APPEAL NO. 110896
FILED AUGUST 15, 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 May 16, 2011, in [City], Texas, with [hearing officer] presiding as hearing officer. With regard to the three issues before him the hearing officer determined that: (1) the appellant (claimant) reached maximum medical improvement (MMI) on February 12, 2009; (2) the claimant's impairment rating (IR) is 12%; and (3) the claimant had disability beginning on March 28, 2009, and continuing through April 19, 2009, and beginning on December 10, 2009, and continuing through February 24, 2010.

The claimant appealed, disputing the hearing officer's determination of MMI and IR, contending that he had not reached MMI on February 12, 2009, because he had surgery and had completed a chronic pain management program after the date of MMI found by the hearing officer. The respondent (carrier) responded, urging affirmance.

The hearing officer's determination that the claimant had disability beginning on March 28, 2009, and continuing through April 19, 2009, and beginning on December 10, 2009, and continuing through February 24, 2010, was not appealed and has become final pursuant to Section 410.169.

DECISION

Reversed and rendered.

The parties stipulated that the claimant sustained a compensable injury on _____, and that Dr. W was appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) to determine the claimant's date of MMI and IR.

The claimant testified that he was an "order puller" in the freezer department of the employer and that on _____, he heard a crack like a tree falling when he was knocked unconscious when two pallets fell on him. The medical records reflect that the claimant sustained facial lacerations, a left shoulder and a neck injury. The claimant had been referred to Dr. I in December of 2008, by his treating doctor.

The claimant saw Dr. W, the designated doctor, on February 12, 2009. Dr. W certified the claimant at MMI on that date with a 12% IR. Dr. W, although not appointed for extent of injury, commented the claimant's injuries included:

> [c]osmetic deformity over the right eye, trigmenial [*sic*] neuralgia affecting the ophthalmic branch. He also sustained a left shoulder impingement injury and a cervical

> syndrome. He has already been release[d] to work on restrictions due to his neuralgia over the right eye.

Dr. W arrived at the 12% IR by assessing 7% impairment for loss of range of motion (ROM) of the left shoulder[1] and 5% for Diagnosis-Related Estimate (DRE) Cervicothoracic Category II: Minor Impairment. Dr. W makes no further comment about the deformity over the right eye or the trigeminal neuralgia affecting the ophthalmic branch.

Subsequently, Dr. I noted a loss of function of the temporal branch of the facial nerve, loss of motion of the right side of the eyebrow and forehead "most likely due to the nerve injury." Dr. I performed surgery on March 27, 2009, on the right supraorbital nerve and right zygomaticofacial nerve under general anesthesia.

The medical records reflect that the claimant completed a chronic pain management program from January 4 through February 24, 2010. On October 29, 2010, Dr. V, a doctor selected by the treating doctor to act in place of the treating doctor, certified the claimant at clinical MMI on February 24, 2010,[2] with a 16% IR. The 16% IR was calculated based on 7% impairment for UE loss of ROM,[3] 5% impairment for DRE Cervicothoracic Category II: Minor Impairment (the same as the designated doctor) and 5% impairment for facial impairment.

Dr. W, the designated doctor, was sent copies of medical reports of Dr. I (and others) and the March 27, 2009, operative report in a letter of clarification dated January 7, 2010. Dr. W replied by letter dated January 11, 2010, stating:

> The extent of his injuries included a cosmetic deformity over the right eye, with trigmenial [*sic*] neuralgia affecting the ophthalmic branch. The records reflect he underwent subsequent surgical revision following the determination of MMI. [The claimant] remains entitled to care for his compensable injuries <u>does not</u> change my determination of MMI. MMI was predicated on the fact [the claimant] had undergone an adequate course of care when I evaluated him and sufficient time had lapsed since his injury to allow healing. Healing had occurred to the extent his impairment would not increase or decrease by more than 3%. For those reasons my determination of [whole person impairment]/MMI despite subsequent surgery remains unchanged. [Emphasis in the original]

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[1] We note that Dr. W does not give measurements or an upper extremity (UE) impairment percent for left shoulder adduction.

[2] Dr. V noted that the MMI date was the date the claimant finished his chronic pain management program.

[3] We note that this is the same impairment for loss of UE ROM as the designated doctor except that Dr. V gives ROM figures for both abduction and adduction.

MMI AND IR

Section 401.011(30)(A) defines MMI as "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 408.125(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 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.

In this case, Dr. I performed surgery involving revision of hypertrophic scarring of the right forehead, right eyebrow, right eyelid with tissue rearrangement, isolation of branches of the right supraorbital nerve and right zygomaticofacial nerve and repair with placement of neuro flex collagen tubes, approximately one month after the claimant was certified at MMI by Dr. W. Dr. W, when made aware of this subsequent surgery, dismisses the surgery saying it "would not increase or decrease [the impairment] by more than 3%."

The definition of MMI is based on reasonable medical probability that further material recovery or lasting improvement can no longer reasonably be anticipated. In this case Dr. I's post-surgery notes indicated the claimant was pain free, and that a "sense of 'feeling' is coming back to the area of injury." The claimant testified that his symptoms have improved since the surgery. The chronic pain management notes state that tenderness in the shoulder has decreased, muscle strength was more pronounced and active ranges of motion in the shoulder and the neck have increased.

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).

We hold that the hearing officer erred in adopting Dr. W's date of MMI as being a "mere difference of opinion between doctors." We further hold that Dr. W's certification of MMI on February 12, 2009, is contrary to the preponderance of the other medical evidence, namely surgery on facial nerves and the chronic pain management program, after the designated doctor's certification of MMI. Accordingly, we reverse the hearing officer's determination of MMI.

Dr. V, acting in place of the treating doctor, certified MMI on February 24, 2010, the date that the claimant completed a chronic pain management program. We hold that Dr. V's certification of MMI is supported by sufficient evidence. We render a new decision that the claimant reached MMI on February 24, 2010.

Because we have reversed Dr. W's MMI date we cannot adopt Dr. W's IR under Rule 130.1(c)(3). The only other IR in evidence that can be adopted with the February 24, 2010, MMI date, is that of Dr. V. We reverse the hearing officer's determination that the claimant's IR is 12% and render a new decision that the claimant's IR is 16% as assessed by Dr. V.

The true corporate name of the insurance carrier is **LIBERTY INSURANCE CORPORATION** 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.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Cynthia A. Brown
Appeals Judge

_____
Margaret L. Turner
Appeals Judge