APPEAL NO. 071599-s
FILED OCTOBER 31, 2007

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 7, 2007. The hearing officer decided that the appellant (claimant) reached maximum medical improvement (MMI) on October 6, 2005, with an impairment rating (IR) of 14% as certified by the Texas Department of Insurance, Division of Workers' Compensation (Division)-appointed designated doctor, Dr. T. The claimant appealed the hearing officer's determinations of MMI/IR, arguing that: (1) Dr. T improperly used 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) by failing to use the required "maximum value" in assessing the impairment for motor loss; (2) Dr. T failed to rate the sensory impairment of the medial antebrachial cutaneous nerve; and (3) because the preponderance of the other medical evidence is contrary to Dr. T's certification, the only valid certification of MMI/IR is from Dr. B, claimant's treating doctor, which should be adopted. The respondent (carrier) responded, urging affirmance.

DECISION

Reversed and rendered.

FACTUAL SUMMARY

It is undisputed that the claimant was injured on _____, when his left arm was caught in a grinder, causing a crushing injury to his left hand, forearm and elbow as well as causing an avulsion injury of the left medial elbow, taking approximately 6 x 3 inches area of skin. A skin graft (approximately 12 x 8 centimeters) at the medial left elbow was done on November 11, 2004.

Dr. T first examined the claimant on June 21, 2005, and opined that the claimant was not at MMI and that he "deserves further rehabilitation of his left arm, probably in the form of either nerve stimulation, injection therapy, intensive rehabilitation, and perhaps even the possibility of ulnar nerve exploration." Dr. T anticipated that the claimant would reach MMI on or about September 21, 2005.

On October 6, 2005, Dr. T re-examined the claimant to determine MMI/IR. In Dr. T's neurological report, the doctor indicates that:

> "on sensory examination, there is total absence of feeling along the ulnar distribution from the elbow to the fingers. There is no decreased sensation on the median nerve distribution."

Based on his certifying exam of October 6, 2005, Dr. T certified MMI on that date and assessed a 14% IR.

A letter of clarification (LOC) was sent to Dr. T, requesting clarification regarding the appropriate gradation for the motor deficit of the left ulnar nerve. In a response dated February 7, 2006, Dr. T explained how he used the maximum value assigned under AMA Guides, Table 15 (page 3/54) to multiply the grade assigned under Table 12 (page 3/49). A second LOC to Dr. T raised Dr. B's concerns about sensory impairment involving the medial antebrachial cutaneous nerve. In his response dated January 17, 2007, Dr. T explained:

> At the time of my evaluation, there was a sensory impairment involving the medial lower arm due to the burn scar, therefore, this was taken into consideration when awarding for the skin disorder (scarring). Dr. [B] also describes the sensory impairment as severe, including a burn scar due to inability to perceive painful sensory stimuli in the medial forearm.

Dr. B, the treating doctor, examined the claimant on November 16, 2006, and certified that the claimant reached MMI on the date of statutory MMI, November 16, 2006, with a 20% IR.

The hearing officer found that the report of the designated doctor with regard to MMI/IR was supported by the preponderance of the evidence and adopted Dr. T's certification. The hearing officer wrote that "[t]he disparity of the findings of Dr. [B] and the [designated doctor] were merely a difference of [medical] opinion."

MMI

Section 401.011(30)(A) provides that MMI is 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." Section 408.1225(c) provides that the report of the designated doctor has presumptive weight, and the Division shall base its determination of whether the employee has reached MMI on the report of the designated doctor unless the preponderance of the other medical evidence is to the contrary. Section 408.1225(c) applies to this case because the CCH was held on or after September 1, 2005.

In the instant case, the hearing officer's determination that the date of MMI was reached on October 6, 2005, is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986). In Appeals Panel Decision (APD) 040887, decided June 10, 2004, the evidence established significant and steady improvement of the claimant's condition after the designated doctor's certified date of MMI. The Appeals Panel reversed the hearing officer's MMI determination because of the claimant's improved condition and rendered a new determination of a later MMI date. In the instant case, the evidence, as in APD 040887, *supra*, establishes significant and steady improvement of the claimant's

condition. Dr. B stated that the claimant's IR should be performed at the statutory date of MMI, [omitted date] since by then "maximum reinnervation would be expected." That statement is consistent with the AMA Guides, page 3/46, which provides:

> Permanent impairment related to a peripheral nerve may be described as an alteration of sensory or motor function that has become stable after an appropriate course of medical management and rehabilitation for a period of time sufficient to permit regeneration and the appearance of other indicators of physiologic recovery.

The medical evidence in the record establishes the claimant continued to receive treatment for the compensable injury after October 6, 2005, the date of MMI certified by Dr. T, the designated doctor, and the additional treatment did improve the claimant's condition. Dr. B's reports dated November 28, 2005, February 23, 2006, May 18, 2006, and November 16, 2006, indicate that changes in medication, with adjustments of dosage, resulted in claimant's improved condition related to the crush injury of his left hand, forearm, and elbow. In his report, dated May 18, 2006, Dr. B reported the claimant was on Lyrica for neuropathic pain and Clonazepam for anxiety, and he was increasing the dosage of Lyrica. Dr. B further noted that the claimant was trying to use his arm more and had returned to work as a welder. Accordingly, we reverse the hearing officer's determination that the claimant reached MMI on October 6, 2005.

IR

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. Section 408.125(c) applies to this case because the CCH was held on or after September 1, 2005. 28 TEX. ADMIN. CODE § 130.1(c)(3) (Rule 130.1(c)(3)) provides that the 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. The preamble of Rule 130.1(c)(3) clarifies that IR assessments "must be based on the injured employee's condition as of the date of MMI." 29 Tex. Reg. 2337 (2004). *See* APD 040313-s, decided April 5, 2004. The designated doctor is required to rate the entire compensable injury and to assign an IR for the entire compensable injury. *See* APD 043168, decided January 20, 2005.

Dr. T, the designated doctor, combines the 9% whole person impairment for upper extremity (UE) motor and sensory deficits with a 5% whole person impairment for a skin disorder which results in the 14% IR, using the Combined Values Chart (page 322). In assessing the UE impairment, Dr. T combined 2% UE impairment for the

median nerve (anterior interosseous branch)[1] and 7% UE impairment for the ulnar nerve (below midforearm)[2] resulting in a 9% UE impairment for motor deficit. Dr. T assigned a 7% UE impairment for ulnar nerve (above midforearm)[3] resulting in a 7% UE impairment for sensory deficit. Then Dr. T combined 9% UE impairment for motor deficit with 7% UE impairment for sensory deficit for a total combined value of 15% UE impairment, which converted to 9% whole person impairment for the UE under Table 3 (page 3/20). In assessing a 5% whole person impairment for the skin disorder, Dr. T used Table 2, Class 1 (page 13/280).

The AMA Guides, Chapter 3, provide for a method of evaluating impairment of the UE due to peripheral nerve disorders. That chapter indicates the medial antebrachial cutaneous nerve for sensory deficit impairment is rated separately from the ulnar nerve sensory deficit impairment, under Table 15. Further, Chapter 13 provides that in evaluating permanent impairment related to a skin disorder that "the actual functional loss is the prime consideration, although the extent of cosmetic or cutaneous involvement may also be important" (page 13/278). It further states that "[w]hen there is a permanent impairment of more than one body system, the extent of whole-person impairment related to each system should be evaluated, and the estimated impairment percentages should be *combined* using the Combined Values Chart (p. 322) to determine the person's total impairment" (page 13/278). That same chapter provides that when the impairment resulting from a burn or scar is based on peripheral nerve dysfunction or loss of range of motion, it may be evaluated according to the criteria in the AMA Guides, Chapters 3 and 4, provided appropriate guidelines exist in those chapters (page 13/280). *See* APD 031168, decided July 2, 2003.

A review of the medical records indicates that the claimant had not only had a loss of sensation at the site of the skin graft of the left arm but a loss of sensation from the elbow to the fingers due to peripheral nerve damage from an avulsion injury, which cannot be calculated by an award for a skin disorder because it would fail to rate the entire compensable injury. Dr. T's neurological reports dated June 21, 2005, and October 6, 2005, indicate that he made findings consistent with sensory deficit

---

[1] For the motor deficit for the median nerve (anterior interosseous branch), Dr. T used a 15% maximum UE impairment for the median nerve (anterior interosseous branch) under Table 15 and assessed a grade 4, 15% loss of muscle strength, under Table 12. He multiplied 15% with 15%, which resulted in a 2% UE impairment.

[2] For the motor deficit for the ulnar nerve (below midforearm), Dr. T used a 35% maximum UE impairment for the ulnar nerve (below midforearm) under Table 15 and assessed a grade 4, 20% loss of muscle strength, under Table 12. He multiplied 35% with 20%, which resulted in a 7% UE impairment.

[3] For the sensory deficit for the ulnar nerve (above midforearm), Dr. T used a 7% maximum UE impairment for the ulnar nerve (above midforearm) under Table 15 and assessed a grade 5, 100% loss of sensibility, under Table 11 (page 48). He multiplied 7% with 100%, which resulted in a 7% UE impairment.

impairment of the medial lower arm, which is shown to be innervated by the medial antebrachial cutaneous nerve. *See* AMA Guides, Figure 45, page 3/50. Dr. T notes in each of his neurological reports that the claimant has no feeling along the inner forearm, from the elbow to the fingers. Dr. T acknowledged in a January 17, 2007, response to the second letter of clarification, that at the time of the certifying examination of October 6, 2005, there was a sensory impairment involving the medial lower arm. Rather than separately rating the sensory impairment for the medial antebrachial cutaneous nerve, Dr. T included the sensory deficit impairment for that specific nerve (medial antebrachial cutaneous) by assessing an impairment for the skin disorder (scarring), noting:

> At the time of my evaluation, there was a sensory impairment involving the medial lower arm due to the burn scar, therefore, this was taken into consideration when awarding for the skin disorder (scarring). Dr. [B] also describes the sensory impairment as severe, including a burn scar due to inability to perceive painful sensory stimuli in the medial forearm.

In this case, Dr. T failed to rate the entire compensable injury because he did not assign an IR for the sensory deficit of the medial antebrachial cutaneous nerve according to the AMA Guides as stated above. Therefore, the 14% IR of Dr. T cannot be adopted and the hearing officer erred in giving presumptive weight to the designated doctor's report. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 14% as certified by Dr. T.

A review of the record shows that there is only one other certification of MMI/IR in evidence that can be adopted. On November 16, 2006, Dr. B examined the claimant and determined that the claimant reached MMI on the date of statutory MMI, on November 16, 2006, with an IR of 20%.

The treating doctor, Dr. B, combines the 16% whole person impairment for UE motor and sensory deficits with a 5% whole person impairment for a skin disorder which results in the 20% IR, using the Combined Values Chart. In assessing the UE impairment, Dr. B assigned 18% UE impairment for the ulnar nerve (below midforearm)[4] resulting in an 18% UE impairment for motor deficit. Dr. B combined a 7% UE impairment for the ulnar nerve (above midforearm)[5] and 3% UE impairment for the

[4] For the motor deficit for the ulnar nerve (below midforearm), Dr. B used a 35% maximum UE impairment for the ulnar nerve (below midforearm) under Table 15 and assessed a grade 3, 50% loss of muscle strength, under Table 12. He multiplied 35% with 50%, which resulted in an 18% UE impairment.

[5] For the sensory deficit for the ulnar nerve (above midforearm), Dr. B used a 7% maximum UE impairment for the ulnar nerve (above midforearm) under Table 15 and assessed a grade 5, 100% loss of sensibility, under Table 11. He multiplied 7% with 100%, which resulted in a 7% UE impairment.

medial antebrachial cutaneous nerve[6] for sensory deficit resulting in a 10% UE impairment for sensory deficit. Then Dr. B combined 18% UE impairment for motor deficit with 10% UE impairment for sensory deficit for a total combined value of 26% UE impairment, which converted to 16% whole person impairment for the UE under Table 3. In assessing a 5% whole person impairment for the skin disorder, Dr. B used Table 2, Class 1.

As required by the AMA Guides, Dr. B rated the entire compensable injury and assigned an impairment for the medial antebrachial cutaneous nerve sensory deficit. The only certification which can be adopted is the certification of Dr. B, certifying that the claimant reached MMI on the date of statutory MMI, November 16, 2006, with a 20% IR.

SUMMARY

Accordingly, we reverse the hearing officer's determination that the claimant reached MMI on October 6, 2005, and that the claimant's IR is 14% and render a decision that the claimant reached MMI on November 16, 2006, and that the claimant's IR is 20%.

[6] For the sensory deficit for the medial antebrachial cutaneous nerve, Dr. B used a 5% maximum UE impairment for the medial antebrachial cutaneous nerve under Table 15 and assessed a grade 3, 60% loss of sensibility, under Table 11. He multiplied 5% with 60%, which resulted in a 3% UE impairment.

The true corporate name of the insurance carrier is **WAUSAU UNDERWRITERS INSURANCE 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.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Veronica L. Ruberto
Appeals Judge

_____
Margaret L. Turner
Appeals Judge