APPEAL NO. 110045
FILED MARCH 28, 2011

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 December 8, 2010, with the record closing on December 17, 2010.

The issues before the hearing officer were:

1. As a result of the decision and order of the CCH in (prior CCH), does the Texas Department of Insurance, Division of Workers' Compensation (Division) have jurisdiction to determine compensability of the conditions claimed in the extent-of-injury (EOI) issue below?

2. Has respondent 1/cross-appellant (claimant) reached maximum medical improvement (MMI), and if so, on what date?

3. If the claimant has reached MMI, what is the impairment rating (IR)?

4. Did the claimant have disability from January 13, 2009, through December 8, 2010, resulting from an injury of _____?

5. Does the compensable injury of _____, extend to and include:

   RIGHT KNEE: sprain/strain (RK#1); joint effusion with soft tissue swelling around the knee (RK#2); prominent bone bruising involving the proximal tibia (RK#3); posterior cruciate ligament tear/complete disruption of the anterior and posterior cruciate ligaments (RK#4); large tear of the lateral meniscus with displacement of meniscal fragment into intercondylar space (RK#5); end stage arthritis/degenerative arthritis/osteoarthritis (RK#6); severe crepitus (RK#7); edema in the prepatellar subcutaneous tissue (RK#8); internal derangement (RK#9); osteochondral defect of the medial femoral condyle and patella (RK#10); osteophytes superior aspect of patella (RK#11); tricompartmental osteophyte formation (RK#12); narrowing of the lateral joint space (RK#13); narrowing of the articular cartilage with spurring at the articular margins (RK#14); severe degenerative joint disease (RK#15); degenerative changes at the tibial-fibular joint with bony eburnation and sclerosis (RK#16); degenerative changes of the lateral femoral compartment (RK#17); subchondral erosions throughout the distal lateral femoral condyle and lateral tibial plateau suggestive of Grade IV chondromalacia as well as probable Grade IV chondromalacia of the patella femoral compartment (RK#18); subchondral sclerosis and subtle erosive changes involving the medial femoral compartment (RK#19); prominent subchondral erosive changes underneath the central and posterior tibial spine (RK#20); and a tiny 1-2

millimeter (mm) free bone fragment adjacent to the fulcrum of the patella resulting in a total knee replacement (RK#21);

LEFT SHOULDER: strain (LS#1); tendinopathy (LS#2); partial tear of the rotator cuff at the level of the supraspinatus tendon (LS#3); rotator cuff syndrome (LS#4); osteoarthritis (LS#5); full thickness tear of the distal fibers of the anterior supraspinatus rotator cuff measuring 8 mm x 8 mm (LS#6); acromioclavicular joint arthrosis (LS#7); abnormal AC joint with inferior spurring causing impingement on the rotator cuff at the level of the supraspinatus tendon (LS#8); subacromial/subdeltiod bursal effusion (LS#9); mild osteoarthritic changes (LS#10); bicep tendon longitudinal split tear resulting in a rotator cuff repair with a Biomet Metal Anchor & acromioplasty (LS#11); and distal clavicle resection (LS#12);

BILATERAL HIPS: right hip contusion (BH#1); and osteoarthritis of bilateral hips (BH#2);

LUMBAR SPINE: sprain/strain (L-Sp#1); multiple bone fragments at L3-4 facet and foramen (L-Sp#2); bilateral facet sclerosis and hypertrophy at L3-S1 (L-Sp#3); and huge osteophytes at L2-4 (L-Sp#4);

CERVICAL SPINE: sprain/strain (CS#1); degenerative disc disease (CS#2); osteoarthritis (CS#3); radiculitis (CS#4); severe spondylosis at C5-7 with narrowing of the disc space (CS#5); osteophyte formation (CS#6); loss of vertebral disc height (CS#7); C2-3 mild annular bulge (CS#8); C3-4 and C4-5 central 3 mm annular protrusion causing slight impingement of the cord with C4-5 slightly milder in severity (CS#9); C5-6 right paracentral 4 mm annular protrusion causing slight cord impingement and mild left foraminal stenosis (CS#10); C6-7 right paracentral 5 mm disc herniation with uncinate osteophytes that cause mild cord impingement and right sided foraminal stenosis (CS#11); mild but definite T2 hyperintensity in spinal cord at lower C6 level that likely represents mild myelomalacia as a result of cord impingement (CS#12); and C7-T1 mild central annular protrusion that causes slight indentation of spinal cord (CS#13);

THORACIC SPINE: injury to the thoracic spine (TS#1);

LEFT ARM: carpal tunnel syndrome (CTS) (LA#1); distal ulnar entrapment (LA#2); and radial sensory neuropathy (LA#3)?

The hearing officer determined that the Division does not have jurisdiction to determine the EOI conditions in dispute with the exception of some lumbar spine conditions (L-Sp#2-4) and the left arm conditions (LA#1-3); and alternatively, if the Division does have jurisdiction of all the claimed EOI conditions in dispute, none of the following EOI conditions are part of the compensable injury of _____ (RK#1-

21; LS#1-12; BH#1-2; L-Sp#1-4; CS#1-13; TS#1; and LA#1-3). Further, the hearing officer determined that the claimant reached MMI on June 22, 2009, with a one percent IR and that the claimant had disability from January 13, 2009, through December 8, 2010.

Appellant/cross-respondent (self-insured) appealed the hearing officer's IR determination, contending that the IR adopted included non-compensable body parts and arguing that the hearing officer erred in failing to admit Self-Insured Exhibits P and Q. The claimant filed a response to the self-insured's appeal within his cross-appeal.

The claimant cross-appealed the hearing officer's determinations on jurisdiction, EOI, MMI, IR, and the dates of disability. The self-insured responded, urging affirmance of the hearing officer's determinations cross-appealed by the claimant.

The appeal file does not contain a response from respondent 2 (subclaimant) to the self-insured's appeal or to the claimant's cross-appeal.

DECISION

Affirmed in part, reversed and remanded in part, and reversed and rendered in part.

FACTUAL BACKGROUND

The claimant testified that on _____, he slipped and fell on his right knee and left shoulder at work, injuring his right knee, low and mid back, neck, left arm, hip, and left shoulder.

It is undisputed that the first designated doctor appointed by the Division to determine MMI/IR and the claimant's ability to return to work was (Dr. M), who examined the claimant on November 18, 2008; the second designated doctor appointed to determine MMI/IR was (Dr. H), who examined the claimant on June 22, 2009; and the third designated doctor appointed to determine EOI was (Dr. L), who examined the claimant on September 18, 2009.

EVIDENTIARY RULING

After the CCH, but prior to the closing of the record, the self-insured offered into evidence Self-Insured's Exhibit P, a report dated December 11, 2010, from (Dr. Bk), peer review doctor, and Exhibit Q, documents regarding a former attorney of the claimant and dispute resolution and letter of clarification (LOC). The claimant objected to the admission of Self-Insured's Exhibits P and Q into evidence and the hearing officer did not admit the exhibits into evidence.

To obtain reversal of a decision based upon error in the admission or exclusion of evidence, it must be shown that the evidentiary ruling was in fact error, and that the

error was reasonably calculated to cause, and probably did cause the rendition of an improper decision. *See* Appeals Panel Decision (APD) 051705, decided September 1, 2005. Even if the exclusion of these documents could be considered error under the facts of this case, any error was harmless, because the hearing officer did not render a decision based on these documents, and it does not amount to reversible error.

DISABILITY

The hearing officer's determination that the claimant had disability from January 13, 2009, through December 8, 2010, is supported by sufficient evidence and is affirmed.

RES JUDICATA

The doctrine of *res judicata* "prevents the re-litigation of a claim or cause of action that has been finally adjudicated as well as related matters that, with the use of due diligence, should have been litigated in the prior suit." Barr v. Resolution Trust Corporation, ex rel. Sunbelt Federal Savings, 837 S.W.2d 627, 628 (Tex. 1992). *See also* City of Seabrook v. Port of Houston Auth., 199 S.W.3d 403, 404 (Tex. App.—Houston [1st Dist.] 2006, pet. dism'd) and APD 061381-s, decided August 16, 2006.

Pursuant to Section 410.002 and Rule 140.1 the Hearings Division is given the authority to resolve benefit disputes, which are defined as a dispute regarding compensability or eligibility for, or the amount of, income or death benefits. Section 401.011(5) defines "[b]enefit" to mean a medical benefit, an income benefit, a death benefit, or a burial benefit based on a compensable injury. The issue before the hearing officer in the instant case that was in fact litigated is: Does the doctrine of *res judicata* preclude the Division from determining the compensability of the conditions claimed in the EOI issue below based on the decision and order of the prior CCH?

The decision and order of the prior CCH was in evidence and states that the compensable injury of _____, includes the following four conditions:

> **RIGHT KNEE:** joint effusion with soft tissue swelling around the right knee (RK#2); prominent bone bruising involving the proximal tibia of the right knee (RK#3); and complete disruption of the posterior cruciate ligament of the right knee (a portion of RK#4); and
>
> **BILATERAL HIP:** right hip contusion (BH#1);

but the compensable injury of _____, does not include the following:

> **RIGHT KNEE:** complete disruption of the anterior cruciate ligament/anterior cruciate ligament tear (a portion of RK#4); large tear of the lateral meniscus with displacement of meniscal fragment into the

intercondylar space of the right knee (RK#5); advanced osteoarthritis (RK#6); or

LEFT SHOULDER: tendinopathy (LS#2); partial tear of the left shoulder rotator cuff at the level of the supraspinatus tendon (LS#3); rotator cuff syndrome (LS#4); or osteoarthritis (LS#5); or

LUMBAR SPINE: sprain/strain (L-Sp#1); or

CERVICAL SPINE: degenerative disc disease (CS#2); cervical osteoarthritis (CS#3); or

THORACIC SPINE: injury to the thoracic spine (TS#1).

The decision and order of the prior CCH, signed on January 27, 2009, was appealed by the claimant; however, it became final pursuant to Section 410.204(c) on April 23, 2009. The parties represented at the CCH that there was no subsequent lawsuit filed in district court regarding the EOI issue in dispute at that prior CCH.

EOI-Res Judicata

Because the hearing officer made a determination on disputed EOI conditions (RK#2-6; LS#2-5; BH#1; L-Sp#1; CS#2-3; and TS#1) at the prior CCH, that portion of the hearing officer's determination in effect based on the doctrine of *res judicata* the Division is precluded from determining the compensability of the following conditions (RK#2-6; LS#2-5; BH#1; L-Sp#1; CS#2-3; and TS#1), which were previously litigated at the prior CCH, is supported by sufficient evidence and is affirmed. We note any EOI determination by the hearing officer in Conclusion of Law No. 5 and decision as to these specific conditions is resolved by the determination on *res judicata* as set out above.

EOI-Not Res Judicata

However, the hearing officer erred in determining other claimed EOI conditions in dispute were litigated at the prior CCH. The evidence reflects that the EOI conditions listed below were not litigated or subsumed in the EOI issue at the prior CCH. Therefore, that portion of the hearing officer's determination that based on the doctrine of *res judicata* the Division is precluded from determining the compensability of the following conditions (RK#1; RK#7-21; LS#1; LS#6-12; BH#2; CS#1; and CS#4-13) is reversed and a new decision is rendered that based on the doctrine of *res judicata* the Division is not precluded from determining the compensability of the following conditions:

RIGHT KNEE: sprain/strain (RK#1); and severe crepitus (RK#7); edema in the prepatellar subcutaneous tissue (RK#8); internal derangement (RK#9); osteochondral defect of the medial femoral condyle and patella (RK#10); osteophytes superior aspect of patella (RK#11);

tricompartmental osteophyte formation (RK#12); narrowing of the lateral joint space (RK#13); narrowing of the articular cartilage with spurring at the articular margins (RK#14); severe degenerative joint disease (RK#15); degenerative changes at the tibial-fibular joint with bony eburnation and sclerosis (RK#16); degenerative changes of the lateral femoral compartment (RK#17); subchondral erosions throughout the distal lateral femoral condyle and lateral tibial plateau suggestive of Grade IV chondromalacia as well as probable Grade IV chondromalacia of the patella femoral compartment (RK#18); subchondral sclerosis and subtle erosive changes involving the medial femoral compartment (RK#19); prominent subchondral erosive changes underneath the central and posterior tibial spine (RK#20); and a tiny 1-2 mm free bone fragment adjacent to the fulcrum of the patella resulting in a total knee replacement (RK#21);

LEFT SHOULDER: strain (LS#1); full thickness tear of the distal fibers of the anterior supraspinatus rotator cuff measuring 8 mm x 8 mm (LS#6); acromioclavicular joint arthrosis (LS#7); abnormal AC joint with inferior spurring causing impingement on the rotator cuff at the level of the supraspinatus tendon (LS#8); subacromial/subdeltiod bursal effusion (LS#9); mild osteoarthritic changes (LS#10); bicep tendon longitudinal split tear resulting in a rotator cuff repair with a Biomet Metal Anchor & acromioplasty (LS#11); and distal clavicle resection (LS#12);

BILATERAL HIPS: osteoarthritis of bilateral hips (BH#2);

CERVICAL SPINE: sprain/strain (CS#1); radiculitis (CS#4); severe spondylosis at C5-7 with narrowing of the disc space (CS#5); osteophyte formation (CS#6); loss of vertebral disc height (CS#7); C2-3 mild annular bulge (CS#8); C3-4 and C4-5 central 3 mm annular protrusion causing slight impingement of the cord with C4-5 slightly milder in severity (CS#9); C5-6 right paracentral 4 mm annular protrusion causing slight cord impingement and mild left foraminal stenosis (CS#10); C6-7 right paracentral 5 mm disc herniation with uncinate osteophytes that cause mild cord impingement and right sided foraminal stenosis (CS#11); mild but definite T2 hyperintensity in spinal cord at lower C6 level that likely represents mild myelomalacia as a result of cord impingement (CS#12); and C7-T1 mild central annular protrusion that causes slight indentation of spinal cord (CS#13).

EOI

Not EOI

That portion of the hearing officer's determination that the compensable injury of _____, does not extend to the following conditions (RK#8-21; LS#6-12; BH#2; L-Sp#2-4; CS#4-13; and LA#1-3) is supported by sufficient evidence and is affirmed.

EOI-Great Weight

Section 408.0041(a) provides in pertinent part that at the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about the extent of the employee's compensable injury. 28 TEX. ADMIN. CODE § 126.7(c) (Rule 126.7(c))[1] provides in pertinent part that a designated doctor examination shall be used to resolve questions about the extent of the employee's compensable injury. Rule 126.7(d) provides that the report of the designated doctor is given presumptive weight regarding the issue(s) in question and/or dispute, unless the preponderance of the evidence is to the contrary. The Appeals Panel has previously held that proof of causation must be established to a reasonable medical probability by expert medical evidence where the subject is so complex that a fact finder lacks the ability from common knowledge to find a causal connection. APD 022301, decided October 23, 2002. *See also* Guevara v. Ferrer, 247 S.W.3d 662 (Tex. 2007). Also, the court held that "an exception to the general rule whereby causation findings linking events and physical conditions could, under certain circumstances, be sufficiently supported by non-expert evidence." *See* Guevara, at 666.

The medical records reflect that the claimant was initially treated at the (Healthcare Provider) on _____, the date of injury. The medical record dated that same day reflects that the claimant had complaints of pain to his neck and left shoulder and there was a diagnosis of acute neck pain. The claimant was subsequently seen on August 28, 2008, by (Dr. C) who diagnosed knee pain and shoulder pain, and who related the claimant's problems to work activities. On August 29, 2008, the claimant was examined by (Dr. W), who initially was the claimant's treating doctor. The report of that first visit reflects initial diagnoses including cervical sprain and strain. Dr. W prescribed physical therapy for the left shoulder, right knee, and cervical area.

In evidence is a carrier-selected peer review report by (Dr. B) performed in October of 2008, in which Dr. B opined that based on the mechanism of injury and documentation reviewed, the compensable injury would include contusion to the left shoulder, cervical sprain/strain, right knee sprain/strain, and right thigh contusion. Dr. B examined the claimant on November 2, 2009, for a required medical examination (RME) and in his report stated that the self-insured accepted a cervical sprain/strain, left

[1] We note that the Division has adopted new rules concerning designated doctor scheduling and examinations effective February 1, 2011. The pertinent part of Rule 126.7(c) cited above is provided in the new Rule 127.1(a); however, the applicable rule in this case is Rule 126.7.

shoulder strain, right hip contusion, and right knee sprain/strain as compensable and noted the claimant had complaints of pain in his neck, shoulder, hip, arm, and right knee.

Consistent with Dr. B's peer review and RME reports, dated October 2008, and November 2, 2009, respectively, is a Notice of Disputed Issue(s) and Refusal to Pay Benefits (PLN-11) dated October 24, 2008, which is in evidence and states "[self-insured] accepts cervical sprain/strain, left shoulder strain, right hip contusion, and a right knee sprain/strain as the only compensable injuries that occurred on [_____]." A subsequent PLN-11 dated February 17, 2009, reflects that the self-insured does not waive any foregoing disputes but cites the hearing officer's EOI determination at the prior CCH, contending that the injury does not extend to or include any other body parts, diagnoses or conditions not addressed on this PLN-11.

As previously discussed, Dr. M was initially appointed by the Division to determine MMI/IR as well as the claimant's ability to return to work and he additionally opined that the compensable injury included a left shoulder strain and cervical strain. Subsequently, the Division appointed Dr. L as a designated doctor to address EOI. Dr. L examined the claimant on September 18, 2009, and opined that the compensable injury of _____, extends to "1) [r]ight knee posterior cruciate ligament and lateral meniscus tear s/p repair with severe crepitus 2) [r]ight hip contusion 3) [l]umbar strain 4) [l]eft shoulder strain." The decision and order at the prior CCH determined EOI as to right knee posterior cruciate ligament and lateral meniscus tear s/p repair, right hip contusion, lumbar strain but not as to right knee severe crepitus and left shoulder strain.

In reviewing a "great weight" challenge, we must examine the entire record to determine if: (1) there is only "slight" evidence to support the finding; (2) the finding is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust; or (3) the great weight and preponderance of the evidence supports its nonexistence. *See* Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

The medical reports in evidence for the claimant's compensable injury indicate that the claimant was initially diagnosed with RK#1; RK#7; LS#1; and CS#1. Dr. B, the carrier-selected peer review and RME doctor, opined in his report dated October 11, 2008, showing that RK#1; LS#1; and CS#1 were part of the compensable injury. Dr. L, the designated doctor appointed to determine EOI, opined that the compensable injury included right knee severe crepitus and a left shoulder strain. The preponderance of the evidence establishes that the compensable injury extends to RK#1; RK#7; LS#1; and CS#1. *See* Guevara, *supra*, at 666.

Accordingly, we reverse the hearing officer's determination that the compensable injury of _____, does not extend to the following conditions (RK#1; RK#7; LS#1; and CS#1) and render a new decision that the compensable injury of _____, extends to a right knee sprain/strain (RK#1); right knee severe crepitus (RK#7); left shoulder strain (LS#1); and cervical sprain/strain (CS#1).

MMI AND IR

Section 401.011(30)(A) defines MMI as "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated." Section 408.1225(c) provides that the report of the designated doctor has presumptive weight, and the Division shall base its determination of whether the employee has reached MMI on the report of the designated doctor unless the preponderance of the other medical evidence is to the contrary. Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Division shall base the IR on that report unless the preponderance of the other medical evidence is to the contrary, and that, if the preponderance of the medical evidence contradicts the IR contained in the report of the designated doctor chosen by the Division, the Division shall adopt the IR of one of the other doctors.

As previously discussed, Dr. H was appointed by the Division to determine MMI and IR. Dr. H examined the claimant on June 22, 2009. Dr. H certified a date of MMI[2] and assigned an IR based on the work injury to include the claimant's right knee and hip but did not consider any injury to the cervical spine or left shoulder. Given that we have reversed the hearing officer's determination that the compensable injury of _____, did not extend to a right knee sprain/strain (RK#1); right knee severe crepitus (RK#7); cervical sprain/strain (CS#1); and left shoulder strain (LS#1) and rendered a new decision that the compensable injury of _____, does extend to a right knee sprain/strain (RK#1); right knee severe crepitus (RK#7); cervical sprain/strain (CS#1); and left shoulder strain (LS#1), we hold that Dr. H, the designated doctor, did not certify a MMI date or assign an IR as to the claimant's entire compensable injury considering the medical record and the certifying examination. There are no other certifications of MMI/IR in evidence that can be adopted. Accordingly, we reverse the hearing officer's determination that the claimant reached MMI on June 22, 2009, with a one percent IR.[3] We remand the MMI and IR issues to the hearing officer.

REMAND INSTRUCTIONS

On remand the hearing officer should allow the parties an opportunity to stipulate to the date of statutory MMI. If the parties are unable to stipulate, the hearing officer

[2] Dr. H initially certified that the claimant reached MMI on January 13, 2009, because he believed that this was the date of statutory MMI. The Division, subsequently in a LOC, informed him that the date of statutory MMI is August 31, 2010. In response to the LOC, Dr. H amended his Report of Medical Evaluation (DWC-69) to reflect that the claimant reached clinical MMI on the date of his exam, June 22, 2009.

[3] We note that Dr. H issued two alternative IRs with the same MMI date, June 22, 2009. Dr. H's assigned one percent IR is a rating for a non-compensable body part, a right knee meniscal tear as previously determined in the decision and order of the prior CCH. The other IR of zero percent does not include any rating for the cervical spine or left shoulder. Therefore, neither IR can be adopted regardless of the MMI date.

should take additional evidence to determine the date of statutory MMI in order to inform the designated doctor of the date of statutory MMI.

Dr. H is the most recent appointed designated doctor to determine MMI and IR. *See* APD 101676-s, decided January 14, 2011. On remand the hearing officer is to determine if Dr. H is still qualified and available to serve as the designated doctor and if so, the hearing officer is to advise the designated doctor that it has been administratively determined that the compensable injury:

As to the RIGHT KNEE:

(1) Includes RIGHT KNEE: sprain/strain (RK#1); joint effusion with soft tissue swelling around the knee (RK#2); prominent bone bruising involving the proximal tibia (RK#3); and right knee posterior cruciate ligament tear/complete disruption of the posterior cruciate ligament of the right knee (a portion of RK#4); severe crepitus (RK#7); but

(2) Does not include RIGHT KNEE: complete disruption of the anterior cruciate ligament/anterior cruciate ligament tear (portion of RK#4); large tear of the lateral meniscus with displacement of meniscal fragment into intercondylar space (RK#5); end stage arthritis/degenerative arthritis/osteoarthritis (RK#6); edema in the prepatellar subcutaneous tissue (RK#8); internal derangement (RK#9); osteochondral defect of the medial femoral condyle and patella (RK#10); osteophytes superior aspect of patella (RK#11); tricompartmental osteophyte formation (RK#12); narrowing of the lateral joint space (RK#13); narrowing of the articular cartilage with spurring at the articular margins (RK#14); severe degenerative joint disease (RK#15); degenerative changes at the tibial-fibular joint with bony eburnation and sclerosis (RK#16); degenerative changes of the lateral femoral compartment (RK#17); subchondral erosions throughout the distal lateral femoral condyle and lateral tibial plateau suggestive of Grade IV chondromalacia as well as probable Grade IV chondromalacia of the patella femoral compartment (RK#18); subchondral sclerosis and subtle erosive changes involving the medial femoral compartment (RK#19); prominent subchondral erosive changes underneath the central and posterior tibial spine (RK#20); or a tiny 1-2 mm free bone fragment adjacent to the fulcrum of the patella resulting in a total knee replacement (RK#21);

As to the LEFT SHOULDER:

(1) Includes LEFT SHOULDER: strain (LS#1); but

(2) Does not include LEFT SHOULDER: tendinopathy (LS#2); partial tear of the rotator cuff at the level of the supraspinatus tendon (LS#3); rotator cuff syndrome (LS#4); osteoarthritis (LS#5); full thickness tear

of the distal fibers of the anterior supraspinatus rotator cuff measuring 8 mm x 8 mm (LS#6); acromioclavicular joint arthrosis (LS#7); abnormal AC joint with inferior spurring causing impingement on the rotator cuff at the level of the supraspinatus tendon (LS#8); subacromial/subdeltiod bursal effusion (LS#9); mild osteoarthritic changes (LS#10); bicep tendon longitudinal split tear resulting in a rotator cuff repair with a Biomet Metal Anchor & acromioplasty (LS#11); or a distal clavicle resection (LS#12);

As to the BILATERAL HIPS:

(1) Includes a right hip contusion (BH#1); but

(2) Does not include osteoarthritis of bilateral hips (BH#2);

As to the LUMBAR SPINE:

(1) Does not include a lumbar sprain/strain (L-Sp#1); multiple bone fragments at L3-4 facet and foramen (L-Sp#2); bilateral facet sclerosis and hypertrophy at L3-S1 (L-Sp#3); or huge osteophytes at L2-4 (L-Sp#4);

As to the CERVICAL SPINE:

(1) Includes a cervical sprain/strain (CS#1); but

(2) Does not include degenerative disc disease (CS#2); osteoarthritis (CS#3); radiculitis (CS#4); severe spondylosis at C5-7 with narrowing of the disc space (CS#5); osteophyte formation (CS#6); loss of vertebral disc height (CS#7); C2-3 mild annular bulge (CS#8); C3-4 and C4-5 central 3 mm annular protrusion causing slight impingement of the cord with C4-5 slightly milder in severity (CS#9); C5-6 right paracentral 4 mm annular protrusion causing slight cord impingement and mild left foraminal stenosis (CS#10); C6-7 right paracentral 5 mm disc herniation with uncinate osteophytes that cause mild cord impingement and right sided foraminal stenosis (CS#11); mild but definite T2 hyperintensity in spinal cord at lower C6 level that likely represents mild myelomalacia as a result of cord impingement (CS#12); and C7-T1 mild central annular protrusion that causes slight indentation of spinal cord (CS#13);

As to the THORACIC SPINE:

(1) Does not include an injury to the thoracic spine (TS#1);

As to the LEFT ARM:

(1) Does not include CTS (LA#1); distal ulnar entrapment (LA#2); or radial sensory neuropathy (LA#3).

The designated doctor is then to be requested to give an opinion on MMI (which cannot be after the statutory MMI date) and IR of the entire compensable injury. If Dr. H is no longer qualified or available to serve as the designated doctor, another designated doctor is to be appointed pursuant to Rule 126.7(h) to determine MMI and IR for the compensable injury. The parties are to be provided with the hearing officer's letter to the designated doctor, the designated doctor's response and are to be allowed an opportunity to present evidence and respond.

SUMMARY

We affirm the hearing officer's determination that the claimant had disability from January 13, 2009, through December 8, 2010.

We affirm that portion of the hearing officer's determination that based on the doctrine of *res judicata* the Division is precluded from determining the compensability of the following conditions:

> right knee joint effusion with soft tissue swelling around the knee (RK#2); right knee prominent bone bruising involving the proximal tibia (RK#3); right knee posterior cruciate ligament tear/complete disruption of the anterior and posterior cruciate ligaments (RK#4); right knee large tear of the lateral meniscus with displacement of meniscal fragment into intercondylar space (RK#5); right knee end stage arthritis/degenerative arthritis/osteoarthritis (RK#6); left shoulder tendinopathy (LS#2); left shoulder partial tear of the rotator cuff at the level of the supraspinatus tendon (LS#3); left shoulder rotator cuff syndrome (LS#4); left shoulder osteoarthritis (LS#5); right hip contusion (BH#1); lumbar sprain/strain (L-Sp#1); degenerative disc disease (CS#2); osteoarthritis (CS#3); and injury to the thoracic spine (TS#1).

We reverse that portion of the hearing officer's determination that based on the doctrine of *res judicata* the Division is precluded from determining the compensability of the following conditions (RK#1; RK#7-21; LS#1; LS#6-12; BH#2; CS#1; and CS#4-13) and we render a new decision that based on the doctrine of *res judicata* the Division is not precluded from determining the compensability of the following conditions:

> **RIGHT KNEE:** sprain/strain (RK#1); severe crepitus (RK#7); edema in the prepatellar subcutaneous tissue (RK#8); internal derangement (RK#9); osteochondral defect of the medial femoral condyle and patella (RK#10); osteophytes superior aspect of patella (RK#11); tricompartmental osteophyte formation (RK#12); narrowing of the lateral joint space (RK#13); narrowing of the articular cartilage with spurring at the articular

margins (RK#14); severe degenerative joint disease (RK#15); degenerative changes at the tibial-fibular joint with bony eburnation and sclerosis (RK#16); degenerative changes of the lateral femoral compartment (RK#17); subchondral erosions throughout the distal lateral femoral condyle and lateral tibial plateau suggestive of Grade IV chondromalacia as well as probable Grade IV chondromalacia of the patella femoral compartment (RK#18); subchondral sclerosis and subtle erosive changes involving the medial femoral compartment (RK#19); prominent subchondral erosive changes underneath the central and posterior tibial spine (RK#20); and a tiny 1-2 mm free bone fragment adjacent to the fulcrum of the patella resulting in a total knee replacement (RK#21);

LEFT SHOULDER: strain (LS#1); full thickness tear of the distal fibers of the anterior supraspinatus rotator cuff measuring 8 mm x 8 mm (LS#6); acromioclavicular joint arthrosis (LS#7); abnormal AC joint with inferior spurring causing impingement on the rotator cuff at the level of the supraspinatus tendon (LS#8); subacromial/subdeltiod bursal effusion (LS#9); mild osteoarthritic changes (LS#10); bicep tendon longitudinal split tear resulting in a rotator cuff repair with a Biomet Metal Anchor & acromioplasty (LS#11); and distal clavicle resection (LS#12);

BILATERAL HIPS: osteoarthritis of bilateral hips (BH#2);

CERVICAL SPINE: sprain/strain (CS#1); radiculitis (CS#4); severe spondylosis at C5-7 with narrowing of the disc space (CS#5); osteophyte formation (CS#6); loss of vertebral disc height (CS#7); C2-3 mild annular bulge (CS#8); C3-4 and C4-5 central 3 mm annular protrusion causing slight impingement of the cord with C4-5 slightly milder in severity (CS#9); C5-6 right paracentral 4 mm annular protrusion causing slight cord impingement and mild left foraminal stenosis (CS#10); C6-7 right paracentral 5 mm disc herniation with uncinate osteophytes that cause mild cord impingement and right sided foraminal stenosis (CS#11); mild but definite T2 hyperintensity in spinal cord at lower C6 level that likely represents mild myelomalacia as a result of cord impingement (CS#12); and C7-T1 mild central annular protrusion that causes slight indentation of spinal cord (CS#13).

We affirm that portion of the hearing officer's determination that the compensable injury of _____, does not extend to the following conditions:

RIGHT KNEE: edema in the prepatellar subcutaneous tissue (RK#8); internal derangement (RK#9); osteochondral defect of the medial femoral condyle and patella (RK#10); osteophytes superior aspect of patella (RK#11); tricompartmental osteophyte formation (RK#12); narrowing of the lateral joint space (RK#13); narrowing of the articular cartilage with

spurring at the articular margins (RK#14); severe degenerative joint disease (RK#15); degenerative changes at the tibial-fibular joint with bony eburnation and sclerosis (RK#16); degenerative changes of the lateral femoral compartment (RK#17); subchondral erosions throughout the distal lateral femoral condyle and lateral tibial plateau suggestive of Grade IV chondromalacia as well as probable Grade IV chondromalacia of the patella femoral compartment (RK#18); subchondral sclerosis and subtle erosive changes involving the medial femoral compartment (RK#19); prominent subchondral erosive changes underneath the central and posterior tibial spine (RK#20); and a tiny 1-2 mm free bone fragment adjacent to the fulcrum of the patella resulting in a total knee replacement (RK#21);

LEFT SHOULDER: full thickness tear of the distal fibers of the anterior supraspinatus rotator cuff measuring 8 mm x 8 mm (LS#6); acromioclavicular joint arthrosis (LS#7); abnormal AC joint with inferior spurring causing impingement on the rotator cuff at the level of the supraspinatus tendon (LS#8); subacromial/subdeltiod bursal effusion (LS#9); mild osteoarthritic changes (LS#10); bicep tendon longitudinal split tear resulting in a rotator cuff repair with a Biomet Metal Anchor & acromioplasty (LS#11); and distal clavicle resection (LS#12);

BILATERAL HIPS: osteoarthritis of bilateral hips (BH#2);

LUMBAR SPINE: multiple bone fragments at L3-4 facet and foramen (L-Sp#2); bilateral facet sclerosis and hypertrophy at L3-S1 (L-Sp#3); and huge osteophytes at L2-4 (L-Sp#4);
CERVICAL SPINE: radiculitis (CS#4); severe spondylosis at C5-7 with narrowing of the disc space (CS#5); osteophyte formation (CS#6); loss of vertebral disc height (CS#7); C2-3 mild annular bulge (CS#8); C3-4 and C4-5 central 3 mm annular protrusion causing slight impingement of the cord with C4-5 slightly milder in severity (CS#9); C5-6 right paracentral 4 mm annular protrusion causing slight cord impingement and mild left foraminal stenosis (CS#10); C6-7 right paracentral 5 mm disc herniation with uncinate osteophytes that cause mild cord impingement and right sided foraminal stenosis (CS#11); mild but definite T2 hyperintensity in spinal cord at lower C6 level that likely represents mild myelomalacia as a result of cord impingement (CS#12); and C7-T1 mild central annular protrusion that causes slight indentation of spinal cord (CS#13);

LEFT ARM: CTS (LA#1); distal ulnar entrapment (LA#2); and radial sensory neuropathy (LA#3).

We reverse the hearing officer's determination that the compensable injury of _____, does not extend to the following conditions: right knee sprain/strain (RK#1); right knee severe crepitus (RK#7); left shoulder strain (LS#1); or cervical

sprain/strain (CS#1) and render a new decision that the compensable injury of _____, extends to a right knee sprain/strain (RK#1); right knee severe crepitus (RK#7); left shoulder strain (LS#1); and cervical sprain/strain (CS#1).

We reverse the hearing officer's determination that the claimant reached MMI on June 22, 2009, with a one percent IR and we remand the MMI and IR issues to the hearing officer.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Division, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* APD 060721, decided June 12, 2006.

The true corporate name of the insurance carrier is **(a self-insured governmental entity)** and the name and address of its registered agent for service of process is

(NAME)
(ADDRESS)
(CITY), TEXAS (ZIP CODE).

_____
Cynthia A. Brown
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Margaret L. Turner
Appeals Judge