APPEAL NO. 061713-s
FILED OCTOBER 20, 2006

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 January 9, 2006, and July 18, 2006. The hearing officer resolved the disputed issues by deciding that: (1) the compensable injury of _____, does not include depression, bilateral carpal tunnel syndrome (CTS), right thumb trigger finger, right ganglion cyst, or lumbar radiculopathy/disc pathology; (2) the appellant/cross-respondent (self-insured) waived the right to dispute the compensability of the respondent/cross-appellant's (claimant) cervical radiculopathy/disc pathology; (3) the claimant's cervical radiculopathy/disc pathology at C4-5, C5-6, and C6-7 has become compensable as a matter of law and is part of the compensable injury of _____, along with a lumbar sprain/strain; (4) the claimant reached maximum medical improvement (MMI) on January 8, 2004, and has a 5% impairment rating (IR); (5) the claimant is entitled to the full amount of temporary income benefits (TIBs) owed for the period in which she received assault leave pay under Texas Education Code, Section 22.003(b) up to her date of MMI in the amount of $713.37; and (6) the self-insured is not entitled to suspend TIBs or impairment income benefits (IIBs) to recoup a previous overpayment of TIBs. Both parties have appealed. The self-insured disputed the waiver and recoupment determinations as well as the determination that the claimant is entitled to TIBs owed for the period she received assault pay up to her date of MMI in the amount of $713.37. The claimant appealed the unfavorable extent-of-injury determinations as well as the IR. The claimant also contends the hearing officer abused his discretion when he appointed a new designated doctor. Additionally, the claimant complains about the hearing officer's failure to discuss or "accept" various pieces of evidence she contends supports her position. Both parties responded to the other's appeal.

DECISION

Affirmed in part, affirmed in part on other grounds, and reversed and rendered in part.

EVIDENTIARY OBJECTIONS

We first respond to the claimant's allegations that the hearing officer abused his discretion by failing to discuss or "accept" numerous pieces of evidence she felt supported her position on various issues. We note that all of the exhibits offered by the claimant were admitted into evidence and that the hearing officer states in his decision that even though all of the evidence presented was not discussed, it was considered, and that the findings of fact and conclusions of law are based on all of the evidence presented. The hearing officer is not required to discuss each individual piece of evidence admitted at the CCH. *See* Appeals Panel Decision (APD) 031086, decided May 30, 2003, and APD 92206, decided July 6, 1992. The self-insured objects to the

claimant's appeal(s), to the extent that it is testimonial in nature. We note that the review of the Appeals Panel is generally limited to the record developed at the CCH. Section 410.203. The claimant contends that the hearing officer abused his discretion in holding the record open for a second CCH session which was held on July 18, 2006. We find this contention to be without merit. The claimant also contends that the hearing officer erred in admitting some of the exhibits offered by the self-insured because she contends the exhibits were irrelevant and that the hearing officer erred in refusing to let her husband testify. 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. APD 91003, decided August 14, 1991. We find no abuse of discretion in the hearing officer's admission of the complained-of exhibits over the claimant's relevancy objection, or the exclusion of the testimony of the claimant's spouse because he was not identified as a witness known to have knowledge of relevant facts. The claimant has failed to show that the admission of the complained-of exhibits or excluded testimony amounted to reversible error.

BACKGROUND INFORMATION

The claimant worked as a teacher. She testified that she was injured on _____, when a fifth grader hugged her by placing his hands around her neck and suspending himself in the air until she was able to loosen one of his hands. The evidence reflects that the claimant sought medical treatment on January 9, 2002, and that her initial diagnoses were cervical, thoracic, and lumbar strain. The claimant was prescribed medication and subsequently physical therapy. The record reflects that on June 12, 2002, the claimant had a three-level cervical fusion (C4-5, C5-6, and C6-7).

WAIVER

Section 409.021, effective for a claimed compensable injury that occurred before September 1, 2003, provides that an insurance carrier shall, not later than the 7th day after the receipt of written notice of an injury, begin the payment of benefits as required by the 1989 Act or notify the Texas Department of Insurance, Division of Workers' Compensation (Division) and the employee in writing of its refusal to pay benefits. In APD 030380-s, decided April 10, 2003, the Appeals Panel noted that in Continental Casualty Company v. Downs, 81 S.W.3d 803 (Tex. 2002), the Texas Supreme Court stated: "Taking some action within seven days is what entitles the carrier to a sixty-day period to investigate or deny compensability." APD 041738-s, decided September 8, 2004, established that when a carrier does not timely dispute the compensability of a claim, the compensable injury is defined by the information that could have been reasonably discovered by the carrier's investigation prior to the expiration of the waiver period. If the carrier does begin the payment of benefits as required by the 1989 Act, Section 409.021(c) provides in part that the initiation of payments by an insurance carrier does not affect the right of the insurance carrier to continue to investigate or deny the compensability of an injury during the 60-day period.

The waiver issue at the CCH was limited to cervical radiculopathy. The hearing officer found that the first written notice of a claimed cervical disc injury consisted of Dr. P report of February 18, 2002, which was received by the self-insured on February 27, 2002, and that the self-insured disputed the compensability of the cervical radiculopathy/disc pathology no earlier than March 10, 2003. The hearing officer concluded that the self-insured waived the right to contest compensability of the cervical radiculopathy/disc pathology by not contesting compensability of the cervical radiculopathy/disc pathology within 60 days of the receipt of Dr. P's report. The hearing officer's analysis of the waiver issue is legally incorrect.

Based upon Appeals Panel decisions prior to March 2000, every time the carrier was notified of a new diagnosis, condition, or claimed body part, the carrier had an additional 60 days from the date it received the notice to dispute the diagnosis, condition, or body part or it again waived. *See* APD 980822, decided June 3, 1998; APD 962415, decided January 9, 1997. In other words, prior to the adoption of 28 TEX. ADMIN. CODE § 124.3 (Rule 124.3), the carrier would waive the extent of an injury if it failed to dispute the additionally claimed diagnosis, condition, or body part within 60 days of receiving notice.

When Rule 124.3 was changed effective March 13, 2000, it provided that the waiver provision of Section 409.021 does not apply to issues of extent of injury. The preamble for the change to Rule 124.3 states:

> Previously the rules were virtually silent on the issue of how to dispute extent of injury. This has led to numerous problems within the system. In the absence of guidance on this issue, the [A]ppeals [P]anel has attempted to provide some structure to this issue. One [A]ppeals [P]anel approach has suggested that when a doctor attempts to treat additional body parts/systems, . . . [Section] 409.021 (regarding Initiation of Benefits; Insurance Carrier's Refusal; Administrative Violation) is invoked and the carrier has 60 days to file a dispute for extent of injury or waive the right to dispute this issue and become liable for this body part/system. This rule does not adopt that interpretation. [Section] 409.021, is intended to apply to the compensability of the injury itself or the carrier's liability for the claim as a whole, not individual aspects of the claim.

It appears from the hearing officer's Finding of Fact No. 11 and discussion that he began the waiver period on February 18, 2002, based on a report from Dr. P regarding a cervical spine injury, instead of from the date the self-insured received first written notice of the injury. In the instant case the evidence reflects that the self-insured received first written notice of injury on January 11, 2002. Therefore, the initial waiver period would be 7 days. The record reflects that the self-insured began payments in accordance with the 1989 Act on January 18, 2002. The initiation of payment within 7 days of receipt of written notice of injury, therefore extended the waiver period to 60 days rather than 7 days. As previously noted, the waiver issue in dispute was limited to cervical radiculopathy. The evidence contains medical records, dated within the 60-day

waiver period applicable to this case, which document the claimant's complaints of cervical radiculopathy and note cervical radiculopathy as a clinical impression. It is undisputed that the claimant's primary injury was to her neck. The self-insured did not contest compensability of the injury on or before the 60th day after the date it received written notice of the injury on January 11, 2002. The hearing officer's determination that the self-insured waived the right to dispute the compensability of the claimant's cervical radiculopathy is affirmed albeit on other grounds. Additionally, the hearing officer's determination that the claimant's cervical radiculopathy has become compensable as a matter of law and is part of the compensable injury of _____, along with a lumbar sprain/strain is affirmed. We note that both Conclusions of Law No. 6 and the decision mistakenly refer to January 8, 2003 (instead of 2002) as the date of the compensable injury. Whether the self-insured waived the right to contest compensability of disc pathology at C4-5, C5-6, and C6-7 was not an issue at the CCH nor was it actually litigated. We hold that the hearing officer in making determinations regarding the disc pathology at C4-5, C5-6, and C6-7 exceeded the scope of the issue before him. We reverse the hearing officer's determination that the compensable injury includes or extends to include cervical disc pathology at C4-5, C5-6, and C6-7 and render a new decision that the disc pathology at C4-5, C5-6, and C6-7 was not a disputed issue before the hearing officer and therefore we strike that portion of Finding of Fact No. 13, Conclusions of Law Nos. 5 and 6 and the decision portion of the hearing officer's decision and order that refers to cervical disc pathology and cervical disc pathology at C4-5, C5-6, and C6-7. We are not determining that such cervical disc pathology is not part of the compensable injury but rather only that the hearing officer erred because the waiver of cervical disc pathology was not an issue before him. Further, we note that Finding of Fact No. 8 "[t]he claimant suffers from degenerative disc disease in the cervical spine, which was aggravated at C4-5, C5-6, and C6-7 by her injury in the course and scope of employment on _____," was not appealed.

EXTENT OF INJURY

There is sufficient evidence to support the hearing officer's determination that the claimant's compensable injury does not include depression, bilateral CTS, right thumb trigger finger, right ganglion cyst, or lumbar radiculopathy. We reverse the hearing officer's determination that the compensable injury does not include or extend to include lumbar disc pathology and render a new decision that the lumbar disc pathology was not a disputed issue before the hearing officer and therefore we strike that portion of Conclusion of Law No. 4 and the decision portion of the hearing officer's decision and order that refers to lumbar disc pathology. The claimant contends that the hearing officer committed error by failing to include a thoracic injury in his extent-of-injury determinations. We find this contention to be without merit because a thoracic injury was not included in the extent-of-injury issue in dispute at the CCH.

IR

The benefit review conference (BRC) report states the parties agreed that the claimant reached MMI statutorily on January 8, 2004. It is undisputed that the claimant underwent a multilevel cervical fusion on June 11, 2002. Cervical radiculopathy was noted as both a preoperative and postoperative diagnosis. Dr. G, the first designated doctor to assign an IR, examined the claimant on December 18, 2002, placed the claimant at clinical MMI on that date and assessed an IR of 33% (combining 25% for the cervical spine, Diagnosis-Related Estimate (DRE) Cervicothoracic Category IV with 10% for the lumbar spine, DRE Lumbosacral Category III), under the Guides to the Evaluation of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000) (AMA Guides). Dr. G subsequently changed his certification of MMI to the statutory date of January 8, 2004, but still assessed a 33% IR. Dr. G reexamined the claimant on June 9, 2004. Several letters of clarification were sent to Dr. G. Dr. G maintained that his rating was correct. Dr. G was sent a letter of clarification requesting that he provide multiple ratings which exclude radiculopathy for both the cervical and lumbar areas. Although he noted his disagreement with excluding radiculopathy, he did provide alternate ratings which exclude radiculopathy for both the cervical and lumbar areas. Dr. G stated that his assessment for impairment of the cervical spine would not change with or without radiculopathy. This is so because Dr. G assessed impairment for the cervical spine placing the claimant in Cervicothoracic DRE Category IV, 25% due to the claimant's multilevel cervical fusion. In his report dated June 9, 2004, Dr. G utilized Advisories 2003-10, signed July 22, 2003, and 2003-10B, signed February 24, 2004, when assessing impairment for the cervical spine, due to the claimant's multilevel cervical fusion. He additionally assessed impairment for the lumbar spine without consideration of radiculopathy as requested, placing the claimant in Lumbosacral DRE Category II, 5%. Dr. G then noted combining 25% impairment for the cervical spine with 5% for the lumbar spine would result in a whole person impairment of 29%. There is insufficient evidence to support the hearing officer's determination that "Dr. [G], the first doctor who assigned an IR, was unwilling to continue as designated doctor after several requests for clarification from the Division, which Dr. [G] refused to consider in assigning an IR."

Dr. G utilized Advisories 2003-10 and 2003-10B in assessing impairment for the claimant's cervical spine. In APD 042108-s, decided October 20, 2004, we held that Division Advisories 2003-10 and 2003-10B, do not require the assignment of an IR based on DRE Category IV if there is a multilevel spinal fusion, but that the Division Advisories must be considered as part of the certifying doctor's process in determining the appropriate IR and that under the Advisories the assignment of an IR based on DRE Category IV for a multilevel spinal fusion is not required but is an option.

In evidence is also a report for a subsequently appointed designated doctor, Dr. A who examined the claimant on October 4, 2005, and certified the claimant reached statutory MMI on January 6, 2004, with a 0% IR. The self-insured contended at the CCH that Dr. A was appointed to act as designated doctor because there was an

agreement between the parties to appoint a new designated doctor because Dr. G was not responsive to letters of clarification which had been sent to him. Although a discussion was held regarding whether an issue should be added to determine who was the designated doctor in this case it was not added as an issue. There is some evidence in the record that a representation was made to the Division that the parties agreed that another designated doctor should be appointed. There are copies of Requests for a Designated Doctor (DWC-32) which note the request is being made because Dr. G failed to respond to a letter or letters of clarification. One such request notes that "the parties agree that Dr. [G] has not/will not respond to the Letters of Clarification; therefore, they have agreed to the appointment of a new DD." However, such evidence is not in the form of a written agreement of the parties nor is it signed by both parties. We have previously held that there are no rules or authority for the appointment of a successor designated doctor based on an agreement by the parties. APD 020457, decided April 5, 2002.

Dr. A examined the claimant on October 4, 2005. In assessing impairment however, Dr. A's report would indicate that he only considered impairment for lumbar radiculopathy and did not consider the claimant's lumbar sprain/strain which is part of the compensable injury. Further, Dr. A noted in his narrative that "the [claimant] does have signs apparently of nonverifiable root pain as [another doctor] had mentioned in his previous exam after surgery of the cervical spine which would give [the claimant] 5% physical impairment related to the body as a whole." Dr. A's report indicates that he only considered whether or not the claimant had radiculopathy in assessing impairment for the cervical spine. The record indicates that the claimant had a multilevel cervical fusion. There was no evidence that Dr. A considered Advisories 2003-10 or 2003-10B in assessing impairment for the cervical spine. Dr. A's report reflects an MMI date a few days earlier then the date the parties agreed the claimant reached MMI. Considering all of these factors, the preponderance of the medical evidence is contrary to Dr. A's report. Therefore, Dr. A's report cannot be adopted.

After the January 9, 2006, session of the CCH, the hearing officer sent the parties correspondence which indicated that he believed it was necessary to appoint a new designated doctor and requested that the parties tell him whether preoperative flexion/extension x-rays were performed so the applicability of certain portions of Advisories 2003-10 and 2003-10B could be determined. However, there is not sufficient evidence to support the hearing officer's finding that Dr. G was unwilling to continue as designated doctor after several requests for clarification from the Division, which Dr. G refused to consider in assigning an IR.

After the January 9, 2006, session of the CCH, Dr. R was appointed designated doctor. Dr. R examined the claimant and certified the claimant reached MMI statutorily with a 5% IR, placing the claimant in Cervicothoracic DRE Category II-5% and Lumbosacral DRE Category I-0%. The hearing officer noted that Dr. R reviewed preoperative cervical flexion/extension x-rays and found normal alignment without fracture or dislocation and "declined to apply Advisory 2003-10 or 10B." However, a review of the evidence indicates that while x-rays were taken pre-operatively of the

claimant's cervical spine, such x-rays were not flexion/extension x-rays. Flexion/extension x-rays are used to evaluate loss of motion segment integrity. *See* AMA Guides, pg. 98. The x-ray report which concludes normal alignment without fracture or dislocation is dated June 9, 2002, and is identified as C-Spine AP Lateral w/ [odontoid]. Because there were no preoperative flexion/extension x-rays for the claimant's multilevel fusion, Dr. R was required to consider Advisories 2003-10 and 2003-10B. Those Division Advisories note that for spinal fusion, the IR is determined by the preoperative x-ray tests for motion segment integrity, and that if preoperative x-rays were not performed, the rating may be determined using the following criteria: b. Multilevel fusion meets the criteria for DRE Category IV, Structural Inclusions, as this multilevel fusion is equivalent to "multilevel spine segment structural compromise" per DRE IV. Because Dr. R does not indicate in his report whether he considered Advisories 2003-10 or 2003-10B, his 5% IR cannot be adopted.

For CCH's which are held on or after September 1, 2005, 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. Rule 130.6(i) provides that the designated doctor's response to a Division request for clarification is considered to have presumptive weight as it is part of the doctor's opinion. Given that there is insufficient evidence to support the hearing officer's finding that Dr. G, the first designated doctor to assign an IR, was unwilling to continue as designated doctor after several requests for clarification from the Division, which Dr. G refused to consider in assigning an IR, we reverse the hearing officer's determination that the claimant's IR is 5%. Therefore the report of Dr. G is entitled to presumptive weight. The hearing officer found that cervical radiculopathy was part of the compensable injury, and that the compensable injury does not include lumbar radiculopathy. It was undisputed that the claimant had a multilevel fusion to her cervical spine in part due to her cervical radiculopathy which has been found to be part of the compensable injury as a matter of law. Dr. G clearly indicated that he assessed impairment for the claimant's cervical spine applying Advisories 2003-10 and 2003-10B due to her multilevel fusion. Dr. G's IR of 29% (Lumbosacral DRE Category II combined with Cervicothoracic DRE Category IV) is supported by a preponderance of the medical evidence. We reverse the hearing officer's determination that the claimant's IR is 5% and render a new determination that the claimant's IR is 29%.

ENTITLEMENT AND AMOUNT OF TIBS

We note that neither party disputes the hearing officer's finding that the claimant's average weekly wage (AWW) is $1,019.10. The hearing officer determined that the claimant is entitled to the full amount of TIBs owed for the period in which she received assault pay under the Texas Education Code, Section 22.003(b) up to her date of MMI in the amount of $713.37 [per week]. Both parties note in their respective pleadings that the 1989 Act provides for a maximum weekly benefit of TIBs and that in

this case $713.37 exceeds the maximum weekly benefit provided by statute. The evidence reflects the claimant was not paid more than the maximum weekly amount of TIBs. Section 408.061(a) provides that a weekly temporary income benefit may not exceed 100% of the state average weekly wage under Section 408.047 rounded to the nearest whole dollar. Section 408.061(g) provides that the maximum weekly income benefit in effect on the date of injury is applicable for the entire time that the benefit is payable. We reverse the hearing officer's determination that the claimant is entitled to the full amount of TIBs owed for the period in which she received assault pay under Texas Education Code, Section 22.003(b) up to her date of MMI in the amount of $713.37 and render a new determination that the claimant is entitled to the full amount of TIBs owed for the period in which she received assault pay under Texas Education Code, Section 22.003(b) up to her date of MMI subject to Section 408.061(a) and (g).

RECOUPMENT OF TIBS/IIBS

It is undisputed that the claimant was receiving "assault pay" under the provisions of Texas Education Code Section 22.003(b) which provides in part that "[n]otwithstanding any other law, assault leave policy benefits due to an employee shall be coordinated with [TIBs] due from workers' compensation so that the employee's total compensation from [TIBs] and assault leave policy benefits equals 100 percent of the employee's weekly rate of pay." It is also undisputed that the claimant was receiving TIBs. The claimant contended that the overpayment received, if any, was due to the assault pay and not the TIBs. The self-insured took the position that the amount of TIBs should be calculated after consideration of payment of the assault pay. The hearing officer noted in his discussion that TIBs are to be paid first and then the difference between it and 100% of the AWW is to come from assault pay. We agree with the hearing officer's analysis that in order to coordinate TIBs with assault leave pay under Texas Education Code 22.003(b) so that the employee's total compensation from TIBs and assault leave pay equals 100% of the employee's weekly rate of pay, the weekly TIBs amount would first be calculated and paid and then the assault leave pay would be calculated to provide for the difference between the weekly TIBs amount and 100% of the employee's weekly rate of pay. This construction is consistent with the courts interpretation of an analogous situation with police officers and firefighters. *See* City of San Antonio v. Vakey, 123 S.W.3d 497 (Tex. App.-San Antonio 2003, no pet.) where the court cited APD 931084, decided January 12, 1994, for the proposition that in applying the offset under Section 504.051, the amount paid under Texas Local Government Code Section 143.073[1] was reduced, not the workers' compensation benefits. *See* Op. Tex. Atty' Gen. No. JM-915 which concluded that assault sick leave under former Texas Education Code 13.904(f) [now Texas Education Code 22.003(b)] may not be offset under former article 8309h, Section 5(a) [now Texas Labor Code 504.051] against workers' compensation benefits. Subsequently, in 1993, former Section 13.904(f) of the Texas Education Code was amended to provide that assault leave benefits be coordinated with workers' compensation benefits to equal the

[1] Texas Local Government Code Section 143.073(a) provides: "A municipality shall provide to a fire fighter or police officer a leave of absence for an illness or injury related to the person's line of duty. The leave is with full pay for a period commensurate with the nature of the line of duty or illness or injury. If necessary, the leave shall continue for at least one year."

employee's usual rate of pay. *See* Tex. Att'y Gen. Letter Opinion-94-030 (1994). As noted, the coordination provision for assault leave and workers' compensation benefits is currently in Texas Education Code 22.003(b). The evidence is sufficient to support the hearing officer's determination that the self-insured is not entitled to suspend TIBs or IIBs to recoup a previous overpayment of TIBs.

SUMMARY

We affirm the hearing officer's determination that the claimant's compensable injury of _____, does not include depression, bilateral CTS, right thumb trigger finger, right ganglion cyst, or lumbar radiculopathy. We affirm the hearing officer's determination that the self-insured waived the right to dispute the compensability of the claimant's cervical radiculopathy, albeit on other grounds. We affirm the hearing officer's determination that the claimant's cervical radiculopathy has become compensable as a matter of law and is part of the compensable injury of _____, along with a lumbar strain/sprain. We affirm the hearing officer's determination that the self-insured is not entitled to suspend TIBs or IIBs to recoup a previous overpayment of TIBs.

We reverse the hearing officer's determination that the self-insured waived the right to dispute the compensability of the claimant's cervical disc pathology and that cervical disc pathology at C4-5, C5-6, and C6-7 has become compensable as a matter of law because the hearing officer exceeded his authority in making such determinations because they were not issues before him and were not actually litigated. We again note that we are not determining that the cervical disc pathology is not part of the compensable injury but are only ruling that the hearing officer erred in deciding the cervical disc pathology was part of the compensable injury because it was not an issue before him. We reverse the hearing officer's determination that the claimant has a 5% IR and render a determination that the claimant's IR is 29%. We reverse the hearing officer's determination that the claimant is entitled to the full amount of TIBs owed for the period in which she received assault pay under Texas Education Code, Section 22.003(b) up to her date of MMI in the amount of $713.37 [per week] and render a determination that the claimant is entitled to the full amount of TIBs owed for the period in which she received assault leave pay under Texas Education Code, Section 22.003(b) up to her date of MMI subject to the provisions of Section 408.061(a) and (g). We reverse the hearing officer's determination that the compensable injury did not include lumbar disc pathology, striking such language from Conclusion of Law No. 4 and the decision because it was not part of the disputed issue.

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

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

_____
Margaret L. Turner
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Veronica L. Ruberto
Appeals Judge