encompasses the foot at or above the ankle. If the leg cannot be used, neither can the foot.

CONTRIBUTION

[002211-S](#) – No File Date Given

Carrier has the burden of proving contribution. Whether there has been a cumulative effect from a prior injury is a question of fact for the hearing officer to decide. Where carrier has requested a reduction of IIBs and/or SIBs, a hearing officer may order that the overpayment of benefits after a request for contribution is filed be repaid from subsequent income benefits. In determining the amount to be withheld from the subsequent income benefits, the hearing officer shall determine a reasonable rate at which such benefits are to be withheld to recoup the overpayment.

[030864-S](#) – Filed June 5, 2003

Carrier has the burden of proving the extent, if any, that claimant's prior compensable injury contributed to her present impairment. A determination of contribution must be based on medical evidence, but the existence of medical evidence supporting contribution does not require an award of contribution.

RECOUPMENT

[002508-S](#) – No File Date Given

Where claimant received an overpayment of TIBs in excess of the total travel reimbursement, carrier was not entitled to recoup an overpayment of income benefits from a medical payment which would have otherwise been made to a health care provider.

[010607-S](#) – No File Date Given

LTD overpayments fall under the rules governing PIE. [Rule 129.2\(d\)\(5\)](#) provides that PIE does not include "any monies paid to an employee under an indemnity disability program paid for by the employee separate from workers' compensation."

[030011-S](#) – Filed February 24, 2003

Carrier is not entitled to take a credit against TIBs for LTD payments made to claimant. The parties stipulated that the LTD plan was funded in part by both claimant and employer. Considering [Rule 129.2](#) and [Appeal 010607-S](#), the hearing officer could find from the evidence

failing to comply with the work search requirements does not create a catch-all for individuals who cannot otherwise comply during the qualifying period.

[101430](#) – Filed November 15, 2010

The hearing officer determined that Claimant was not entitled to SIBS for the fourth quarter. Claimant argued an active work search was performed every week of the qualifying period. The hearing officer determined that although the claimant made and documented 41 work search efforts, with a minimum of three per week during the qualifying period, the claimant only made two job applications and therefore did not meet the requirements of Rule [130.102\(d\)\(1\)\(D\)](#).

The AP reversed the hearing officer's determination that the claimant was not entitled to SIBs and rendered a new decision the claimant was entitled to SIBs for the fourth quarter. The AP noted that the preamble to Rule [130.12\(d\)\(1\)\(2\)](#) clarifies that "work search efforts" encompass both job applications and work search contacts as described by DWC rules. The AP noted the work search efforts were sufficiently documented by making job applications and work search contacts for each week during the entire qualifying period.

SPINAL SURGERY

[052063-S](#) – No File Date Given

An IRO decision regarding the appropriateness of spinal surgery is irrelevant if the surgery had already been performed before the decision was issued.

[080812-S](#) – Filed July 25, 2008

A party who wishes to establish that the preponderance of evidence is contrary to the decision of an IRO must present "evidence based medicine" consistent with the definition in [Tex. Lab. Code 401.011\(22-a\)](#).

SUBCLAIMANT

[002977-S](#) – No File Date Given

Under [Tex. Lab. Code 409.009](#), a person may file a claim with the Division as a subclaimant to recover reimbursement for compensation if the person has provided compensation directly to or for an employee and has sought and been refused reimbursement from carrier. An employer has standing under [Section 409.009](#) of the 1989 Act as a subclaimant to seek reimbursement under [Tex. Lab. Code 408.127](#).

TEMPORARY INCOME BENEFITS

[012074-S](#) – Filed October 24, 2001

Money collected by claimant's business was income, i.e., wages earned for personal services, that should have been reported to the self-insured to reduce the amount of TIBs that might otherwise be due claimant. The self-insured correctly sought to have claimant's self-employment income reduce the amount of TIBs, contending that this "income," in whole or part, constituted wages earned for personal services as opposed to passive income.

CHOICE OF DOCTOR/TRAVEL EXPENSE REIMBURSEMENT

[010522-S](#) – No File Date Given

Rule 134.6(b), states: An injured employee is entitled to reimbursement for travel expenses only if medical treatment for the compensable injury is not reasonably available within 20 miles of the injured employee's residence.

[060440-S](#) – Filed May 2, 2006

Rule 134.6 does not make provision for reimbursement of travel expenses to include food and lodging for a travel companion or spouse; it addresses travel expenses incurred by the injured employee. The allowable lodging reimbursement is the state rate for claimant alone, plus allowable taxes.

JURISDICTION

[060701-S](#) – Filed May 23, 2006

Disputes containing limitation language sufficiently dispute any injury other than the one specifically accepted.

[072002-S](#) – Filed December 20, 2007

The filing of a [PLN-11](#) disputing TIBs is a dispute of benefit entitlement and is not a dispute of compensability. In filing a dispute of benefits entitlement, carrier retains the right to contest compensability and liability of the claim within the 60-day period by filing a PLN-11.

REQUIRED MEDICAL EXAM

[062535-S](#) – Filed February 9, 2007

An agreement for an RME appointment that carrier is not entitled to does not have the effect of an order and carrier's failure, therefore, to comply with the rule regarding the selection of an RME precludes carrier from taking action with respect to benefits based upon the report of the doctor.

ATTORNEYS FEES

[011478-S](#) – Filed August 13, 2001

Attorney's fees may only be awarded for services performed after carrier disputes the SIBs quarter in question.

[030641-S](#) – Filed March 27, 2003

If claimant seeks SIBs for a particular quarter and carrier disputes claimant's entitlement to that quarter and claimant prevails at a CCH, claimant's attorney's fees are not deducted from claimant's recovery. In those cases, carrier is liable for payment of SIBs for that quarter and for attorney's fees necessary to dispute the denial for that quarter.

[061040-S](#) – Filed June 19, 2006

An issue of contribution, even when it has an effect on SIBs, is not an issue that gives rise to carrier's liability for attorney fees separate from claimant's benefits. A request for an order on contribution is not a dispute of a commissioner's determination of SIBs.

SUBCLAIMANT

[052857-S](#) – Filed February 8, 2006

A carrier that pays benefits during a time that another carrier was liable has standing as a subclaimant to pursue reimbursement.

[070647-S](#) – Filed July 18, 2007

A healthcare provider subclaimant is entitled to receive notice of a contested case hearing as well as a "10-day letter."

[080576-S](#) – Filed July 2, 2008

Where the date of injury is prior to September 1, 2007, and where subclaimant was not provided with information regarding the workers' compensation claim until after January 1, 2007, subclaimant has no standing under [Tex. Lab. Code 409.0091](#) to pursue a workers' compensation claim. Further, [409.0091](#) does not apply where carrier denies compensability of the injury or where the Division has determined that claimant does not have a compensable injury.

[081065-S](#) – Filed September 22, 2008

A healthcare insurer has standing pursuant to [Tex. Lab. Code 409.009](#) to seek adjudication of a dispute when a carrier has denied compensability and claimant has declined to pursue the claim. However, a collection agency paid only on a contingency basis for the healthcare provider does not have standing pursuant to [409.009](#) because has not provided compensation, directly or indirectly, to claimant. Where claimant is barred from receiving benefits, the subclaimant is barred as well.

SUBROGATION

[032973-S](#) – Filed December 29, 2003

Carrier is not entitled to subrogation where the UM policy was paid for by the injured worker: (1) there were no amounts paid to the injured worker "by a third party"; (2) there are no "damages" involved because the term damages means those recovered from a third party who is liable to the injured worker because the third party breached a contract or committed a tortious act against the injured employee; and (3) neither law nor equity is satisfied where the public policy against double recoveries trumps the public policy favoring giving people what they paid for when they have been prudent and have paid out of their own pocket for an insurance policy to protect themselves.

CAUSATION/EXPERT EVIDENCE

[100539](#) – Filed June 23, 2010

At issue is whether the compensable injury extended to the diagnoses of an L4-5 herniated disc, incomplete cauda equina syndrome with fecal and urinary incontinence and bilateral radiculopathy. It was the hearing officer's determination the extent of injury extends to a diagnoses of an L4-5 herniated disc and bilateral radiculopathy was supported by the evidence.

In regards to the cauda equina, there was a radiology report of an MRI that notes the cauda equina appears normal. There was conflicting evidence in the records regarding whether the claimant actually suffered from incomplete cauda equina syndrome with fecal and urinary incontinence. As there was no medical evidence to establish that the claimant's fall at work caused the incomplete cauda equina syndrome with fecal and urinary incontinence, that portion of the hearing officer's determination was found to be so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust.

[100752](#) – Filed August 19, 2010

The extent of injury question was whether the compensable injury extends to include cervical spine disc herniations at C3-4, C4-5, and C5-6; cervical radiculopathy; lumbar spine disc herniation and spondylolisthesis at L5-S1 with cauda equina syndrome; bulging disc at L2-3 and L4-5; and bowel dysfunction. Claimant was injured when she slipped and fell injuring her neck and lower back at work. As cited by the Appeals Panel Decision in [100539](#) and the court case of *City of Laredo v. Garza*, 293 S.W.3d 625 (Tex. App.—San Antonio 2009, no pet.), proof of causation must be established to a reasonable medical probability by expert evidence where the subject is so complex that a fact finder lacks the ability from common knowledge to find a causal connection.

In evidence was a letter from claimant's treating doctor dated April 17, 2010 where he states he evaluated claimant after the compensable injury. Dr. E. states that the claimant "states that she had no previous problems prior to the on the job injury and this is the only basis for my diagnosis as far as etiology or cause." Dr. E.'s letter does not establish within reasonable medical probability that the claimant's compensable injury extends to the disputed diagnoses/conditions. Review of the records shows that there were no expert medical evidence presented to establish that the claimant's slip and fall at work caused the disputed extent of injury conditions. Accordingly, the hearing officer's determination on extent of injury was reversed.

[100786-s](#) – Filed August 3, 2010

At issue is whether claimant's compensable injury extends to include right carpal tunnel syndrome. It was undisputed claimant injured his right hand when a coworker ran a 12 inch drill bit through his hand while they were drilling and the drill bit went all the way through the right hand, causing a penetrating injury. Subsequently, claimant began having problems of pain and numbness in his right upper extremity in September of 2009. It was the Appeals Panel's finding that the hearing officer's conclusion a puncture wound through the hand would cause carpal tunnel syndrome is a matter beyond common knowledge or experience and unlike repetitive trauma in this specific and unusual situation would require expert medical evidence. See *Guevara v. Ferrer*, 247 S.W.3d. 662 (Tex. 2007). Although an EMG performed indicated

CAUSATION/EXPERT TESTIMONY

[100895](#) – Filed August 23, 2010

Claimant's initial injury was to his right arm and shoulder when he was loosening fittings with a wrench at work on the date of injury. He eventually had right shoulder surgery and rotator cuff repair. Claimant testified that when he awoke from the surgery, he had numbness and tingling in his left leg. An MRI performed showed a 5 mm disc protrusion and posterior annular tear at the L5-S1 level and disc bulges at several other levels. Claimant alleges the L5-S1 disc protrusion/herniation occurred or was aggravated during the surgery for the compensable right shoulder injury.

Dr. B. was appointed as the designated doctor to determine the extent of the compensable injury. Dr. B. wrote that the back and left leg possible radiculopathy "certainly should be considered part of the compensable injury." No explanation was provided regarding this conclusion. In responding to a letter of clarification, Dr. B. commented that while positioning during surgery would not cause an aggravation of a lumbar condition in most cases but does not completely rule out the plausibility or probability of that happening does not meet the required standard of proof of causation within a reasonable medical probability required by *Guevara* and *Laredo*.

[100934](#) – Filed September 13, 2010

One of the issues to be resolved was whether the injury extended to include lung problems. Claimant testified that he was working at a car dealership and showing a Ram 1500 truck to a couple when one of the couples' children opened the door to the vehicle and a gust of wind caught the door and caused it to strike the claimant on his right side. He testified the strike was significant enough that he fell backward a few steps and experienced immediate pain on his right side. Initial medical treatment showed he might have a contusion or injured rib and he was prescribed pain killers. Claimant returned to work and a month later went to the emergency room for severe pain on his right side. The CT of the chest revealed hypo-inflation with a moderate right pleural effusion and adjacent opacity likely representing compression atelectasis; mild cardiomegaly; perihepatic ascites with an indeterminate low attenuation hepatic lesion; and status post cholecystectomy.

Claimant testified that a lung specialist at the emergency room told him the trauma at work had induced the pleural effusion. The hearing officer's decision claimant sustained a compensable injury was affirmed; however, the determination claimant sustained an injury to the right lung resulting in pneumonia is so complex that a fact finder lacks the ability from common knowledge to find a causal connection, and as such requires expert medical evidence to establish causation.

In this case, Dr. I., the Division appointed designated doctor, was asked to address causation. He stated that it was more likely than not that an injury resulted from the claimed incident. The Appeals Panel held that Dr. I.'s opinion does not constitute expert medical evidence within reasonable medical probability to establish that the injury caused an injury to the right lung resulting in pneumonia.

WAIVER OF RIGHT TO CONTEST COMPENSABILITY

[101227](#) – Filed November 5, 2010

In this case, the Decedent died from multiple gunshot wounds. The main issue was whether the self-insured waived its right to contest compensability of the claimed injury on or before the sixtieth day after the date on which the self-insured was notified of the injury. The AP indicated that section [409.021\(f\)\(2\)](#) provides that a political subdivision that self-insures receives notice on the date the intergovernmental risk pool or other entity responsible for administering the claim for the political subdivision receives notice. Section [504.002\(d\)](#) provides that “written notice” to a political subdivision occurs only on written notice to the intergovernmental risk pool or other entity responsible for administering their claim.

In this case, the hearing officer failed to make a finding as to the date the intergovernmental risk pool or other entity responsible for administering the claim received “written notice” of the injury. The hearing officer based his determination on the receipt of the first written notice of the self-insured on various dated documents indicating the Decedent was an employee at the time of the incident and was involved in a shooting; however, there was no indication that the intergovernmental risk pool or other entity responsible for administering the claim for the self-insured received those documents on that date.

The AP noted that the only evidence of when the intergovernmental risk pool or other entity responsible for administering the claim for the self-insured received first written notice were the interrogatories and PLN-1 indicating that the entity responsible for administering the claim received written notice on January 29, 2008. The AP reversed the hearing officer’s determination that the self-insured waived the right to contest compensability and rendered a new decision that the self-insured did not waive the right to contest compensability of the claimed injury.

EMPLOYEE’S CLAIM FOR COMPENSATION

[101342](#) – Filed November 15, 2010

This appeal discusses whether a carrier is relieved from liability under Texas Labor Code [§409.004](#) because of the claimant’s failure to timely file a claim for compensation within one year of the injury as required under section [§409.003](#). This decision discusses the requirements for timely filing a claim, the tolling statute, and carrier’s liability if a claimant fails to timely notify his employer.

Claimant filed an Employee’s Claim for Compensation (DWC-41) with the Division on February 14, 2007, and this was acknowledged by the Division in a letter to the claimant dated February 14, 2007. This is occupational disease claim and a lost time claim. On March 3, 2008, the Division sent a letter to the carrier stating that the Division had received notice of an injury to the claimant with an alleged date of injury, requesting that the carrier electronically submit its first report of injury to the Division. The employer filed its First Report of Injury or Illness on April 2, 2008.

NEWLY DISCOVERED EVIDENCE ON APPEAL

[101100](#) – Filed October 13, 2010

At issue was whether claimant was entitled to SIBs for the 12th quarter qualifying period. Claimant alleged she was entitled to SIBs due to a combination of active work search efforts documented by job applications and active participation in a vocational rehabilitation program conducted by the DARS. After the CCH, claimant was arrested for intended use of another person's credit card and possession of a fake state identification card. The carrier had received a call from a police department detective who informed the carrier that claimant had told the detective she possessed a fake state driver's license so that she could work in Texas undetected by the carrier and the Texas Department of Insurance, Division of Workers' Compensation and simultaneously receive workers' compensation benefits. It was the Appeals Panel's determination this is one of the few circumstances where the carrier has provided newly discovered evidence on appeal where remand as warranted based on that evidence.

NINETY-DAY RULE

[100316](#) – Filed May 7, 2010

The certification of MMI and IR by a referral doctor acting in place of a treating doctor was sent to claimant by verifiable means. In evidence was an envelope sent by the postal service, certified mail return receipt requested, showing it was mailed to claimant at his correct address. After three attempts to deliver the piece of mail, it was unclaimed by claimant and returned to sender. Claimant testified he did not receive the [DWC-69](#) and thus his MMI and IR has not become final. The Appeals Panel cited Decision [080745](#), decided July 25, 2008 as a similar case in which claimant was given written notice through verifiable means. Despite the fact he never actually received the [DWC-69](#).

[100636-s](#) – Filed July 16, 2010

At issue is whether the first certification of MMI and IR from Dr. L. on June 20, 2007, became final under section [408.123](#) and Rule [130.12](#). In evidence was a DWC-69 with a certification date of June 20, 2007, that reflects that Dr. L. examined the claimant on June 20, 2007 and he certified that the claimant reached MMI on that same date with a 5 percent impairment rating. The parties had previously stipulated that claimant's statutory date of MMI was June 5, 2007. Meaning, Dr. L.'s certification of MMI was after the statutory date of MMI and was prospective, according to the hearing officer. Thus, the hearing officer determined Dr. L.'s certification of MMI was invalid.

It was clarified by the Appeals Panel that a date of MMI becomes prospective if it is projected to occur at sometime after the certification of MMI is made. Although the MMI date certified by Dr. L. is after the date the parties stipulated to MMI, the MMI date of June 20, 2007 is not prospective because it is not projected to occur at some time after the certification of MMI was made on June 20, 2007. As such, the DWC-69 in evidence is the first valid certification of MMI. Claimant did not dispute Dr. L.'s certification of MMI within 90 days after receipt of notice by verifiable means and his certification became final pursuant to Texas Labor Code section [408.123](#) and Rule [130.12](#).

XVI. TEXAS SUPREME COURT DECISIONS

PRODUCING CAUSE

On August 27, 2010, the Supreme Court of Texas issued a major decision regarding workers' compensation claims in *Transcontinental Insurance Co. v. Crump*, 53 Tex. Sup. Ct. J. 1124, (August 27, 2010). In this case, the Supreme Court defined "producing cause" and reversed the judgment of the Court of Appeals. The injured worker died after experiencing complications from a knee injury, and the Division awarded death benefits on a finding that a work related injury was a producing cause of the injured worker's death. The Supreme Court ruled that it was reversible error to instruct the jury that "'producing cause' means an efficient, exciting, or contributing cause that, in a natural sequence, produces the death in question. There may be more than one producing cause." The Supreme Court indicated that this was an improper definition and indicated that the omission of "but-for" language rendered that definition legally incorrect. The Supreme Court stated that "producing cause" in workers' compensation cases is defined as a substantial factor in bringing about an injury or death, and without which the injury or death would not have occurred.