APPEAL NO. 120453
FILED MAY 7, 2012

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 February 1, 2012, in [City], Texas, with [hearing officer] presiding as hearing officer. With regard to the two disputed issues the hearing officer determined that the compensable injury of [date of injury], extends to complex regional pain syndrome (CRPS) and reflex sympathetic dystrophy (RSD) and that the respondent's (claimant) impairment rating (IR) is 20%.

The appellant (carrier) appeals the hearing officer's determinations on extent of injury and IR, contending that the designated doctor improperly rated the compensable injury. The claimant responded, urging affirmance.

DECISION

Affirmed in part and reversed and remanded in part.

The parties stipulated that the claimant sustained a compensable pelvic fracture and left sciatic nerve neurapraxia injury on [date of injury], and that the claimant reached maximum medical improvement (MMI) on September 9, 2011. The parties also stipulated that [Dr. C] was appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) to examine the claimant for MMI, IR and extent of injury, and that Dr. C certified that the claimant reached MMI on September 9, 2011, and assigned a 20% IR. The parties further stipulated that [Dr. F], a carrier-selected required medical examination (RME) doctor, certified that the claimant reached MMI on September 9, 2011, and assigned a 10% IR.

The claimant testified that he was an automobile mechanic and he sustained a pelvic crush injury at work while standing between the door jam of a pick-up truck that was moving forward and a metal pole.

EXTENT OF INJURY

The hearing officer's determination that the compensable injury of [date of injury], extends to CRPS and RSD is supported by sufficient evidence and is affirmed.

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. 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 most recently appointed designated doctor, Dr. C, examined the claimant on September 9, 2011, certified clinical MMI on that date (the stipulated MMI date), and assigned a 20% IR. Regarding extent of injury, Dr. C determined that the compensable injury extends to "a sciatic nerve pain with major [causalgia] or RSD/CRPS." Dr. C 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) and stated:

> The AMA Guides are used on page [3/56] concerning causalgia, defining causalgia as a term that describes a constant intense burning pain, and major causalgia designates an extremely serious form of RSD produced by an injury to a major mixed nerve used in the proximal portion of the extremity.

Nonetheless, Dr. C rated the claimant's condition under Gait Derangement, Section 3.2b page 3/75 of the AMA Guides. Dr. C explained his reasoning:

> His calculation of impairment from various impairment charts, in my opinion, does not have any significance in the actual impairment this claimant has sustained.
>
> Therefore, the best method that I can see for his [IR] is from Table 36, page [3/76], which shows a moderate-severe antalgic limp that requires routine use of a cane or crutch, which yields a 20% whole person impairment.
>
> This impairment, while at a large percentage, is reflective of the significant pain and intense nerve symptoms that this claimant is having in his leg.

The instruction under Gait Derangement on page 3/75 of the AMA Guides states that Gait Derangement may serve as a general guide for estimating lower extremity impairments, however, whenever possible the evaluator should use the more specific methods of those other parts in estimating impairments. That section further instructs

that "Section 3.2b does not apply to abnormalities based only on subjective factors, such as pain . . . ."

The carrier contends that the claimant's injury should have been rated under Section 3.1k on page 3/56 of the AMA Guides entitled "Causalgia and [RSD]." That section provides:

Causalgia and [RSD]

> Causalgia is a term that describes the constant and intense burning pain usually seen with [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.
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> * * * *
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> The impairment secondary to causalgia and RSD is derived as follows:
>
> 1. Rate the upper extremity [UE] 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 [UE] impairment. Major causalgia may result in a complete loss of function and an impairment of the extremity as great as 100%.

Section 3.2l page 3/89, of the AMA Guides, entitled "Causalgia and [RSD]," defines Causalgia and RSD and instructs that "[w]hen these conditions occur in the lower extremity, they should be evaluated as for the [UE] (Section 3.1k, p. 56)." In Appeals Panel Decision (APD) 111684, decided January 12, 2012, the Appeals Panel rejected the IR of a designated doctor who did not attempt to rate CRPS under Section

3.1k entitled "Causalgia and [RSD]." In APD 052243-s, decided November 29, 2005, the Appeals Panel explained that the "rating method for RSD is set forth on [p]age [3/56] of the AMA Guides in the part entitled 'Causalgia and [RSD].'"

Dr. C did not adequately explain why he used Section 3.2b Gait Derangement instead of Section 3.1k Causalgia and RSD other than to say the Gait Derangement is reflective of the significant pain and intense nerve symptoms the claimant is having. As previously noted, Section 3.2b (Gait Derangement) does not apply to abnormalities based only on subjective factors, such as pain or sudden giving away. Dr. C did not attempt to rate CRPS/RSD in the manner outlined in the AMA Guides. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 20%.

Because the designated doctor's IR cannot be adopted, we consider the other IRs in evidence.

Dr. F, the RME doctor, in a Report of Medical Evaluation (DWC-69) and narrative dated November 3, 2011, certified clinical MMI on September 9, 2011 (the stipulated date of MMI) and assigned a 10% IR. The hearing officer, in his Background Information, commented that Dr. F's IR did not include CRPS/RSD and that Dr. F "did not have any clinical confirmation of any objective findings to support a CRPS/RSD diagnosis." We note that Dr. F did recognize "the RSD/CRPS diagnosis" as being compensable and attempted to rate it. However, Dr. F referenced page 3/89, Table 68 which is the table for rating complete motor or sensory loss of named peripheral nerves. As previously noted, Section 3.2l page 3/89 entitled "Causalgia and [RSD]" instructs that "[w]hen these conditions occur in the lower extremity, they should be evaluated as for the [UE] (Section 3.1k, p. 56)." Dr. F failed to use the Causalgia and RSD Section 3.1k on page 3/56 of the AMA Guides. As such, his IR cannot be adopted. *See* APD 052243-s, *supra*.

One other IR report in evidence is a DWC-69 and narrative report dated May 4, 2011. [Dr. SC], who is the initial designated doctor for MMI and IR, certified MMI on May 4, 2011 (a date different than the stipulated date of MMI) and assigned a 0% IR. Dr. SC did not rate the CRPS or RSD. That report cannot be adopted. There are no other reports of IR with a September 9, 2011, MMI date in evidence.

REMAND INSTRUCTIONS

We therefore remand the issue of IR to the hearing officer. The designated doctor in this case is Dr. C. The hearing officer is to determine whether Dr. C is still qualified and available to be the designated doctor, and if so, request that the designated doctor rate the compensable injury which includes an accepted pelvic fracture and left sciatic neurapraxia injury and the administratively determined CRPS

and RSD, in accordance with the rating criteria in the AMA Guides, and this decision, based on the claimant's condition as of the stipulated date of MMI of September 9, 2011. If Dr. C is no longer qualified and available to serve as the designated doctor then another doctor is to be appointed to determine the claimant's IR. The hearing officer is to provide the designated doctor's response to the parties and allow the parties an opportunity to respond and then make a determination regarding the IR.

SUMMARY

We affirm the hearing officer's determination that the compensable injury extends to CRPS and RSD.

We reverse the hearing officer's determination that the claimant's IR is 20% and remand the issue of the IR to the hearing officer for further action consistent with this decision

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 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* APD 060721, decided June 12, 2006.

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

RON O. WRIGHT, PRESIDENT
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723.

Thomas A. Knapp
Appeals Judge

CONCUR:

Cynthia A. Brown
Appeals Judge

Margaret L. Turner
Appeals Judge