APPEAL NO. 991872

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on June 23 and July 21, 1999. She (hearing officer) determined that the appellant's (claimant) correct whole body impairment rating (IR) was seven percent arrived at by applying a "pure mathematical correction" to the designated doctor's 28% IR. The claimant appeals this determination, contending that the hearing officer performed not a purely mathematical but an impermissibly substantive correction of the designated doctor's report. The respondent (carrier) replies that the hearing officer, rather than correcting the report of the designated doctor, should have adopted the two percent IR certified by another doctor. It, nonetheless, did not appeal the actions of the hearing officer.

DECISION

Reversed and remanded.

The claimant sustained a compensable right upper extremity nerve injury on _____. Dr. A was the designated doctor selected by the Texas Workers' Compensation Commission (Commission). The parties stipulated that the claimant reached maximum medical improvement on March 17, 1998, the date of Dr. A's examination of the claimant. Dr. A completed a Report of Medical Evaluation (TWCC-69) in which she certified a 28% IR for an injury to the right ulnar and medium nerves.

To arrive at this IR, Dr. A used Tables 10 and 12, and perhaps Table 11, and Figure 47 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides). She first determined that the ulnar nerve roots involved were C8 and T1, and that the median roots involved were C5 and C6. Figure 47, the dermatome chart referred to in Table 10.b.1, refers to C-8 and T1 for ulnar nerve involvement, but refers to C6 through C8 for median nerve involvement, not C5 as included in Dr. A's calculations. The end result for maximum percent of loss for median involvement under Table 12 is five percent and eight percent, whether the nerve root is C5 and C6 or C6 and C7. The correctness of the selection of C5 by Dr. A is, however, problematic because C5 is not listed for the median nerve in Figure 47 and its use in this case may be an improper additive to the IR. Whether it is simply a typographical error we have no way of knowing. In any case, Dr. A then graded the claimant's decreased sensation at 50% pursuant to Table 10.a.3. For sensory loss, the next step would be to multiply 50% times five percent times two (for C8 and T1) and 50% times five percent and 50% times eight percent (for C6 and presumably C7) derived from Table 12. This yields a five percent ulnar right upper extremity IR plus a seven percent median right upper extremity which combines to give a 12% right upper extremity IR which in turn converts to a seven percent whole body IR. *See* Table 3.

Dr. A's calculations reflect an ulnar right upper extremity IR of 50% and a medium right upper extremity IR of 40% which she combined to yield a 27% whole body IR to which

she added one percent more for range of motion (ROM) deficit for a whole body IR of 28%. From her worksheet, these calculations appear to be based only on sensory impairment, not motor or strength loss. And while her calculations appear to reflect a proper source in Table 12 for sensory loss, it is impossible to tell from where she derived the additional impairment, that is, whether it was also for loss of function due to loss of strength under Table 12. If she is using this loss of strength column from Table 12, we question whether her diagnostic worksheets support this use. If there is loss of strength present, we further perceive no source in this column of Table 12 for the figures used and we question how Dr. A applied Table 11, based on her clinical examination of the claimant, to the maximum percent strength loss in Table 12. The Commission sought clarification from Dr. A, but has not received a satisfactory answer, because, we speculate, the right questions were not asked. In addition, we observe that a premise of assigning an IR for a peripheral nerve loss lesion under Part 3.1i of the AMA Guides is that ROM calculations are not to be used in addition to Table 12. *See* p. 36 of the AMA Guides.

Section 408.125(e) provides that the report of a Commission-selected designated doctor assigning an IR is given presumptive weight. Section 408.124 also provides that an award of impairment income benefits "shall be made on an [IR] determined using the" AMA Guides. We have in the past approved a simple mathematical correction of a designated doctor's report to reflect the correct use of the AMA Guides, even though this results in what some may consider an anomaly of an IR not contained in any doctor's report. *See, e.g.*, Texas Workers' Compensation Commission Appeal No. 950616, decided May 24, 1995. *See also* Texas Workers' Compensation Commission Appeal No. 950558, decided May 24, 1995. Our concern in the case we now consider is whether the hearing officer accurately characterized her amendment of Dr. A's report as a mathematical correction. We believe it was more than that and had the effect of imposing a degree of medical judgement on that report. We reach this conclusion for two reasons: first, and most significantly, Dr. A appears to be including some IR for loss of strength, thus attempting to use two columns of Table 12 cumulatively. If Dr. A had a clinical reason for making this attempt, the action of the hearing officer eliminated this possibility based on her own conclusion that what was at issue was only sensory loss. Second, in her recalculation of the IR, the hearing officer correctly did not add loss of ROM. However, the fact that ROM is not an additive may or may not have entered into Dr. A's determination of what grading scheme to select under Table 10 (for sensory loss) and Table 11 (for loss of function).

For these reasons, we reverse the decision of the hearing officer that she made a simple mathematical correction of Dr. A's 28% IR and remand for further inquiry of Dr. A. Such inquiry should be as specific as possible and include: whether Dr. A, in her examination, found both sensory and function loss such that both columns of Table 12 are involved in this rating; whether C5 is the appropriate median nerve root; whether the clinical examination justifies the grading scheme adopted under Table 11, if there is function loss; whether the provisions including ROM are complied with; whether the figures selected for the calculations are contained and identifiable in Table 12 for the nerve roots impaired; and any other questions deemed appropriate. Mindful that we have no more remands in this case, if the hearing officer is still dissatisfied with Dr. A's response (which may include an

additional examination if appropriate in Dr. A's opinion), she may consider the appointment of a second designated doctor or elect an option contained in Section 408.125(e). Except for directly communicating with Dr. A, the parties should be involved in each step of the process of remand to insure that the respective viewpoints are considered by 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 Commission's Division of Hearings, pursuant to Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

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Alan C. Ernst
Appeals Judge

CONCUR:

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Philip F. O'Neill
Appeals Judge

_____
Dorian E. Ramirez
Appeals Judge