APPEAL NO. 992828

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on November 9, 1999. The record closed on November 23, 1999. The issues at the CCH involved whether the respondent, who is the claimant, sustained injuries to his neck, low back, and wrists, in addition to a right shoulder injury on _____; whether he had disability as a result; whether the employer made a bona fide offer of employment to the claimant; and whether the appellant (carrier) waived the right to dispute compensability of the claimed injury by not contesting compensability within 60 days after being notified. Although not expressly stated as an issue, the waiver issue was actually litigated in terms of whether the carrier had newly discovered evidence as the basis for seeking to reopen the issue of compensability over the extent of the injuries, as the only Payment of Compensation or Notice of Refused/Disputed Claim (TWCC-21) that disputed the claim was not filed until 1999. The parties agreed at the beginning of the CCH to withdraw the bona fide job offer issue.

The hearing officer held that the carrier had waived the right to dispute compensability of the injury by not filing a TWCC-21 within 60 days after receiving written notice of injury. She found that the carrier received written notice of the claimed extent of the claimant's injuries not later than October 1, 1998, but failed to file a TWCC-21 until February 26, 1999. The hearing officer found that the carrier did not dispute the low back, that its TWCC-21 was insufficient to dispute the cervical injury, and that it expressly disputed only the claimed wrist injury, but the carrier did not base its dispute on any evidence which could not have been discovered by it earlier. The hearing officer found that the claimant sustained injuries to his neck, low back, and right wrist, in addition to his right shoulder, on _____, while at work. She held that he had disability from June 14, 1998, until the date of the CCH.

The carrier appeals. On the waiver issue, the carrier argues that the adjuster acted "immediately" to request certain information and that there is no sound basis for disputing certain aspects of the injury until two doctors stated their opinions that such conditions might be chronic or preexisting. The carrier also argues that the evidence does not support the connection of any injuries but the right shoulder to the incident in question. Finally, the carrier argues that there is no disability, in large part, because the claimant failed to follow up on his employer's offer of light duty. The carrier argues that results of the functional capacity evaluation (FCE) conducted by the treating doctor are not indicative of a person who is "disabled." The claimant responds that the adjuster failed to do a diligent or adequate investigation of the claim and that its belatedly filed TWCC-21 was not based on matters that could not have been discovered well before efforts at medical evidence development were made. The claimant further argues that the decision is supported as to injury and disability. Although there is no appeal of the hearing officer's determination that the carrier filed a TWCC-21 on February 26, 1999, the claimant asserts that there is no indication that any TWCC-21 was filed prior to April 22, 1999, and that earlier TWCC-21s are "suspect."

DECISION

We affirm the decision of the hearing officer.

The claimant was employed by (employer) to do routine maintenance work on vehicles which did not involve technical work, such as balancing tires, changing oil and filters, or cleaning up around the shop. He said that on _____, he was assisting with his first alignment and was underneath a car, sitting cross-legged, where he said it was hard to get "leverage." The claimant said that he was supposed to twist two bolts, while holding two wrenches, in opposite directions. Instead, he tightened the wrong way and therefore had to attempt to "break," or loosen, these bolts to correctly do the aligning. It was in the loosening process that he exerted pressure, felt tension, and suddenly felt an "electric shock" from his neck to his toes. The claimant said he reported this to his supervisor, who told him he would probably feel better in a couple of days after applying heat and soaking in the tub. He did not and in a week complained to the employer and was sent to its recommended clinic, (P Clinic). Thereafter, Dr. M became the claimant's treating doctor. He said that he was treated extensively with therapy and pain medication. The claimant was scheduled for right shoulder surgery in April 1999, but he literally left the gurney prior to his surgery, so it did not occur. The claimant said he was also referred to Dr. R on October 21, 1998, for his neck and back and has been denied recommended testing and treatment. The claimant was examined by a doctor for the carrier, Dr. P, at an October 26, 1998, required medical examination (RME).

The claimant agreed he had some prior injuries and surgery to his left wrist, but he was not claiming that the current accident had injured that wrist. A statement from the Texas Workers' Compensation Commission (Commission) shows claims for injuries as follows: 1979 (wrist); 1981 (multi); 1987 (knees); 1987 (left wrist); 1988 (knee); and 1991 (back). The 1987 and 1988 claims resulted in a compromise settlement agreement.

The claimant underwent an FCE for which a report was issued on September 18, 1998, showing he could do medium-level work with restrictions and unrestricted light-category work. The claimant said that although he had the desire to work, he doubted that he could at this point. He said that no one for the employer explained to him exactly what he was supposed to do when a written offer of light-duty work was made, but agreed that he had done no more than call and talk to the first person who answered the telephone, who did not know any of the specifics.

SUMMARY OF MEDICAL RECORDS

The sequence of the claimant's medical treatment is summarized here. We note that he recited to his doctors a history of the accident consistent with his testimony at the CCH.

- June 16, 1998: P Clinic. The claimant complains of right wrist, arm, shoulder, neck, and back pain. Diagnosed with cervical, wrist, and shoulder

sprain. Physical therapy [PT] scheduled. Diagnostic codes pertinent to these areas are included on the Initial Medical Report (TWCC-61) filed by P Clinic.

- June 18, 1998: P Clinic follow-up finds claimant no better. The employer is billed for these services.

- June 23, 1998: Dr. M examines claimant for the first time and diagnoses cervical and lumbar radiculopathy and sprain of right shoulder. Date-stamped July 17, 1998, by "Medcheck"; identified by the carrier's witness as performing medical oversight services for the carrier. Claimant taken off work. Claimant has regular visits with Dr. M and [PT] at his practice.

- July 14, 1998: Cervical CT scan. Finds moderate sized 3-4mm posterior central disc herniation which impinges upon the thecal sac. No resulting central spinal canal stenosis.

- Dr. M's notes of September 17 and 18, 1998, show that he faxed patient information to Dr. R to await pre-authorization. Dr. M then spoke with the adjuster, Ms. J, who denied the referral without *"clinical, so I faxed* (emphasis added)." Dr. M further notes talking with Ms. J who then authorized the referral.

- Claimant was undergoing work hardening therapy at this time through Dr. M's office.

- On October 12, 1998, Dr. M wrote to Ms. J and stated that the claimant was being treated for sprain/strain of his cervical musculature. Dr. M said that this resulted in spasm of neck and shoulder with pain radiating down the right arm. Dr. M recommended that a pain relief appliance that claimant used on a trial basis be purchased for his continued use. Ms. J was invited to contact his office if she had further questions.

- October 21, 1998: Consultation with Dr. R, whose report is copied to the carrier and to Dr. M. Previous knee surgeries noted. In addition to cervical CT and positive EMG, Dr. R noted that an MRI of the shoulder is consistent with possible partial tendon tear. He recommended further evaluation of low back pain and cervical radiculopathy with MRIs. He noted that before approving anything, carrier wanted an RME.

- October 26, 1998: Dr. P, on behalf of the carrier, examines the claimant and reports cervical and lumbar sprain with degenerative disc disease, right shoulder sprain and bilateral carpal tunnel syndrome (CTS) [based on EMG results]. Dr. P stated that a cervical MRI would be reasonable, and that claimant was not at MMI [maximum medical improvement] pending further cervical evaluation.

- November 10, 1998: Dr. M's notes reflect a visit by the medical case manager for the carrier, [Mr. A]. Other notes are not entirely legible as to what transpired.

- November 18, 1998: Dr. R reports that the cervical MRI was grainy, but showed bulge at C3-4 and spondylosis at C5-6 and C6-7. Dr. R noted low back pain on straight leg raising. A copy of this report was sent to the carrier.

- December 22, 1998: Nerve conduction studies report moderate to severe right CTS. No evidence of cervical radiculopathy.

- January 20, 1999: Dr. M notes in his Specific and Subsequent Medical Report [TWCC-64] that he has scheduled claimant for an orthopedic consultation with [Dr. L]. Dr. M continues to keep claimant off work [as he has throughout the course of his treatment].

- February 25, 1999: Right shoulder MRI shows a full tear in the supraspinatus tendon.

The claimant undertook evaluation of his shoulder by Dr. H, who scheduled surgery that was approved but canceled by the claimant at the last minute. He eventually had surgery in July 1999.

The Adjustor's Testimony & Related Evidence

The Employer's First Report of Injury or Illness (TWCC-1) filed by the employer is not in evidence. The adjuster, Ms. J, alluded to the fact that one may have been filed when she stated that the "claim" came in from the carrier's central office, where notification of some sort had been sent to them. She stated that the "claim" came in as a "medical only." Ms. J called the employer's corporate offices and was told that, although the claimant had "been off" a couple of days and had been to see P Clinic, there was no lost time as the claimant was "expected" to return to work.

Ms. J therefore said that this file was established as a "medical only" claim, the consequences of which are thus described:

> [W]hen it's a medical only claim, we do not make an attempt to contact the claimant. We make an attempt to contact the insured and then to contact [local employer outlet] themselves. I spoke to the supervisor at work and got basically the same story, a little bit different.

However, 10 days to two weeks later, Ms. J said she got a representation letter from the claimant's attorney and notice that he had been to P Clinic. A letter in evidence from the attorney was mailed certified mail and received by the carrier on July 9, 1998. The

letter requested a copy of medical reports, any TWCC-21s, and wage statements, and enclosed the claimant's Employee's Notice of Injury or Occupational Disease and Claim for Compensation (TWCC-41). The TWCC-41 claimed injuries to the right arm, right hand, shoulder, back, and body.

Ms. J said that she contacted the claimant's attorney soon after first hearing from her and asked to arrange for a recorded statement with her client. This was refused because the carrier was not paying benefits. Ms. J said that she responded that they did not have documentation to show he had been off work. Ms. J said that the first time the carrier received "documentation" that the claimant was actually off work was July 20th. (If this was in response to any contact of the employer by Ms. J, this was not brought out.) Off-work slips were sent to Ms. J by the claimant's attorney on August 4, 1998. On August 26, 1998, off-work slips from Dr. M, showing the working diagnoses, were also "faxed" to Ms. J. Similar faxes followed on September 2nd and 29th and October 6th, 14th, and 22nd. The parties stipulated at the CCH during Ms. J's testimony that all records from P Clinic were received by the carrier on August 1, 1998, when Ms. J was unable to recall exactly when she first received them.

Ms. J's explanation for her failure of recollection of specific dates was that she had in excess of 300 case files and it was impossible for her to recall specific dates without resorting to a case file log (which was not used or not available to refresh her recollection for much of her testimony). Ms. J said that she "automatically" (at some undetermined date) requested previous claims information from the Commission. She said that she received this on September 3 or 8, 1998. Although the carrier argued that Ms. J "immediately" requested a copy of the detailed lumbar claims file, the note on the TWCC claims history indicated that this was not requested until September 30th. Ms. J said that she got it 60 days later (which would be roughly November 30th or December 8th).

On October 1, 1998, Dr. T wrote to Ms. J, stating that he had reviewed records she provided, including the TWCC-1, the TWCC-41, Dr. M's records from June through August 1998, a CT scan report, x-rays, a nerve conduction studies report, and claimant's PT records from June through late August 1998. He noted that a lumbar x-ray showed osteophyte formation throughout that region. Dr. T reviewed the claimant's medical treatment and agreed what had been done was reasonable and necessary. He further found that the time off from claimant's work as an oil mechanic was warranted and that a return to work before further improvement could aggravate the neck, shoulder, wrist, and back pain.

Ms. J agreed that she also received Dr. P's RME report, detailing the various injured body parts, but pointed out that just because he listed these conditions in his report which approved the reasonableness and necessity of medical treatment didn't mean that these conditions were not preexisting. Ms. J said that there were two medical case reviewers who were working for the carrier to review the course of medical care. She said that one was Mr. A who, after he could not make contact with Dr. M and was allegedly unable to get answers or responses in December 1998, "basically quit working the file." Another medical

reviewer was not charged with the file until the end of February 1999. Ms. J stated that she herself, and through these two reviewers, made "several" contacts with Dr. M but that it had "from day one, been extremely hard" to get information from Dr. M. Notwithstanding the avowed difficulty, Ms. J agreed she had never actually written to Dr. M to inquire about the nature and extent of the injury.

Ms. J said that some time after receiving "the record check" (which one was not specified), she had a conference with her supervisor. (The importance of such a conference was alluded to by Ms. J later in her testimony when she maintained that she had no judgment to dispute a claim and such action could only be taken after supervisory consent was given.) She said that her supervisor suggested contacting Dr. R. Ms. J also indicated that an inquiry to Dr. R was prompted by her failure to get "any response" from Dr. M as to "what claimant's status was, his MMI . . . what we were going forward with, what we were not going forward with." In any case, Ms. J apparently ran up against another office procedural problem: “We have a two week gap in there--it's Christmas--that nothing really gets done."

Nothing got done to contact Dr. R until January 14, 1999, when Ms. J wrote to Dr. R to ask not about extent of injury but the necessity for further conservative care and the length and nature of same. She queried whether Dr. R was aware that the claimant had had another lumbar injury and MRI in 1992 and, as he had requested a lumbar MRI, "I am asking that you be sure to compare the prior 1992 films with the current films to be done as contribution will have to be addressed." Dr. R's February 3rd response was a letter in which he volunteered an observation that the claimant's CTS and cervical spondylosis were chronic in nature, taking a long time to develop. He said he had not yet performed a low back evaluation because it was not approved.

This response, characterized as "newly discovered evidence" by the carrier, apparently galvanized Ms. J. She acted to dispute the claim, albeit not until after the required conference with her supervisor. In fact, notes from the Commission's Dispute Resolution Information System contact log reflect that Ms. J was specifically asked if the carrier disputed anything about the injury up to that point and Ms. J said it did not. Ms. J explained that she had not at that point conferred with her supervisor.

The only page of her adjuster's log in evidence records a February 26th conference with the supervisor and indicated a plan to file a denial of cervical and CTS injuries. According to Ms. J, although she does not usually type and sends her work to a typing pool, she personally typed the TWCC-21, but did not sign or date it, and sent it to the Commission on February 26, 1999. Although her testimony on this point was confusing, Ms. J indicated that the typing pool shared a responsibility to file TWCC-21s by electronic means. However, Ms. J subsequently found out when she spoke with a Commission representative on April 22nd that neither TWCC-21 was received. She faxed another copy that day.

The TWCC-21 disputes the bilateral CTS and "bone spurs" based upon newly discovered evidence, cited as Dr. R's letter; the carrier asserts that these are preexisting conditions. The form goes on to state that the claimant could not possibly have developed these conditions over the two and one-half months he worked for the employer prior to his injury.

Ms. J also requested another peer review and on May 3, 1999, Dr. B responded by questioning the extent of medical treatment from Dr. M after his initial treatment and suggesting that the claimant could then return to limited work with restrictions.

Asked why she had not questioned in 1998 the areas of the body eventually disputed by the carrier, Ms. J described the carrier's investigative strategy: "[T]he specific way we handle the file is just to logistically believe it when it comes, to do--to do an investigation on the points that we believe need to be investigated."

The Waiver/Reopening of Compensability Issue

A carrier is given 60 days under Section 409.021(c) to contest compensability of a claim, or it waives this right.[1] The 60-day period runs from the carrier's earliest receipt of "written notice of injury," as defined in Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 124.1 (Rule 124.1). An employer's TWCC-1 is, by definition, written notice of injury. Rule 124.1(a)(1). The details of the injury are to be supplied through investigation of the claim upon receipt of this TWCC-1. In the absence of a TWCC-1, notice of injury is "any other notification regardless of source, which fairly informs the insurance carrier of the name of the injured employee, the approximate date of the injury, and facts showing compensability." We have stated before that the facts need to merely show, and not establish, compensability. Texas Workers' Compensation Commission Appeal No. 990822, decided June 3, 1999 (Unpublished); Texas Workers' Compensation Commission Appeal No. 951346, decided September 27, 1995; and Texas Workers' Compensation Commission Appeal No. 961618, decided October 3, 1996.

In this case, the hearing officer was faced with an array of documents, anyone of which could reasonably satisfy the requirements of Rule 124.1(a)(3), the TWCC-1 not being in evidence. Her determination that notice of injury was received by the carrier not later than October 1, 1998, is amply supported by the evidence. As the carrier did not file any dispute by 60 days after this date, or by November 30, 1998, it waived the right to dispute compensability.

The additionally argued issue in this case, whether the carrier could reopen compensability, is restricted by the 1989 Act. Sections 409.021(d) and 409.022(b) allow for

[1] We note that a recent case from the San Antonio Court of Civil Appeals, Downs v. Continental Casualty Company (No. 04-99-00111-CV, filed January 26, 2000) holds that waiver can occur if a carrier fails to pay benefits or file a TWCC-21 within seven days.

reopening compensability or expanding the grounds for dispute upon a finding of evidence that is newly discovered. Section 409.021(d) says:

> An insurance carrier may reopen the issue of the compensability of an injury if there is a finding of evidence that could not reasonably have been discovered earlier.

Section 409.022(b) says:

> The grounds for the refusal specified in the notice constitute the only basis for the insurance carrier's defense on the issue of compensability in a subsequent proceeding, unless the defense is based on newly discovered evidence that could not reasonably have been discovered at an earlier date.

Plainly, there are two components to being allowed to reopen compensability or present additional grounds: the information must not only be "newly discovered" but further proven to have been unavailable or unaccessible through the carrier's reasonable exercise of its duty to investigate the claim (in other words, not discoverable at an earlier time). Thus, while Dr. R's report was received on February 3, 1999, this is not the ending point of inquiry. The hearing officer was also required to analyze whether the critical information contained therein was information that could not have been reasonably discovered earlier by the carrier. While we cannot entirely agree that Dr. R's opinions are necessarily common knowledge, we concur in the assessment that his statements are something other than what could have been discovered in this case through the exercise of reasonable diligence.

We made clear in Texas Workers' Compensation Commission Appeal No. 93967, decided December 9, 1993, and cases that followed, including most recently Texas Workers' Compensation Commission Appeal No. 992526, decided December 30, 1999, that the carrier's duty to investigate is proactive and involves more than serving as a passive repository of records and filed information. Appeal No. 93967, *supra*, also discussed, at length, the basis for the legislatively-mandated 60-day investigation (or waiver) provisions of the 1989 Act. It made clear that the 60 days does not run from the receipt of information upon which the carrier determines to mount a defense of the claim, but runs from written notice of injury. In a sense, that decision is similar factually because the carrier's determination not to launch an investigation of the merits of the claim was also premised, as here, upon an initial categorization of the claim as "medical only." There is no lesser standard of investigation because a carrier believes (in this case, erroneously) that income benefits are not due.

Although we do not entirely agree that Dr. R has stated matters within common knowledge, his opinions state matters that with the exercise of reasonable diligence would have been apparent to the carrier well within 60 days from the date the hearing officer found written notice of injury was received by the carrier. The record reflects a nearly leisurely pace by the carrier in investigating the claim and following up on information

received (for example, the 22-day gap between receipt of past claims information and the request for the complete file on the lumbar injury). Frankly, the notes of Dr. M reflect that, at some points, contacts were made with carrier representatives who were also asked to contact him if they had questions. Dr. R was involved in the claimant's care within the 60-day period after the date the hearing officer found notice of injury was received and could have been contacted if there was, in fact, recalcitrance from the treating doctor.

Finally, we agree with the hearing officer that the TWCC-21 that was filed was insufficient to dispute the cervical or lumbar injuries. Disputing the compensability of "bone spurs" has essentially no obvious correlation to the claimed and treated cervical (herniated disc) and lumbar injuries. We affirm the decision of the hearing officer that the right of the carrier to contest compensability of aspects of this injury was waived and that the carrier failed to present grounds to either sufficiently dispute some of the injuries in this case, or that constituted newly discovered evidence that could not reasonably have been discovered earlier.

Issues of Injury and Disability

Although the waiver issue is dispositive of compensability, we affirm the hearing officer's determination that the scope of the claimant's injury included his neck, right wrist, and lower back. These regions were claimed as injured from the beginning; the hearing officer could believe that the mechanics of the injury resulted in strains and other harm that were treated. To the extent that there may have been preexisting physical infirmities, this would not preclude compensability. As we have stated many times, an aggravation of a preexisting condition is an injury in its own right. INA of Texas v. Howeth, 755 S.W.2d 534, 537 (Tex. App.-Houston [1st Dist.] 1988, no writ). A carrier that wishes to assert that a preexisting condition is the sole cause of an incapacity has the burden of proving this. Texas Employers Insurance Association v. Page, 553 S.W.2d 98, 100 (Tex. 1977); Texas Workers' Compensation Commission Appeal No. 92068, decided April 6, 1992.

It is axiomatic, in case law having to do with aggravation, that the employer accepts the employee as he is when he enters employment. Gill v. Transamerica Insurance Company, 417 S.W.2d 720, 723 (Tex. Civ. App.-Dallas 1967, no writ). An incident may indeed cause injury where there is preexisting infirmity where no injury might result in a sound employee, and a predisposing bodily infirmity will not preclude compensation. Sowell v. Travelers Insurance Company, 374 S.W.2d 412 (Tex. 1963). However, the compensable injury includes these enhanced effects and, unless a first condition is one for which compensation is payable under the 1989 Act, a subsequent carrier's liability is not reduced by reason of the prior condition. St. Paul Fire & Marine Insurance Company v. Murphree, 357 S.W.2d 744 (Tex. 1962). If the prior condition is compensable, the appropriate reduction for a prior compensable injury must be allowed through contribution determined in accordance with Section 408.084.

The decision of the hearing officer as to the scope of the injury originally sustained by the claimant is sufficiently supported by the evidence. While there is conflicting

evidence as to disability, the hearing officer, as sole judge of the weight and credibility of the evidence, was charged with sorting out the conflicts. We cannot agree that her determination on the period of disability is so against the great weight and preponderance of the evidence as to be manifestly unfair or unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

We affirm the decision and order of the hearing officer on all appealed points.

_____
Susan M. Kelley
Appeals Judge

CONCUR:

_____
Tommy W. Lueders
Appeals Judge

_____
Elaine M. Chaney
Appeals Judge