STATE BAR OF TEXAS

WORKERS COMPENSATION SECTION NEWSLETTER

JUNE 2008

VOLUME 1, ISSUE 2

LETTER FROM THE CHAIR

BY STUART COLBURN

The Workers' Compensation Section received tremendous responses to its first newsletter. We are delighted that you agree the Workers' Compensation newsletter enhances the practice of workers' compensation law and our profession.

Workers' compensation lawyers have a legal, ethical, and moral duty to represent the interests of their respective clients. We are all members of a legal profession which distinguishes the practice of law from other careers or business ventures. It is indeed the hope and goal of the Section to better the professional aspirations of all of our members through education and discussion of important issues germane to the practice of workers' compensation law. As members of the same profession, we have an ethical and professional responsibility to each other. Most of us have very strong professional relationships and, indeed, friendships with our legal adversaries. Such professionalism enhances the practice of workers' compensation law, our clients, and our own lives.

The professional ideal must co-exist with business realities. These are certainly challenging times to practice workers' compensation law. In September 2005, the first month HB-7 went into effect, the Division conducted 1,675 Benefit Review Conferences. In February 2008, the Division held 851. Such a reduction is illustrative of a trend that many believe permanently affects the practice of workers' compensation law. The reasons for this trend are beyond the scope of this article.

The Workers' Compensation Section has been extremely busy with several tasks to help its members and the profession. Clearly, this newsletter is the most public of our contributions to our members. The Section and its members expresses its deep gratitude to Kay Goggin for accepting the appointment of Newsletter Editor. The Section Council believes she has done an outstanding job of encouraging timely submission of articles by Section members (to quote Section Council and officer Joe Anderson, "It is something akin to herding cats or bottling smoke."). Under Kay's direction, the Section newsletter includes articles that are of benefit to both sides of the Bar. I would also like to express my appreciation to Pete Rogers and Matt Lewis, Bob Lang, Joe Anderson and others who have tirelessly worked on articles or reviews of case law which enhances the practice of workers' compensation law.

The Workers' Compensation Section is once again co-hosting the State Bar of Texas (SBOT) Advanced Workers' Compensation Seminar. The 2008 seminar is scheduled in Austin on August 21 and 22. The Workers' Compensation Section will hold its annual meeting on the evening of August 21, 2008 during a sponsored happy hour. We hope all of you will attend the 2008 Advanced Workers' Compensation Seminar and Section Annual Meeting.

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.The planning committee for the State Bar of Texas Advanced Workers' Compensation Seminar is constantly searching for new and innovative ways to present seminar material. In recent years, the planning committee assigned speakers from both sides of the Bar to the same topic encouraging a balanced approach and healthy debate. This year, the 2008 seminar enhances this format with a full pattern loosely modeled on current events. The pattern gives all speakers the opportunity to make their rhetorical points or craft mock arguments for their respective clients before the audience. Trey Gillespie single-handedly created the fact pattern and is deserving of our admiration and thanks. We are certainly excited that seminar attendees will enjoy the lively debate and take more useful information and tactics back to their individual practice.

We anticipate an exciting development with Lexis-Nexis within the next few months: they are creating a Texas workers compensation resource page and blog, which will be available free.

Please let us know what you like or do not like about the newsletter. We welcome and encourage newsletter article contributions. Feel free to contact me at 512-751-6017.

Workers' Compensation Commissioner Albert Betts Resigns

*June 3, 2008*AUSTIN –

Albert Betts, Commissioner of Workers' Compensation, Texas Department of Insurance, has announced his resignation effective August 31, 2008. Betts was appointed as the first commissioner of the Division of Workers' Compensation at the Texas Department of Insurance in 2005.

"In serving as Commissioner of Workers' Compensation over the last three years, and previously as the Chief of Staff for the Department of Insurance, Albert has proven his unwavering commitment to the citizens of Texas," said Governor Rick Perry. "I commend Albert for his service to the state, and wish him well in his future endeavors."

Commissioner Betts provided the following statement:

"We have accomplished much in the past three years in implementing the workers' compensation system reforms spelled out in the 2005 legislation. We have laid a solid foundation for the system going forward, including working to reform the agency itself to become an effective regulator and manager of the workers' compensation system in Texas.

"There is still work to be done, especially in the area of outreach and education to system stakeholders, but I am pleased with the progress made during my tenure as Commissioner.

"It remains critical that that injured workers get the service they need from their workers' compensation insurance carrier as well as the agency, and that efforts be continued to keep workers' compensation costs at a reasonable level for Texas employers. In addition, the commitment to resolving disputes in a timely manner, and to helping injured workers return to work as soon as possible must be maintained.

"With these continued efforts, and the agency talent and resources I have been privileged to lead for the past three years, I believe the future looks bright for the Texas workers' compensation system."

Texas Insurance Commissioner Mike Geeslin said "Commissioner Betts is a great leader, one who took on an assignment that involved merging two agencies while implementing major reform legislation. Few in the history of this state's government can lay claim to an accomplishment of this magnitude. Albert will be missed, and I wish him the best."

BITS and PIECES ABOUT DWC

A Little of This..A Little of That:

Trivia that Only Workers' Comp Geeks Would Notice

Of the hearing officers currently employed by the Texas Department of Insurance, Division of Workers' Compensation, the following were working as hearing officers for the Texas Workers' Compensation Commission in March of 1994. One of them, (Wagner) left employment for a while and then returned:

Nannette W. Amador (aka Nanette Webster)

Charles T. Cole

Cheryl E. Dean

Sandra Weber Fullerton

Craig L. Moffatt

Wes E. Peyton

G.W. Quick

Patrice R. Squirewell (aka Patrice Fleming)

Ellen Vannah

David L. Wagner

Sarah B. Wiegand

Who's Suing Whom?

JUDICIAL REVIEW

YEAR	TOTAL	CLAIMANT	INSURANCE CARRIER
2001	481	226	225
2002	518	223	295
2003	516	229	287
2004	505	212	293
2005	482	259	223
2006	415	180	235
2007	320	158	162

Do You Remember Where You Were in 2005 Through 2008?

THE NUMBER OF BENEFIT REVIEW CONFERENCES (BRC) HELD

THE NUMBER OF (CCH) HELD

SETEMBER 1, 2005—FEBRUARY 29, 2008

YEAR /MONTH	BRC	CCH
2005/09	1,675	569
2005/10	1,344	594
2005/11	1,356	558
2005/12	1,285	457
2006/01	1,450	635
2006/02	1,082	446
2006/03	1,465	639
2006/04	1,223	556
2006/05	1,309	615
2006/06	1,408	564
2006/07	1,129	453
2006/08	1,519	604
2006/09	1,303	547
2006/10	1,355	613
2006/11	1,296	526
2006/12	1,172	473
2007/01	1,258	558
2007/02	1,134	507
2007/03	1,155	529
2007/04	1,066	513
2007/05	1,203	542
2007/06	1,047	484
2007/07	1,044	482
2007/08	995	411
2007/09	995	441
2007/10	1,116	504
2007/11	1,004	419
2007/12	884	408
2008/01	1,023	535
2008/02	851	387

FEATURE ARTICLE

RECOUPMENT: Its Limitations & Procedural Pitfalls

By Matthew B. Lewis

One of the hot topics of dispute resolution before the Division of Workers' Compensation these days is recoupment. Recoupment is an attempt by an insurance carrier to recover overpaid benefits from a claimant by reducing the claimant's future benefits by a set percentage until all of the overpaid benefits have been recovered. For years, it was a matter of fairness, and the Division made decisions with respect to recoupment on the basis of equity. The carrier's ability to recoup overpaid benefits has been significantly reduced, and when it can, how much it may reduce benefits may not be based on anything to do with fairness or equity.

THAT'S NOT FAIR!

Recoupment is now governed by Rule 128.1(e). That rule went into effect on May 16, 2002. Claimants made no immediate rush to embrace the windfalls allowed under the rule, and it wasn't until nearly two years later that the rule began to be included with any prominence in the recoupment discussions of the Appeals Panel. This is in part due to the lack of cases that were brought up on the issue. Even since 2004, when the Appeals Panel issued a "significant" decision on the matter, claimants have not aggressively pursued the use of the rule to their benefit. That rule, and the decisions addressing its interpretation, are now becoming widely known, and cases involving recoupment are becoming more common.

Rule 128.1(e) significantly limits a carrier's ability to recoup overpaid benefits. It has been interpreted to limit recoupment only to those situations where the overpayment is the result of a miscalculation in or change of average weekly wage (APDs 033358-S and 060318). The general rule is that in order to recoup overpaid benefits, there must be a statutory provision that allows such recoupment. In APD 060318, the panel noted provisions such as Texas Labor Code §415.008 (concerning fraudulently obtaining benefits), §408.003 (concerning reimbursement of benefit payments made by an employer), and §410.209 (allows reimbursement from the subsequent injury fund for payments made under a Division order which is reversed or modified), as statutory provisions that could allow a recoupment of benefits. But these instances are rare.

The results of Rule 128.1(e) can be rather harsh and unfair, and may certainly be without any consideration of equity. The only "significant" decision on this matter is Appeals Panel Decision (APD) 033358-S. The overpayment in this case resulted from a change made to the average weekly wage when the carrier received the DWC-3 wage statement. It was not received until the claim had progressed halfway through the payment of impairment income benefits (IIBs) based on a fifteen percent impairment rating. The carrier then suspended IIBs to recoup its overpayment on the notion that based on the number of weeks temporary income benefits were owed (TIBs) and the number of weeks IIBs would be owed, and multiplying that number of weeks by the benefit rate due, the amount of benefits the claimant was entitled to receive had already been paid. The panel found that logic to be "nonsensical."

The argument that a claimant will be paid a certain amount of benefits based on the benefit rate and the number of weeks owed is highly logical. For instance, a claimant with a TIBs rate of $250.00 who misses ten weeks of work and has a five percent impairment rating should receive a total of $6,250.00 ($2,500.00 in TIBs + $3,750.00 in IIBs) in workers' compensation indemnity benefits. That makes sense and is easy to calculate. But what if a change in average weekly wage results in a benefit rate of $200.00 and ten weeks of IIBs have already been paid? This means that the carrier has paid a total of $5,000.00 under the prior rate, and the claimant should only receive a total of $5,000.00 in indemnity, and yet there are five weeks of IIBs left to pay. The panel determined that the claimant is legally entitled to the remaining weeks of IIBs, holding that, "the amount of recoupment is a factor in determining the amount of benefits that will be paid to a claimant rather than the amount of recoupment being determined by a predetermined amount of total benefits." This means that a claimant can receive more in indemnity benefits than the calculation of benefit rate times weeks owed would yield because the claimant is legally entitled to benefits for a certain time period based on the impairment rating.

"Recoupment is an attempt by an insurance carrier to recover overpaid benefits from a claimant by reducing the claimant's future benefits by a set percentage until all of the overpaid benefits have been recovered."

If the claimant has a five percent impairment rating, he is owed fifteen weeks of benefits from the date of maximum medical improvement. Any adjustment made to the benefits owed calculation that precludes an income benefit for that legally entitled period runs afoul of the first part of Rule 128.1(e).

RECOUPMENT: Its Limitations & Procedural Pitfalls

(Continued from page 4)

This does not mean that an adjustment is not made to allow the carrier to recoup an overpayment resulting from a change in average weekly wage from future benefits. Rule 128.1(e)(2) determines the amount of recoupment that will be allowed. If the claimant's benefits are being reduced to pay attorney fees or to recoup a Division approved advance of benefits, then the carrier is allowed to recoup the overpayment at a rate of ten percent. If the claimant's benefits are not being reduced to pay attorney fees or an advance, then the carrier is allowed to recoup at a rate of twenty-five percent.

In APD033358-S discussed above, the carrier determined that it had paid all of the benefits it owed pursuant to the calculation of benefit rate times weeks owed. It then suspended benefits to recoup the overpayment. In essence, it determined on its own to recoup at the rate of one hundred percent. The Appeals Panel determined that this was inconsistent with the rule. The rule only allows either a ten percent reduction in benefits or a twenty-five percent reduction in benefits, depending upon the circumstances. The rule does not allow a one hundred percent reduction in benefits. That panel ordered a ten percent reduction in benefits because the claimant's benefits were being reduced to pay attorney fees.

"The Appeals Panel has determined that in order for a carrier to recoup overpaid benefits, there must be a statutory provision allowing for that recoupment."

OR IS IT?

The problem with the result in APD 033358-S is that the carrier did not avail itself of the protections offered in Rule 128.1 (e)(2)(c). The last section of the rule is a return to equity analysis. It allows for recoupment at a rate greater than that allowed in Rule 128.1(e)(2)(A) or (B) if the carrier enters into a written agreement with the claimant, or if unable to do so, by asking the Division to approve a higher recoupment rate. The rule specifically states that the primary factor that the Division should use in determining the rate of recoupment is the likelihood that the entire overpayment will be recouped! It provides that "the rate should be set such that it is likely that the entire overpayment can be recouped." The rule further states that the Division is to also consider the cause of the overpayment and the financial hardship that may be created for the claimant. This is equity analysis.

The bottom line here is that if the overpayment is due to a change in the average weekly wage, that overpayment can be recouped at any rate that the carrier can get the Division to approve, but it must ask for a rate to be set by the Division rather than setting the rate itself. Failure to request a rate from the Division will result in the default recoupment rates of Rule 128.1(e)(2)(A) and (B).

There are procedural questions that remain unanswered by the rule and by the Appeals Panel. How does a carrier request a rate of recoupment greater than the default rates? A quick review of the Division's website shows that there is no form that can be filed for such a purpose. Does the timing of the request matter? Do the default rates control until the date the carrier requests a change in the recoupment rate from the Division similar to a contribution case? Who makes the decision at the Division as to the amount of recoupment allowed prior to a benefit review conference or contested case hearing? Does the carrier have to provide evidence that it sought an agreement from the claimant as a condition precedent to the Division approving a change in the recoupment rate?

There are no answers to these questions, which will surely be litigated in time. It appears that the carrier must attempt to reach an agreement with the claimant before requesting a change in recoupment rates from the Division. There must, then, be a request made to the Division to approve a recoupment rate based the equities of Rule 128.1(e)(2)(C). At that point, the carrier would be protected by the Rule and in any subsequent dispute resolution proceeding, it would be able to ask for a rate of recoupment greater than the default rates based on equity and fairness.

CONCLUSION

The carrier's ability to recoup an overpayment of indemnity benefits from future indemnity benefits has been limited to a large degree by Rule 128.1(e). The Appeals Panel has determined that in order for a carrier to recoup overpaid benefits, there must be a statutory provision allowing for that recoupment. Rule 128.1(e) only allows for recoupment when the overpayment results from a change in average weekly wage. When this occurs, the default recoupment rates are ten percent or twenty-five percent, depending on the circumstances. If the carrier wants to recoup the overpayment at a rate greater than the default rates, it must request that the claimant agree to a greater rate. If the claimant will not agree to a greater rate of recoupment, the carrier must request that the Division approve a greater rate based on the equities of Rule 128.1(e)(2)(C). If the carrier fails to make this request of the Division, then it will be limited to the default rates of Rule 128.1(e)(2)(A) and (B).

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APPEAL PANEL SUMMARIES

By Robert Lang and Stuart Colburn

Course and Scope

C suffered injuries due to a MVA while talking on a cell phone as she drove a school bus; E had a policy prohibiting the use of cell phones by bus drivers while driving the employer's buses; and E was aware of this policy. HO determined that C was not in the C&S of employment because C's use of a cell phone at the time of her injury violated the employer's policy. HO stated C's "conduct in using her cell phone while driving the bus is not viewed as merely violating a workplace rule governing simply the method by which she was to perform her work. For this reason, C's injury is not compensable …." The AP reversed and rendered a decision that the IE was in the course and scope of employment. In so doing, the AP stated that the employer's prohibition against using a cell phone while driving the bus was a safety policy in prescribing the manner in which the main job (driving the school bus) was to be performed, and was not a rule limiting the scope of employment. Therefore, the violation of the employer's policy in this case did not remove C from the C&S of her employment.

APD 080320-s

AWW IIBs School District Employee

C, a school district employee, sustained a compensable injury about a month and a half after her date of hire. C had been employed by several other employers during the year prior to her employment with the school district, and provided evidence of wages earned from the other employers during that time. The HO determined the AWW for IIBs based on a "fair and reasonable" method. The AP reversed and remanded the case for a determination of the AWW for IIBs based on the total wages the IE earned in the 12 months immediately preceding the date of injury (DOI), divided by 50 weeks, in accordance with 408.0446 (c) and 128.7(e). In doing so, the AP noted that the only provision for using a "fair and just" method is in Section 408.0446(d); it is allowed when it is impractical to determine that AWW because the employee did not earn wages during the 12 months immediately preceding the DOI. The AP pointed out that in this case the IE proved she earned wages during the 12 months preceding the injury. The AP also noted that Rule 128.7(e)(2) does not require that the "other employers" be non-claim employers and that the IE still be employed with them at the time of the injury.

APD 080268-s

Impairment Rating- Lumbosacral Radiculopathy

The designated doctor assigned the IE an 18% IR, 10% of which was for lumbosacral radiculopathy under DRE Lumbosacral Category III. The RME doctor assigned the IE a 7% IR, 5% of which was for the lumbar spine under DRE Lumbosacral Category II. The hearing officer determined that the IE's IR was 7%. The HO's determination of the injured employee's IR was based solely on the fact that the atrophy found was not greater than 2 centimeters but rather 2 centimeters exactly. In reversing and remanding the HO's determination, the AP noted that although the general directions control when a conflict exists between the general directions and the figures in the AMA Guides, in the instant case the general directions for rating lumbosacral radiculopathy specifically refer to the differentiator 3 in Table 71, which gives a further description of "Decreased circumference, atrophy." Differentiator 3 clarifies that for atrophy to be a significant sign of radiculopathy, for which the IE is entitled to receive a rating, the atrophy must be spine-injury related and the measurements show loss of girth of 2 centimeters or more above or below the ankle. The AP clarified that to receive a rating for radiculopathy, the IE must have significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of 2 centimeters or more above or below the knee, compared to measurements on the contralateral side at the same location, and the atrophy or loss of relevant reflexes must be spine-injury related.

APD 072220-s

Injury: hernia and impairment rating

The DD assigned C a 19% IR for an hernia surgically repaired. The 19% IR was based on Class 2 of Table 7: Classes of Hernia-related Impairment, page 10/247 of the AMA Guides. According to the AMA Guides, to be placed in Class 2, Table 7 there must be a palpable defect in supporting structures of abdominal wall and:

APPEAL PANEL SUMMARIES (CONTINUED FROM PAGE 6)

> frequent or persistent protrusion at the site of the defect with increased abdominal pressure; manually reducible; or
>
> frequent discomfort, precluding heavy lifting, but not hampering normal activity.

The DD did not specifically state that there was a palpable defect at the hernia sight. Instead in his report he stated:

> [t]here is pain on palpation but no persistent, irreducible or irreparable protrusion at the site of the one defect.

In response to a letter of clarification on this point he stated the hernias were repaired, but the problems were not solved, and listed some of the claimant's physical limitations. Dr. M then referenced the criteria listed in Table 7 of the AMA Guides, for Class 2 "frequent discomfort, precluding heaving lifting but not hampering normal activity."

In evidence was a report from a RME doctor who stated that on physical examination he could not palpate a hernia defect.

The AP affirmed the HO's decision that the medical evidence was contrary to the DD's 19% IR. The case was remanded to the HO because there was no other IR that could be adopted. On remand, the HO was instructed to send a letter of clarification to Dr. M, if he is still qualified and available, informing him:

> that to assess impairment for a hernia-related injury under Table 7 of the AMA Guides, there must be a palpable defect in the supporting structures of the abdominal wall, he is not limited to consideration of Table 7 in assessing the claimant's impairment, and
>
> the IR for the compensable injury must be based on the claimant's condition as of the stipulated date of MMI.

APD 072253-s

Commutation of Impairment Income Benefits

An injured employee (IE) legally qualified to commute impairment income benefits (IIBs) under Section 408.128 and Rule 147.10 will not be relieved of the effects of his or her election to commute IIBs based on a finding of mutual mistake regarding the extent of the compensable injury because there is no good cause exception to be relieved of the effects of the election to commute IIBs.

APD 080469-s.

Notice of Health Care Network Requirements

The threshold question in APD 080416-s was whether the injured employee (IE) received notification from the employer that health care services were being provided through a health care network (HCN) pursuant to Insurance Code Sections 1305.005 and 1305.103(c). The hearing officer (HO) made a finding of fact that the employer notified the IE on March 29, 2007, that it would be joining a HCN on March 31, 2007. The date of injury was November 30, 2006. The Appeals Panel (AP) held that whether the IE received the required notification from the employer is a matter to be decided by the HCN and Texas Department of Insurance (Department) as set out in Insurance Code Chapter 1305 and the implementing rules, particularly Insurance Code Section 1305.401 and Rule 10.122, and that the HO was not authorized to make a determination regarding whether the IE received this notification from the employer. The case was remanded to the HO for further development of the evidence to include a determination by the HCN and/or the Department regarding whether the IE received the proper notification that health care services are to be provided by the HCN and when that notice was provided to the IE.

APD 080416-s.

Waiver

The carrier received notice on September 18, 2006. An MRI was dated November 8, 2006 showing L5-S1 posterior protrusion of disc material and chronic disc degenerative changes at L5-S1 with posterolateral disc protrusion. Therefore, the Appeals Panel held, "The carrier could have reasonably discovered in its investigation that either a protrusion or herniated nucleus pulposus at L5-S1 equated to the same condition and was part of the claimed injury in the 60 day waiver period." The carrier waived its right to dispute the findings of an MRI that was taken on the 51st day and not received by the carrier within the first 60 days.

APD 072259

APPEAL PANEL SUMMARIES (CONTINUED FROM PAGE 7)

Maximum Medical Improvement

The Hearing Officer found an earlier date of maximum medical improvement because the claimant did not have any material recovery or lasting improvement. The Appeals Panel, quoting from APD No. 012284, helds, "It is of no moment that the treatment did not ultimately prove successful in providing material recovery or lasting improvement in the claimant's condition, where, as here, the recovery and improvement could reasonably be anticipated according to the designated doctor." The Appeals Panel will only look to whether or not treatment was provided with a reasonable medical probability that further material recovery is possible. Apparently, the Appeals Panel will not require actual improvement or recovery when determining MMI.

APD 072242

Waiver

Carrier received written notice on August 30, 1996. The Appeals Panel utilized '409.021 as found in 2003. The Appeals Panel found the carrier had seven days to take action and therefore the carrier waived its right to dispute compensability. The Appeals Panel then used its created "waiver period" to determine the extent of the injury that the carrier waived within the first 60 days. The Appeals Panel found, "The carrier could have reasonably discovered in its investigation the diagnosed acute exacerbation of degenerative arthritis/osteoarthritis was part of the claimed injury within the seven day waiver period."

APD 072129

90 Day Rule Finality

The first doctor diagnosed a left shoulder contusion. A December 15, 2006 MRI showed a full rotator cuff tear. The Hearing Officer found the claimant was told he had a tear of the left shoulder in July 2006 and should have disputed impairment at that time. The Appeals Panel "relied upon Appeals Panel No. 061493-S holding the exceptions in Section 408.123(f)(1)(a), (b) and (c) do not provide the exceptions only apply if knowledge of the facts giving rise to exception occurs after the 90 day period has expired." Therefore, the Appeals Panel found the first impairment did not become final because there was compelling medical evidence of a clearly mistaken diagnosis or previously undiagnosed medical condition.

APD 072090

Computation of Time

The Hearing Officer found the carrier waived its right to dispute the eleventh quarter of supplemental income benefits. The tenth day was a Sunday. The Hearing Officer should have extended the time period to the next working day. Hence, the Appeals Panel reversed the Hearing Officer's decision and found the carrier timely requested a Benefit Review Conference. It affirmed the Hearing Officer's decision that the claimant was entitled to supplemental income benefits.

APD 072028

Impairment Rating

The parties stipulated to a July 10, 2006 maximum medical improvement date. However, the designated doctor's first 34% impairment rating was based on an MMI date of July 17, 2006.

The Hearing Officer found the designated doctor's impairment rating was incorrect because he invalidated range of motion. The Appeals Panel writes, "We have long recognized that a designated doctor can invalidate range of motion based on observation." The Court cites Appeals Panel Decision No. 071283-S for discussion of the proper calculation of lower extremities and there may be instances in which elements from diagnostic and examination approaches can apply to a specific case.

Therefore, the Appeals Panel reversed the findings of the Hearing Officer and held the designated doctor's 7% impairment rating was valid and not overcome by the great weight of other medical evidence.

APD 072011

Impairment Rating

The designated doctor's report is dated June 21, 2006. However, the maximum medical improvement date of June 21, 2006, was marked out and a new date of maximum medical improvement of July 8, 2006 was substituted with the designated doctor's initials. The date of maximum medical improvement was prospective from the date of the report (there is no mention of when the doctor amended the DWC-69). Furthermore, the parties stipulated the MMI date was June 27, 2006. Therefore, the designated doctor's impairment rating is based on the wrong MMI date.

The treating doctor's 16% impairment rating was based upon a November 9, 2006 MMI date and not

APPEAL PANEL SUMMARIES (CONTINUED FROM PAGE 8)

the stipulated MMI date of June 27, 2006. The Appeals Panel remanded for further communication with the designated doctor.

APD 072003

Waiver

The carrier received notice of the claimed injury on May 18, 2007. On June 1, 2007, the carrier filed a PLN-11 disputing liability. On June 29, 2007, the carrier filed a second PLN disputing compensability of the claim. The Hearing Officer found waiver. The preamble to Rule 124.3 states a disputed benefit entitlement such as temporary income benefits is not a dispute of compensability/ liability. Thus, the carrier retains the right to contest compensability and liability within the 60 day time period, even though it has previously filed a dispute to benefit entitlement. Because the first PLN only disputed temporary income benefits, the carrier still had 60 days to file any compensability disputes.

APD 072002-S

Impairment Rating

The designated doctor found maximum medical improvement on September 14, 2006. However, in answers to Depositions on Written Questions, the designated doctor agreed to the May 22, 2007 date of maximum medical improvement. At the contested case hearing, the parties stipulated to the May 22, 2007 date of maximum medical improvement. However, the designated doctor did not examine the claimant after the first date of maximum medical improvement given, and therefore, the impairment rating was not based upon a physical examination certifying the May 22, 2007 date of maximum medical improvement.

The two treating doctor reports admitted in evidence were premised on the belief the claimant had a two-level spinal fusion. The claimant only had a one level spinal fusion. Thus, neither of the reports could be adopted. Therefore, the Appeals Panel reversed and ordered the Hearing Officer to contact the designated doctor and determine the claimant's impairment rating as of the stipulated May 22, 2007 date of maximum medical improvement.

APD 071988

Timely Filing A Claim for Compensation Form

The Appeals Panel affirmed the Hearing Officer's finding the decedent did not suffer a compensable injury resulting in his death. The decedent's beneficiaries filed a lawsuit against the employer on or about November 8, 2006, which was answered on or about December 21, 2006. The employer did not file a DWC-1 with the Division until February 12, 2007. The DWC-42 was filed on March 23, 2007. The Appeals Panel found the employer knew of the claimed death within one year of the date of injury and failed to file the DWC-1. Because the DWC-1 was not filed timely, the time frame for the claimant to file the claim for compensation form was tolled. Therefore, the Appeals Panel reversed the finding and held the claimant did timely file her claim for compensation form.

APD 071960

Issue Determination

The Hearing Officer simultaneously held a hearing on two separate claims. However, the Hearing Officer apparently failed to make a finding of fact or conclusion of law on one of the issues. The Appeals Panel could not determine if it was a clerical error or oversight. Therefore, the case was remanded to make further findings of fact and conclusions of law.

APD 071942

Waiver

The Appeals Panel affirmed the Hearing Officer's findings the carrier waived the right to dispute degenerative arthritis and degenerative joint disease of the left knee. However, the Appeals Panel reversed the Hearing Officer's finding the carrier waived chondromalacia, osteoarthritis, and traumatic arthritis. The Hearing Officer found these conditions were neither worsened nor accelerated by the compensable injury; however, the carrier waived all those conditions because they were alternately referred to as osteoarthritis, traumatic arthritis, degenerative arthritis, and degenerative joint disease. The Appeals Panel found these conditions were not included in the waiver issue before the Hearing Officer. They also were not litigated by the parties. Therefore, the Appeals Panel reversed the findings of fact and conclusions of law that the carrier waived these diagnoses. The Appeals Panel found the chondromalacia, osteoarthritis, and traumatic arthritis were not waived and were not related to the compensable injury.

APD 071925

APPEAL PANEL SUMMARIES (CONT'D FROM PAGE 9)

Waiver

The Appeals Panel affirmed the Hearing Officer's decision the carrier waived its right to contest thoracic disc protrusion/herniation at T2-3 and thoracic fibromyositis. The carrier did not dispute extent of injury within the first 60 days after the carrier received notice of the claim and these diagnoses were found in doctor reports authored within the Appeals Panel-created "waiver period."

APD 071919

Finality of Impairment Rating in SIBs Cases

The Hearing Officer found no party disputed the impairment rating prior to the end of the first quarter of supplemental income benefits, and therefore, under Rule 130.102(g), the 20% impairment rating became final. The Appeals Panel reversed the finding the first impairment rating was disputed timely by the claimant and the parties were never able to resolve their dispute by the end of the 1st quarter of SIBs. Therefore, the impairment rating could not become final pursuant to Rule 130.102(g). The designated doctor awarded 20% impairment rating based upon the range of motion model, presumably at the direction of the TWCC Advisories 2003-10 and 10b. The designated doctor did not use the range of motion model as a differentiator, but rather, improperly used the range of motion model to calculate the impairment rating. The case was remanded to find a proper impairment rating.

APD 071880

Proper Impairment Rating

The first designated doctor issued three reports, each of which was invalid (wrong MMI date, wrong AMA Guides, and using the range of motion model without explaining why the DRE model should not be used). He refused to provide any more clarifications.

The second designated doctor issued two reports, but neither included the MMI date stipulated to by the parties. Therefore, the Division adopted the carrier RME doctor's impairment rating of 10% because it rated all of the body parts and had the correct MMI date. The Hearing Officer felt the RME doctor improperly awarded an impairment rating for radiculopathy without loss of relevant reflexes or atrophy greater than 2 cm. The Appeals Panel believed the carrier RME doctor did find loss of relevant reflexes, and there was an EMG which suggested right L5 and SI nerve root radiculopathy.

APD 071872

The 90 Day Finality Provisions

The designated doctor certified a 0% impairment rating. He did not provide a diagnosis or impairment for the left knee. An MRI revealed new diagnoses, including probable tears of the medial and lateral meniscus. The carrier's RME doctor felt the left knee was related to the claimant's work injury. The claimant underwent a left knee arthroscopy with a partial medial meniscectomy and a patellofemoral chondroplasty. The Appeals Panel found compelling medical evidence of a clearly mistaken diagnosis or a previously undiagnosed medical condition.

APD 071822

Carrier Attorney Fees

The Hearing Officer denied five entries for duplicative service and/or multiple reasons. The Appeals Panel has previously stated "multiple reasons" is not a "sufficient explanation for denial of fees and that such notation is unacceptable and does not allow a meaningful review." The Appeals Panel approved these hours. However, there were additional hours the carrier's attorney requested to attend a proceeding on a date where the Division's records did not indicate a hearing was held. (The Hearing Officer approved the travel time and attendance time for a contested case hearing held two days before.) As such, the Appeals Panel upheld the Hearing Officer's Order denying these fees for different dates of service, albeit on different grounds.

APD 071788

Waiver

Within the sixty day "waiver period", the carrier filed a PLN disputing bilateral shoulder impingement syndromes, bilateral wrist sprains/strains, bilateral elbow sprains/strains, and nerve entrapment. The PLN did not include any specific language limiting the accepted injuries. After the PLN was filed but still within the "waiver period", the claimant had bilateral shoulder, elbow and wrist MRIs with various findings. The Appeals Panel held carrier waived its right to dispute all the diagnosis found on the MRIs. Further, the carrier waived shoulder impingement syndrome because there was no evidence as to whether or not the various findings on the shoulder MRI were an impingement syndrome. The carrier waived those diagnosis as well.

APPEAL PANEL SUMMARIES (CONT'D FROM PAGE 10)

Newly Discovered Evidence

The Division set a designated doctor examination on extent of injury and disability. Rule 126.7(I)(1) states both the treating doctor and insurance carrier shall provide the designated doctor copies of all employee's medical records in its possession. It is clear the designated doctor did not have the treating doctor's initial reports. In an addendum, the designated doctor indicated he did not have those reports and it would change his opinion. This report came in after the Contested Case Hearing and was attached to the appeal. The Appeals Panel held the claimant provided newly discovered evidence on appeal and a remand was warranted based upon that evidence.

APD 071721

Good Cause for Failure to Appear at a CCH

The claimant did not appear at the Contested Case Hearing. The claimant's attorney filed a response to the "ten day" letter. It appeared claimant died and therefore the Hearing Officer issued a decision in favor of the carrier on all issues. The Appeals Panel held the claimant, if alive, or his estate can proceed with the remaining issues pursuing all accrued income benefits.

APD 071706

Appeals Panel Serves Up One and Two Percent Solutions

THE PERCENT OF CASES IN WHICH THE APPEALS PANEL HAS REVERSED
THE RULING OF THE HEARING OFFICER BY CALENDAR YEAR

YEAR	CASESS REVERSED	CASES NOT REVERSED	CASES	PERCENT REVERSED
2000	122	2,812	3,007	4%
2001	51	2,966	3,063	2%
2002	47	3,259	3,346	1%
2003	49	3,294	3,370	1%
2004	38	3,219	3,287	1%
2005	45	2,877	2,952	2%
2006	40	2,671	2,750	1%
2007	42	2,325	2,398	2%
2008	2	314	322	1%

NOTE: The outcome Appeal proceedings is based on issues. If all issues result in reversing the Contested Cause Decision, the decision is reversed. If all issues result in any other outcome, the decision is not reversed.

FEATURE ARTICLE Entergy Gulf States, Inc. v. Summers

"The Road Goes on Forever, and the Party Never Ends!"

By Joe R. Anderson and Juliana C. Griggs

On August 31, 2007, the Texas Supreme Court delivered a controversial opinion in *Entergy Gulf States, Inc. v. Summers*. The Court held that a premises owner can, in certain circumstances, be a "general contractor" under the Texas Workers' Compensation Act (Act), and thus qualify for the exclusive remedy defense. Now, injured workers may be prevented from suing a premises owner for negligence.

The decision has been harshly criticized by labor groups as one that will allow negligent companies to escape liability for failing to maintain a safe workplace. Some state legislators contend that the decision incorrectly expands liability protection for employers under the Act. These reactions prompted announcements by the Texas Department of Insurance and the House and Senate committees that they will further evaluate the decision. On April 4, 2008, amidst the outcry, the Texas Supreme Court granted Summers' request for rehearing.

"If the Texas Supreme Court 's decision stands, opponents fear that companies will run dangerous workplaces because they no longer face the threat of costly litigation."

John Summers worked as a millwright turbine mechanic for International Maintenance Corporation (IMC), and was injured while repairing a hydrogen cooler on a generator located on Entergy Gulf States, Inc.'s (EGSI) premises. EGSI had previously agreed to provide workers' compensation coverage to IMC's employees performing work at the EGSI Sabine Plant, through an owner-provided insurance program pursuant to Tex. Lab. Code Ann. § 406.123(a). Summers filed a workers' compensation claim for his injury and received benefits under the EGSI coverage.

Summers then sued EGSI for negligence in district court, alleging that EGSI provided defective equipment, which proximately caused his work injury. EGSI filed for summary judgment, arguing immunity from the negligence suit because the workers' compensation benefits Summers' received were his exclusive remedy for his work injury under the Act. Summers contended that a premises owner could not also be a "general contractor" and escape tort liability for negligence.

EGSI contended that, although it owned the premises upon which Summers was injured, it qualified as a "general contractor" under 406.121, because it procured the maintenance and repair of turbines and generators through its own employees and the use of IMC. IMC would be a "subcontractor" under section 406.121, because it contracted with EGSI to perform all or part of the work that EGSI had undertaken to perform. As such, section 406.123 applies to EGSI, making EGSI an "employer" of Summers, and all of the IMC employees, for purposes of the Act. Summers' exclusive remedy for his work injury would then be the workers' compensation benefits he obtained. The trial court granted the motion, and dismissed the suit.

The Ninth Court of Appeals reversed, holding that EGSI did not establish it had undertaken to perform work or services and then subcontracted part of that work to IMC, as a general contractor would have done. EGSI appealed the Ninth Court of Appeals' judgment to the Texas Supreme Court, which held that the contract between EGSI and IMC made EGSI a "statutory employer" of Summers for workers' compensation purposes, so that Summers' only remedy was to obtain workers' compensation benefits.

The Court held that EGSI had established that it procured the performance of work by asking a subcontractor to supply workers to perform maintenance. As such, EGSI was a "general contractor" entitled to the exclusive remedy defense provided by the Act. The Court explained that the fact that EGSI also owned the premises where the accident occurred was immaterial.

Entergy Gulf States, Inc. v. Summers (CONTINUED FROM PAGE 6)

Summers requested a rehearing, which the Court recently granted. Briefing in this case may be obtained from the Texas Supreme Court website:

http://www.supreme.courts.state.tx.us/ebriefs/files/20050272.htm

The Senate Committee on State Affairs held an interim hearing on Monday, April 28th where it heard invited and public testimony relating to the Texas workers' compensation system, the continued implementation of HB 7, and to evaluate the impact of *Entergy*. The House and Senate committees are also scheduled to review the decision as part of their studies before the next scheduled session of the Legislature in January 2009.

If the Texas Supreme Court's decision stands, opponents fear that companies will run dangerous workplaces because they no longer face the threat of costly litigation. Injured contract employees would be limited solely to workers' compensation benefits without the ability to pursue legal action. Supporters of the Court's decision believe that prohibiting a premises owner from providing workers' compensation will negatively affect the use of OCIP, ROCIP and CCIP programs, which are integral in ensuring that all workers are covered by workers' compensation insurance in the event of a work injury.

The very nature of workers' compensation is to be the exclusive remedy for workplace injuries. Its purpose is to provide no-fault protection to employees, while also limiting the employer's liability. While not perfect, the system is designed to protect both parties—and, it will be interesting to see what the Court and Legislature decide.

"Supporters of the Court's decision believe that prohibiting a premises owner from providing workers' compensation will negatively affect the use of (programs), which are integral in ensuring that all workers are covered by workers' compensation insurance in the event of a work injury."

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Case Law Updates

McAteer v. Silverleaf Resorts, Inc. 514 F. 3d 411 (2008) (Jan. 15, 2008), a non-subscriber case alleging employer failed to maintain a safe working environment. Case was removed to federal court based upon ERISA preemption. The Fifth Circuit reversed the District Court's decision dismissing McAteer's claims against Silverleaf Resorts based upon an ERISA plan. The court explained that preemption is appropriate when the law or claim relates to an ERISA plan; not when the ERISA plan relates to a law or claim. McAteer could bring a state law negligence claim against Silverleaf even if she signed a waiver pursuant to her ERISA disability plan.

Fairfield Insurance Company v. Stephens Martin Paving, ___ S.W.3d ___ (Tex. 2008), 2008 WL 400397, 51 Tex. Sup. Ct. J. 491. (Feb. 15, 2008). On certified question from United States Court of Appeals for the Fifth Circuit. Held public policy does not prohibit coverage for exemplary damages under an employer's liability policy for the employer's gross negligence which caused the employee's death.

State Office of Risk Management v. Lawton ___ S.W.3d ___ (Tex. App. -- Waco, April 16, 2008) No. 10-07-00072-CV Appeal from a summary judgment where trial court affirmed DWC that carrier had waived its right to contest the compensability of an injury. Court of Appeals distinguishes *TIG Premier Insurance Co. v. Pemberton*, 127 S.W.3d 270 (Tex. App.—Waco 2003, pet. denied, on waiver of conditions discoverable within 60 days with an analysis of Tex. Labor Code §409.021

State Office of Risk Management v. Lankins, ___ S.W.3d ___ (Tex. App. – Waco, May 21, 2008) No. 10-00338-CV Reversed and remanded as expert testimony was required to establish depression be causally related to head injury.

2008 Cases of Interest
By Peter Rogers

Westlaw has reported three interesting cases in 2008 although two of them are not reported in S.W.3d.

The reported case is ***State Office of Risk Management (SORM) v Allen***, Court of Appeals Dallas, Texas, No. 05-07-00508 CV, March 18, 2008.

Allen was a corrections officer who allegedly injured his head, shoulder and low back. SORM accepted the head and shoulder injuries but disputes the low back. After SORM lost its dispute before TWC/DWC it filed suit in Dallas County and lost again before a jury.

The issues on appeal included whether the hearing officer's discussion and decision was admissible evidence in its entirety. SORM took the position that the hearing officer's summary of the evidence contained inadmissible hearsay. In deciding this issue against SORM, the court stated that the information contained in the hearing officer's summary of the evidence was properly in evidence in other parts of the record of trial.

Another issue in the case involved the question of whether Allen's back condition was merely a continuance of a chronic condition. With respect to this issue, the court noted Allen's own testimony and remarked that even if he had a preexisting condition affecting his lower back, the aggravation of a preexisting condition is a compensable injury.

The first of the unreported decisions is a memorandum opinion from the Fort Worth Court of Appeals entitled ***Baker v Cook Children's Physician Network***, No. 2-07-174-CV, February 28, 2008. The Baker case involves the exclusive remedy provision and points out that since mental trauma injuries caused by legitimate personnel actions are not covered by comp, suits for damages for those injuries are not barred by the Act. The case also makes it clear that the exclusive remedy provision does not bar suits for damages for intentional torts.

The second unreported case involved the intoxication defense and a Motion for Sanctions. In a memorandum opinion from the Court of Appeals for Houston's 1st District, entitled ***Texas Mutual Insurance v Havard***, No. 01-07-00268-CV, March 6, 2008, the court reviewed the evidence and found sufficient evidence to support the jury verdict in Havard's favor and determined there was no abuse of discretion by the trial judge in denying the TMIC Motion for Sanctions.

The intoxication issue was litigated using the recent change to the Act that requires a person who tests positive for drugs to prove he was not intoxicated. The court, however, found sufficient evidence to support the jury finding that Havard had successfully rebutted the presumption of intoxication. The case involved whether Havard was under the influence of cocaine and there is no standard for cocaine intoxication.

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PJC CLOSER TO REALITY

David Garcia, a claimant's attorney from Laredo, and Tim Singley, a carrier's attorney from San Antonio, co-chair for the Workers Compensation Section of the State Bar's pattern jury committee. Reporting on their progress at the January 18, 2008 and March 10, 2008 section board of directors meetings, Garcia noted that the PJC for workers' compensation law has not been up-dated since 1989 when the law changed and many lawyers ceased taking workers compensation case. "Today, judges and lawyers need guidance on how to prepare charges in workers' compensation case," Garcia explained. He and Singley, along with other volunteers, have been working on pattern jury charges for judicial review cases, starting from scratch but using the same format as the State Bar used in other charges. Their goal is to have the work legally correct which has been time consuming. At least fifteen chapters are complete. At the January board meeting, Sharon Sandle, Director of State Bar Books, said the State Bar has a major series of books on Pattern Jury Charges and that the oversight committee working on the charges suggested that workers' compensation should be incorporated into a volume with pattern jury charges in Malpractice Cases or in General Negligence and Intentional Personal Torts. The Council members agreed that the second book was the one most suitable to include workers' compensation.

Community News

Workers' Compensation attorneys in Texas make up a small community. We are interested in what is going on wit you, both personally and professionally. News to share with the rest of us? A change in job? A personal achievement? A tribute? E-mail newsletter notices to workerscomp@gogginlaw.com

Congratulations!

- Charles Morse has been named a shareholder in Downs Stanford
- Stuart Colburn has been appointed to an Advisory Committee with Lexis-Nexis

In Loving Memory...

With deepest sympathy, the workers' compensation bar offers condolences to Joe R. Anderson and his family on the death of his daughter, Madeline Jane Anderson. She was born in Austin on February 7, 1995 and died May 25, 2008 in an accident.

On the Move

Tommy W. Lueders II, formerly with Stone Loughlin & Swanson has formed the Law Office of Tommy Leuders.

His new contact information is:

2303 Ranch Rd., 620 S.
Suite 135 #168
Lakeway, Texas 78734
512-589-0235
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Peggy Campbell, formerly with the Thomas Barnes Law Firm, has formed Peggy M. Campbell, Esq., P.C.

Her new contact information is:

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Arianna Garcia, agarcia@jdavis-law.com, and Whitney Jones-Briscoe, wjones-briscoe@jdavislaw.com, are new associates with JA Davis and Associates.

Their contact information is:

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BRO Johnny Goodwin Retires

Johnny Goodwin

Long-time Benefit Review Officer in the Dallas Field Office, Johnny Goodwin, retired in March 2008. He can now be found fishing, riding, hunting, golfing and generally enjoying retirement at:

18502 CR 152, Brashear, TX 75240.

Telephone: 214-477-7218

L to R, Retired BRO Charlie Way , BRO Johnny Goodwin (Dallas Field Office), and BRO Marilyn McBee (Denton Field Office). Way and McBee and offer advice to retiring BRO Goodwin at his March 8, 2008 retirement party that was well attended by both sides of the bar and Division staff. (Picture by Kay Goggin)