FOLIO

A PRIVILEGED ATTORNEY—CLIENT COMMUNICATION BY FLAHIVE, OGDEN & LATSON

DALLAS COURT SYNTHESIZES CAUSATION

Over the past several years, Texas courts have recognized the increasing importance of addressing causation in workers' compensation cases through the use of expert testimony. Generally, such causation evidence must be offered using competent medical evidence.

Recently, the Dallas Court of Appeals synthesized many of the most important rules in State Office of Risk Management v. Adkins, 347 S.W.3d 394 (Tex. App. – Dallas, 2011). The case involved the compensability of a back injury. Following a jury verdict in favor of the claimant, the Court of Appeals reversed the judgment and rendered judgment that the evidence was legally insufficient to support the judgment. In so doing, the court held:

> Essentially, Adkins merely provided his medical records and expected the jury to understand them. We cannot conclude that laypersons have the knowledge to understand the intricacies involved in diagnosing a back injury without some guidance from a medical expert. Accordingly, Adkins failed to provide more than a scintilla of evidence to support his claim of a compensable injury. Thus, the evidence is legally insufficient to support the jury's answer that Adkins suffered a compensable injury on August 11, 2006.

In This Issue…

DWC Reminder to Carrier …………………p. 4

Upcoming DWC Holidays …………………..p. 12

The Court of Appeals relied upon a number of recent decisions in reaching the decision, including *Guevara v. Ferrer*, *City of Laredo v. Garza*, and *LaRock v. Smith.*

The court clearly announced a number of legal principles, which are set out below:

- IRO decisions do not provide legally sufficient evidence of causation;
- A board certified orthopedic surgeon is not necessarily qualified to opine as to causation simply because of his board certification;
- Any opinion regarding causation must at least describe the mechanism of injury;
- An assertion that a work-related mechanism aggravated an employee's preexisting condition must generally be proved by expert evidence;
- Any opinion of causation must discuss *how* the injury is related;
- Evidence involving different nomenclature of spinal conditions such as disc bulges, herniations, protrusions, etc., must be explained by an expert;
- Expert testimony must be used to explain how a specific injury mechanism caused an HNP as opposed to causing the claimant to know that he had an HNP;
- If medical records are to be considered expert testimony, they must be evaluated applying the same principles used to evaluate the opinion of an expert; and

Flahive, Ogden & Latson, a 19 lawyer firm, defends contested workers' compensation cases statewide every day. The firm has represented insurance companies and employers before the Texas Workers' Compensation agency for more than 50 years. For general questions concerning the newsletter call: (512) 435-2234.

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FO&L OFFICE HOURS

Monday—Friday

8:15 a.m.—4:45 p.m.

If you need to call after 4:45 p.m. please call Patsy Shelton at (512) 435-2234. She will be on duty until 6:00 p.m. daily.

Don't wait until the last hour of the day for deadline filing. Any faxes with information due must be received by 3:30 p.m. for any deadline handling for same day delivery to the Division, and faxed according to the fax directory listed on the last page of FOLIO. Furthermore, if you have a last minute deadline, call our office by 3:00 p.m. and speak with Sally Matthews or Patsy Shelton to advise that a last minute filing is necessary to meet a deadline. We will be watching and waiting for the fax. Otherwise, last minute faxes could delay receipt. Our last daily run to the Division will be at 4:00 p.m., in order to get across town to meet their 5:00 p.m. closing time.

- An expert must offer more than simply an opinion that employs "magic words," like reasonable medical probability.

Carriers should review cases in litigation to assure that any testimony offered by their own experts meet these standards. Moreover, to the extent that an opposing party's expert evidence falls short of the rules set out in this case, steps should be taken to bring the failure to the attention of the trial court or the appellate court.

At the administrative level, the decision highlights the importance of the involvement of an expert witness who is familiar with the underlying facts of the claim, and who is qualified by experience, education and training in the area involved in the claim.

The Commissioner Adopts Changes to Pharmacy Rules 134.503 and 134.504

On September 30, 2011, the Commissioner of Workers' Compensation, Rod Bordelon, adopted amendments to Rules 134.503 and 134.504 of Title 28 of the Texas Administrative Code regarding Pharmacy Fee Guideline and Pharmaceutical Expenses incurred by injured employees. The adoption was published in the October 14, 2011 issue of the *Texas Register* and may be viewed on the Secretary of State website at http://www.sos.state.tx.us/texreg/index.shtml. A courtesy copy of the adopted rules may be viewed on the Texas Department of Insurance website at http://www.tdi.texas.gov/wc/rules/adopted/index.html.

The purpose of the amendments is to adopt a pharmacy fee guideline under section 408.028(f) of the Texas Labor Code. The adoption also implements new provisions found in section 408.0281 of the Texas Labor Code and other legislative amendments found in House Bill 528 (HB 528), enacted by the 82nd Legislature, Regular Session, that impact the reimbursement of pharmacy and pharmaceutical services provided in the Texas workers' compensation system. The require-

ments adopted under HB 528 became effective on June 17, 2011.

The adopted amendments found in Rule 134.503 establish the pharmacy fee guideline for prescription drugs and nonprescription drugs and/or over-the-counter medications that are dispensed for outpatient use. It does not apply to parenteral drugs. Parenteral drugs are defined as those that are administered in a manner other than through the digestive tract. Amended Rule 134.503 applies to claims subject to a certified workers' compensation healthcare network (network), claims not subject to a healthcare network, and claims handled under section 504.053(b)(2) of the Texas Labor Code (Employees of Political Subdivisions). Amended Rule 134.503 also allows the insurance carrier and health care provider to contract for amounts that are inconsistent with the pharmacy fee guideline as long as the contract complies with the provisions of section 408.0281 of the Texas Labor Code and the applicable Division rules.

The adopted amendments found in Rule 134.504 conform to the changes made in Rule 134.503. The adopted amendments to Rules 134.503 and 134.504 will apply to the reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications that are dispensed on or after October 23, 2011, the effective date of the amendments.

If there are any questions regarding the information in this memo, contact Elena Cablao at 512-804-4748, or lena.cablao@tdi.state.tx.us.

The Texas Department of Insurance, Division of Workers' Compensation (the Division) is accepting comment on informally proposed amendments to 28 Texas Administrative Code (TAC) §§127.1, 127.5, 127.10, 127.20, 127.25, 130.6, 180.23, the informally proposed repeal of §180.21, and informally proposed new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220.

The purpose of these informal draft rules is to implement the statutory changes made in House Bill 2605, enacted by the 82nd Legislature, Regular Session, effective September 1, 2011 that affect designated doctor scheduling, certification, and qualifications. Additionally, these informal draft rules seek to implement other changes necessary for the efficient administration of the designated doctor system and to clarify established Division policies not currently expressed in the rule.

The informal working draft was published on October 14, 2011 and may be viewed on the TDI website at http://www.tdi.texas.gov/wc/rules/drafts.html.

The comment period on the informal proposal closed on November 4, 2011 at 5 p.m. Central Standard Time. This informal working draft is not a formal rule proposal; accordingly, comments will not be treated as formal public comment for the purposes of the Texas Administrative Procedure Act. In addition to commenting on this informal proposal, there will be the opportunity to formally comment once the rules are proposed and published in the *Texas Register*. The Division anticipates formal publication of the rules in December 2011. The informal working draft may contain drafting notes and formatting which will be changed as necessary to comply with the *Texas Register* formatting. Comments may be submitted by e-mailing InformalRuleComments@tdi.state.tx.us or by mailing or delivering the comments to Maria Jimenez at:

> Texas Department of Insurance, Division of Workers' Compensation
>
> Workers' Compensation Counsel, MS-4D
>
> 7551 Metro Center Drive, Suite 100
>
> Austin, Texas 78744-1645

If there are any questions regarding the information in this memo, contact Nicholas Gonzalez at (512) 804-4277 or Nicholas.Gonzalez@tdi.state.tx.us.

Division of Workers' Compensation Victoria Office Closed on November 1, 2011

Division of Workers' Compensation Victoria Office Closed on November 1, 2011

Injured employees and other workers' compensation system participants in the Bee, Calhoun, Dewitt, Goliad, Gonzales, Jackson, Karnes, Lavaca, Refugio and Victoria counties will now receive customer service from the TDI-DWC Austin, Corpus Christi, Houston East and San Antonio field offices.

Injured employees should call:

TDI-DWC at 1-800-252-7031 or the Office of Injured Employee Counsel (OIEC) at 1-866-393-6432 for assistance with their workers' compensation claim. The OIEC is a state agency created by the Texas Legislature to represent the interests of injured employees in the workers' compensation system.

For information on where to send all correspondence and faxes, including official actions and forms, relating to claims managed by the Victoria Field Office, call 1-800-252-7031.

DWC Reminder to Carriers:

Insurance Carriers who submitted an incomplete DWC EDI-03 form or who have not yet submitted a DWC EDI-03 form must submit the form to the TDI-DWC by 5:00 P.M. on Friday, December 9, 2011.

Division Announces Health Care Provider PBO Results

Health care providers have significantly improved their scores in the Division's revamped performance based oversight review, according to results announced by the agency this week. The 2011 results featured far more high-tier performers than in the 2009 review, as well as far fewer poor-tier performers.

The review of health care providers this year focused on three different performance categories. The selected health care providers were assessed on the following measures:

DWC Form-073, Work Status Report, category
1. Completeness of the DWC Form-073, Work Status Report – *50% weight*
2. Timely release to return to work – *50% weight*

DWC Form-069, Report of Medical Evaluation category
1. Timely filing of the DWC-069, Report of Medical Evaluation – *100% weight*

Lumbar Spine Magnetic Resonance Imaging
1. Timeliness of MRIs – *0% weight*

The Lumbar Spine MRI category was given zero weight because the Division was unsure whether that evaluation category would be meaningful or measurable. The agency will review the 2011 results in this category to determine whether to incorporate the measurement methodology as a weighted category in 2013.

A breakdown of the 2011 provider results is found in the following table.

2011 Health Care Provider Tier Placements per Performance Category

Performance Categories	Number of Providers	High Tier Performers	Average Tier Performers	Poor Tier Performers
DWC Form-073, Work Status Report	100	49	34	17
DWC Form-069, Report of Medical Evaluation	99	87	10	2
Lumbar Spine Magnetic Resonance Imaging (MRI)	41	32	9	0

PBO results broken down by individual health care provider can be found at the following link: http://www.tdi.texas.gov/wc/pbo/pboresults.html.

The 2011 results represent a significant improvement in performance for health care providers over the measurement two years ago. Of the 274 health care providers reviewed in the 2009 PBO assessment process, 4 had scores placing them in the high performer tier, 51 were in the average performer tier, and 219 had scores placing them in the poor performer tier. In 2009, the Division evaluated the performance of health care providers by assessing their performance with timely filing the Report of Medical Evaluation Form,

DWC Form-069; timely filing of the Work Status Report, DWC Form-073; and completeness of the DWC Form-073.

The PBO process is unique to Texas. Beginning in 2005, the Texas legislature required the Division to establish a performance-based oversight system that included development of key regulatory goals for assessing insurance carriers and health care providers, tiering of insurance carriers and health care providers based upon performance, and development of regulatory incentives to promote compliance. The Division's regulatory resources will be focused more strategically on overall compliance issues and history affecting an insurance carrier or a health care provider, placing emphasis on participants with continuing compliance problems in the workers' compensation system.

The purpose of PBO is to:

- Encourage and reward excellence and continuous improvement
- Foster improved and timely communications
- Establish performance objectives, measurements, and expectations
- Focuse on results rather than prescriptive requirements

The Division is mandated to, at least biennially, assess the performance of insurance carriers and health care providers. Beginning in 2010, insurance carriers were designated to be assessed in even numbered years (2010, 2012, etc.) and health care providers are assessed in odd numbered years (2011, 2013, etc.).

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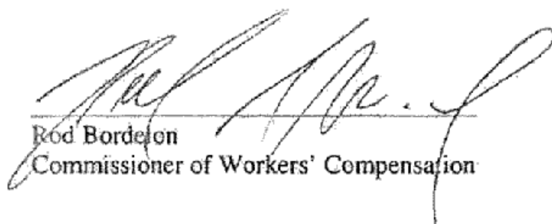
Adjusted Gross Annual Payroll Requirements Determined for Coverage of Seasonal Workers

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) has determined, pursuant to the authority and direction given under the Texas Workers' Compensation Act (Texas Labor Code, Section 406.162), the adjusted annual payroll requirement of an employer for the coverage of seasonal workers has increased from $49,962 to $51,061. This is an increase of 2.2% based on the inflation rate calculated by the Texas Comptroller of Public Accounts. This gross payroll amount will be used in year 2012 to apply against an agricultural employer's year 2011 gross payroll, and to determine whether a farm or ranch worker is covered by workers' compensation.

For more information about the adjusted gross annual payroll requirement for coverage of seasonal workers, contact Brent Hatch at brent.hatch@tdi.state.tx.us.

Issued in Austin, Texas on October 28, 2011.



Rod Bordelon
Commissioner of Workers' Compensation

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Memorandum

To: Workers' Compensation System Participants

From: Jeff Carothers, Director, Office of Workers' Compensation Counsel

Date: November 9, 2011

Subject: Adopted Amendments: 28 TAC §141.2 and §141.3 Regarding Canceling or Rescheduling a Benefit Review Conference and Failure to Attend a Benefit Review Conference and §143.2 Regarding Description of the Appeal Proceeding

On October 31, 2011, the Commissioner of Workers' Compensation Rod Bordelon, adopted amendments to 28 Texas Administrative Code (TAC) §141.2 and §141.3, regarding Canceling or Rescheduling a Benefit Review Conference and Failure to Attend a Benefit Review Conference, and §143.2, regarding Description of the Appeal Proceeding. These adoptions will publish in the November 18, 2011 issue of the *Texas Register* and may be viewed on the Secretary of State website at http://www.sos.state.tx.us/texreg/index.shtml once published. A courtesy copy of these adoptions may be viewed on the Texas Department of Insurance website at http://www.tdi.texas.gov/wc/rules/adopted/index.html. The amendments are effective November 20, 2011.

The purpose of the adopted amendments to 28 TAC §141.2 and §141.3 is to implement certain legislative changes made by House Bill 2605, 82nd Legislature, Regular Session, effective September 1, 2011 (HB 2605), that affect the rescheduling of benefit review conferences (BRCs). HB 2605 amended Texas Labor Code §410.028 to require the Commissioner of Workers' Compensation by rule to define "good cause" for rescheduling a BRC and establish deadlines for requesting that a BRC be rescheduled. The adopted amendments include provisions that define "good cause" for rescheduling a BRC both prior to the scheduled BRC and in situations where a party fails to attend the BRC. The adopted amendments also establish procedures for requesting to reschedule a BRC when a party has failed to attend the BRC. These new provisions and other amendments to these rules will apply to a request for a BRC that is filed on or after December 1, 2011. The provisions in previous 28 TAC §141.2 and §141.3 will continue to apply to a request for a BRC that is filed before December 1, 2011.

The DWC Form-045, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC),* has been revised to conform with the adopted amendments to 28 TAC §141.2 and §141.3 and is to be used for requests for a BRC filed with the TDI-DWC on or after December 1, 2011. The previous version of the DWC Form-045 will not be accepted after November 30, 2011. The revised form may be accessed and downloaded from the Texas Department of Insurance website at http://www.tdi.texas.gov/forms/form20.html.

The purpose of the adopted amendments to 28 TAC §143.2 is to implement certain legislative changes made by HB 2605 to Texas Labor Code §410.203 and §410.204. These legislative changes authorize the Texas Department of Insurance, Division of Workers' Compensation's (TDI-DWC) Appeals Panel to affirm the decision of the hearings officer in a case described by Texas Labor Code §410.204(a-1). Texas Labor Code §410.204(a-1) authorizes an Appeals Panel to issue a written decision affirming the decision of a hearings officer if the case is a case of first impression, involves a recent change in law, or involves errors at the contested case hearing that require correction, but do not affect the outcome of the hearing. These adopted amendments incorporate these new provisions into existing TDI-DWC rules affecting the Appeals Panel.

If there are any questions regarding the information in this memo, contact James Dodds at 512-804-4725, or james.dodds@tdi.state.tx.us.

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Memorandum

To: Workers' Compensation System Participants

From: Jeff Carothers, Director, Office of Workers' Compensation Counsel

Date: November 9, 2011

Subject: Form: Revised DWC Form-045, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC)*

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) has revised the DWC Form-045, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC)*, to conform with adopted amended 28 Texas Administrative Code (TAC) §141.2 and §141.3, regarding canceling or rescheduling a benefit review conference and failure to attend a benefit review conference. The revised form is available for downloaded from the Forms and Notices page on the TDI website at http://www.tdi.texas.gov/forms/form20.html.

The amendments to 28 TAC §141.2 and §141.3 were adopted by the Commissioner of Workers' Compensation Rod Bordelon on October 31, 2011. The revised DWC Form-045 is to be used beginning December 1, 2011. The previous DWC Form-045 will not be accepted after November 30, 2011.

The adoption order amending 28 TAC §141.2 and §141.3 was submitted to the Texas Secretary of State on October 31, 2011 and will be published in the November 18, 2011 issue of the *Texas Register.* It may be viewed on the Secretary of State website at http://www.sos.state.tx.us/texreg/index.shtml once published. A courtesy copy of this adoption may be viewed on the Adopted Rules page on the TDI website at http://www.tdi.texas.gov/wc/rules/adopted/index.html.

If there are any questions regarding the information in this memo, contact James Dodds at 512-804-4725, or James.Dodds@tdi.state.tx.us.

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Memorandum

To: Workers' Compensation System Participants

From: Jeff Carothers, Director, Office of Workers' Compensation Counsel

Date: November 8, 2011

Subject: Informal Working Draft: Rules Relating to Notice and Reporting Requirements for Subscribing and Non-Subscribing Employers; and Rules Relating to Notice of a Texas Labor Code §504.053(b)(2) Election by a Self-Insured Political Subdivision

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) is accepting comment on informally proposed rules to add new 28 Texas Administrative Code (TAC) §§110.7, 110.103, 110.105, and 160.1, and to amend 28 TAC §§110.1, 110.101, 160.2, and 160.3. This informal working draft relates to various notice and reporting requirements imposed upon subscribing and non-subscribing employers, and is primarily designed to update and clarify these notice and reporting requirements. This informal working draft also contains a new rule that would require a self-insured political subdivision to notify the TDI-DWC when the political subdivision elects to provide medical benefits in accordance with Texas Labor Code §504.053(b)(2).

The informal working draft was published on November 8, 2011 and may be viewed on the TDI website at http://www.tdi.texas.gov/wc/rules/drafts.html. The comment period on the informal proposal closes December 5, 2011 at 5:00 p.m. Central Standard Time.

This informal working draft is not a formal rule proposal. Accordingly, comments will not be treated as formal public comment for the purposes of the Texas Administrative Procedure Act. In addition to commenting on this informal proposal, there will be the opportunity to formally comment once the rules are proposed and published in the *Texas Register*. The TDI-DWC anticipates formal publication of the rules in January 2012. The informal working draft may contain drafting notes and formatting which will be changed as necessary to comply with the *Texas Register* formatting.

Comments may be submitted by e-mailing InformalRuleComments@tdi.state.tx.us or by mailing or delivering the comments to Maria Jimenez at:

> Texas Department of Insurance, Division of Workers' Compensation
> Workers' Compensation Counsel, MS-4D
> 7551 Metro Center Drive, Suite 100
> Austin, Texas 78744-1645

If there are any questions regarding the information in this memo, contact Jarren Wenderlein at (512) 804-4296 or Jarren.Wenderlein@tdi.state.tx.us.

Upcoming DWC Holidays

Thanksgiving Day	All agencies closed.	11-24-11	Thursday
Day after Thanksgiving	All agencies closed.	11-25-11	Friday
Christmas Eve Day		12-24-11	Saturday
Christmas Day		12-25-11	Sunday
Day after Christmas	All agencies closed.	12-26-11	Monday
New Year's Day		01-01-12	Sunday

Texas Division of Workers' Compensation Appeal No. 111095

Under Rule 142.7, it is abuse of discretion to add an issue over a party's objection when 1) it was not certified out of the BRC, and 2) there was no good cause was shown for the addition of this issue.

Facts: Claimant is alleging an occupational disease in the form of chemical sensitivity headaches, allergic reactions, and asthma as a result of exposure to carbon monoxide and/or mold. Self-insured disputed. The Benefit Review Officer's report included the occupation disease compensability issue, disability issue, and issue of timely filing with the Division as follows: Is the self-insured relieved from liability under §409.004 because of claimant's failure to timely file a claim for compensation with the Division within one year of the injury as required by §409.003?" The claimant's position was that the self-insured had waived the right to raise this defense because it was not raised in the denial of claim. The claimant did not file a response to the BRC report or otherwise request that "carrier waiver" be added as an issue. A CCH was held on compensability, disability, timely filing of a claim with the Division. After the CCH, the hearing officer decided to add the issue of whether the self-insured waived the defense of the claimant's failure to file a claim within one year of the injury by not timely stating this as a defense to paying benefits because the waiver issue was discussed at the CCH and because it should have been certified after the BRC. The hearing officer determined that: 1) claimant did not sustain a compensable injury in the form of an occupational disease; 2) claimant did not timely file a claim for compensation with the Division within one year of the injury as required by §409.003, but did have good cause for failing to timely file a claim; 3) the self-insured is not relieved from liability under §409.002 because of the claimant's failure to timely notify the employer pursuant to §409.001; 4) because claimant did not sustain a compensable injury, claimant had no disability; and 5) the self-insured waived the defense of the claimant's failure to file a claim within one year of the date of injury by not timely filing the grounds for refusing to pay benefits in accordance with §409.022. The claimant appealed the hearing officer's determinations on compensability and disability. The self-insured cross-appealed the determinations that the claimant had good cause for failing to file her claim for compensation within one year; that the self-insured was not relieved of liability under §409.002 because of the claimant's failure to timely notify the employer pursuant to §409.001; and that the hearing officer improperly added the issue of "whether the self-insured waived the defense of the claimant's failure to file a claim within one year of the injury by not timely stating this as a defense to paying benefits in accordance with §409.022"

Holding: Affirmed in part and reversed and rendered in part. The hearing officer's determinations that claimant did not sustain a compensable occupational disease injury, that the self-insured was not relieved of liability because of the claimant's failure to timely file a claim; that the claimant did not have disability; and that the self-insured was not relieved of liability because of the claimant's failure to timely notify the employer were supported by sufficient evidence and the Appeals Panel affirmed. The Appeals Panel however reversed and rendered on the issue of whether the self-insured waived the defense of the claimant's failure to file a claim within one year of the injury by not timely stating this defense. The Appeals Panel noted that the waiver (self-insured's waiver of the defense of failure to file a claim) issue was not litigated at the CCH and in fact was first brought up in the claimant's closing argument. The Appeals Panel commented that perhaps the issue of carrier waiver of the defense of claimant's failure to file a claim should have been certified at or after the BRC; however, the fact of the matter was that it was not requested to be added by either party and was not even mentioned at the CCH until the claimant's closing argument. The claimant did not request that the waiver issue be added for good cause nor did the hearing officer make a ruling on whether the waiver of the defense was to be added as an issue. The Appeals Panel noted that under Rule 142.7, disputes not expressly included in the benefit review offi-

cer's statement of disputes will not be considered by the hearing officer. The Appeals Panel noted that under Rule 142.7 (c), a party may submit a response to the disputes identified as unresolved in the BRC report. And, Rule 142.7(d) is a provision for adding disputes by unanimous consent. The Appeals Panel found that neither of these provisions applied to this case. Under Rule 142.7(e), a party may request the hearing officer to include in the statement of disputes one or more disputes not identified as unresolved in the benefit review officer's report. In this case, however, neither party requested the issue of carrier waiver of a defense to be added nor was there a determination of good cause by the hearing officer. The Appeals Panel therefore found that it was an abuse of discretion to add an issue of carrier waiver of a defense over the self-insured's objection because: 1) it was not certified out of the BRC, and 2) no good cause was shown for the addition of this issue. The hearing officer erred in the addition of an issue that had not been raised as an issue at the BRC nor reported by the benefit review officer in the BRC report. The Appeals Panel therefore reversed the hearing officer's determination that the self-insured waived the defense of the claimant's failure to file a claim within one year of the injury by not timely filing the grounds for refusing to pay benefits and rendered a new decision by striking this issue from the decision.

Texas Division of Workers' Compensation Appeal No. 111227

*Under §408.123(f)(1)(A), the failure to rate **the entire compensable injury** constitutes compelling medical evidence of a significant error by the certifying doctor in applying the appropriate AMA Guides or in calculating the IR.*

Facts: The claimant sustained a compensable injury while working as a cattle handler. Dr. S, a designated doctor appointed by the Division to determine MMI, IR and return to work, examined claimant in September 2010, and certified clinical MMI on the date of exam, with a 5% IR. Dr. S's diagnoses were 1) right hemothorax, resolved; 2) transverse process fracture, lumbar spine; 3) multiple contusions, resolved; and 4) fracture, right proximal phalanx, thumb. Dr. S rated a lumbar fracture concerning the posterior element without radiculopathy as DRE Lumbosacral Category II (5%). Dr. S found no impairment to the pulmonary, right thumb, intracranial, or pelvis. Claimant called a Division field office to dispute Dr. S's certification but the Division instructed claimant to contact his attorney. In December 2010, a CCH was held to determine the extent of the claimant's compensable injury, and it was determined that the compensable injury included a "thoracic spine injury." That decision was not appealed.

A CCH was held to address the finality of the first certification of MMI and IR. The hearing officer found that claimant did not dispute Dr. S's rating by requesting a BRC under Rule 141.1 within 90 days after the rating was provided to the claimant by verifiable means, and that the first certification of MMI and assigned IR from Dr. S became final under §408.123. The claimant appealed, contending that he timely disputed Dr. S's IR within the 90-day period and that one or more of the exceptions to finality in §408.123(f)(1) was applicable. The claimant also argued that Dr. S, in his certification of MMI and IR, does not mention and does not rate the thoracic spine injury as determined by the December 2010 CCH. The claimant also argued that he received improper or inadequate treatment of his injury before the date of the certification (September 3, 2010), because he had been unable to get medical treatment for his thoracic spine injury. The carrier responded, urging affirmance.

Holding: Reversed and a new decision rendered. The hearing officer found that the claimant did not dispute Dr. S's IR within 90 days after the rating was provided to the claimant by verifiable means. That finding is supported by the evidence. The Appeals Panel first rejected claimant's argument that he received improper or inadequate treatment for his

injury, noting that under §408.123(f)(1)(C), to apply the exception to finality, there must be compelling medical evidence of improper or inadequate treatment before the date of certification or assignment. The Appeals Panel found no compelling medical evidence that the claimant received improper or inadequate treatment for his injury before September 3, 2010, the date of Dr. S's certification of MMI/IR. As an exception to the 90-day finality of §408.123(e), under §408.123(f), an employee's first certification of MMI or assignment of IR may be disputed after the period described by §408.123(e), if there is 1) compelling medical evidence exists of: (A) a significant error by the certifying doctor in applying the appropriate AMA's guidelines or in calculating the IR; (B) clearly mistaken diagnosis or a previously undiagnosed medical condition; or (C) improper or inadequate treatment of the injury before the date of the certification or assignment that would render the certification or assignment invalid.

The Appeals Panel noted that under Rule 130.12(b)(1), only an insurance carrier, an injured employee, or an injured employee's attorney or representative under Rule 150.3(a) may dispute a first certification of MMI or assigned IR under Rule 141.1 (related to Requesting and Setting a BRC) or by requesting the appointment of a designated doctor, if one has not been appointed. In this case, the first valid certification was provided by Designated Doctor, Dr. S, so the only way to dispute the first valid certification of MMI and IR was to request a BRC under Rule 141.1. The Appeals Panel noted its prior decisions, APD 060170-s and APD 071283-s, which made clear that under §408.123(f)(1)(A), the failure to rate *the entire compensable injury* constitutes compelling medical evidence of a significant error by the certifying doctor in applying the appropriate AMA Guides or in calculating the IR. In this case, Dr. S did not rate the thoracic spine injury, did not mention a thoracic spine injury and his diagnosis did not include a thoracic spine injury. While Dr. S, in listing the records he reviewed, included thoracic spine x-rays, the inclusion of such does not amount to rating a thoracic spine injury. The Appeals Panel concluded that because Dr. S did not rate the thoracic spine injury, part of the compensable injury, the failure to do so is an exception to finality under §408.123(f)(1)(A). The Appeals Panel reversed the hearing officer's determination that the first certification of MMI and IR by Dr. S became final, and rendered a new decision that the first certification of MMI and IR by Dr. S did not become final under §408.123(f)(1)(A).

COURT OF APPEALS CASE SUMMARIES

***State Office of Risk Mgmt. v. Adkins*, 347 S.W.3d 394**

(Tex. App.—Dallas 2011, no pet.).

Court reverses and renders a jury finding regarding compensability because the medical evidence is insufficient to prove causation.

Facts: In July 2006, Adkins was involved in a violent altercation at his job as a corrections officer at TDCJ. He said he was not injured at that time. In August 2006, he turned his head to the right when he heard a commotion at work and felt a pop and pain in his neck. Diagnostic studies showed a suspected right paracentral lateral herniation at C5-6, and bilateral C-5-6-7 radiculopathy and bilateral entrapment across the elbows. Adkins filed a workers' compensation claim and the State Office of Risk Management (SORM) denied the injury, alleging that the herniated discs did not naturally flow from the August 2006 incident, and that Adkins had no disability.

Before this, in 2006, Adkins was injured in a work-related motor vehicle accident. He had a cervical MRI that showed bulging of several discs. That carrier accepted the diagnosed injuries of cervical sprain/strain and traumatic bilateral carpal tunnel syndrome. Adkins saw no doctors between December 2005 and March 2006. Thereafter, he saw the designated doctor who placed him at MMI for his cervical strain and lumbar strains.

A hearing officer agreed with SORM and found against Adkins, and the Appeals Panel let that decision stand. Adkins sued, and a jury then found that he had sustained a compensable injury on 8/11/2006 resulting in disability. SORM appealed that jury verdict, alleging that Adkins failed to provide expert testimony establishing an aggravation of a pre-existing condition.

Holding: Reversed and rendered. Adkins had the burden of proof at trial since he lost at the administrative level. The longstanding general rule is that "expert testimony is necessary to establish causation as to medical conditions outside the common knowledge and experience of jurors." However, there is an exception to this, as noted in *Guevara v. Ferrer,* 247 S.W.3d 662, where there is a sequence of events that logically traces a connection between the accident and the physical condition when the claimed conditions (1) are within the common knowledge and experience of laypersons, (2) did not exist before the accident, (3) appeared after and close in time to the accident, and (4) are within the common knowledge and experience of laypersons.

In this matter, the court determined that expert evidence was indeed necessary as laypersons do not have the knowledge to understand the intricacies involved in diagnosing a back injury without some guidance from a medical expert and because there is no strong, logically traceable connection between the event and the condition. A layperson cannot conclude that Adkins turning his head caused anything more than pain at that moment.

The court noted that Adkins basically "provided his medical records and expected the jury to understand them."

The court gave a thorough discussion of what actually constitutes the required expert evidence and made several points: First, the court noted that an IRO report (Adkins used this as evidence) is not evidence of causation, but merely a report on the reasonableness and necessity of medical treatment. It fails to establish whether the IRO doctor is qualified to render an opinion on causation (an expert must have "knowledge, skill, experience, training, or education regarding the specific issue before the court which would qualify the expert to give an opinion on that particular subject"). The mere fact

that the IRO doctor was board certified does not render him qualified without other information regarding education, background, experience, or training.

Second, an expert must use more than “magic words” in the report. The report must be based on reasonable medical probability instead of on possibility, speculation, or surmise. A statement that there was “an acute exacerbation of cervical radiculopathy” does not equate to causation evidence. The doctor must at least mention the compensable incident in his report.

Liberty Mutual Ins. Co. v. Adcock, No. 02-11-00059-CV, 2011 WL 5009821

(Tex. App.—Ft. Worth Oct. 20, 2011, no pet. h.)

Division of Workers’ Compensation has no jurisdiction to review a prior award of Lifetime Income Benefits under § 408.161 after the initial administrative and appellate remedies have been exhausted.

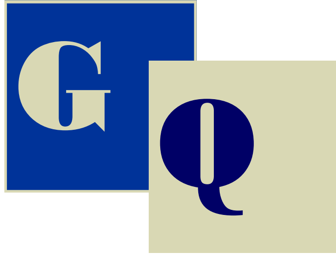
Facts: Adcock suffered a compensable injury and the DWC later determined that he was entitled to Lifetime Income Benefits (LIBs) due to the total and permanent functional loss of use of the right foot above the ankle and the right hand up to the wrist. The carrier did not appeal that finding.

Liberty Mutual later challenged ongoing entitlement to LIBs because it believed Adcock did have the use of the right foot and hand at that time. The issues at the administrative level were whether he was entitled to LIBs and whether the Division had jurisdiction over the issue of continuing entitlement to LIBs. The DWC found that Adcock remained entitled to LIBs and that the Division had jurisdiction over the issue.

Adcock appealed the issue of jurisdiction and the trial court issued summary judgment in his favor noting that the Division could not reopen the earlier LIBs case due to res judicata and collateral estoppel. Liberty Mutual appealed.

Holding: Affirmed. In construing the Texas Workers’ Compensation Act, the court noted that an administrative agency may only exercise the powers that the Legislature confers upon it in clear and express language. The court also noted that it must construe the Act’s provisions liberally in favor of the injured worker in order to effectuate the Act’s purpose, which is compensating injured workers and their dependents.

The Act does not give the Division any power to review the determination of entitlement to LIBs and the language that the LIBs are “paid until the death of the employee” shows the Legislature’s intent that LIBs are permanent. This is also shown by the fact that other benefits, such as TIBs, SIBs, and DIBs, can be reviewed under changes in circumstance, yet the LIBs provision is silent on this point.



CORNER

Q: A 22 year-old child beneficiary is receiving death benefits. She is attending nursing school. For the current semester, she works as an intern without pay but her class schedule is less than full time. The current semester is structured in this manner by the nursing school. Is there any basis to deny death benefits to the child beneficiary?

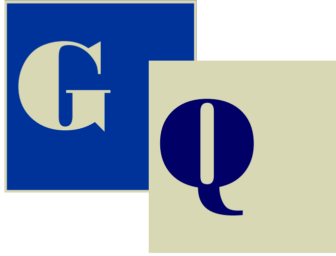
A: No. While the statement that "her class schedule is less than full time" may be correct (and it may not be), such is irrelevant if the beneficiary is otherwise a "full time student." Interning is a necessary element of a degree in nursing. Rule 132.8 provides that a child beneficiary who is entitled to receive death benefits as a full-time student is entitled to receive benefits until the earliest of (1) the date the child ceases, for the second consecutive semester (excluding summer semesters), to be enrolled as a full-time student; (2) the date the child turns 25; or (3) the date on which the child dies. Thus, whether she has a full time class schedule is irrelevant. She would currently qualify because the nursing school considers her a full-time student for the current semester. Assuming that she weren't, however, she still has not been a part-time student for two consecutive quarters.

Q: Prior to 9/1/11, the treating doctor stated that the injured worker could return to work with restrictions. The employer did not have any light duty jobs available. On 9/1/11, the treating doctor provided a full duty release for the injured worker. The injured worker did not return to work because he felt he was still unable to perform his pre-injury job duties and requested a designated doctor (DD) exam to address his ability to return to work. This DD exam took place on 10/15/11. The DD stated that the injured worker could return to work, but with restrictions, from 9/1/11 through 11/15/11. Does the carrier owe temporary income benefits (TIBs), and if so, for what period?

A: Yes, the carrier owes TIBs from 9/1/11 through 11/15/11. While there may be an argument that the DD's opinion about future disability status, 10/16 through 11/15/11, may be somewhat speculative depending upon the status of injured worker's compensable injury, the better practice is to pay benefits according to the DD's report. Section 408.0041(f) of the Texas Labor Codes provides that the carrier shall pay benefits based on the opinion of the DD during the pendency of the dispute. If the carrier wishes to challenge the DD's determination of disability, then the carrier should request administrative hearings to overturn the DD's report by a Commissioner's order. If it is able to do so, then section 408.0041(f-1) provides that the carrier may seek reimbursement for the overpayment of TIBs due to the DD's report from the subsequent injury fund.

Q: If the first written notice of injury is given to the third-party administrator (TPA), but not the carrier, has the carrier received notice of injury pursuant to section 409.021 (Initiation of Benefits; Insurance Carrier's Refusal; Administrative Violation) of the Texas Labor Code?

A: If the carrier has an agreement with a TPA to act on its behalf, then under the law of agency, the carrier has received notice of a work-related injury when the TPA receives this notice. In AP Decision No. 032932, the claimant argued that the carrier did not file a notice of refusal because the TPA filed it, not the carrier. The Appeals Panel did not give credence to this argument because the TPA was clearly acting with the authority given to it by the carrier.



CORNER

Q: The injured employee suffered a compensable low back injury in 2001. The carrier never filed a PLN-11 limiting the nature and the extent of the compensable low back injury. The injured employee stopped seeking medical treatment for his low back in 2006. Recently, the injured employee returned to his treating doctor for treatment to his low back. The treating doctor submitted medical bills to the carrier. In those medical records, a description was given that the injured employee's low back started hurting again about four months ago when he was playing with his grandchildren. Given the gap in medical treatment and the apparent subsequent and intervening event, can the carrier deny payment of these medical bills based upon the defense that the treatment was not provided for the compensable low back injury even though the carrier has not yet filed a PLN-11?

A: The carrier may not deny a medical bill on the basis of relatedness unless it has previously filed or simultaneously files a PLN-11. The fact that it has not previously filed one does not preclude denial of the bill if the carrier simultaneously files one with the Explanation of Benefits (EOB). The carrier will need to identify an extent of injury dispute in its EOB. See Rules 133.240 (e), 124.2(h), and 133.240(g).

Q: The injured worker was performing physical therapy for a compensable shoulder injury. The physical therapist lifted a bar above the injured worker's head in order to perform a particular shoulder exercise. The physical therapist dropped the bar onto the injured worker's head causing a laceration which required stitches. Is the carrier liable for the medical treatment for the head laceration?

A: Yes. When there is sufficient, credible evidence that medical treatment for the compensable injury causes a subsequent injury, then the subsequent injury becomes part of the original compensable injury and the carrier is liable for income and medical benefits related to the subsequent injury. See Appeals Panel Decision No. 032594, in which the Appeals Panel affirmed findings that the claimant's compensable injury extends to and includes strokes suffered following surgery for the compensable neck injury. There was sufficient evidence that the surgery for the compensable neck injury caused the claimant to suffer strokes, and therefore, the strokes became part of the compensable injury. See also AP Decision Nos. 93672 and 93855.

Q: The employee suffered a compensable injury but he has submitted all of his medical treatment, including surgery, under his group health insurance. The employee is off work due to the surgery. Is the carrier liable for the medical benefits even if pre-authorization was not obtained for the surgery? Does the carrier owe temporary income benefits (TIBs)?

A: The carrier is liable for TIBs if the employee is disabled from the compensable injury and has not reached maximum medical improvement. It is irrelevant whether the carrier pays for the treatment received. IF the compensable injury is a producing cause of the inability to obtain or retain employment at the pre-injury wage, then the employee is disabled. Additionally, the carrier could be liable for the medical benefits if the group health insurer files a request for reimbursement with the workers' compensation carrier. See Tex. Lab. Code §§ 409.009 or 409.0091. If the health care insurer files a claim for reimbursement under section 409.0091 of the Texas Labor Code, then the carrier may not raise as a defense against payment of the medical bill the failure to obtain pre-authorization. See Tex. Lab. Code § 409.0091(e)(2).

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