

APPEAL NO. 122159
FILED DECEMBER 11, 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 September 26, 2012, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that the date of maximum medical improvement (MMI) is August 27, 2011, and that the appellant's (claimant) impairment rating (IR) is 5% as assigned from [Dr. K], the designated doctor appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) for purposes of MMI and IR. The claimant appealed, disputing the hearing officer's IR determination, contending that Dr. K did not assign an IR 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). The respondent (carrier) responded, urging affirmance.

The hearing officer's MMI determination was based on the parties' stipulation that the claimant's date of MMI is August 27, 2011, as certified by Dr. K and by [Dr. O], the claimant's treating doctor.

DECISION

Reversed and remanded.

The parties stipulated that on [date of injury], the claimant sustained a compensable injury. It was undisputed that the claimant cut the tip of his left middle/long finger off while at work as a machinist and it was not possible for his treating doctor to reattach the tip of his finger at the hospital.

In evidence is the x-ray dated [date of injury], of the left middle finger which stated the impression of "[a]mputation of the distal phalanx and the head of the middle phalanx of the third digit of the left hand." In a medical report dated March 3, 2011, Dr. O, the claimant's treating doctor, stated that "[t]here has been an amputation through the distal metaphyseal flare of the middle phalanx of the long finger. The soft tissue apparently has healed over the tip of the bone adding approximately 4 to 5 mm of padding over the tip of the bone."

Dr. K, the designated doctor, examined the claimant on August 27, 2011, and certified that the claimant reached MMI on that date with 4% IR. In his explanation of the assigned 4% IR, in his narrative report attached to his Report of Medical Evaluation

(DWC-69) Dr. K noted that the amputation “cut the distal phalanx of [the claimant’s] left long finger” and further stated:

I examined [the claimant] and per the [AMA Guides] on page [3/30], Figure 13, his amputation gives a 40% finger impairment. From page [3/18], Table 1 of the [AMA Guides], a 40% finger [impairment] gives an 8% hand impairment. Page [3/19], Table 2, gives an 8% hand impairment a 7% upper extremity [UE] impairment. A 7% [UE] impairment, using page [3/20], Table 3, gives a 4% whole person [WP] impairment.

Although Dr. K noted under the results of his examination of the claimant that the left long finger is still “hypersensitive,” Dr. K did not assign any impairment for sensory loss. We note that there is no Figure 13 on page 3/30 of the AMA Guides. It is apparent that Dr. K is referring to Figure 17 on page 3/30.

A letter of clarification (LOC) dated March 6, 2012, was sent to Dr. K and stated:

You examined the [claimant] on [August 27, 2011], for the purpose of determining the date of [MMI] and the [IR]. You found that the [claimant] reached [MMI] on [August 27, 2011], with a 4% [WP] [IR] for the compensable injury involving the amputation of the distal phalanx of the left long finger. [The Division] need[s] clarification regarding your determination of the final [IR]. Please review pages 66, 67, and 68 (example-Figure 49A) and answer the following questions: (1) Did you consider sensory impairments for the involved digit? Please explain. (2) Did you consider motion impairment for each remaining digital joint on the involved digit? Please explain. (3) Did you consider digit impairments due to other disorders for the involved digit? Please explain. (4) Did you consider impairment for loss of strength or other disorders under Section 3.1m, page [3/58]? Please explain.

In response to the Division’s LOC, Dr. K submitted an amended DWC-69 that certified the claimant reached MMI on August 27, 2011, with 5% IR. In his narrative report dated March 27, 2012, attached to his amended DWC-69, Dr. K stated:

I am asked to clarify my calculations. I have reviewed my calculations and it appears that I failed to add the impairment related to the sensory loss. To reiterate, this claimant, during the normal course of his vocation, sustained an injury to his left hand, in particular an amputation of his left long finger at the distal interphalangeal [DIP] joint. This had healed and I felt he was at [MMI].

I examined the claimant and I found that due to the amputation on page [3/30], Figure 17, he had 40% finger impairment from the amputation. Using the same Figure 17 he also had 20% finger impairment due to loss of sensation. Following the [AMA Guides] the 40% is combined with the 20% using the [Combined Values Chart (CVC)] on page 322. The 40% and 20% combined is 52% finger impairment. A 52% finger impairment using page [3/18], Table 1 is equal to 10% hand impairment. A 10% hand impairment using page [3/19], Table 2 is equal to 9% [UE] impairment. A 9% [UE] impairment using Table 3 on page [3/20] is 5% [WP] impairment.

I have examined this claimant and have found no abnormal range of motion [ROM] to contribute or impairments due to other disorders. I have evaluated him for those and find no justification for either of those two aspects of the injury to contribute, only the amputation with loss of sensory combined as I previously stated.

The carrier contended that Dr. K rated the compensable injury in accordance with the AMA Guides and that Dr. K and Dr. O used the same methodology in applying the AMA Guides. The carrier argued that Dr. K's opinion was entitled to presumptive weight and that the preponderance of the medical evidence is not contrary to Dr. K's opinion. The hearing officer adopted the assigned 5% IR by Dr. K, the designated doctor, commenting that the difference in the assigned 7% IR by Dr. O and the 5% by Dr. K was a mere difference in medical opinion.

The AMA Guides, on page 3/66, provide a summary of steps for evaluating impairments of the UE. For the hand region, the AMA Guides state:

Use [UE] Evaluation Record Part 1 ([page 3/16]). [We note that this is the worksheet recommended by the AMA Guides for calculating hand impairment. Neither Dr. K or Dr. O used this worksheet.]

- A. Determine and record *amputation* impairments for each digit (. . . fingers [page 3/30]).
- B. Determine and record *sensory* impairments for each digit (. . . fingers [page 3/30]).
- C. Measure and record *motion* impairment for each digital joint (. . . finger DIP [page 3/31] [proximal interphalangeal (PIP), page 3/33]; [metacarpophalangeal (MP) page 3/34]). The motion impairments are rounded to the nearest 10 [degrees].

. . . The motion impairments at the DIP, PIP, and MP joints of the fingers are *combined* ([CVC] [page] 322).

- D. Record digit impairments due to *other disorders* for each joint or digit (Section 3.1m [page 3/58]).
- E. Individual digit impairment: *combine* impairments due to amputation, sensory loss, loss of motion, and other disorders ([CVC] [page 322]).
- F. *Convert* digit impairments to hand impairments (Table 1 [page 3/18]).
- G. Total hand impairment: *add* the hand impairment values related to the involved digits.
- H. Convert hand impairment to [UE] impairment (Table 2 [page 3/19]).
- I. If applicable, determine the [UE] impairment percent due to loss of strength and *combine* this with other [UE] impairments evaluated according to Section 3.1m [page 3/64].

* * * *

- K. If no other [UE] impairment exists, convert the [UE] impairment related to the hand region to [WP] impairment (Table 3 [page 3/20]).

On page 3/30 of the AMA Guides, Figure 17 assigns sensory loss for total transverse sensory loss, which was used by Dr. K in assigning sensory loss for the left middle finger. However, on page 3/30, in Section 3.1g “Fingers,” in subsection “Sensory Loss of Fingers,” “Transverse Sensory Loss (both digital nerves involved), the AMA Guides provide:

- 1. Determine the type and level of *transverse sensory loss* with the two-point discrimination test (Section 3.1c [page 3/20]).

Two-point discrimination values greater than 15 mm are considered to be *total sensory losses* and receive 50% of the impairment amount for amputation.

Two-point discrimination values from 15 through 7 mm represent partial sensory losses and receive 50% of the total sensory loss value, or 25% of the amputation impairment value.

Two-point discrimination sensibility of 6 mm or less is normal and not an impairment.

2. Consult [Figure] 17 . . . bottom scale, to determine the finger impairment for total transverse sensory loss according to level of occurrence.

In Section 3.1g “Fingers,” of the AMA Guides, the fingers have three joints, DIP, PIP, and MP. The amputation of a portion of a digit may result in an abnormal ROM at the remaining joints of that digit. The AMA Guides describe how to measure abnormal ROM for the finger DIP, Figure 19, page 3/32, for the finger PIP, Figure 21, page 3/33, and for the finger MP, Figure 23, page 3/34.

In Appeals Panel Decision (APD) 111384, decided November 23, 2011, the hearing officer found that the certifying doctor assigned an IR in accordance with the AMA Guides; however, the Appeals Panel disagreed and noted that the certifying doctor did not follow the steps for evaluating impairment of the UE found on page 3/66 of the AMA Guides. Specifically that certifying doctor in rating a sensory loss of a digit, did not report whether both digital nerves were involved or whether one digital nerve was involved and did not indicate whether the two-point discrimination findings were normal or abnormal findings. The Appeals Panel stated that to calculate the claimant’s UE impairment there must be a calculation of impairment for the digits/hand according to the AMA Guides, and without which, there is no adoptable IR because the preponderance of the other medical evidence contradicts the IR by the certifying doctor.

Finding of Fact No. 6 states that the preponderance of the medical evidence supports Dr. K’s assigned IR of 5%. We disagree. In this case, Dr. K, the designated doctor did not identify if one or two digital nerves were involved in the claimant’s left middle finger. Dr. K failed to indicate that he performed the two-point discrimination test in his examination in order to calculate sensory loss of the finger or, if he had performed the test, to record his findings. Furthermore, Dr. K reports that he found no abnormal ROM for the claimant’s remaining digital joints, but he provides no worksheet or measurements to document or analyze his assignment of no impairment for abnormal ROM. 28 TEX. ADMIN. CODE § 130.1(c)(3)(D) (Rule 130.1(c)(3)(D)) provides in pertinent part that the certifying doctor in assigning an IR shall describe and explain specific clinical findings related to each impairment, including 0% IR and describe how the findings relate to and compare with the AMA Guides criteria for the applicable chapter of the AMA Guides. For these reasons, the hearing officer erred in adopting the assigned 5% IR by Dr. K.

There is only one other assigned IR in evidence. Dr. O, the claimant’s treating doctor, examined the claimant on March 8, 2012, and certified that the claimant reached MMI on that date with 7% IR. Subsequent to that certification of MMI/IR, Dr. O amended his DWC-69 to agree with the date of MMI certified by Dr. K and placed the

claimant at MMI on August 27, 2011, with 7% IR. That amended DWC-69 is in evidence. In his narrative report dated March 8, 2012, Dr. O states:

The left hand is missing the tip of the long finger through the distal metaphysis of the middle phalanx. . . . He has altered sensation according to him by subjective report, which extends down to the PIP joint. [ROM] of the PIP joint is from -5 to 95 degrees of flexion for a 100-degree flexion arc. MCP flexion is normal. I would conclude that his impairment is due to a combination of loss of [ROM] and loss of sensory function. I believe he has partial loss of sensation from the PIP flexion crease to the tip of the finger. His [ROM] loss is 6%. This is based on the AMA [G]uides. . . . This is because of his lack of PIP joint flexion at 95 degrees when normal is . . . 100 degrees on [F]igure 21 on page [3/33]. He has 50% impairment due to amputation through the distal part of the middle phalanx. This is according to the amputation chart [F]igure 17 on page [3/30]. I would give him an additional 10% loss of function of the finger due to the altered sensation in that middle phalanx. This is based on the fact that altered sensation is approximately 50% of the value of amputation and is an estimate based on [F]igure 17 and [T]able 8 on page [3/30 and 3/31]. These combine with amputation and sensory deficit to be 55% impairment and combine again 6% [ROM] impairment to a 58% impairment of the finger. A 58% impairment of the finger converts to a 12% impairment of the hand in [T]able 1 on page [3/18], a 12% impairment of the hand converts to an 11% impairment of the [UE] in [T]able 2 and an 11% impairment of the [UE] converts to a 7% impairment of the [WP] in [T]able 3.

Like Dr. K, Dr. O does not follow the AMA Guides as described above in rating a sensory loss of the middle finger. There is no documentation of the findings of the two-point discrimination test, if performed. Because Dr. O did not assign an IR in accordance with the AMA Guides, his 7% IR cannot be adopted.

It is also interesting to note that Dr. K and Dr. O do not agree as to the application of Figure 17, page 3/30. Under Section 3.1g, "Fingers," the AMA Guides provide that for an amputation of the finger, first determine the length of the finger remaining after the amputation and then determine the impairment by consulting the top scale of Figure 17. No doctor documents the length of the claimant's finger remaining after the amputation and Dr. K assigns a 40% impairment for amputation at the DIP joint. In contrast, Dr. O assigns a 50% impairment for amputation between the DIP and the PIP joint. If the certifying doctor determines that there is a total transverse sensory loss (both digital nerves involved) and calculates the sensory loss using Figure 17, it is

necessary to calculate the length of the finger remaining after the amputation. If the certifying doctor determines that there is a longitudinal sensory loss, then he must follow the steps outlined on page 3/31 of the AMA Guides.

We reverse the hearing officer's determination that the claimant's IR is 5% and remand the IR issue to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

Dr. K is the designated doctor. On remand, the hearing officer is to determine whether Dr. K is still qualified and available to be the designated doctor. If Dr. K is no longer qualified or available to serve as the designated doctor, then another designated doctor is to be appointed to determine the claimant's IR for the compensable injury of [date of injury].

The hearing officer is to advise the designated doctor that Rule 130.1(c)(3) provides that 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; and (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% [IRs]; and (ii) [a] description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained.

The hearing officer is to request that the designated doctor assign an IR for the claimant's compensable injury of [date of injury], based on the claimant's condition as of August 27, 2011, the MMI date stipulated to by the parties, considering the claimant's medical record and the certifying examination.

The parties are to be provided with the hearing officer's letter to the designated doctor and the designated doctor's response. The parties are to be allowed an opportunity to respond. The hearing officer is then to make a determination on MMI/IR supported by the evidence and 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 **ULLICO CASUALTY COMPANY** and the name and address of its registered agent for service of process is

**CT CORPORATION SYSTEMS
350 NORTH ST. PAUL
DALLAS, TEXAS 75201.**

Cynthia A. Brown
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Margaret L. Turner
Appeals Judge