APPEAL NO. 110509
FILED JUNE 16, 2011

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 March 21, 2011.

The hearing officer resolved the sole issue in dispute by determining that the appellant's (claimant) impairment rating (IR) is 5%. The claimant appealed the hearing officer's IR determination. The respondent (carrier) responded, urging affirmance.

DECISION

Reversed and rendered.

The parties stipulated that the claimant sustained a compensable injury, to at least his head, on _____; that the claimant reached maximum medical improvement (MMI) on October 2, 2009; and that (Dr. I) was appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) to determine MMI/IR. The claimant testified that while at work, he was hit in the jaw by a 20-pound sledgehammer, causing him to lose consciousness and fall to the ground.

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.

28 TEX. ADMIN. CODE § 130.1(c)(3) (Rule 130.1(c)(3)) provides in pertinent part that the assignment of an IR shall be based on the injured worker's condition as of the MMI date considering the medical record and the certifying examination and the doctor assigning the IR shall:

A. identify objective clinical or laboratory findings of permanent impairment for the current compensable injury;

B. document specific laboratory or clinical findings of an impairment;

C. analyze specific clinical and laboratory findings of an impairment;

D. compare the results of the analysis with the impairment criteria and provide the following:

(i) A description and explanation of specific clinical findings related to each impairment, including [0%] [IR]; and

(ii) A description of how the findings relate to and compare with the criteria described in the applicable chapter of 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)]. The doctor's inability to obtain required measurements must be explained.

Dr. I examined the claimant on January 12, 2010, to determine MMI/IR. Dr. I diagnosed the claimant with the following: (1) mouth/facial/tooth contusion; (2) status post root canal of "2 upper right teeth x 2;" (3) headaches secondary to contusion; and (4) head concussion with brain contusion and mental impairment/continual confusion (change in mental status). Dr. I certified that the claimant reached MMI on October 2, 2009, the date that the parties stipulated to as the date of MMI, and assigned a 5% impairment. In her narrative report dated January 12, 2010, and attached to a Report of Medical Evaluation (DWC-69), Dr. I stated the following for her IR based on the AMA Guides:

1. Mouth/facial/tooth: 0% [IR] per Table 4, page 230-unilateral total facial paralysis/pain

2. Change in mental status-Class 2: 5% [IR]

3. Headaches: 0% [IR] (self limiting)

Dr. I did not include in her narrative report a list of what medical records of the claimant that she reviewed or any testing done or reviewed in connection with the claimant's mental status. Furthermore, Dr. I did not provide any explanation for assigning a 5% IR for a change in mental status. Thus, Dr. I failed to provide and to document the required objective and clinical and laboratory findings on which her IR was based as required under Rule 130.1(c)(3). *See* Appeals Panel Decision (APD) 951447, decided October 9, 1995; APD 030622, decided April 30, 2003.

In reviewing a "great weight" challenge, we must examine the entire record to determine if: (1) there is only "slight" evidence to support the finding; (2) the finding is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust; or (3) the great weight and preponderance of the evidence supports its nonexistence. *See* Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

Because Dr. I did not explain what rating criteria under the AMA Guides were utilized in rating the claimant's mental status, we hold that the hearing officer erred in finding that the preponderance of the medical evidence was not contrary to the

designated doctor's IR. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 5%.

A review of the record reflects that there is one other certification of MMI/IR in evidence. (Dr. P), a doctor selected by the treating doctor in place of the treating doctor, examined the claimant on August 13, 2010, and certified the claimant reached MMI on the stipulated MMI date of October 2, 2009. Dr. P assigned a 20% IR for the claimant's compensable injury based on 0% impairment for the "Ear Nose Throat" in Chapter 9; 0% impairment for "Headache" in Chapter 15; and 20% impairment for "Traumatic Brain Injury" in Chapter 4, Table 2. Dr. P stated that under Table 2 Mental Status Impairments, page 4/142 of the AMA Guides, the claimant's impairment requires "direction and supervision of daily living activities" which renders a range of 15-29% IR. Dr. P states that "[a]s the [claimant] is currently working with direct supervision of his sibling and is able to function at the work site only under these limited circumstances and is unable to do most high-level activities of daily living at home with direct supervision of his wife, I feel that he qualifies for a mid range 20% impairment of the whole person in this case." In an earlier letter dated May 14, 2010, Dr. P stated that he had reviewed Dr. I's certification of MMI/IR and disagreed with Dr. I's assigned 5% IR for a Class II impairment for mental status regarding the claimant's head trauma. Dr. P in that letter stated that the claimant's difficulties with work and his requirement for supervision on the job site as well as at home for even simple tasks is supported by the neurodiagnostic testing which was performed. We note that in evidence is a Neuropsychological Evaluation dated March 6, 2010, performed by (Dr. M), Ph.D., a clinical neuropsychologist, which included diagnoses of cognitive disorder, major depressive disorder, traumatic brain injury, and chronic pain and which stated that "[w]ith respect to [activities of daily living] [the claimant] is encouraged to do as much for himself as he possibly can, while taking care not to overwhelm himself. Due to forgetfulness and confusion, his wife is advised to assist him with taking his medications on time and as directed, managing money, and making important decisions (i.e., medical or legal decisions)." Dr. P's assigned 20% IR is in accordance with the AMA Guides and can be adopted.

We reverse the hearing officer's determination that the claimant's IR is 5% and we render a new decision that the claimant's IR is 20%.

The true corporate name of the insurance carrier is **LIBERTY MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TEXAS 78701-3218.

_____
Cynthia A. Brown
Appeals Judge

CONCUR:

_____
Carisa Space-Beam
Appeals Judge

_____
Margaret L. Turner
Appeals Judge