TDI Division of Workers' Compensation

Appeals Panel Decisions (APDs) for Designated Doctors

As of November 7, 2023

APD#	Subject	Relevancy
130191 150224	Maximum Medical Improvement (MMI)	The Medical Disability Guidelines (MDG) cannot be used alone, without considering the injured employee's (IE) physical examination and medical records, in determining an IE's date of MMI.
040313-s 040998-s	MMI/Impairment Rating (IR)	An IR assignment shall be based on the injured employee's condition as of the MMI date, considering the medical records and the certifying examination. 28 Texas Administrative Code (TAC) §130.1(c)(3). That rule has been interpreted to mean that the IR shall be based on the condition as of the MMI date and is not to be based on subsequent changes, including surgery.
043168 110267	MMI/IR: Consideration of Compensable Injury	The doctor evaluating permanent impairment must consider the entire compensable injury.
200978 172017 131554	MMI	An injured employee cannot be found to have not reached MMI once the statutory MMI date has passed.
211351	IR	For IR assignment there should not be internal inconsistency between the DWC-69 and the narrative report. Checking the box for "no permanent impairment" on the 69 is not the same as assigning a 0% IR.
030091-s 142524	Radiculopathy	The AMA Guides indicate that to find radiculopathy, doctors must look to see if there is a loss of relevant reflexes or unilateral atrophy with greater than a 2-centimeter decrease in circumference compared with the unaffected side [see APD 072220-s, below, for clarification that, in order to have significant signs of radiculopathy based on atrophy, the measured unilateral atrophy is 2 centimeters or more, not greater than 2 centimeters].
040924, 091039, 111710	Radiculopathy	Loss of relevant reflexes is a decrease or an absence. The AMA Guides do not require a total loss of reflexes to qualify for an IR of radiculopathy.
072220-s 141799	Radiculopathy	The AP clarified that to receive a rating for radiculopathy the IE must have significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of 2 centimeters or more above or below the knee, compared to measurements on the contralateral side at the same location, and the atrophy or loss of relevant reflexes must be spine-injury-related.
051456 080375	Radiculopathy	The significant clinical signs of radiculopathy may be verified by electrodiagnostic testing; however, electrodiagnostic testing indicating radiculopathy is insufficient by itself to assign impairment for radiculopathy in the absence of significant signs of radiculopathy (loss of relevant reflexes or unilateral atrophy).

APD#	Subject	Relevancy
022509-s	Spine	In the event the evaluating doctor must choose between two or more Diagnosis-Related Estimate (DRE) categories that may apply, the range-of-motion (ROM) Model may be used in conjunction with the DRE Model as a "differentiator" to make that choice.
032336-s	Spine	The evaluating doctor may not merely choose an IR that is between the IRs provided for in the DRE categories.
090639	Spine	Radiculitis and radiculopathy are not the same condition.
030288-s	Spine	If none of the categories of the DRE Model are applicable the evaluating doctor may use the ROM Model for assigning the IR. The doctor's report must have a specific explanation why the DRE Model could not be used. A comment that the evaluator merely prefers "to use the Model that he or she feels is most appropriate" is insufficient justification for using the ROM rather than the DRE Model."
051306-s 221500	Spine Cervical, Thoracic Lumbar	In using the DRE Model, the doctor should select the region primarily involved and rate that region. If the injury is primarily to the cervical spine the rating would be for cervicothoracic spine impairment; if the injury was primarily to the thoracic spine the rating would be for thoracolumbar spine impairment; and if the injury is primarily to the lumbar spine the rating would be for lumbosacral spine impairment. If more than one spine region is impaired, the doctor determines the impairment of the other regions and combines the regional impairments using the Combined Value Chart (CVC) on page 322 of the AMA Guides to express the total spine impairment.
080966-s	Spine Guarding	Table 71, AMA Guides, page 109, lists DRE Impairment Category Differentiators. The Guarding portion of Table 71 states “muscle guarding or spasm or nonuniform loss of ROM.” By placing the word “or” between guarding, spasm and nonuniform loss of ROM, those terms are in the disjunctive. The AP held that guarding can be used as a differentiator if guarding or spasm or nonuniform loss of ROM is present or has been documented by a physician, not that all three items of guarding, spasm and non-uniform loss of ROM must be present or documented by a physician before it can be used as a differentiator.
022504-s 220745	Upper Extremity (wrist radial/ulnar deviation) Range of Motion (ROM)	Where a conflict exists between the general directions and the figures in the AMA Guides, the general directions control. The general directions for rating radial and ulnar deviation provide that the measurements be rounded to the nearest 10 degrees. Because the general directions control, the measurements for radial and ulnar deviation should be rounded to the nearest 10 degrees, not 5 degrees as provided in Figure 29 on page 3/28 of the AMA Guides.

APD#	Subject	Relevancy
151158-s 160851	Upper Extremity Resection Arthroplasty of the Distal Clavicle	The language contained on page 3/58 is ambiguous, whereas the language on page 3/62 provides clearer instruction regarding the rating of arthroplasty procedures. Therefore, a distal clavicle resection arthroplasty that was received as treatment for the compensable injury results in 10% upper extremity impairment under Table 27 on page 3/62, which is then combined with ROM impairment, if any, as provided by the AMA Guides. The AP has previously held that impairment for a distal clavicle resection that was received as treatment for the compensable injury results in 10% UE impairment under Table 27 of the AMA Guides, which is then combined with ROM impairment, if any, as provided by the AMA Guides.
221683	Upper Extremity Resection Arthroplasty of the Distal Clavicle	The distal clavicle resection the injured employee received was not for treatment of the compensable injury and it was improper to include an impairment from Table 27 on p. 3/61 of the AMA Guides.
230890	Upper Extremity Total Shoulder Arthroplasty v. Hemiarthroplasty	Impairment cannot be assessed using Table 27, page 3/61 of the AMA Guides for a total shoulder arthroplasty if that procedure was not performed. A hemiarthroplasty is not the same as a total arthroplasty.
061569-s	Upper Extremity	Upper extremity impairments for a limb are combined using the CVC to determine the total upper extremity impairment and then the total upper extremity impairment is converted to a whole person impairment.
150931	Upper Extremity- Both Arms	If both limbs involved, calculate the whole person impairment for each separately and combine the percent using the CVC.
120897 132413	Upper Extremity Contralateral Comparison	There is no provision in the AMA Guides which require or prohibit using the contralateral side as a comparison and it is in the discretion of the certifying doctor to do so or not.
052243-s	Upper Extremity RSD/CRPS	Impairment secondary to causalgia and RSD is derived as set forth on page 3/56 of the AMA Guides "Causalgia and RSD", not from Table 17 "Impairment of Upper Extremity Due to Peripheral Vascular Disease" on page 57 of the AMA Guides.
210939	Upper Extremity RSD/CRPS	The AMA Guides, 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 upper extremity (UE) (Section 3.1k, page 56).”
211091-s	Lower Extremity ROM	AMA Guides on page 3/75 states that for impairments of the same lower extremity part, or different parts, the whole person impairments should be combined. This includes ROM impairments within the same joint.
132734 220150	Lower Extremity ROM	There are no specific directions in the AMA Guides which prohibit addressing loss of motion in the different directions of motions or vectors of motion in assessing impairment for a single joint. Section 3.2e does not require that a certifying doctor must only use the most severe impairment for an individual direction of motion within the same table.

APD#	Subject	Relevancy
220810	Lower Extremity ROM	There is no specific provision in the AMA Guides in the Lower Extremity section that requires ROM deficits be utilized to increase the impairment for a single joint, and it is within the certifying doctor's discretion as a matter of medical judgment to use or not use the different angles of loss of ROM in a single joint.
220893	Lower Extremity Both Limbs	The AMA Guides provide on page 3/17 that if both limbs are involved, calculate the whole-person impairment for each on a separate chart and combine the percents of each limb.
101481	Lower Extremity Peripheral Nerve Loss	The AMA Guides on page 3/88 state that all estimates listed in Table 68 are for complete motor or sensory loss of the named peripheral nerves and that partial motor loss should be estimated on the basis of strength testing.
230225	Lower Extremity Peripheral Nerve Loss	The AMA Guides provide on page 3/88 that all estimates listed in Table 68 on page 3/89 are for complete motor or sensory loss for the named peripheral nerves.
111720	Lower Extremity Amputation	A lower extremity impairment based on gait derangement for an extremity cannot exceed the impairment estimate for amputation of the extremity, which would be 40% whole person impairment.
220145	Lower Extremity Hip	Table 40 on page 3/78 of the AMA Guides describes the ROM measurements for hip extension as degrees of flexion contracture.
220810	Lower Extremity Hip	There is no specific provision in the AMA Guides in the Lower Extremity section that requires ROM deficits be utilized to increase the impairment for a single joint, and it is within the certifying doctor's discretion as a matter of medical judgment to use or not use the different angles of loss of ROM in a single joint.
072253-s 130849 191070	Hernia	To assess an impairment for a hernia-related injury under Table 7, "Classes of Hernia-related Impairment", on page 10/247 of the AMA Guides, is used to assess impairment for a hernia-related injury. there must be a palpable defect in the supporting structures of the abdominal wall. Each class listed in Table 7 for rating a hernia-related impairment requires a palpable defect in the supporting structures of the abdominal wall in conjunction with other criteria.
230137	Respiratory	The AMA Guides provide on page 5/163 that Table 8 presents criteria for estimating the extent of permanent impairment and that spirometry and single breath diffusing capacity of carbon monoxide (Dco) must be performed.

APD#	Subject	Relevancy
230102	Respiratory	Under Class 1 of Table 8 on page 5/162 of the AMA Guides, all of the listed criteria except for measured exercise capacity (VO2) max must be met. The required methodology includes, in part, measurements made from at least three acceptable spirometric tracings of forced expiration: forced vital capacity (FVC), forced expiratory volume in the first second (FEV1), and the FEV1/FVC, a predicted normal single-breath Dco Value for an individual according to age, and utilization of Table 8 (page 5/162) for estimating the extent of permanent impairment.
230999	Nerve Injuries	Chapter 4 of the AMA Guides provides for measuring impairment from nerve injuries, including neurological impairment of respiration in Section 4.3c on page 4/149.
071599-s	Skin/Peripheral Nerve	Impairment for a skin disorder under Chapter 13 of the AMA Guides may be combined with peripheral nerve impairment under Chapter 4 using the CVC to determine total impairment.
031168	Skin	Impairment for a skin disorder under Chapter 13 may be combined with impairment for loss of ROM under Chapter 3 using the CVC to determine total impairment.
162301	Skin disorders Class 1 and 2	For Class 1 and 2, Table 2 on page 13/280 of the AMA Guides, notes "[t]he signs and symptoms of disorders in classes 1 and 2 may be intermittent and not present at the time of the examination. The impact of the skin disorder on daily activities should be the primary consideration in determining the class of impairment. The frequency and intensity of the signs and symptoms and the frequency and complexity of medical treatment should guide the selection of an appropriate impairment percentage and estimate within any class."
060949 121772	Vision Loss	The AP stated that the AMA Guides require that all five steps be followed even if only one eye is injured. Subsection 8.4 page 217 lists the steps in determining impairment of the visual system and whole person. Step 1 is to determine the percentage loss of central vision for each eye combining the losses of near and distance vision. Step 2 is to determine loss of visual field for each eye. Step 3 is loss of ocular motility. Step 4, after "determining the level of impairment of each eye, use Table 7 (page [8]/219) to determine visual system impairment." Step 5 is to convert the visual system impairment to a whole person IR.

APD#	Subject	Relevancy
042912-s	Syncope	Syncope is rated for impairment under Table 22 entitled "Impairments Related to Syncope or Transient Loss of Awareness" on page 4/152 of the AMA Guides, and not under Table 5 on page 4/143.
051277 961699	Mental and Behavioral Disorders	Although Chapter 14 of the AMA Guides does not provide impairment percentages in the Table entitled "Classifications of Impairments Due to Mental and Behavioral Disorders", the certifying doctor may consider Chapter 4 relating to the Nervous System to calculate the impairment percentage for mental and behavioral disorders from Chapter 14. Chapter 4 at page 142 of the AMA Guides, the first column, provides that the criteria for evaluating the emotional and behavioral impairments in Table 3 of Chapter 4 relate to the criteria for mental and behavioral impairments in Chapter 14.
030622 961699	Mental and Behavioral Disorders	An IR for a mental or behavioral disorder must be supported by objective clinical or laboratory findings. The mental or behavioral disorder must be permanent to be rated for impairment.
231193	Mental and Behavioral Disorders	Section 4.1: The Central Nervous System – Cerebrum or Forebrain on page 4/140 of the AMA Guides provides that a patient may have more than one of nine types of cerebral dysfunction, which are identified as: (1) disturbances of consciousness and awareness; (2) aphasia or communication disturbances; (3) mental status and integrative functioning abnormalities; (4) emotional or behavioral disturbances; (5) special types of preoccupation or obsession; (6) major motor or sensory abnormalities; (7) movement disorders; (8) episodic neurologic disorders; and (9) sleep and arousal disorders. The AMA Guides provide that the most severe of the first five of the nine categories of cerebral dysfunction should be used to represent the cerebral impairment, and any impairments in the last four categories may be combined with the most severe of the first five categories.
002967	Aggravation	A claimed injury that causes additional damage or harm to the physical structure of the body. May include any naturally resulting disease or infection. Can include an enhancement, acceleration or worsening or an underlying condition.
120311-s	Extent of Injury	Differential diagnosis is not required to establish expert medical causation evidence.
141797	Extent of Injury	Designated doctors must address all disputed injuries listed by the requestor when assessing extent of injury.
221016	Extent of Injury	Designated doctors must have all of the injured employee's medical records to determine the extent of the compensable injury. The treating doctor and insurance carrier shall provide to the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor. 28 TAC §127.10(a) and (b).

APD#	Subject	Relevancy
210067	Extent of Injury	The designated doctor must perform additional testing when necessary to resolve the issue in question. 28 TAC §127.10(c).
220009	IR Adjustments	The adjustments under page 2/9 of the AMA Guides provide for additional impairment in cases where: (1) treatment of an illness results in apparent remission of symptoms, but the patient has not regained his or her prior good health; and (2) pharmaceuticals themselves may lead to impairment.
090692-s	IR Adjustments	Adjustments to IR for effects of treatment or lack of treatment on page 2/9 – should be applicable to circumstances of injured employee's case to be used to assess impairment.
121131-s	Lifetime Income Benefits (LIBs)1 - Imbecility or Incurable Insanity	Discusses the concept beyond Texas Labor Code § 408.161(a)(6) and strictly legal definitions and looks to case law. The AP cited case law that contained instructive language on the definition of incurable insanity or imbecility. The AP noted that case law stated a worker's mental illness is "insanity" if he or she suffers severe social dysfunction and a worker's intellectual impairment is "imbecility" if he or she suffers severe cognitive dysfunction, and that social or cognitive dysfunction is "severe" if it affects the quality of the worker's personal, non-vocational life in significant activity comparably to the loss of two members or sight of both eyes, and is incurable if it is unlikely that normal functioning can be restored.
070063-s	LIBs	The AP cited prior APDs and case law rejecting the argument that because the IE had a spinal injury, the only way the IE could prove entitlement to LIBs was to show permanent and complete paralysis of his legs under Section 408.161(a)(5). The AP cited to case law that had approved entitlement to LIBs based on the total and permanent loss of use of the legs and/or feet, as total loss of use is defined in *Travelers Insurance Co. v. Seabolt*, 361 S.W.2d 204 (Tex. 1962), where the injury was to the spine. Also, the AP cited case law that had rejected the argument that the standards applied to loss of use under the prior law should not apply to cases decided under the 1989 Act.

DISCLAIMER: This list of APD decisions is provided as a quick reference guide, which does not constitute a substitute for review of the relevant APD in its entirety.

1 Effective: Dates of injury prior to September 1, 2023. House Bill (H.B.) 2468 of the 88th Texas Legislature, Regular Session (R.S.), amends Texas Labor Code Section 408.161, for dates of injury on or after September 1, 2023.

Appeals Panel Decision Manual - Acronyms

Acronym	Phrase
Act	Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001
AIDS	Acquired Immune Deficiency Syndrome
AMA	American Medical Association
AP	Appeals Panel
APA	Administrative Procedure Act
APD	AP Decision
AWW	Average Weekly Wage
BRC	Benefit Review Conference
BRO	Benefit Review Officer
BCTS	Bilateral Carpal Tunnel Syndrome
BFOE	Bona Fide Offer of Employment
CAD	Coronary Artery Disease
CE	Claim Employer
CCH	Contested Case Hearing
CPR	Cardio Pulmonary Resuscitation
CRPS	Complex Regional Pain Syndrome, was RSD, Reflex Sympathetic Dystrophy
TS	Carpal Tunnel Syndrome

CVC	Combined Values Chart
D&O	Decision and Order (Hearing Officer's)
DARS	Department of Assistive and Rehabilitative Services formerly (TRC)
DB	Death Benefits
DD	Designated Doctor
Department	Texas Department of Insurance (TDI)
Division	Division of Workers' Compensation (DWC)
DOI	Date of Injury
DRE	Diagnosed-Related Estimates
DSM III R 1	Diagnostic and Statistical Manual of Mental Disorders (3rd edition ? revised)
DW	Deceased Worker
DWC-52	Application for Supplemental Income Benefits
ER	Emergency Room
FCE	Functional Capacity Evaluation
FMLA	Federal Medical Leave Act
FO	Field Office
Guides 3rd Ed.	Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association
Guides 4th Ed.	AMA Guides (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the AMA prior to May 16, 2000), fourth edition
HCN	Health Care Network

HD	Hearings Division
HNP	Herniated Nucleus Pulposus
HO	Hearing Officer
IC	Insurance Carrier
IIBs	Impairment Income Benefits
IPE	Individualized Plan for Employment
IR	Impairment Rating
IRO	Independent Review Organization
IW	Injured Worker
LIBs	Lifetime Income Benefits
LHWCA	Longshore and Harbor Workers' Compensation Act
LMSI	Loss of Motion Segment Integrity
LOC	Letter of Clarification
MDA	Medical Disability Advisor
MDR	Medical Dispute Resolution
MMI	Maximum Medical Improvement
MRD	Medical Review Division
MVA	Motor Vehicle Accident
OAO	Official Action Officer

ODG	Official Disability Guidelines
PIP	Personal Injury Protection
PT	Physical Therapist
PTSD	Post Traumatic Stress Disorder
ROM	Range of Motion
ROMM	Range of Motion Model
RME	Required Medical Examination
RSD	Reflex Sympathetic Dystrophy-now CRPS-Complex Regional Pain Syndrome
SS	Spinal Surgery
SIBs	Supplemental Income Benefits
SIF	Subsequent Injury Fund
TD	Treating Doctor
TIBs	Temporary Income Benefits
TRC	Texas Rehabilitation Commission (Department of Assistive and Rehabilitative Services)
TWC	Texas Workforce Commission
TWCC	Texas Workers' Compensation Commission
URA	Utilization Review Agent
VRP	Vocational Rehabilitation Program