APPEAL NO. 052243-s
FILED NOVEMBER 29, 2005

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 August 29, 2005. The issues at the CCH were: (1) whether the respondent (claimant) has reached maximum medical improvement (MMI), and if so, on what date; and (2) the claimant's impairment rating (IR). The hearing officer resolved the disputed issues by deciding that: (1) the claimant reached MMI on October 20, 2003; and (2) the claimant's IR is 19%. The appellant (carrier) appealed, contending that the date of MMI found by the hearing officer is four months past the statutory date of MMI; that the designated doctor did not properly apply 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) in assigning the 19% IR; and that the claimant reached MMI on July 17, 2002, with an 11% IR as reported by the carrier's required medical examination (RME) doctor. The claimant responded that the hearing officer's decision should be affirmed.

DECISION

Reversed and remanded.

BACKGROUND INFORMATION

The claimant sustained a compensable injury on _____, when she fell while performing her job duties. She fell on her right knee, right hand, and right elbow, and later developed problems with her right shoulder and depression. She fractured her right hand in the fall and developed reflex sympathetic dystrophy (RSD), which is also referred to as complex regional pain syndrome (CRPS).

The initial treating doctor saw the claimant on June 18, 2001, and diagnosed the claimant as having a fracture of the right fifth metacarpal. He reported that the claimant's work-related injury prevented the claimant from returning to work as of _____. A splint was applied to the right hand and later a cast was applied. In July 2001, the initial treating doctor diagnosed the claimant as having "RSD (CRPS I)" and in August 2001 noted RSD of the right hand and wrist and referred the claimant to a pain clinic for that condition. In October 2001, the initial treating doctor reported that the claimant was experiencing depression as a result of her work-related injury and RSD and recommended that a psychologist see her. Also in October 2001, the initial treating doctor noted that the claimant had "slowly healing RSD (CRPS II)" and he was concerned about extension of the RSD into the elbow. He also noted that the claimant was having pain in her right shoulder. In November 2001, the initial treating doctor noted right arm "RSD (CRPS I)" with shoulder signs. In December 2001 and January 2002 the claimant had several psychotherapy sessions for diagnosed depression. The initial treating doctor continued to treat the claimant through April 14, 2003, and work

status reports reflect that he continued the claimant in an off-work status through that date. The claimant was referred to another doctor for her shoulder problems.

The claimant had physical therapy. The doctor at the pain clinic gave the claimant stellate ganglion blocks for her right arm "CRPS" and noted in April 2002 that the claimant was at MMI with regard to her right hand and discharged the claimant from the pain clinic. The claimant returned to the pain clinic in February 2003 upon referral from the initial treating doctor for recurrence of signs and symptoms of CRPS of the right hand and wrist, and reports reflect treatment at the pain clinic through August 2003. A doctor who may have been the second treating doctor reported in September 2004 that the claimant had resolving RSD and discharged her from his care.

The designated doctor examined the claimant on July 17, 2002, and in a Report of Medical Evaluation (TWCC-69) certified that the claimant reached MMI on July 17, 2002, with a 15% IR. The 15% IR included impairment for the right hand (fingers), right wrist, and right shoulder, and for RSD. The designated doctor noted that the claimant's fracture was healed. A carrier peer review doctor reviewed the designated doctor's TWCC-69 with the 15% IR and reported that the IR should be 10%. A carrier RME doctor examined the claimant on March 17, 2003, and in a TWCC-69 certified that the claimant reached MMI on July 17, 2002, with an 11% IR. The designated doctor reexamined the claimant on December 3, 2003, and in a TWCC-69 certified that the claimant reached statutory MMI on October 20, 2003, with a 19% IR. The 19% IR included impairment for the right hand (fingers), right wrist, and right shoulder, and for RSD/CRPS and depression. The carrier's peer review doctor reviewed the designated doctor's TWCC-69 with the 19% IR and concluded that it contained several errors.

In a letter dated August 11, 2005, a person identified herself as the adjuster handling the claimant's workers' compensation claim and stated that the claimant was taken off work on _____, based on a medical report from the employer; that the initial treating doctor took the claimant off work; that the claimant was eligible for and received salary continuation from the employer that started when she was taken off work and continued for 120 days concluding on October 15, 2001; and as a result, temporary income benefits (TIBs) were started on October 16, 2001.

The claimant testified that on the day of her work-related injury, _____, she was taken to the employer's airport emergency room, that she has been unable to work since that time, and that her inability to work began on the day of the injury. The claimant was not asked about salary continuation.

MMI ISSUE

The carrier asserts that the hearing officer erred in determining that the claimant reached MMI on October 20, 2003, the date identified as the date of statutory MMI in the designated doctor's TWCC-69 of December 3, 2003. The carrier contends that the claimant reached MMI on July 17, 2002, the date of MMI certified by the designated doctor in his TWCC-69 of July 17, 2002, and the date certified by the RME doctor. The

carrier also contends that the October 20, 2003, date of MMI is four months past the date of statutory MMI.

Section 401.011(30) provides that MMI means the earlier of:

(A) the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated;

(B) the expiration of 104 weeks from the date on which income benefits begin to accrue; or

(C) the date determined as provided by Section 408.104.

It is undisputed that the claimant's statutory date of MMI was not extended under Section 408.104.

An injured worker's accrual date for TIBs is the worker's eighth day of disability. 28 TEX. ADMIN. CODE § 124.7(b) (Rule 124.7(b)). Disability means the inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage. Section 401.011(16).

Section 408.003(f) provides as follows:

(f) Salary continuation payments made by an employer for an employee's disability resulting from a compensable injury shall be considered payment of income benefits for the purpose of determining the accrual date of any subsequent income benefits under this subtitle.

Section 408.121(a) provides that an employee's entitlement to impairment income benefits begins on the day after the date the employee reaches MMI.

Rule 129.1(1) provides as follows:

(1) Salary Continuation (also Wage continuation)—Monies paid by the employer to compensate the injured employee (employee) for wages lost as a result of a compensable injury. Salary continuation does not include monies paid to an employee as compensation for work such as wages paid while an employee is on modified duty.

In Appeals Panel Decision (APD) 050565, decided May 2, 2005, the Appeals Panel held that an injured worker had disability for a period of time he was unable to work after his compensable injury but received salary continuation.

The claimant's attorney stated in opening statement that there was no dispute that the claimant began losing time immediately after the injury and that she did have

salary continuation "until October" and that is when TIBs were initiated. The carrier's attorney stated in opening statement that the claimant began losing time immediately on the date of injury and never returned to work, and that although she was paid salary continuation for a period of time by the employer, that does not mean that disability was not running during that time period and, therefore, an MMI date of October 20, 2003, is past the 104 weeks. The carrier's position was that the July 17, 2002, MMI date first assigned by the designated doctor was the correct MMI date. In closing argument the carrier referenced Section 408.003(f) and contended that the statutory date of MMI was June 22, 2003. The claimant testified that her inability to work began on the day of injury, _____, and has continued since that date. As noted, the claimant did not testify about salary continuation, but there is the previously mentioned adjuster's note in evidence regarding salary continuation until October 15, 2001.

In the designated doctor's second TWCC-69, dated December 3, 2003, wherein he determined that the claimant reached statutory MMI on October 20, 2003, with a 19% IR, the designated doctor noted that he had previously examined the claimant on July 17, 2002, for an IR and had assigned a 15% IR and that in a letter dated November 19, 2003, the Texas Department of Insurance, Division of Workers' Compensation (Division) asked him again to determine whether the claimant had reached MMI and, if so, the IR. The designated doctor also stated:

> Since the [IR] on 17 July 2002, she relates she has had more stellate ganglion blocks by [pain clinic doctor]. She has had to change treating doctors because [initial treating doctor] no longer participates in the Worker's Compensation program. Other than that, I am not certain why she is being sent back for another [IR]. She has her previous Worker's Compensation form which states she had to be at MMI by 20 October 2003. This was her statutory MMI. Since she has had some treatment since I last saw her, I placed her on [MMI] on 17 July 2002. I will now place her on statutory MMI on 20 October 2003. She has not gone back to work and, according to her, she is worse.

Considering the claimant's testimony and the medical reports, it appears that the claimant's disability began on _____, and continued thereafter, and that the October 20, 2003, date of MMI is several months beyond the statutory date of MMI, which we calculate to be June 22, 2003. The fact that the employer paid the claimant salary continuation for a period of time while she was off work due to her compensable injury does not exclude that period of time from the calculation of statutory MMI (the expiration of 104 weeks from the date income benefits began to accrue) when Section 408.003(f) is applied. Pursuant to Rule 130.1(c)(3), assignment of an IR for the current compensable injury shall be based on the injured employee's condition as of the MMI date considering the medical record and the certifying examination. We remand the case to the hearing officer for the hearing officer to inform the designated doctor of the statutory date of MMI and for the designated doctor's determination on whether the claimant reached MMI on a date prior to statutory MMI or not until statutory MMI was reached.

IR ISSUE

The carrier contends that the hearing officer erred in determining that the claimant's IR is 19% as reported by the designated doctor in his second TWCC-69. It is undisputed that the claimant's compensable injury includes RSD. The carrier contends that the designated doctor erred in using Table 17 on page 57 of the AMA Guides to rate the claimant's RSD.

Section 3.1k of the AMA Guides is entitled "Impairment of the Upper Extremity Due to Peripheral Nerve Disorders." The last part of Section 3.1k, which is on page 56, is entitled "Causalgia and Reflex Sympathetic Dystrophy" and provides as follows:

Causalgia and Reflex Sympathetic Dystropy

> Causalgia is a term that describes the constant and intense burning pain usually seen with reflex sympathetic dystrophy (RSD) when the causative lesion involves injury to a nerve.
>
> The term "major causalgia" designates an extremely serious form of RSD produced by an injury to a major mixed nerve, usually in the proximal portion of the extremity. The term "minor causalgia" designates a more common form of RSD produced by an injury to the distal part of the extremity involving a purely sensory branch of a nerve.
>
> Other forms of RSD not associated with injury of a peripheral nerve include minor traumatic dystrophy, shoulder-hand syndrome, and major traumatic dystrophy.
>
> The four cardinal signs and symptoms of RSD are pain, swelling, stiffness, and discoloration. The diagnosis of RSD may be supported with a three-phase nucleotide flow study, cold stress testing, recurrence of pain after previously successful stellate ganglion blocks, in which case Horner's syndrome must be present, or Bier blocks.
>
> The impairment secondary to causalgia and RSD is derived as follows:
>
> 1. Rate the upper extremity impairment due to loss of motion of each joint involved (Sections 3.1f through 3.1j).
>
> 2. Rate the sensory deficit or pain impairment according to instructions in this section and Table 11a (p. 48).
>
> 3. Rate the motor deficit impairment of the injured peripheral nerve, if it applies (Table 12a, p. 49).

4. The appropriate impairment percents for loss of motion, pain or sensory deficits, and motor deficits if present are *combined* using the Combined Values Chart (p. 322) to determine the upper extremity impairment. Major causalgia may result in a complete loss of function and an impairment of the extremity as great as 100%.

Section 3.1l of the AMA Guides is entitled "Impairment Due to Vascular Disorders of the Upper Extremity" and is on page 57 of the AMA Guides. Table 17 on page 57 of the Guides is entitled "Impairment of Upper Extremity Due to Peripheral Vascular Disease." Page 57 of the AMA Guides states "Table 17 (below) provides a classification of impairments due to peripheral vascular disease."

The designated doctor mentions RSD and causalgia several times in assigning the 15% IR in the narrative report to his first TWCC-69 dated July 17, 2002. The designated doctor stated "Thus, to rate her, I first rated the [RSD]. For this, I believe page 57 applies, i.e., the first column, 0-9%." Although the designated doctor did not specifically mention Table 17, it is clear that he used that table because Table 17 on page 57 of the AMA Guides provides for an upper extremity impairment of "(0-9)" for "Class 1." The designated doctor then stated in the next paragraph in his narrative report that:

> On physical examination, one notes the lack of range of motion [ROM] of the right wrist and the contractures at the proximal interphalangeal joints at the index, long, ring, and small fingers. The temperature is clearly different, even after forty-five minutes in the room with her, and discussing her case and examining her. Thus, I believe that a 9% impairment of the upper extremity for [RSD] is indicated.

After assigning a 6% upper extremity impairment for the right shoulder for capsulitis, the designated doctor stated "Next, as noted in the RSD page, I rated [ROM] of the wrists." The designated doctor provided his findings on ROM and stated "Thus, the upper extremity rating is 8% for loss of [ROM] of the right wrist due to trauma and subsequent [RSD]."

In addressing the 9% upper extremity impairment the designated doctor assigned for RSD, the carrier's peer review doctor stated:

> The first aspect of this [IR] was for [RSD]. [The designated doctor] assigned this from Table 17 on page 57. The error is that this table is for peripheral vascular disease. This is a peripheral neurologic malady. Further, the basis for a [RSD] [IR] is noted on page 56. The proper method would be to assign an [IR] for loss of [ROM], loss of sensation and loss of motor. Noting that the [ROM] was assigned an [IR] separately, this 9% upper extremity [IR] would be redundant.

The carrier's RME doctor also disagreed with the designated doctor's use of Table 17 on page 57 of the AMA Guides for rating RSD, and stated that the appropriate method for rating RSD is given on page 56. The RME doctor stated that the 11% IR he assigned was based on the protocol on page 56.

In the narrative report to the TWCC-69 dated December 3, 2003, wherein the designated doctor certified that the claimant reached statutory MMI on October 20, 2003, with a 19%, the designated doctor assigned impairment for depression due to pain, crepitus of the right shoulder, loss of ROM of the right wrist, and flexion contractures of the fingers of the right hand. With regard to rating RSD, the designated doctor stated:

> She is also rated as before for [RSD] or what is more correct [CRPS]. The page designation for this is 3-56. Since I have been asked questions on this before, I will be very clear. She meets the criteria. She has pain, stiffness, and discoloration and temperature changes in the right hand compared to the left. This is the same as the last time. Even after half an hour in the office, her right hand is colder than the left hand. There is no swelling today. However, this qualifies as a [RSD]. It is rated under Table 17, Upper Extremity Impairments, Class 1. It has progressed. However, by tape measure, there is no atrophy in the arm or forearm. There is no atrophy of the intrinsic muscles. Thus, it does not support a rating other than Class 1, so she is given a 9% upper extremity impairment, Class 1, for a peripheral vascular disease, i.e., causalgia [RSD] which is more correctly [CRPS]. She receives a 9% upper extremity rating for this.

The carrier's peer review doctor reviewed the designated doctor's report of a 19% IR and, with regard to the rating for RSD, noted that the designated doctor had correctly cited page 56 of the AMA Gudies for the part pertaining to RSD, but then used Table 17 to assign the IR, which was incorrect because RSD is not a peripheral vascular disease and use of Table 17 is not how the AMA Guides instruct on how to assign an RSD IR.

It is clear that the designated doctor used Table 17 to assign the claimant a 9% upper extremity impairment for RSD in both his first and second TWCC-69s. Table 17 on page 57 of the AMA Guides is for rating upper extremity impairment due to peripheral vascular disease. The designated doctor did not explain why he used Table 17 to rate the claimant's upper extremity RSD. The rating method for RSD is set forth on Page 56 of the AMA Guides in the part entitled "Causalgia and [RSD]" and that part does not reference Table 17 pertaining to peripheral vascular disease nor does it describe RSD as a peripheral vascular disease. We reverse the hearing officer's determination that the claimant's IR is 19% and we remand the case to the hearing officer for the hearing officer to seek clarification from the designated doctor on the IR for RSD and to inform the designated doctor that the impairment secondary to causalgia and RSD is derived as set forth on page 56 of the AMA Guides and not by using Table 17 relating to peripheral vascular disease.

In summary, we reverse the hearing officer's decision that the claimant reached MMI on October 20, 2003, with a 19% IR and we remand the case to the hearing officer for the hearing officer to: (1) inform the designated doctor that the date of statutory MMI was June 22, 2003; (2) request the designated doctor to determine the MMI date, which may be on or before statutory MMI, but not after statutory MMI; (3) inform the designated doctor that impairment secondary to causalgia and RSD is derived as set forth on page 56 of the AMA Guides under the part entitled "Causalgia and RSD," and not under Table 17 relating to impairment of the upper extremity due to peripheral vascular disease; (4) request the designated doctor to assign an IR according to the AMA Guides as of the date of MMI; (5) allow the parties an opportunity to respond to the designated doctor's response; and (6) make findings of fact, conclusions of law, and a decision on the disputed issues of MMI and IR.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Division, pursuant to Section 410.202, as amended effective _____, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of time in which a request for appeal or a response must be filed.

The true corporate name of the insurance carrier is **AMERICAN HOME ASSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701.

_____
Robert W. Potts
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Margaret L. Turner
Appeals Judge