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SIGNIFICANT REPORTED AND UNREPORTED COURT DECISIONS

Jurisdiction and Invalid Advisories

***Texas Dept. of Ins., Div. of Worker's Compensation v. Lumbermens Mut. Cas. Co.*, 212 S.W.3d 870 (Tex. App. – Austin, 2006, pet. granted March 7, 2007).**

Texas Department of Insurance, Division of Worker's Compensation (the Division) appealed an order entered by a trial court in a declaratory judgment action brought by Lumbermens and several other carriers, declaring that the issuance of two advisories by the Division constituted an invalid attempt at *ad hoc* rule making, that the application of the advisories is an ultra vires act, and enjoining the Division from further applications and enforcement of the advisories.

In the underlying case, the claimant sustained a compensable injury, and proceeded to an impairment rating. The Texas Labor Code requires the Division to use *Guides to the Evaluation of Permanent Impairment*, published by the AMA, in determining the existence and degree of an injured worker's permanent impairment. Ultimately, the Division adopted the Fourth Edition of the *Guides* which must be used for impairment ratings issued on or after October 15, 2001.

The principle methodology found in the Fourth Edition of the *Guides* is its injury model, which uses objectively verifiable evidence to place patients into one of eight diagnosis-related estimate (DRE) categories. The dispute in this case revolved around the proper standard for assessing the DRE IV category for a lumbosacral spine which has undergone spinal fusion surgery. The *Guides* requires either loss of motion segment integrity or a structural inclusion for a patient to be given a rating of DRE IV, for the lumbosacral spine.

For a patient to be diagnosed with loss of motion segment integrity for the lumbosacral spine, the *Guides* require that flexion and extension x-rays be taken before the spinal fusion surgery to establish motion of the spine in the event that one or more disks are removed in the process of the surgery.

The problem arose where doctors performed the spinal fusion but did not take pre-operative flexion and extension x-rays, which created a "big hole in the system" according to the testimony of the Division's medical advisor, Dr. William Nemeth. Because of this confusion, Dr. Nemeth drafted Advisory 2003-10, which was issued by the Division's executive director on July 22, 2003, followed by Nemeth-drafted Advisory 2003-10B, which the executive director issued on February 24, 2004. The advisories attempted to eliminate the "big hole in the system" by providing an alternative standard for assessing a DRE IV. category when there are no pre-operative x-rays.

The controversial provision included in both advisories stated that "if pre-operative x-rays were not performed, the rating may be determined using the following criteria: . . . b. multi-level fusion meets the criteria for DRE Category IV structural inclusions, as this multi-level fusion is equivalent to multi-level spine segment structural compromise per DRE IV."

The carriers based their complaint about the advisories on the statement in the *Guides* that "[w]ith the injury model, surgery to treat an impairment does not modify the original impairment estimate, which remains the same in spite of any changes in signs or symptoms that may follow the surgery and irrespective of whether the patient has a favorable or unfavorable response to treatment." The carriers further argued that the advisories allowed doctors to place injured workers in categories DRE IV and DRE V when the *Guides* would require them to be placed in DRE II or DRE III, resulting in increased impairment income benefits. In addition, because category DRE III for the lumbosacral translates to a 10% impairment rating while DRE IV. translates to a 20% impairment rating, the advisories allow some injured workers to become eligible for supplemental income benefits when they would not otherwise be eligible under the Labor Code.

Lumbermens filed suit against the Division for declaratory judgment under the Administrative Procedure Act, and the Uniform Declaratory Judgments Act. After trial, the district court entered judgment declaring that the issuance of the advisories was an invalid attempt at *ad hoc* rule making, and that the application of the advisories is an ultra vires act, and enjoining the Division from applying the advisories.

The Division appealed, arguing that the trial court lacked subject matter jurisdiction, that the Division is immune from suit because of sovereign immunity, and that the decision was improper because the advisories are not rules and applying them is within the Division's statutory authority.

Addressing the subject matter jurisdiction issue first, the Austin Court of Appeals rejected the Division's argument that the trial court lacked jurisdiction under the UDJA, and rejected the Division's argument that the carriers with complaints about particular enforcement of the advisories should have taken action to do so by appealing those particular decisions to court per the provisions of the Texas Labor Code. The court rejected this as well, holding that while carriers do object to the appeals panel enforcement of the advisories, the carriers also complained of the issuance of those advisories. The court further reasoned that since the advisories were inconsistent with the *AMA Guides*, issuance of any advisories inconsistent with those *Guides* was outside the Division's authority.

In its third and fourth issues, the Division contended that the trial court erred by declaring the Division's issuance of the advisories was invalid, as well as the trial court's injunction against any further use of the advisories.

The Division first argued that the advisories in question could not be *ad hoc* rules because they are not rules within the definition in the APA. While not specifically addressing this argument and attack on the trial court's characterization of the advisories as an "attempt at *ad hoc* rule making," the Court of Appeals nevertheless held that the advisories were invalid from their issuance, regardless of the label attached to them, because they exceeded the Division's statutory authority. The Court of Appeals further held that under the injury model of the *Guides*, doctors may not use their medical judgment or experience to take surgery or the effect of surgery into account when assigning impairment ratings. The court concluded that by issuing and applying advisories which allowed doctors to do just that, the Division had acted outside its statutory authority because the Fourth Edition of the *Guides* is the only permissible source for determining impairment under the Texas Labor Code.

The Court of Appeals held that, while the current statutory scheme may require revision or amendment, the Division was not authorized to suggest any alternative criteria for determining impairment ratings. It concluded that because the advisories contradict the Fourth Edition of the *Guides* and thus contradict Labor Code §408.124 and Division Rule 130.1, the trial court was correct in declaring that the issuance was invalid and that the application was an ultra vires act, and was proper in enjoining their continued use.

SIBS and Exhaustion of Remedies

***Guideone Ins. Co. v. Cupps*, 207 S.W.3d 900 (Tex. App. – Fort Worth 2006, pet. denied).**

In August 1998 Cupps sustained an injury in the course of her employment with Temple Christian School. She filed a worker's compensation claim, thereafter proceeding to an impairment rating in excess of 15% and an application for supplemental income benefits on the basis that she was permanently and totally disabled. Initially, Guideone paid those supplemental income benefits (SIBS) without contesting her claim of disability.

In July 2003, Guideone investigated Cupps' disability and, as a result, determined that she was not permanently and totally disabled and had been fraudulently obtaining SIBS. Instead of requesting a Benefit Review Conference to contest her entitlement to benefits or requesting the initiation of an administrative violation proceeding, in July 2004 Guideone sued Cupps in state district court for fraud, conversion, negligent misrepresentation, and violation of the theft liability act in seeking SIBS.

Cupps filed a motion for summary judgment asserting, among other things, that the trial court lacked subject matter jurisdiction because Guideone had failed to exhaust its administrative remedies. The court granted the motion, and Guideone appealed.

Guideone first argued that it was not required to exhaust its administrative remedies because the commission did not have exclusive jurisdiction over its claims. The court reasoned that under the exclusive

jurisdiction doctrine, the Legislature grants an administrative agency the sole authority to make an initial determination in a dispute. An agency has exclusive jurisdiction when a pervasive regulatory scheme indicates that the Legislature intended for the regulatory process to be the exclusive means of remedying the problem to which the regulation is addressed. For example, when a cause of action and a remedy are derived not from the common law but from a statute, the statutory provisions are mandatory and exclusive and must be complied with. If an agency has exclusive jurisdiction, a party must exhaust all administrative remedies before seeking judicial review of the agency's action.

In this case, the court determined that the Labor Code was a pervasive regulatory scheme that gives the commission exclusive jurisdiction over Guideone's claims against Cupps:

> The Act "vests the power to award compensation benefits solely in the worker's compensation commission . . . subject to judicial review." *American Motorists Ins. Co. v. Fodge*, 63 S.W.3d 801, 803 (Tex. 2001). This power encompasses disputes involving compensation benefits. *Fodge*, 63 S.W.3d at 804.

The court next turned to §408.147 of the Act, providing that an insurance carrier may request a Benefit Review Conference to contest an employee's entitlement to SIBS. The court also noted that the Act further contains specific provisions addressing administrative violations committed in the course of obtaining worker's compensation benefits, under §415.008 of the Act, which contains provisions for notifying a person accused of administrative violations. That person may then challenge the administrative violations if assessed, proceed to a hearing under the Act on those determinations, and ultimately appeal those determinations for judicial review under Chapter 2001 of the Government Code.

The court concluded that this pervasive regulatory scheme evidences the Legislature's intent to give the commission exclusive jurisdiction to resolve the issues raised by Guideone's claims, either through a Benefit Review Conference or through the administrative violations procedure. The Court of Appeals therefore affirmed the trial court's summary judgment in favor of Cupps.

Death Benefits

***Dunlap-Tarrant v. Association Cas. Ins. Co.*, 213 S.W.3d 452 (Tex. App. – Eastland 2006).**

Angela Dunlap-Tarrant appealed from a take-nothing summary judgment in a worker's compensation case following the trial court's granting of a no-evidence motion for summary judgment by the carrier, Association Casualty Insurance Company. On appeal Dunlap asserted that the trial court erred because there was at least some evidence to support Dunlap's claims.

Dunlap's summary judgment evidence revealed that Robert L. Tarrant left their home in Odessa in his personal pick-up at 5:00 a.m. on Tuesday, August 21, 2001 to drive to his jobsite, a plant in Denver City. At around 6:00 a.m. while on the way to Denver City, Tarrant rolled his pick-up and died later that morning from injuries sustained in the accident. Tarrant's work shift was to start at 7:00 a.m., and he was paid a per diem of $50 for lodging and meals on Monday through Thursday of each week. Tarrant was also paid for travel time and mileage on Monday morning and Friday evening. Rather than using the per diem to stay in Denver City on week nights, Tarrant chose to drive the 117.5 miles back to Odessa every night. The employer's wage statement tended to indicate that Tarrant was paid for some mileage in addition to the one round trip between Odessa and Denver City per week.

In addressing Dunlap's attack of the granting of the no-evidence motion, the court pointed to the traditional definition of compensable injury as "an injury that arises out of and in the course and scope of employment for which compensation is payable." Texas Labor Code §401.001(10). The court further noted that the term "course and scope of employment" does not include transportation to and from the place of employment unless one of several exceptions is met.

On appeal, Dunlap asserted that she presented some evidence showing that Tarrant was paid for his transportation costs and that he was in the furtherance of the affairs of his employer, and that therefore the summary judgment was improper. The court disagreed, holding that even if there was some evidence that Tarrant was being reimbursed for his transportation costs, there must also be some evidence that Tarrant's injury was incurred in the furtherance of the affairs of his employer. The court noted that there

was nothing in the record to indicate that Tarrant was furthering the business of his employer at the time of his accident and held that since Tarrant's trip home was made for purely personal reasons, his return trip to work was not made in the furtherance of the affairs of the employer.

Issue Preservation

***Lopez v. Zenith Ins. Co.*, 2007 WL1150879 (Tex. App. – Eastland 2007, no pet.).**

Lopez was employed at Best Inn & Suites in Midland as a housekeeper, and claimed that she injured herself in the course and scope of her employment on March 21, 2003. Stephanie Carby, an adjuster for Zenith, interviewed Lopez on June 18 and June 23, 2003. The second interview was recorded and was conducted with the benefit of an interpreter. During this interview, Lopez told Carby that she had also hurt herself sometime in April. Carby estimated that the second injury occurred on April 1.

A Benefit Review Conference was held on August 28, 2003, during which Lopez contended that the April incident occurred on April 4, 2003. The parties were unable to reach an agreement during the conference, but apparently did not proceed to a CCH at that time. On September 4, 2003, Zenith filed a notice of controversion which was dated June 25, 2003, and identified the date of injury as April 1, 2003.

A CCH was held in November 2003. Following the hearing, the hearing officer issued a decision, finding that Lopez did not injure herself or suffer damage or harm to the physical structure of her body during the course and scope of her employment, and that she did not timely report an April injury to her employer. The hearing officer further found that Zenith received written notice of the April 1 claim on June 18, and written notice of the April 4 claim on September 13 when Lopez responded to Zenith's interrogatories, and that Zenith therefore did not timely dispute the claims within seven days of receiving notice. However, the hearing officer held that Zenith had not waived its right to contest Lopez's claim because she did not suffer a compensable injury and, therefore, Zenith was not liable for benefits.

Lopez, but not Zenith, appealed this decision to the TWCC appeals panel. The panel utilized the April 4th injury date and found that, because Zenith did not begin paying benefits or deny the claim within seven days of receiving the interrogatories answers, it waived the right to contest the compensability of that injury. Zenith appealed the panel's decision to state court and filed a traditional motion for summary judgment. The trial court granted Zenith's motion and entered a final judgment reversing the appeal panel's decision.

On appeal, the Court of Appeals held that it did not need to address the issue of whether oral notice can constitute a written notice of injury (as argued by Lopez) or if Zenith timely controverted Lopez's claim because the trial court lacked jurisdiction to consider that issue. Noting that the hearing officer specifically found that Zenith did not file a notice of controversion within seven days of receiving written notice of injury, and that only Lopez appealed the hearing officer's findings, the court concluded that Zenith failed to preserve error by filing a cross-appeal of the hearing officer's decision with the appeals panel. The court therefore held that the trial court lacked jurisdiction to consider the new issue of the timely filing of the waiver, because Zenith failed to exhaust its administrative remedies.

Zenith also argued on appeal that the hearing officer's findings implied that the claimant did not injure herself, and therefore relied on *Continental Cas. Co. v. Williamson*, 971 S.W.2d 108 (Tex. App. – Tyler 1998, no pet.), for the proposition that Zenith did not waive its right to contest Lopez's claim because she suffered no injury. The appeals panel rejected this contention, holding that *Williamson* applied only when there was a finding of no injury but not when there was a finding of no compensable injury. The Court of Appeals agreed, reasoning that because the medical records established that Lopez had cervical/brachial syndrome, a shoulder sprain/strain, an elbow injury, and a wrist sprain/strain and because Zenith did not appeal the hearing officer's findings that Lopez had those conditions, *Williamson* did not apply and Zenith waived the right to contest compensability.

Subject Matter Jurisdiction

***Texas Dept. of Ins., Div. of Worker's Compensation v. Jackson*, 2007 WL1218361 (Tex. App. – Eastland 2007, no pet.).**

In this case, the worker's compensation claimant filed suit to appeal the Texas Worker's Compensation Commission's Appeals Panel decision that he was not entitled to lifetime income benefits. The TWCC filed a Petition in Intervention to support the panel's decision, and the case was set for trial. During a hearing on the parties' motions in limine, the TWCC included a request that no party argue or present any evidence on any issue other than Jackson's entitlement to LIBS as of the date of the CCH. After considering the argument, the trial court denied the TWCC's request, allowed Jackson to file a trial amendment, and announced that it would allow evidence of Jackson's disability as of the date of trial. TWCC then urged a plea to the jurisdiction. The trial court denied the plea, but abated the case to allow the TWCC to prosecute an interlocutory appeal. The Court of Appeals reversed and remanded.

After first discussing the administrative dispute resolution process, the Court of Appeals noted that the appeal of a contested case hearing into a judicial review proceeding is not a trial *de novo*, but is limited to review of the CCH record. Holding that "the only exception to this is the CCH, and ultimately, this exception is controlled by the hearing officer, . . . who is the only individual with the authority to excuse exhaustion of administrative remedies upon a showing of good cause." The court next examined the hearing officer's decision. Following the CCH, the hearing officer determined Jackson's eligibility for lifetime income benefits "as of the date of the hearing." Whether Jackson was entitled to lifetime income benefits as of the date of the trial, the court reasoned, was a related but separate question.

In addressing the trial court's concern of judicial economy, that limiting the trial to Jackson's eligibility for LIBS as of the date of the CCH and requiring him to initiate a new administrative proceeding to determine his eligibility for subsequent benefits would be inefficient, the Court of Appeals agreed, but nevertheless held that the Legislature did not give trial courts the authority to excuse exhaustion of administrative remedies and invested sole ability to address subsequent administrative disputes initially in the TWCC, and not with the courts.

The Court of Appeals therefore held that the trial court lacked jurisdiction to consider Jackson's eligibility for LIBS beyond the date of the CCH and sustained the TWCC's ruling.

SIGNIFICANT APPEALS PANEL DECISIONS

Mental Trauma Injury-Evidence

Appeal No. 061729-S (September 28, 2006)

During the robbery of her employer's place of business, the claimant testified that she was held at knife point by the assailant. At issue was whether the claimant sustained a mental trauma injury. At the Contested Case Hearing, the hearing officer found that the claimant did not sustain a compensable physical injury, but that she did sustain a compensable mental trauma injury. The carrier appealed, arguing that the hearing officer erred as a matter of law in finding that the claimant sustained a compensable mental trauma injury.

On appeal, the appeals panel initially recognized that generally, the existence of an injury may be established through the testimony of the claimant alone. However, it also recognized that in Appeal No. 941551 (December 23, 1994), it had previously noted that the cause, progression and aggravation of a mental disease is a subject of such a technical nature that expert medical evidence is required. This holding was bolstered by Appeal No. 960966 (July 5, 1996) which required expert medical evidence to make the necessary causal connection between the mental condition and a specific incident at work.

In this particular appeal, although the occurrence of a traumatic event (the robbery) was undisputed, the hearing officer correctly noted that there was no medical evidence in the record supporting a mental trauma injury. In fact, the medical records contained no diagnosis of mental trauma injury whatsoever.

Given that the record did not include any medical evidence of a mental trauma injury, the appeals panel reversed the hearing officer's determination finding a mental injury, and rendered the decision that the claimant did not sustain such an injury.

Intoxication

Appeal No. 062507-S (January 31, 2007)

On March 29, 2006, the claimant had undergone a pre-employment drug screen, which was negative. He began working on March 30, 2006, going to work at a drilling rig at 5:45 a.m. During the course of that morning's work, the claimant sustained

a crush injury to the ring finger of his right hand, and was taken to a hospital emergency room, undergoing surgery on the right hand. A drug screen performed at the hospital tested positive for amphetamines and positive for methamphetamines. At the CCH to determined the compensability of the injury, the claimant testified that after the pre-employment drug test on March 29, 2006, he met a friend and "snorted" a line of methamphetamine.

Following the CCH, the hearing officer entered a decision that the claimant sustained a compensable injury to the right hand and that the injury did not occur while the claimant was in a state of intoxication. The carrier appealed, contending that the hearing officer failed to apply the proper legal standards to the claimant's proof requirements, and the appeals panel reversed and rendered a new decision.

The appeals panel began by setting forth the new standards promulgated by the Texas Legislature, which became effective September 1, 2005. First, the appeals panel recognized that §406.032(1)(A) provides that the carrier is not liable for compensation if the injury occurred while the employee was in a state of intoxication. Section 401.013(a)(2)(B) defines intoxication as not having the normal use of mental or physical faculties resulting from the voluntary introduction into the body of a controlled substance or controlled substance analog as defined by §481.002 of the Health & Safety Code [a definition in which both amphetamine and methamphetamine are included]. Section 401.013(c) provides that on the voluntary introduction into the body of any such substance, based on a blood test or urinalysis, it is a rebuttable presumption that a person is intoxicated and does not have the normal use of mental or physical faculties.

The appeals panel then held that in this case, the drug screen performed at the hospital established a rebuttable presumption that the claimant was intoxicated based on the positive presence of both amphetamines and methamphetamines.

In the Background Information section of his decision and order, the hearing officer discussed the claimant's testimony regarding his use of methamphetamine, and stated that the claimant testified that "he had the normal use of his mental and physical faculties at the time of the accident." However, the appeals panel noted that the claimant was actually asked "Do you feel you were intoxicated at the time of this injury" to which the claimant replied "No, ma'am". No attempt was made to define intoxication to the claimant or elicit testimony about the normal use of his mental and physical faculties.

The hearing officer also commented in the Background Information section that "it is common knowledge that methamphetamine is a short acting drug that can be detected sometime after its effects have worn off." The appeals panel held that the hearing officer committee reversible error by applying a "common knowledge" standard on the metabolism rate of methamphetamines. It held that the rate and means by which the body metabolizes different substances is not subject to common knowledge and may be affected by several different factors. It therefore held that the metabolism rate of methamphetamine and amphetamines require expert evidence. The appeals panel further held that the hearing officer erred in making no comment or finding regarding the positive drug screen for amphetamines, and the resulting rebuttable presumption of intoxication for amphetamines.

Accordingly, the appeals panel reversed and rendered a new decision that the carrier was relieved of liability by virtue of the claimant's intoxication.

Required Medical Examination Procedure

Appeal No. 062535-S (February 9, 2007)

In this dispute over supplemental income benefits, the parties stipulated that the claimant reached maximum medical improvement with a 30% impairment rating, and applied for and received SIBS for the first twelve quarters. At the CCH over the dispute on entitlement to the thirteenth quarter, the claimant acknowledged that for the qualifying period (which ran from June 2, 2006 to August 31, 2006) he had conducted no job searches. It was further undisputed that the first selected carrier RME doctor was Dr. N, who conducted RME examinations on the claimant in June 2000, August 2003, and on April 14, 2005. After the August 2003 RME, Dr. N rendered the opinion that the claimant was unable to work because of constant pain in the right hip as well as immobility, and because the claimant's pain would limit his ability to concentrate.

At the CCH, the claimant testified that on May 10, 2006, he received and signed a one-page form from the carrier requesting that an RME be scheduled to evaluate the claimant's medical status and requesting that the claimant agree to attend the medical evaluation. The form in evidence did not

indicate which doctor would be selected by the carrier for that examination. At the CCH, the carrier admitted a separate document into evidence, a form DWC-22 dated June 5, 2006, which the carrier asserted was attached to that agreement form assigned by the claimant. However, in his testimony, the claimant denied ever receiving the DWC-22 from the carrier. That DWC-22 indicates that the carrier was selecting Dr. H for the requested RME exam. When the claimant ultimately saw Dr. H, Dr. H sent the claimant for a functional capacity evaluation which indicated that the claimant had some ability to work.

It was further evident from the CCH that the DWC-22 relied upon by the carrier in naming Dr. H did not indicate that the carrier's request to change RME physicians was approved or denied by the Division.

Following the CCH, the hearing officer decided that the claimant was not entitled to supplemental income benefits for the thirteenth quarter and that the carrier was entitled to take action with respect to benefits, including SIBS, based on the report of Dr. H.

The claimant appealed, arguing that the carrier did not comply with Rule 126.5 and 126.6 and urging reversal.

Regarding procedure, on appeal, the carrier argued that it was not required to comply with the applicable provisions of Rule 126.5(a)(b)(1) and (g) because it substantially complied with Rule 126.6(a) which provided in part that "an agreement between the parties for an examination under this title that the carrier has a right to, has the same effect as the Division's formal order." The appeals panel disagreed. It noted that it had previously held that the provisions of Rules 126.5 and 126.6 clearly state that an agreement for an RME is to be made in compliance with the provisions of Rule 126.5. It held that under Rule 126.5, in order for the carrier to change RME physicians, it must first seek approval from the Division.

In this case, there was no evidence that the requested subsequent RME by Dr. H was approved by the Division, and the carrier therefore failed to comply with Rule 126.5(b)(1).

The appeals panel strengthened this holding by noting the preamble to the proposed Rule 126.5, which discussed that previously carriers were obtaining the employees agreement to attend an examination by the carrier's choice of doctor and not reporting the examinations to the Division as required by the previous Rule 126.5.

Accordingly, the appeals panel reversed the hearing officer's decision that the carrier was entitled to rely on Dr. H's report, but nevertheless affirmed the hearing officer's decision that the claimant was not entitled to the thirteenth quarter of SIBS, since the claimant failed to provide a narrative report which specifically explained how the injury caused a total inability to work.

Lifetime Income Benefits - Statutory Construction

Appeal No. 070063-S (March 22, 2007)

At the Contested Case Hearing in this matter, the parties stipulated that the claimant sustained a compensable injury, and that he ultimately underwent a posterior spine reconstructive surgery with multi-level laminectomy with instrumentation, fusion of L3 through L5, and pedical screws bilaterally, with a cage placed at L4-5 in December 2001. Other medical records establish that the claimant "has a terribly failed back syndrome."

Following the Contested Case Hearing over whether the claimant was entitled to lifetime income benefits (LIBS), the hearing officer determined that while the claimant had totally and permanently lost the functional use of his legs, his legs had not been permanently paralyzed due to the compensable spinal injury and therefore the claimant was not entitled to lifetime income benefits. The claimant appealed, and the appeals panel affirmed in part and reversed and rendered in part.

First, the appeals panel affirmed the hearing officer's determination that the claimant had totally and permanently lost the functional use of his legs, since that determination was supported by sufficient evidence.

Next, the appeals panel turned to the statutory provisions with reference to lifetime benefits as they relate to the claimant's condition;

> Section 408.161. **Lifetime Income Benefits**

(a) Lifetime income benefits are paid until the death of the employee for:

* * *

(2) Loss of both feet at or above the ankle;

* * *

(5) An injury to the spine that results in permanent and complete paralysis of both arms, both legs, or one arm and one leg;

(b) For purposes of subsection (a), the total and permanent loss of use of a body part is the loss of that body part.

On appeal, the carrier argued that, based on principles of statutory construction, with a spinal injury the claimant can only be entitled to LIBS if he meets the requirements of §408.161(a)(5). The carrier argued, and the hearing officer agreed, that that section requires a showing of total and complete paralysis of the affected limbs before a spinal injury will entitle the claimant to LIBS for "loss" of the extremities.

In its analysis, the appeals panel compared the current provisions in the LIBS section of the Texas Labor Code to the previous provisions, and held that in enacting the 1989 Act, the Legislature did not intend to change the substantive law with respect to entitlement to LIBS.

Next, the appeals panel went on to point out that "total loss of use" of a member of the body exists whenever that member no longer possesses any substantial utility as a member of the body or the condition of the injured member is such that the worker cannot get and keep employment requiring the use of that member, that this definition was approved by the Texas Supreme Court in *Travelers Ins. Co. v. Seabolt*, 361 S.W.2d 204, 206 (Tex. 1962), and has been consistently applied since then.

Thus, the appeals panel held that the correct standard in determining whether the claimant was entitled to LIBS is whether his legs no longer possessed any substantial utility or whether the condition of the legs was such that he could not get and keep employment requiring the use of the legs.

Accordingly, the appeals panel held that the claimant was entitled to LIBS, and reversed and rendered a decision to that effect.