APPEAL NO. 141129
FILED JULY 29, 2014

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on November 14, 2013, February 3, 2014, and April 7, 2014, with the record closing on April 22, 2014, in Dallas, Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that the compensable injury of [date of injury], does not extend to complex regional pain syndrome (CRPS)/reflex sympathetic dystrophy (RSD) of the left upper extremity (UE)[1] and that the appellant's (claimant) impairment rating (IR) is 11%.

The claimant appealed the hearing officer's IR determination, contending that the hearing officer should have adopted the IR of the treating doctor referral doctor, (Dr. M). Respondent 1 (carrier) responded, urging affirmance of the hearing officer's IR determination. The appeal file does not contain a response from respondent 2 (subclaimant) to the claimant's appeal. The hearing officer's determination that the compensable injury of [date of injury], does not extend to CRPS/RSD of the left UE has not been appealed and has become final pursuant to Section 410.169.

DECISION

Reversed and remanded.

The parties stipulated that the claimant sustained a compensable injury on [date of injury], and that the carrier has accepted a left hand strain, left wrist strain, left carpal tunnel syndrome (CTS), left ulnar neuropathy, and cervical myofascial neck pain. The parties also stipulated that the claimant reached maximum medical improvement (MMI) on December 4, 2012, the date of statutory MMI, and that the Texas Department of Insurance, Division of Workers' Compensation (Division) selected (Dr. V) as the designated doctor to determine MMI, IR, and extent of the compensable injury. The claimant testified that he felt a pop in his elbow while putting his full body pressure on his arm to install a frame.

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

[1] We note that the parties stipulated at the CCH that the compensable injury does not extend to CRPS/RSD of the left UE.

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 hearing officer determined that the claimant's IR is 11% as certified by Dr. V, the designated doctor.

Dr. V initially examined the claimant on July 19, 2012, and certified that the claimant had not reached MMI. Dr. V subsequently examined the claimant on January 25, 2013, and certified that the claimant reached MMI statutorily on December 4, 2012, with an 11% IR. Using 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), Dr. V assigned 4% UE impairment for decreased range of motion (ROM) of the left elbow, and 6% UE impairment for decreased ROM of the left wrist. Dr. V also assigned 4% UE impairment for sensory deficit of the ulnar nerve above the midforearm by multiplying 61% sensory deficit of the left ulnar nerve above the midforearm and 7% maximum UE impairment due to sensory deficit or pain. Dr. V additionally assigned 6% UE impairment for sensory deficit of the left median nerve below the midforearm by multiplying 15% sensory deficit of the left median nerve below the midforearm and 38% maximum UE impairment due to sensory deficit or pain. Dr. V noted in his narrative report that:

> . . . the AMA Guides do now allow an evaluator to combine [ROM] deficit with a motor deficit as this would result in a multiplication/duplication of the [IR]. Therefore, no impairment is awarded for the motor deficit as the impairment for the [ROM] deficit awards the [claimant] with the higher impairment.

Dr. V combined the UE impairment assigned for decreased ROM of the left elbow and wrist with the UE impairment for sensory deficit of the left ulnar nerve above the midforearm and left medial nerve below the midforearm for 11% whole person impairment. After a letter of clarification notifying Dr. V that cervical myofascial neck pain has been accepted by the carrier, Dr. V placed the claimant in Diagnosis-Related Estimate Cervicothoracic Category I: Complaints or Symptoms for 0% impairment, and amended his certification to include that impairment.

We note that the AMA Guides provide the following on page 3/46:

> To evaluate impairment resulting from the effects of peripheral nerve lesions, it is necessary to determine the extent of loss of function due to (1) sensory deficits or pain (Table 11 [page 3/48]); and (2) motor deficits

(Table 12 [page 3/49]). Characteristic deformities and manifestations resulting from peripheral nerve lesions, such as restricted motion, atrophy, and vasomotor, trophic, and reflex changes, have been taken into consideration in preparing the estimated impairment percents shown in this section.

If an impairment results strictly from a peripheral nerve lesion, the physician should not apply impairment percents from Sections 3.1f through 3.1j ([pages 3/24 through 3/45]) of this chapter [Figures 26 and 29 included], and this section [3.1k Impairment of the (UE) Due to Peripheral Nerve Disorders (Table 16 included)], because a duplication and an unwarranted increase in the impairment percent would result.

If restricted motion cannot be attributed to a peripheral nerve lesion, the motion impairment should be evaluated according to Sections 3.1f through 3.1j and the nerve impairment according to this section [3.1k]. Then the motion impairment percent should be *combined* (Combined Values Chart [page 322]) with the peripheral nerve system impairment percent.

The AMA Guides further provide in Section 3.1k, Entrapment Neuropathy, on page 3/56:

Impairment of the hand and [UE] secondary to entrapment neuropathy may be derived by measuring the sensory and motor deficits as described in preceding parts of this section.

In Appeals Panel Decision (APD) 043155, decided January 28, 2005, the disputed issue was the IR. The certifying doctor, a designated doctor, calculated the impairment for the wrist by combining a UE impairment for loss of motion with UE impairment for mild median nerve entrapment neuropathy under Table 16, page 3/57 of the AMA Guides. The hearing officer adopted the assigned IR from the designated doctor. The Appeals Panel reversed the hearing officer's IR determination and remanded the IR issue because:

Although the records indicate that the designated doctor based his assessment of impairment for the right wrist solely on the diagnosis of [CTS], the designated doctor assessed impairment for abnormal motion of the right wrist under Section 3.1h [abnormal ROM for the wrist] and then combined that rating with impairment he assessed for the right wrist under Table 16 [UE Impairment Due to Entrapment Neuropathy] based on mild impairment of the median nerve of the wrist. Clarification should be sought from the designated doctor to determine whether or not the

impairment for the right wrist results strictly from a peripheral nerve lesion.

The Appeals Panel remanded the case for the hearing officer to seek clarification from the designated doctor and request the designated doctor provide an IR report that is in compliance with the AMA Guides. APD 043155, *supra*, was followed in APD 111965, decided February 24, 2012, which held that loss of ROM and peripheral nerve involvement cannot be combined to obtain a rating for CTS without a distinct lesion of some sort causing the ROM loss, separate from the nerve involvement. *See also* APD 130342, decided April 3, 2013.

In the case on appeal, Dr. V did not state whether or not the claimant's impairment results strictly from a peripheral nerve lesion. Dr. V noted that the AMA Guides do not allow an evaluator to combine ROM deficit with a motor deficit, and therefore he combined UE impairment based on ROM deficit of the claimant's left elbow and wrist with sensory deficits in the claimant's ulnar nerve above the midforearm and medial nerve below the midforearm. However, the AMA Guides, as discussed above, provide that if impairment results strictly from a peripheral nerve lesion, the certifying doctor should not combine ROM deficit with section 3.1k, Impairment of the UE Due to Peripheral Nerve Disorders, which includes impairment for both sensory deficit and motor deficit.

Furthermore, we note that Dr. V found a 14° radial deviation of the claimant's left wrist and assigned a 1% UE impairment, and that Dr. V found a 27° ulnar deviation of the claimant's left wrist and assigned a 1% impairment. Page 3/37 of the AMA Guides instructs that in measuring radial and ulnar deviation readings "[r]ound the figures to the nearest 10°." Radial deviation of 14° should either be rounded up to 20° for 0% UE impairment, or down to 10° for 2% UE impairment. Ulnar deviation of 27° should either be rounded up to 30° for 0% UE impairment, or down to 20° for 2% UE impairment. Dr. V's 6% UE impairment based on ROM of the claimant's left elbow and wrist is incorrect.

For the reasons stated, Dr. V's IR cannot be adopted. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 11%.

There is only one other MMI/IR certification in evidence, which is from Dr. M, a treating doctor referral doctor. Dr. M examined the claimant on December 4, 2012, and certified that the claimant reached MMI statutorily on December 4, 2012, with an 18% IR. Dr. M lists in his narrative report a single diagnosis of a "postoperative entrapment neuropathy, moderate in degree, of the left ulnar nerve following ulnar transposition. . . ." As discussed above, the parties stipulated that the carrier has accepted a left hand strain, left wrist strain, left CTS, left ulnar neuropathy, and cervical myofascial neck pain.

Dr. M does not consider and rate the entire compensable injury, and as such, his IR cannot be adopted.

As there is no IR in evidence based on the stipulated MMI date of December 4, 2012, that can be adopted, we remand the issue of IR to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

Dr. V is the designated doctor in this case. On remand, the hearing officer is to determine whether Dr. V is still qualified and available to be the designated doctor.

The hearing officer is to advise the designated doctor that the compensable injury of [date of injury], includes a left hand strain, left wrist strain, left CTS, left ulnar neuropathy, and cervical myofascial neck pain. The hearing officer is also to advise the designated doctor that the compensable injury of [date of injury], does not extent to CRPS/RSD of the left UE.

The hearing officer is to request the designated doctor to rate the entire compensable injury based on the claimant's condition as of the December 4, 2012, date of MMI based on the claimant's medical record and certifying examination.

The hearing officer is to advise the designated doctor to comply with Rule 130.1(c)(3) of the AMA Guides. The designated doctor, if he/she chooses to combine ROM and peripheral nerve involvement, is to clarify whether the assigned impairment for the wrist and/or elbow results strictly from a peripheral nerve lesion or if the restricted motion cannot be attributed to a peripheral nerve lesion. The doctor is also to round ROM figures as required by the AMA Guides.

The parties are to be provided correspondence to the designated doctor, the designated doctor's response and are to be allowed an opportunity to respond. The hearing officer is then to make a determination on the IR 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

RICHARD J. GERGASKO, PRESIDENT
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723.

Carisa Space-Beam
Appeals Judge

CONCUR:

Veronica L. Ruberto
Appeals Judge

Margaret L. Turner
Appeals Judge