APPEAL NO. 121900
FILED NOVEMBER 29, 2012

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). This case returns following our remand in Appeals Panel Decision (APD) 112010, decided March 2, 2012. The original contested case hearing (CCH) was held on November 29, 2011, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues on November 29, 2011, by deciding that the respondent (claimant) reached maximum medical improvement (MMI) on May 3, 2011, with an impairment rating (IR) of 29%, as certified by [Dr. B], the designated doctor appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) to opine on MMI/IR. The issues of MMI/IR were remanded to the hearing officer with instructions to determine the date of statutory MMI (by stipulation or by evidentiary findings), to ensure that all medical records were forwarded to the designated doctor, to determine if Dr. B was still qualified to render an opinion on MMI/IR, and if so, to request Dr. B provide alternative certifications based on disputed body parts/conditions.

The hearing officer notes in her decision that Dr. B was still qualified as the designated doctor for MMI/IR and that a letter of clarification (LOC) was sent to Dr. B with the claimant's medical records. Dr. B was informed of the statutory MMI date, which the parties stipulated was May 3, 2011, and was requested to provide alternative certifications. Dr. B's response to the LOC, including alternative certifications of MMI/IR (Reports of Medical Evaluation (DWC-69) and narrative report) were forwarded to the parties, who were given an opportunity to respond. Both parties responded in writing (Hearing Officer's Exhibits Nos. 6 and 7) although no further CCH was held on remand. There were additional exhibits admitted into evidence: Hearing Officer's Exhibits Nos. 3 through 7 and Carrier's Exhibits K through N.

On remand, the hearing officer resolved the disputed issues by deciding that the claimant reached MMI on May 3, 2011, with an IR of 16% as certified by Dr. B.

The appellant (carrier) appeals the hearing officer's determinations of the claimant's MMI date and IR, contending that none of the certifications of MMI/IR by Dr. B can be adopted and urging the adoption of the certification of MMI/IR by [Dr. C], a post-designated doctor required medical examination (RME) doctor. The appeal file does not contain a response from the claimant.

DECISION

Reversed and rendered in part and reformed in part.

CLERICAL CORRECTION

We note that the hearing officer's decision on remand did not reflect that official notice was taken of the record, the hearing officer's decision and order and APD 112010, *supra*, pertaining to [Docket No. 1]. We reform the hearing officer's decision to reflect that official notice was taken of the record, the hearing officer's decision and order and APD 112010, *supra*, pertaining to [Docket No. 1].

MMI/IR

At the November 29, 2011, CCH, the parties stipulated that the claimant sustained a compensable injury on [date of injury], and that the Division appointed Dr. B as the designated doctor for the purpose of MMI and IR.

At the November 29, 2011, CCH the claimant testified that he injured his left wrist when lifting a 50-60 pound tub of sand at work. The evidence reflects that the claimant underwent two wrist surgeries performed by [Dr. L], the claimant's current treating doctor in 2009: (1) a left wrist arthroscopy with a triangular fibrocartilage complex (TFCC) debridement, scapholunate and lunotriquetral debridement, scapholunate and lunotriquetral pinning, capsular shrinkage on June 10, 2009; and (2) a left diagnostic wrist arthroscopy with extensive debridement and ulnar shortening osteotomy on December 9, 2009. The evidence reflects that Dr. L diagnosed the claimant with complex regional pain syndrome (CRPS). The evidence further reflects that the carrier has accepted an injury of a left wrist strain and TFCC tear with ulnar motor dysfunction on the left.

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.

The record indicates that Dr. B, the designated doctor, examined the claimant on May 18, 2011, and certified that the claimant reached statutory MMI on May 3, 2011 (the date that the parties stipulated on remand to be the date of statutory MMI), with 29% IR. The hearing officer adopted Dr. B's original certification of MMI/IR, which the Appeals Panel reversed because Dr. B did not have all of the claimant's medical records before certifying an MMI date and assigning an IR and because Dr. B did not perform an IR evaluation in accordance with 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 not explaining how he assessed an impairment for the peripheral nerve system or CRPS. Because there were other conflicting certifications of MMI/IR in evidence, the Appeals Panel could not render a decision on MMI/IR but remanded the issues of MMI/IR to the hearing officer.

In response to the LOC, in a narrative report dated May 23, 2012, Dr. B listed the medical records that he reviewed and identified and explained five alternative certifications of MMI/IR, including his worksheets. Each is set out below:

> ALTERNATIVE CERTIFICATION #1: LIGAMENTOUS DISRUPTION OF THE LEFT WRIST. What was considered here is the range of motion [ROM] deficits of the left wrist and this would include the problem with the ligamentous structures. No neurologic deficits were included; [CRPS] was not considered. [Dr. B assigned 7% IR but there is no DWC-69 with 7% IR admitted into evidence on remand.]
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> ALTERNATIVE CERTIFICATION #2: [CRPS] (ULNAR NERVE) just considering the ulnar nerve. In this situation [ROM] deficits of the wrists were not considered. The neurologic residuals of his left upper extremity [UE] were considered but just to include the ulnar nerve. Originally, this individual is rated as a [s]ensory [g]rade 4 for the ulnar nerve, which is 80% which will be a 6% impairment of the [UE]. There is also a motor [g]rade 2 of 25% of his left [UE] which will be a 9% impairment.
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> However, these values were reduced under the following formula.[1] After reviewing all the additional data I received; what are of significance are the

1 The worksheet for alternative certification #2 reflects that the ulnar nerve (sensory grade 4) was calculated by 80% x 7% results in 6% UE. 6% divided by 1/3 results in 2% UE impairment for ulnar sensory deficits. It also reflects the ulnar nerve (motor grade 2) was calculated by 25% x 35% results in 9% UE. 9% divided by 1/3 results in

[EMG] studies done which indicate that [the claimant] did have a generalized peripheral neuropathy which was of significance. I attribute his neurologic deficits of the left [UE] to be 1/3 because of that (peripheral neuropathy).

Although reviewers of the original [d]esignated [d]octor report state that [ROM] deficits and neurologic impairments should not be jointly considered; [t]he [AMA Guides] Newsletter clearly mentions the [ROM] loss plus the neurologic loss is to be considered.

Also the MRI examination of the cervical spine indicated multiple levels of disc herniation central and a severely compromised spinal canal. The diagnosis of cervical spondylitic myelopathy was made because of the myelomalacia seen on the cervical spine.

This is of significance and as much as the cervical spondylitic myelopathy can account for significant neurologic problems in the [UE], EMG/nerve conduction studies, weakness and atrophy as well as other neurologic findings. So I attributed 1/3 of his neurologic findings to that diagnosis (cervical spinal cord problems). The remaining 1/3 was attributed to residuals from the [CRPS] and using that formula, one came up with a 5% impairment of the left [UE] and 3% impairment of the whole person [WP]. [Dr. B submitted a DWC-69 with 3% IR, which is admitted into evidence on remand.][2]

ALTERNATIVE CERTIFICATION #3: (MEDIAN NERVE). This certification considers residual impairment due to a [CRPS] considering the median nerve. Initially the first [d]esignated [d]octor [r]eport of [the claimant] stated a 30% impairment of the [UE] because of the [g]rade 4 impairment of the median nerve (sensory) and a 3% impairment of the left [UE] on the basis of motor deficits.

I utilized the same formula attributing [2/3] to other concurrent but not causally related neurologic problems and a 1/3 to the residuals of the

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3% UE for ulnar motor deficits. Combining 3% with 2% results in 5% UE impairment which converts to 3% under Table 3, page 3/20 of the AMA Guides.

2 We note that the amended DWC-69 admitted on remand lists the date of exam as May 18, 2012, and date of certification by Dr. B on May 23, 2012. There was no re-examination of the claimant. Dr. B only examined the claimant on May 18, 2011, and there were clerical errors on the amended DWC-69s listing the date of exam in 2012 rather than in 2011.

CRPS, again utilizing [Tables 11, 12, and 15].[3] Neurologic deficits were combined to an 11% impairment of the left [UE] or a 7% impairment of the [WP]. [Dr. B assigned 7% IR but there is no DWC-69 with 7% IR admitted into evidence on remand.]

ALTERNATIVE CERTIFICATION #4: (ALL [ROM] DEFICITS CONSIDERED) this included a left wrist sprain with the [TFCC] tear. What I did in this situation was not only I modified the [ROM] deficits to include only functions of the wrist (flexion/extension [and] radial/ulnar deviation) but also I included from the elbow section supination [and] pronation. In as much as the [TFCC] does affect rotation of the forearm and would impact this function.

In this situation there was a 13% impairment of the left [UE] based on [ROM] deficits. This was [an] 8% impairment of the [WP]. [Dr. B submitted a DWC-69 with 8% IR, which is admitted into evidence on remand.][4]

ALTERNATIVE CERTIFICATION #5. (ALL [ROM] DEFICITS CONSIDERED PLUS NEUROLOGIC DEFICITS UTILIZING 1/3 FORMULA).

In this certification all of the [ROM] deficits were combined with the neurologic deficits using the 1/3 formula. [ROM] deficits included flexion/extension, radial/ulnar deviation, supination and pronation. I also included the neurologic impairment of both the ulnar and median nerve and this all combined to a 27% impairment of the left [UE] or a 16% impairment of the [WP]. [Dr. B submitted a DWC-69 with 16% IR, which is admitted into evidence on remand.]

Reference for ALTERNATIVE CERTIFICATION #[5] is the American Medical Association Guides Newsletter . . . instruction is given the how to rate [CRPS].

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[3] Table 11, page 3/48; Table 12, page 3/49; and Table 15, page 3/54 are in the AMA Guides.

[4] Dr. B's worksheet for alternative rating #4 reflects that based on ROM deficits for the left wrist, adding 3% impairment (40º flexion) with 4% impairment (35º extension) with 2% impairment (10º radial deviation) with 2% impairment (20º ulnar deviation) results in 11% impairment. It also reflects ROM deficits for the left elbow, adding 2% impairment for 50º pronation with 0º for 90º supination results in 2% impairment. Combining the 11% impairment for the wrist with 2% impairment for the elbow, using Combined Values Chart (CVC), page 322 of the AMA Guides, results in 13% UE impairment which converts to 8% WP under Table 3.

The hearing officer on remand adopted the alternative rating #5 and determined that the claimant reached MMI on the statutory date of MMI, May 3, 2011, with 16% IR. The 16% IR is based on the following: (1) Dr. B assigned 11% impairment for ROM deficits of the left wrist; (2) because Dr. B opined that a TFCC tear affects the ROM of the elbow, Dr. B assigned 2% impairment for ROM deficits of the left elbow; (3) combining the ROM deficits of the left wrist and left elbow (11% with 2%) results in 13% regional impairment of the left UE (*see* footnote no. 4 for a detailed explanation of the regional impairment); (4) assigning 5% impairment for the ulnar sensory and motor deficits (*see* footnote no. 1 for a detailed explanation of his use of Tables 11, 12, and 15 and his 1/3 formula); (5) assigning 11% impairment for the median sensory and motor deficits (*see* footnote no. 1 for a detailed explanation of his use of Tables 11, 12, and 15 and his 1/3 formula; and (6) combining 13% regional impairment of UE (for ROM deficits of the left wrist and elbow) with 11% UE median nerve impairment with 5% UE ulnar nerve impairment results in 27% UE impairment which converts to 16% WP impairment.

The hearing officer's finding that the 16% IR performed by Dr. B is in accordance with the AMA Guides is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. In assigning the 16% IR, Dr. B includes a body part, the left elbow, which was not in dispute nor accepted as part of the compensable injury. Further, the calculation of using the "1/3 formula" in assigning a peripheral nerve system impairment is not found in the provisions of the AMA Guides. Dr. B in rating a left wrist injury with CRPS was required to follow the steps outlined on page 3/56, of the AMA Guides which provide:

1. Rate the [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 ([page 3/48]).

3. Rate the motor deficit impairment of the injured peripheral nerve, if it applies (Table 12a [page 3/49]).

4. The appropriate impairment percents for loss of motion, pain or sensory deficits, and motor deficits if present are *combined* using the [CVC] ([page] 322) to determine the [UE] impairment.

By utilizing the tables for sensory and motor deficits but dividing the impairments by 1/3 because on 1/3 of the neurologic deficits were causally related to the compensable injury and 2/3 of the neurologic deficits were causally related to non-compensable

conditions of cervical spinal stenosis and spinal cord involvement, Dr. B failed to follow the AMA Guides in calculating his 16% IR.

Because the 16% IR cannot be adopted, we must consider the other alternative certifications of MMI/IR by Dr. B, the designated doctor. Alternative certification #1 rates only the ROM deficits of the left wrist and does not include a rating for the left ulnar motor deficits. The carrier has accepted an injury of a left wrist strain and TFCC tear with ulnar motor dysfunction on the left. The alternative certification #1 by Dr. B does not rate the entire compensable injury and there is no DWC-69 for the 7% IR; therefore, the 7% IR cannot be adopted by the hearing officer.

Dr. B's alternative certification #2 assigns an IR based on sensory and motor deficits of the left ulnar nerve. Dr. B's alternative certification #3 assigns an IR based on sensory and motor deficits of the left median nerve. Neither alternative certification #2 nor alternative certification #3 include an impairment for the ROM deficits for the left wrist. Therefore, the alternative certification #2 and alternative certification #3 do not rate the entire compensable injury and cannot be adopted by the hearing officer. Additionally, there is no DWC-69 in evidence on remand for the 7% IR for the left median nerve.

Dr. B's alternative certification #4 assigns 8% IR for the ROM deficits for the left wrist and for the left elbow. The left elbow was not a body part being disputed as part of the compensable injury. Because Dr. B rated a non-compensable body part, his 8% IR cannot be adopted.

None of the alternative certifications #1 through #5 by Dr. B can be adopted because none of the IRs rate the compensable injury in accordance with the AMA Guides.

Because none of the certifications of MMI/IR by Dr. B, the designated doctor, can be adopted, we must consider if the Division can adopt the IR of one of the other doctors.

As discussed in APD 112010, *supra*, the Appeals Panel did not adopt a certification of MMI/IR by the other doctors because there was conflicting medical evidence regarding MMI/IR. However, pursuant to Rule 143.2, the Appeals Panel may not remand a case more than once.

[Dr. S] was initially appointed by the Division as the designated doctor for the issues of MMI/IR. Dr. S examined the claimant on May 27, 2010, and certified that the claimant was not at MMI but was expected to reach MMI on or about August 27, 2010. Dr. S diagnosed the claimant's injury as "[l]eft wrist strain. TFCC tear ([status/post]

osteotomy)." Dr. S's explanation of why the claimant was not at MMI included future scheduled treatment, a left stellate ganglion block. On his DWC-69, Dr. S indicated that, although the claimant had not reached MMI, the claimant was expected to reach MMI on or about August 27, 2010. In his narrative report dated May 23, 2012, Dr. B stated that the claimant had a number of stellate ganglion blocks for the diagnosis of CRPS of the left UE. Because the claimant had the additional future treatment considered by Dr. S when he certified that the claimant was not yet at MMI on the date of his examination, May 27, 2010, we find that Dr. S's certification of MMI/IR is not supported by a preponderance of the evidence and cannot be adopted.

[Dr. CA], the second designated doctor appointed on the issues of MMI/IR, examined the claimant on November 30, 2010, and certified that the claimant was not at MMI but was expected to reach MMI on or about March 2, 2011. Dr. CA diagnosed the claimant's injury as "[s]tatus post left wrist, arthroscopic surgery, with debridement and capsular shrinkage procedure. Status post left ulnar osteotomy with shortening. Status post delayed nonunion, healed now. Severe limitation of [ROM] of the left wrist with a significant amount of pain and fear avoidance." In his narrative report, Dr. CA stated that:

> The [claimant] is not at [MMI] as of today's examination, November 30, 2010. He requires [rehabilitation] to the left [UE], with instruction on how to deal with fear avoidance, and also instruction on cognitive behavior training, and skills to deal with the pain that he is having, which appeared to be somewhat out of proportion to the objective findings.

A review of the medical reports by Dr. L, the claimant's treating doctor, indicate that on January 4, 2011, the claimant was not reporting any aching or throbbing pain in his finger and the claimant reported that the numbness in his fingers and discoloration was gone.

The remaining certification of MMI/IR in evidence is by Dr. C, the RME doctor. Dr. C examined the claimant on August 2, 2011, and certified that the claimant reached clinical MMI on January 4, 2011, with 10% IR. The evidence reflects that Dr. C noted in his narrative report (dated August 2, 2011, and attached to his DWC-69) that he diagnosed the compensable injury as a left wrist sprain with TFCC tear status post-surgery. Dr. C explained that his certified MMI date of January 4, 2011, is supported by Dr. L's medical record dated that same date in which Dr. L noted that the claimant's symptoms had improved. Dr. C stated in his report that "[s]ince that time no significant change has been experienced in his condition and no treatment rendered has altered his condition." Dr. C additionally stated in his narrative:

> As an aside, I would note that in Dr. [B's] report, he referenced CRPS in his terminology for rating. It should be understood that there is no specific rating listed in the AMA Guides for CRPS or [reflex sympathetic dystrophy]. Rather, the rating is based upon the physical presentations of sensory or motor loss and/or ROM restriction. However, at today's examination [August 2, 2011], there were no clinical findings that would support the diagnosis of CRPS. If he had the condition in the past, then the absence of the findings would be confirmation of MMI.

Regarding Dr. C's IR evaluation, we note in APD 112010, *supra*, that after calculating the ROM deficits for the left wrist, Dr. C performed and documented sensory testing for the ulnar and median nerves. However, he only provided an explanation for assigning an impairment for the motor deficits of the ulnar nerve without going through the same analysis using Tables 12 and 15, pages 3/49 and 3/54 respectively, of the AMA Guides for the median nerve. Dr. C failed to assign any impairment, including 0% impairment, for motor deficits of the median nerve. In his addendum to his narrative report dated March 22, 2012, Dr. C complied with Rule 130.1(c)(3) to identify, document, analyze, and explain the motor impairment of the median nerve.

Dr. C assigned 10% IR for the compensable injury based on: (1) 10% UE impairment for the abnormal ROM of the left wrist (adding 2% impairment for 50º flexion with 4% impairment for 40º extension with 2% impairment for 10º radial deviation with 2% impairment for 20º for ulnar deviation results in 10% impairment of the UE); (2) no neurologic impairment for sensory consideration because no findings of decreased sensibility for the ulnar and the motor nerve; (3) assigning an impairment for the ulnar motor nerve deficit using Tables 12 and 15 (multiplying grade 4 impairment of 25% with 35% value of the nerve results in 7% UE impairment); (4) assigning 0% impairment for the median nerve (assigning a grade 5 for 0% motor deficit); and (5) using the CVC, combining the 7% impairment for the ulnar motor deficit with the 10% regional impairment for the UE results in a 16% UE impairment which converts to 10% WP IR (using Table 3) for the compensable injury.

Therefore, the certification of MMI/IR by Dr. C is supported by a preponderance of the evidence and can be adopted.

We reverse the hearing officer's decision that the claimant reached MMI on May 3, 2011, with 16% IR as certified by Dr. B and render a new decision that the claimant reached MMI on January 4, 2011, with 10% IR as certified by Dr. C.

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

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Cynthia A. Brown
Appeals Judge

CONCUR:

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Thomas A. Knapp
Appeals Judge

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Margaret L. Turner
Appeals Judge