APPEAL NO. 002399

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on September 28, 2000. The appellant (claimant) and the respondent (self-insured) stipulated that the claimant reached maximum medical improvement (MMI) by operation of law on June 22, 1998; that on December 23, 1998, Dr. BB, the Texas Workers' Compensation Commission (Commission)-selected designated doctor, assigned a 25% impairment rating (IR); and that on July 27, 2000, Dr. BB amended his report assigning a 14% IR. The hearing officer determined that the amended report dated July 27, 2000, certifying that the claimant's IR is 14% was rendered in accordance with the provisions of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) and is entitled to presumptive weight; that that report is not contrary to the great weight of the other medical evidence; and that the claimant's IR is 14%. The claimant appealed; contended that Dr. BB did not amend the December 23, 1998, certification of a 25% IR because he thought it was wrong; and requested that the Appeals Panel reverse the decision of the hearing officer and render a decision that his IR is 25%. The self-insured replied, contended that the hearing officer properly applied an Appeals Panel decision concerning impairment for acromioplasty and arthroplasty of a shoulder, urged that the evidence is sufficient to support the decision of the hearing officer, and requested that it be affirmed.

DECISION

We reverse and remand.

An operative report from Dr. WB dated October 15, 1997, contains the following:

> FINDINGS AND TECHNIQUE: . . . Under general anesthesia, the left shoulder was prepped and draped in a normal sterile fashion. Diagnostic arthroscopy was performed through a standard posterolateral portal. Marked amounts of degeneration and wear were seen around the anterior labrum, rotator interval, and the glenoid surface. There was significant amount of fraying and wear at the insertion of the bicipital tendon. Debridement through an anterior portal site was performed using a 5-mm full-radius shaver. Debridement of the degenerated tissue and the rotator interval and labrum was performed.
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> Arthroscopic instruments were then extracted from the glenohumeral joint as a lazy-S incision was created over the anterolateral aspect of the shoulder. Bovie cauterization was then used to expose the distal clavicle and acromion, as an oblique subperiosteal incision was performed using Bovie cauterization. A #15 surgical blade was used in a subperiosteal manner, to expose the anteromedial and anterolateral corners of the acromion. The distal clavicle was exposed in a subperiosteal manner using Bovie

cauterization. An anterior and anteromedial acromioplasty was then performed using a large osteotome. Decompression of the subacromial space was performed using rongeurs. The oscillating saw was then addressed to the distal clavicle, as the distal 1-cm osteophytic changes were removed from the distal clavicle.

The wound was then washed out with copious amounts of irrigation. A large triangular 2 cm 1 cm rotator cuff tear was identified over the greater tuberosity. The soft tissue was then debrided longitudinally to reveal the bicipital tendon. The bicipital tendon was cut at its proximal insertion site of the glenoid and advanced distally into the bicipital groove. The bicipital groove was prepared using a dental bur as two corkscrew anchors were placed deep into the bed of the bicipital groove as a bicipital tendon was reapproximated and incorporated into its respective soft tissue closure of the rotator cuff. A dental bur was then used to create petechial bleeding bone from the subchondral layer, over the greater tuberosity for preparation of repair of the rotator cuff. Three Mitek suture anchors were then placed into the proximal humerus as a Mason-Allen suture technique, and the transosseous anchor with double knot (TOADK) technique was performed in creating the rotator cuff tear repair. Easy reapproximation of its original insertion site was performed in an effort that the rotator cuff appeared to be repaired easily. With the bicipital tenodesis and the rotator cuff repair performed, the wound was washed out with copious amounts of normal saline as the deltotrapezial interval was reapproximated using #2 Vicryl in a figure-of-eight suture fashion. The subcutaneous skin was reapproximated using 3-0 Vicryl in a buried suture fashion. The skin was closed in a subcuticular manner using 3-0 prolene.

* * * * *

ADDENDUM: A radical bursectomy was performed immediately after the distal clavicle and acromioplasty procedures.

In a note dated June 2, 1998, Dr. WB stated that he had previously noted that the claimant reinjured himself lifting a 40-pound mop at work; that an MRI shows what appears to be a partial re-tear, but not a total dehiscence of his cuff repair; that the claimant's IR is slightly increased from February 12, 1998, with flexion being 90°, abduction 90°, and the rest the same; that the claimant needs an IR on his back; and that he was sent to Dr. Br for that. The claimant moved to California, and Dr. A became his treating doctor. Dr. A filed a five-page First Industrial Report of Injury dated July 24, 1998. It contains:

Patient eventually underwent left shoulder rotator cuff repair with biceps tenodesis and distal clavicle excision with acromioplasty. Patient continued to work and noted he began having gradual increase in left shoulder pain again. According to records, he underwent a repeat MRI of the left shoulder

> by [Dr. WB] on April 25, 1998, which showed significant degraded images related to artifact from prior acromioplasty and rotator cuff tear; a localized collection of fluid in the anterior aspect of the subdeltoid bursa. This was felt to possibly [be] due to recurrent tear.
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> * * * * *
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> The patient has tenderness on palpation of the left shoulder with limited range of motion [ROM] of the shoulder. Flexion of the left shoulder is 56°, abduction 70°, internal rotation 60°, external rotation 35°, extension 30°. The right shoulder shows extension 30°, abduction 170°, flexion 170°, internal rotation 60°, and external rotation 80°. There is no asymmetry in bilateral upper extremities.
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> * * * * *
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> The patient shows a 20% total body disability in the spine precluding very heavy lifting. Patient has an upper extremity impairment due to the lack of rotation, abduction, and flexion of 14%.

In a Report of Medical Evaluation (TWCC-69) dated August 10, 1998, Dr. WB certified that the claimant reached MMI on August 10, 1998, with a 28% IR. In a note date August 10, 1998, Dr. WB stated that he received the claimant's IR of the lumbar spine from Dr. A and combined the 20% for the lumbar spine with the 8% for the upper extremity to determine the 28% IR. Dr. A continued to treat the claimant and kept him off work. In a report dated May 4, 2000, Dr. A reported that the claimant continued to have significant pain in his shoulder, that the diagnoses were rotator cuff tear and myofascial shoulder pain, that the claimant will continue with therapy and will remain off work, and that his disability status was permanent and stationary.

In a TWCC-69 dated December 23, 1998, Dr. BB, the designated doctor, stated that he was not asked to address the date the claimant reached MMI and certified that the claimant's IR was 25%. In attachments to the TWCC-69, Dr. BB stated that he used the AMA Guides to determine the claimant's IR; summarized the medical reports he reviewed, including the operative report of Dr. WB; stated that the diagnoses included "[l]eft rotator cuff tear (727.6) status post repair, with biceps tenodesis and acromioplasty, bursectomy Mumford procedure, recurrent tear highly suspected"; included ROM measurements for the left shoulder and a note stating "left acromioplasty 24% U.E. (Per Table 19)"; and wrote:

> Regarding the left shoulder, [claimant] has an impairment of the upper extremity due to loss of [ROM] which equals 14% and an impairment of the upper extremity per Table 19 of 24%. Using the combined values chart, this is 35%, which equates to 21% of the whole person, based on the left shoulder.

Dr. BB combined the 21% for the upper extremity with 5% for the lumbar spine to arrive at the 25% IR.

The self-insured had the report of Dr. BB reviewed by a physician's assistant. In a letter dated January 26, 1999, the physician's assistant stated that the designated doctor established the procedure as an acromioplasty and that under Appeals Panel decisions an acromioplasty does not warrant a rating under Table 19. The self-insured sent a letter dated February 1, 1999, to the Commission. The letter includes:

> First, referring to Table 19, this award is for an arthroplasty of specific bones or joints. An acromioplasty would eliminate this aspect of the [IR]. Acromionoplasty [sic] and arthroplasty are not synonymous. Second, the shoulder has been defined by the Guides, in Table 17, as the glenohumeral joint. The acromioclavicular joint, where the acromioplasty occurred, would not qualify under this definition. Third, the Appeals Panel has ruled in numerous decisions the the acromioclavicular joint does not warrant this impairment. Therefore, nothing [sic] that the Designated Doctor has clearly established this as an acromioplasty, this would not warrant a Table 19 impairment.
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> * * * * *
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> 4.) Please state reason for the use of Table 19, in assessing a 24% upper extremity impairment for an acromioplasty when this award is for an arthroplasty of specific bones or joints.
>
> 5.) If your medical opinion is changed as to the Whole Body of Impairment, please submit an amended T.W.C.C. 69.

Even though the letter is dated February 1, 1999, a stamp on it indicates that it was received by the Commission field office handling the claim on January 24, 2000. In a letter to Dr. BB dated February 4, 2000, a Commission disability determination officer provided Dr. BB a copy of the February 1, 1999, letter; asked him to review the letter; and requested that he respond.

In a supplemental report dated July 27, 2000, Dr. BB noted that the request for additional information and clarification was more than one year after his original report and wrote:

> Obviously, I believed I was using the criteria you established and the worksheets you require using to make determinations relative to [claimant's] impairment.
>
> As to the left shoulder impairment, the Table 19 listing of specific bones or joints for impairment due to resection arthroplasty lists "shoulder", without

specific joints named. Likewise, the text under the heading Arthroplasty on page 46 of the Guides, does not specify only one joint. The instructions 3.1k, pg 43, do not state that Table 19 is defined by Table 17 or that they are only to be used in conjunction with each other. If as Ms. Villela [Ms. V] states, the Appeals Panel has made "numerous" rulings on this matter, it would seem the issue is not clearly defined in the Guides. If in fact your Appeals Panel has decided that the AC [acromioclavicular] joint does not warrant the impairment allowance, then so be it. It would seem the decision is not mine to make.

Regarding the left shoulder [ROM], 15% upper extremity impairment per Table 8 would be equal to 9% whole person.

* * * * *

In summary, per your determinations, the whole person impairment would be 9% (shoulder) plus 5% (back), for a combined total of 14%.

The first Appeals Panel decision on the interpretation of Table 19 of the AMA Guides as it relates to the shoulder is Texas Workers' Compensation Commission Appeal No. 94583, decided June 21, 1994. In that case, the operative report was not in evidence. In a letter dated April 23, 1993; Dr. R, the surgeon who was the claimant's treating doctor, wrote:

The patient did have a resection arthroplasty which adds 24% impairment to his upper extremity which comes to 15% overall total body impairment. This plus the 2% for loss of [ROM] gives him a final [IR] of 17%.

Dr. P, the designated doctor, in a narrative attached to a TWCC-69 dated September 29, 1993, stated that he had not received any of the claimant's medical records; said that a resection of the distal aspect of the clavicle is not a resection arthroplasty as used in Table 19; and assigned a 4% IR for loss of ROM.

In a letter dated November 17, 1993, Dr. E, who apparently has a Ph.D. and performed impairment evaluations for Dr. R, stated:

[Claimant] underwent surgical removal of part of the right acromion at the acromioclavicular joint (resection arthroplasty, in particular, acromioplasty) for reshaping the injured joint to alleviate pain and restore function.

Under the heading and section 3.1j [should be k] Impairment Due to Other Disorders of the Upper Extremity, subheading "Arthroplasty" (page 50), a table (Table 19) is provided to determine [IRs] for specific joints of the upper extremities. The determination for the procedure in [claimant's] case is Level of Arthroplasty - Shoulder, Resection Arthroplasty - 24% upper extremity,

> which explains the increase in rating for permanent impairment. The acromioclavicular joint is considered part of the shoulder complex.

On November 23, 1993, a Commission benefit review officer sent Dr. P the claimant's medical records and asked him whether he changed his opinion as to whether the resection of the distal aspect of the clavicle is a resection arthroplasty as used in Table 19 of the AMA Guides. In a letter dated December 9, 1993, Dr. P responded:

> Table 19 of the [AMA Guides] refers to a resection arthroplasty of the shoulder. That refers to the glenohumeral articulation as does an implant arthroplasty which is in the next column over. We are talking about a removal of the upper head of the humerus and/or a total joint replacement. That is a resection arthroplasty of the shoulder joint. That is not what this patient had. What he had was a resection of the distal aspect of the clavicle in an attempt to deal with an abnormal acromioclavicular joint.

The hearing officer determined that the designated doctor did not include a value as a result of the claimant's surgery because, in his opinion, the claimant had a resection of the distal end of the clavicle, as opposed to a resection of the proximal aspect of the humerus or of the humeral head which would serve as basis for additional impairment under Table 19 of the AMA Guides; that the great weight of the other medical evidence is not contrary to the report of the designated doctor; and that the claimant's IR is 4% as assigned by the designated doctor. The Appeals Panel wrote:

> This case clearly presents difficult choices, where the designated doctor disagrees with the treating doctor who performed the surgery as to the scope of that surgery. Nevertheless, based upon the very limited medical evidence in the record, we cannot say that the hearing officer erred in determining that the "great weight" of the medical evidence did not override the designated doctor's report.

The Appeals Panel did not specifically address whether the report of Dr. P was made in compliance with the provisions of the AMA Guides. It affirmed the decision of the hearing officer.

In Texas Workers' Compensation Commission Appeal No. 960844, decided June 20, 1996, the designated doctor, Dr. N, assigned a 25% IR, including upper extremity impairment of 24% for a "non-implant resection arthroplasty of the joint" under Table 19 of the AMA Guides. Dr. O reviewed medical records for the carrier and stated that the AMA Guides left out the acromioclavicular joint for arthroplasty, that leaving that out was an oversight, that it was corrected in the fourth edition of the Guides, that impairment for loss of ROM of the shoulder could be given, but that impairment for a specific disorder under Table 19 could not be given. The Appeals Panel wrote:

With regard to Dr. O's argument that the distinction between acromioplasty and arthroplasty was an oversight later corrected by the Guides, he stated that he had been taught at a Commission-sponsored designated doctors' course to adhere strictly to the statutorily-prescribed version of the Guides, and that "in that light, I cannot and shall not make ANY reference to future Guides." He said that at this course he had raised a question concerning the lack of distinction between the AC joint and the gleno-humeral joint and did not receive any guidance. He stated:

> I was told that the AC joint is as integral to shoulder function (and disease there can be just as disabling as if it were to affect the gleno-humeral joint), that in standard medical texts it is determined to be an integral part of the shoulder-joint complex and that, as such, it must be left to the individual examining physician (almost at his/her whim, with little specific guidance from the 3rd edition of the Guide [sic] to judge whether or not to count it as so. In this particular case, shoulder function is impaired to an extend [sic] that I opted to count it. I concur that awarding such a high percentage may not be appropriate, but then, the Guide [sic] offers no opportunity to just arbitrarily decrease it. If [the Commission] now wishes to express more clear guidelines, I'd love to hear them.

* * * * *

In his discussion of the evidence, the hearing officer wrote as follows:

The reviewing doctors disagree with the impairment assigned by the designated doctor. Specifically, [Dr. O] cites two Appeals Panel decisions as proof that the Commission does not accept the acromioplasty procedure as an arthroplasty. In reviewing the decisions quoted by [Dr. O], it is apparent the Appeals Panel determined that the decision is a medical one, not a legal one. In the cases involved, the Appeals Panel upheld a Hearing Officer who upheld a designated doctor who chose not to treat the procedure as an arthroplasty. In the case at hand, the designated doctor chooses to treat the operations as an arthroplasty. [Dr. N] points out in his report that this area is unclear with no guidance from the Guides. A later edition does rate an acromioplasty at a ten percent (10%) upper extremity impairment. [Dr. O] argues that no rating should be allowed since there is none provided in the Guides which [Dr. N] states it is in his discretion to make that determination. The Appeals Panel decisions support [Dr. N's] decision and Claimant is entitled to the higher [IR].

* * * * *

> The Appeals Panel has addressed issues same or similar to the ones herein on three prior occasions. In [Appeal No. 94583, *supra*], we affirmed a hearing officer's acceptance of the IR of the designated doctor, who disagreed with the treating doctor that the claimant had undergone a resection arthroplasty involving removal of part of the right acromion at the AC joint. The designated doctor disagreed, stating that the resection of the distal aspect of the clavicle is not a resection arthroplasty as that phrase is used in Table 19 of the Guides, and thus should not be included in assessing an IR. In that case, we held that the great weight of the medical evidence did not overcome the designated doctor's report. The same result was reached in Texas Workers' Compensation Commission Appeal No. 941545, decided January 2, 1995. In Texas Workers' Compensation Commission Appeal No. 951188, decided August 31, 1995, the designated doctor, having originally given a three percent IR, changed the claimant's IR to 16% to include upper extremity impairment and [ROM] impairment. He later re-amended his report, leaving intact only impairment for loss of [ROM]; this was due to his opinion, based upon discussion with orthopedic surgeons, that "[b]ecause an acromioplasty is not an invasive procedure into the joint capsule, many feel that an acromioplasty does not count as a resection arthroplasty as per Table 19, page 47. Thus, it is no longer clear that acromioplasty alone merits impairment as per Table 19, under Resection Arthroplasty of the shoulder." The Appeals Panel affirmed the amended IR, noting that the claimant did not offer medical evidence to the contrary and stating that whether the claimant's surgery fell within the tables or terms used in the Guides "is primarily a medical, and not a legal, decision."
>
> Unfortunately, the Guides themselves do not explicitly answer the question posed by the above cases and the instant case. Nor, it appears from Dr. N's correspondence, has the Commission provided any guidance, at least at the time Dr. N made his inquiry in 1994. However, one of the legislative intents behind the 1989 Act was, as noted in 1 MONTFORD, BARBER & DUNCAN, A GUIDE TO TEXAS WORKERS' COMP REFORM § 4B.24, Butterworth Legal Publications, Austin (1991), "to achieve uniformity in permanent income benefits determinations." This end cannot be achieved if a particular surgical procedure is rated by one designated doctor but is rejected by another. We therefore hold that our prior decisions are precedential, and that we must remand to allow Dr. N to determine claimant's IR without reference to any specific disorder rating relative to claimant's acromioplasty (although, as noted in the above-cited decisions, and argued herein, [ROM] impairment can be given).

Section 3.1k of the AMA Guides is entitled Impairment Due to Other Disorders of the Upper Extremity and begins on page 42. It provides in part:

Other derangements can contribute to impairment of the hand and upper extremity and should be considered in the final impairment determination, including bone and joint deformities (including postreconstructive surgery) and musculotendinous disorders. Impairments due to skin disorders of the upper extremity, including scars, are evaluated according to the criteria in Chapter 13.

Table 16 shows relative impairment values of the upper extremity for the *loss of function* of the hand, wrist, elbow and shoulder due to the conditions described below. This table is distinct from Figure 2, which shows *values for amputation* at these levels. Table 17 more finely converts upper extremity joint abnormalities to impairment of the digit, hand, upper extremity and whole person, using the relative impairments of Table 16.

Bone and Joint Deformities
Joint Crepitation with Motion

Joint crepitation with motion can reflect synovitis or cartilage degeneration. The impairment degree is multiplied by the relative value of the joint.

The evaluator must use appropriate judgment to avoid duplication of impairments when other findings, such as synovial hypertrophy or carpal collapse with arthritic changes, are present. The latter findings could indicate a greater severity of the same underlying pathological process and take precedence over joint crepitation, which should not be rated in these instances.

Joint Crepitation Severity	**% Joint Impairment**
Mild: Inconstant during active ROM	10
Moderate: Constant during active ROM	20
Severe: Constant during passive ROM	30

* * * * *

Table 17. Impairment Values for Digits, Hand, Upper Extremities, and Whole Person for Disorders of Specific Joints

Joints	**% Impairment of Unit**	**% Impairment of Hand**	**% Impairment of Upper Extremity**	**% Impairment of Whole Person**
Shoulder				

Glenohumeral	–	–	60	36
Elbow				
Ulnohumeral	–	–	50	30
Proximal Radioulnar	–	–	20	12

[Continues with wrist, thumb, etc.]

* * * * *

Arthroplasty

Simple resection arthroplasty is given 40% of the impairment of the upper extremity due to loss of function of a joint; implant arthroplasty is given 50% of the impairment of the upper extremity due to loss of function of a joint. Table 19 provides [IRs] for the upper extremity for arthroplasty of specific joints, based on these values. Arthroplasty impairment may be combined with impairments due to restricted [ROM], using the Combined Values Chart (*Note*: [ROM] impairments must be brought to the level of the upper extremity before combining can occur).

[Examples concerning the wrist, fingers, thumb, and hand are provided. Examples concerning the shoulder and elbow are not provided.]

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Table 19. Impairment of the Upper Extremity Following Arthroplasty of Specific Bones or Joints

Level of Arthroplasty	**Resection Arthroplasty % Impairment of Upper Extremity**	**Implant Arthroplasty % Impairment of Upper Extremity**
Shoulder	24	30
Total elbow	28	35
Radial head (isolated)	8	10
Total wrist	24	30

[More bone and joints and percentages are listed.]

The following definitions are from DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, (28th ed. 1994):

> acromioclavicular - pertaining to the acromion and clavicle, especially to the articulation between the acromion and clavicle.
>
> acromioplasty - surgical removal of the anterior hook of the acromion to relieve mechanical compression of the rotator cuff during movement of the glenohumeral joint; called also *anterior acromioplasty*.
>
> arthroplasty - plastic surgery of a joint or of joints; the formation of movable joints.
>
> glenohumeral - pertaining to the glenoid cavity and to the humerus.
>
> glenoid - resembling a pit or socket; see *cavitas glenoidalis*.
>
> resection - excision of a portion or all of an organ or other structure.
>
> shoulder - the junction of the arm and trunk; also that part of the trunk which is bounded at the back by the scapula.

It appears that in Table 17, the use of "Glenohumeral" under "*Shoulder*" was not done to define shoulder, but was used to provide the percent of impairment for surgery to a specific part of the shoulder. It further appears that acromioplasty was inadvertently omitted. There is no doubt that an acromioplasty was performed. The operative report describes other procedures. Debridement was performed, perhaps on the glenoid surface. A tendon was cut at the proximal insertion site of the glenoid and reattached. A radical bursectomy was performed immediately after the distal clavicle and acromioplasty procedures. The designated doctor did not change his mind about the impairment that he assigned for the surgery, but stated that it seemed that the decision was not his to make. The designated doctor made his decision to amend his initial report based upon a letter from the self-insured to the field office handling the claim that is not completely accurate.

The hearing officer made Finding of Fact No. 2 that states:

> [Dr. BB's] report of July 27, 2000, is entitled to presumptive weight because he is the designated doctor and it correctly applies the standards set forth in the [AMA Guides].

She also made a finding of fact that the great weight of the other medical evidence is not contrary to that report. She made a conclusion of law and rendered a decision that the claimant's IR is 14%. We reverse those determinations. We remand for the hearing officer to obtain another report from the designated doctor and to make the necessary determinations to decide the claimant's IR. The designated doctor is to be advised that

under the provisions of the AMA Guides, as interpreted by the Commission, an acromioplasty is not to be rated as resection or implant arthroplasty of the shoulder because only glenohumeral was listed under shoulder in Table 17 of the AMA Guides and acromioplasty was not. He should further be advised that he should review the operative report to determine if the operative procedures result in an impairment for an arthroplasty and to determine if the claimant's condition results in other impairment under the provisions of Section 3.1k of the AMA Guides.

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.

Tommy W. Lueders
Appeals Judge

CONCUR:

Gary Kilgore
Appeals Judge

Thomas A. Knapp
Appeals Judge