APPEAL NO. 121772
FILED NOVEMBER 15, 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 July 27, 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 July 29, 2009, and the appellant's (claimant) impairment rating (IR) is 16%. The claimant appealed, disputing the hearing officer's determinations on MMI and IR. The respondent (carrier) responded, urging affirmance.

DECISION

Reversed and remanded.

The parties stipulated that: (1) on [date of injury], the claimant sustained a compensable injury; (2) the Texas Department of Insurance, Division of Workers' Compensation (Division) appointed [Dr. D] as the designated doctor for purposes of MMI, IR, and disability; and (3) the date of statutory MMI is June 18, 2011. In the Background Information section of her decision, the hearing officer stated:

> It was undisputed that [the] claimant sustained a compensable injury on [date of injury], when he was hit in the face by a steer, resulting in facial fractures. An [oral antral] fistula developed. [The] [c]laimant also has visual loss and diplopia.

The hearing officer further stated:

> Dr. . . . [(Dr. T)] [the] carrier's [post-designated doctor] required medical examination doctor, certified that [the] claimant reached [MMI] on July 29, 2009, with an [IR] of 16%. Dr. [T's] [IR] was lower than that of Dr. [D] because he used best corrected vision to assess the visual impairment. Dr. [T] also did not provide an [IR] for loss of smell and taste. These conditions were undocumented in the medical records. The preponderance of the evidence is contrary to the opinion of the designated doctor [Dr. D].

The claimant contends that the hearing officer erred in adopting the certification of MMI and IR by Dr. T.

Dr. T examined the claimant on February 21, 2012, and certified that the claimant reached MMI on July 29, 2009, with 16% IR. The 16% IR is based on combining 10% for the visual system impairment and 7% Criteria for Facial Impairment, Class 2, on

page 9/229 of 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). In the narrative report, attached to his Report of Medical Evaluation (DWC-69), Dr. T stated that a "700 [pound] steer jumped and hit [the claimant] in the face with its head. The claimant sustained a blunt force injury [on [date of injury]], that resulted in facial fracture and the need for more than 15 metal screws in facial bones. There was an open reduction and internal fixation performed on the malar fracture through multiple approaches. He developed from the fractures the presence of an [oral antral] fistula on the left side that has been unresponsive to closing after four surgical attempts."

Dr. T placed the claimant at MMI on July 29, 2009, because the claimant had surgery for his left malar fracture on June 23, 2009, and was released by his plastic surgeon, [Dr. W] for facial fractures on July 1, 2009. There was a further record dated August 24, 2009, that the claimant was released by ophthalmology on July 29, 2009. However, in evidence is a report dated August 25, 2009, from [Dr. M], the claimant's treating doctor, which states that the claimant is not at MMI on that date, even though the claimant has been released to full duty. Dr. T also noted in his narrative report that the claimant underwent an additional surgery after the certified date of MMI of July 29, 2009, on January 28, 2011, for the closure of the oral antral fistula. However, Dr. T, in certifying an MMI date, did not address whether or not additional treatment for the oral antral fistula could result in further material recovery or lasting improvement. Rather, Dr. T placed the claimant at MMI on the date that the claimant was released by ophthalmology on July 29, 2009, without addressing the resolution of the oral antral fistula/jaw injury.

Furthermore, Dr. T's IR of 16% cannot be adopted because Dr. T, in assessing an impairment for ocular motility and diplopia, documented diplopia in the central 20 degrees of binocular vision (Figure 3, page 8/217, states this equals 100% loss which is estimated in Table 6, page 8/218, to be 25% impairment of the visual system) and then used prisms to correct the diplopia and to assign 0% impairment. The AMA Guides state on page 8/217 that:

> Examination is made in each of the eight major meridians by using a small test light or the projected light of approximately Goldmann III-4e without adding colored lenses or correcting prisms.
>
> To determine the impairment of ocular motility, the patient is seated with both eyes open and the chin resting in the chin rest and centered so that the eyes are equidistant from the sides of the central fixation target.

> The presence of diplopia is then plotted along the eight meridians of a suitable visual field chart (Fig. 1 p. 213). The impairment percentage for loss of ocular motility due to diplopia in the meridian of maximum impairment, according to Fig. 3 (below), is *combined* with any other visual impairment (Combined Values Chart, p. 322).

In evidence is Dr. T's worksheet, attached to his narrative report and his DWC-69, which assigned 0% impairment for "best-corrected" diplopia field using a prism to remove the claimant's diplopia. Dr. T's methodology is not done according to the provisions of the AMA Guides as discussed above.

Under the facts of this case, because: (1) July 29, 2009, was not the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury could no longer reasonably be anticipated due to subsequent surgical attempts to close the claimant's oral antral fistula; and (2) Dr. T did not correctly rate the claimant's impairment for diplopia according to the AMA Guides, the hearing officer's determination that the claimant reached MMI on July 29, 2009, with 16% IR is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust.

There are two other certifications of MMI and IR in evidence. There is one by the designated doctor, Dr. D, and one by the claimant's treating doctor, Dr. M.

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.

Dr. D examined the claimant on August 31, 2011, and certified that the claimant reached MMI on that date with 31% IR. Upon receipt of a letter of clarification informing

him that the date of statutory MMI is June 18, 2011, Dr. D amended his certification of MMI to be June 18, 2011, assigning 31% IR.

Dr. D placed the claimant at the date of statutory MMI because the claimant was not evaluated and treated for his visual loss and diplopia by an ophthalmologist until August 31, 2011 (a date past the date of statutory MMI). In his narrative report, Dr. D referenced the failed surgeries to close the fistula.

The assigned 31% IR is based on combining 24% for the visual system impairment with 7% IR for Facial Impairment, Class 2,[1] on page 9/229, with 3% for loss of smell and taste under 9.3c Olfaction and Taste, page 9/231. We note there is support for the rating for facial impairment but to assign a rating under Olfaction and Taste, the certifying doctor would need to explain if the claimant had complete bilateral loss of either sense due to peripheral lesions. This explanation was not provided in the narrative report by Dr. D. Also that portion of the AMA Guides, on page 9/232, states "[d]etection by the patient of any odor or taste, even though he or she cannot name it, precludes a finding of permanent impairment." Dr. D referred the claimant to [Dr. R], an ophthalmalogist for the vision system impairment.

In Chapter 8, The Visual System, on page 8/209, the AMA Guides provide:

> Visual impairment occurs in the presence of a deviation from normal in one or more of the functions of the eye, which include: (1) corrected visual acuity for near and far objects; (2) visual field perception; and (3) ocular motility with diplopia. Evaluation of visual impairment is based on evaluation of the three functions.

On page 8/217, in Section 8.4, Steps in Determining Impairment of the Visual System and of the Whole Person, the AMA Guides state:

> *Step 1*: Determine and record the percentage loss of central vision for each eye separately, combining the losses of near and distance vision.
>
> *Step 2*: Determine and record the percentage loss of visual field for each eye separately (monocular) or for both eyes together (binocular).
>
> *Step 3*: Determine and record the percentage loss of ocular motility.

1 This is the same category that Dr. T, as well as Dr. M, placed the claimant in for Facial Impairment. This Class 2 provides a range of 5% to 10%, which can be assigned by the certifying doctor when there is a loss of supporting structure of the face, with or without cutaneous disorder. Depressed cheek, nasal, or frontal bones constitute Class 2 impairments.

Section 8.1 Central Visual Acuity, Determining the Loss of Central Vision in One Eye, on page 8/211 explains Step 1:

> First, measure and record the best central visual acuity for distance and the best acuity for near vision, with and without conventional corrective spectacles or contact lenses. [Table 2, page 8/211]
>
> Then consult Table 3 [page 8/212] to derive the overall loss, combining the values for best corrected near and distance acuities. Allow, if indicated, for the additional loss of central vision that results from monocular aphakia or pseudophakia.
>
> *Example*: A 55-year-old man's Snellen rating for distance vision of the left eye was 20/30, and the rating for near vision of the same eye was 14/24. The man's native lens was present. Table 3 [page 8/212] indicates that the loss of central vision of the eye was 9%.

In evidence is the report from Dr. R (to whom the designated doctor referred the claimant for a visual IR) assigning a 24% IR for the visual system. However, in that report dated August 31, 2011, Dr. R does not follow Step 1 in determining the loss of central vision in one eye. Dr. R indicates he corrected the distance vision for the eyes to 20/20.[2] However, Dr. R gives no measurement for the near vision and does not apply Table 3 to determine the loss of central vision of the eye. Dr. R only documents the following: "Visual Acuity – corrected to 20/20 – 0% impairment." This is not the required documentation as provided by the AMA Guides.

Also, Dr. R does not follow the guidelines as explained for Step 2 to evaluate the claimant's visual field. Section 8.2, Visual Fields, provides for two methods by which to do an evaluation. In his report, Dr. R does not document the use of either of the two methods. Dr. R only writes "[v]isual [f]ield [d]efect – OD [right eye] 0% impairment, OS [left eye] 19% impairment" without an explanation how he reached the 19% impairment.

Only Step 3 is documented in Dr. R's report. Dr. R records diplopia (without adding colored lenses or correcting prisms) within the central 20 degrees, which is estimated to be 100% impairment of ocular motility according to Figure 3, page 8/217. This is equivalent to the total loss of vision of one eye, which is estimated to be a 25% impairment of the visual system.

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[2] Dr. R notes "OD 20/25, correctable to 20/20 and OD 20/30, correctable to 20/20." We note the medical term OD is used for the right eye. It is probable that Dr. R's report has a typographical error and that one of the measurements is for the left eye, OS.

Also, in Appeals Panel Decision (APD) 060949, decided June 21, 2006, the Appeals Panel discussed the three steps as set out in the paragraphs above, but also stated that there are two additional steps that must be followed for the AMA Guides. "Step 4, after 'determining the level of impairment of each eye, use Table 7 (page [8]/219) to determine visual system impairment.' [The certifying doctor] refuses to follow this step because only one eye was injured. Step 5 is to convert the visual system impairment to a whole person IR." In that case, the Appeals Panel stated that the AMA Guides require that all five steps be followed even if only one eye is injured.

Because Dr. R failed to rate the visual system impairment (for which he assigned 24%) according to the AMA Guides, the designated doctor's assigned 31% IR cannot be adopted by the hearing officer.

We next consider the IR by the claimant's treating doctor, Dr. M. Dr. M examined the claimant on April 14, 2011, and certified that the claimant reached MMI on that date with 18% IR. There is in evidence a DWC-69 submitted by Dr. M which contains the date of clinical MMI. In his narrative report dated that same day, Dr. M discusses the definition of MMI and that the claimant has arrived at that date on April 14, 2011. Dr. M notes that the claimant has sustained an oral antral fistula that has been unresponsive to four surgical attempts to close it.

Dr. M's assigned 18% IR is based on "combining a 0% whole-person impairment for diplopia at the edges of his vision with a 10% whole-person impairment for recession of his left eye due to his orbital fracture, with a 5% impairment for his dietary changes, with a 3% impairment for alteration of taste and smell, and a 0% whole-person impairment for the effect of the trigeminal nerve of that persistent numbness over that region, gives him a total impairment of 18% for this injury." An impairment for Mastication and Deglutition, Section 9.3b, page 9/231, requires that the patient's diet must be limited to semi-solid or soft foods for an impairment to be assigned. There is no documented diet for the claimant as to semi-solid or soft foods, rather only a statement by Dr. M that the claimant "cannot eat certain very small foods, such as rice, peas, popcorn, and other very tiny foods that might get stuck in his fistula." Also, as discussed above, there is no explanation of the 3% impairment assigned for alteration of taste and smell as suggested by the AMA Guides. Dr. M did not follow the necessary steps as set out in Chapter 8 for the impairment of the visual system impairment. Dr. M is the only certifying doctor attempting to rate a trigeminal nerve injury under Table 11, page 3/48, for persistent numbness over the cheek around the bridge of the nose and around the side of the cheek. However, the AMA Guides provide that Chapter 4, The Nervous System, is used to assign an impairment for cranial nerve V, a trigeminal nerve, in Table 9, page 4/145. Accordingly, Dr. M did not assign an IR for the claimant's

compensable injury according to the AMA Guides and the assigned 18% cannot be adopted.

There are two certified MMI dates in evidence other than the July 29, 2009, date certified by Dr. T. As previously discussed, because of the continued treatment, including surgery, for the oral antral fistula, the July 29, 2009, date, cannot be adopted. Dr. D certified the date of statutory MMI, June 18, 2011, as the date the claimant reached MMI. Dr. M certified April 14, 2011, the date of his examination, as the date the claimant reached MMI. Because there are two certified dates of MMI in evidence that reference the treatment and surgeries for oral antral fistula, the Appeals Panel cannot render the date that the claimant reached MMI. Rather, we will remand the issues of MMI and IR for the hearing officer to determine from the evidence what is the date that the claimant reached MMI, either clinically or statutorily, for the compensable injury of [date of injury], and the claimant's IR based on the claimant's condition as of the MMI date considering the medical record and the certifying examination.

SUMMARY

We reverse the hearing officer's decision that the claimant reached MMI on July 29, 2009, with 16% IR as certified by Dr. T. We remand the issues of MMI and IR to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

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

The designated doctor is to be requested to re-examine the claimant and to give a certification of MMI/IR for the claimant's compensable injury of [date of injury], based on the claimant's condition as of the MMI date, which can be no later than the parties' stipulated date of statutory MMI, June 18, 2011, considering the claimant's medical record and the certifying examination.

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%] [IR]; 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 ensure that the designated doctor is furnished with all the claimant's relevant medical records, which include, but are not limited to, the records of evaluation or treatment/surgeries of the oral antral fistula.

After the designated doctor re-examines the claimant and submits a new certification of MMI and IR, the parties are to be provided with the designated doctor's DWC-69 and narrative report. The parties are to be allowed an opportunity to respond. The hearing officer is then to make a determination on MMI and IR that is 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 **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.

Cynthia A. Brown
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Margaret L. Turner
Appeals Judge