APPEAL NO. 130342
FILED APRIL 3, 2013

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 28, 2012, with the record closing on December 20, 2012, in [City], Texas, with [hearing officer] presiding as hearing officer. With regard to the two disputed issues, the hearing officer determined that the respondent (claimant) reached maximum medical improvement (MMI) on August 1, 2011, and that the claimant's impairment rating (IR) is 21%.

The carrier appealed, contending that the evidence is insufficient to establish the claimant reached MMI on August 1, 2011, with a 21% IR and that the claimant should have either a 1% IR as assessed by [Dr. O] or 3% IR as assessed by [Dr. D]. The appeal file does not contain a response from the claimant or his estate.

DECISION

Affirmed in part and reversed and remanded in part.

The hearing officer, in the Background Information, commented that the claimant is deceased and recited the efforts made to contact the claimant's beneficiary, to no avail. The carrier stipulated that the claimant sustained a compensable injury on [date of injury]. The hearing officer noted that the Request for a Designated Doctor Examination (DWC-32) for the appointment of [Dr. H] listed injuries accepted as compensable by the carrier as:

> (1) left knee tear lateral meniscus, chronic patellas tendinitis, chondral [defect] patellofemoral joint; (2) status post-left knee partial lateral meniscectomy, debridement of patellar tendon, chondroplasty patellofemoral joint; (3) right wrist sprain/strain; (4) status post-right carpal tunnel release; (5) status post-right elbow CTR (cubital tunnel release); [(6)] sprain/strain left shoulder; [and (7)] loss of central incisor teeth.

The medical evidence establishes that the claimant, a drywall mechanic, slipped and fell 6 feet off a ladder sustaining injuries to his left knee, right wrist, right elbow, left shoulder, and loss of teeth.

MMI

The hearing officer's determination that the claimant reached MMI on August 1, 2011, is supported by sufficient evidence and is affirmed.

IR

Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Texas Department of Insurance, Division of Workers' compensation (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 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 hearing officer, in his Background Information, commented that the Division had appointed three designated doctors in this claim. [Dr. N], the first designated doctor, examined the claimant on November 16, 2010, and certified the claimant was not at MMI. The hearing officer further commented that because Dr. N no longer possessed appropriate qualifications the Division appointed [(Dr. R] as the designated doctor for MMI, IR and return to work. Dr. R examined the claimant on April 12, 2011, and certified that the claimant was not at MMI.

The hearing officer recited that because Dr. R no longer possessed qualifications appropriate to the issues in this case, the Division appointed Dr. H as the designated doctor for the issues of MMI, IR and return to work. Dr. H examined the claimant on November 21, 2011, and certified MMI on August 1, 2011, with a 21% IR. The hearing officer, in the Background Information, commented that Dr. H had rated the injury accepted as compensable by the carrier. Dr. H assigned 1% whole person (WP) impairment from Table 64, page 3/85 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) for a partial left lateral meniscectomy, a rating which the carrier does not dispute. In addition, Dr. H assigned 12% upper extremity (UE) impairment for decreased range of motion (ROM) of the right wrist, 5% UE impairment for decreased ROM of the right elbow, and 7% UE impairment for decreased ROM of the left shoulder.[1] Dr. H also assigned 2% UE impairment for 30% sensory deficit of the right ulnar nerve below mid forearm, 11% UE impairment for 30% sensory deficit of the right median nerve below midforearm, and 1% UE impairment for 20% sensory deficit of the right ulnar nerve above midforearm.

[1] The hearing officer incorrectly indentifies the 7% UE impairment for decreased ROM of the right shoulder.

The carrier, at the CCH, in a brief, and on appeal argued that Dr. H should not have used both ROM deficit and sensory nerve deficit for the wrist injury, referring to Section 3.1k. entitled Impairment of the [UE] Due to Peripheral Nerve Disorders, of the AMA Guides. That section provides in pertinent part, 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.

The hearing officer, in his Background Information, summarized this section of the AMA Guides stating:

In other words, use both ROM and peripheral nerve deficit, unless the ROM decrease is due to the peripheral nerve lesion. There was no showing that was the case here. In fact, it is hard to see how a peripheral sensory nerve lesion could cause a ROM deficit. Motor nerves stimulate motion. Sensory nerves transmit sensations.

The Appeals Panel has previously discussed the carrier's argument in Appeals Panel Decision (APD) 043155, decided January 28, 2005. In APD 043155, the disputed

issue was the IR. The certifying doctor, a designated doctor, calculated the impairment for the wrist by combining an 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 carpal tunnel syndrome [(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, in that case, remanded the case to the hearing officer 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.

In the case before us, Dr. H does not indicate whether or not the impairment results strictly from a peripheral nerve lesion. The hearing officer's interpretation of Dr. H's report is reasonable, but does not constitute evidence from Dr. H on whether or not the impairment for the wrist and elbow resulted strictly from a peripheral nerve lesion.

We also note that Dr. H found a 15° radial deviation of the claimant's right wrist and assigned a 1% UE 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 15° should either be rounded up to 20° for 0% UE impairment, or down to 10° for 2% UE impairment. Dr. H's 1% UE impairment is incorrect.

For the reasons stated, Dr. H's IR cannot be adopted. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 21%.

Also in evidence is a Request of Medical Evaluation (DWC-69) and narrative from Dr. O, the carrier-selected required medical examination doctor. Dr. O examined the claimant on February 27, 2012, and in a report dated March 14, 2012, certified the claimant at MMI on August 1, 2011 (the same date as Dr. H) with a 1% IR. Dr. O

agreed with Dr. H on the MMI date and 1% WP impairment for the medial meniscectomy. Otherwise, Dr. O finds symptom magnification and invalidates all ROM stating "[the claimant's] [ROM] is invalid." Dr. O does not mention the accepted condition of loss of central incisor teeth which are part of the compensable injury. Nor does Dr. O give ROM measurements, even if invalidated by observation, as required in Rule 130.1(c)(3). Dr. O's IR cannot be adopted for the reasons stated.

In evidence is a DWC-69 and narrative dated September 10, 2011, from Dr. D, a doctor selected by the treating doctor acting in place of the treating doctor. The hearing officer, in his Background Information, commented that Dr. D's "IR calculation was incomprehensible." Dr. D certified the claimant at clinical MMI on September 10, 2011, the date of his examination, and assessed a 3% IR. Although not clear, Dr. D apparently rates a 1% WP IR for the meniscectomy and 2% WP IR for loss of ROM of the shoulder. It does not appear that Dr. D rated the right wrist, right elbow or teeth. In any event, Dr. D's IR cannot be adopted because the report has an MMI date different from the MMI date given by Dr. H, Dr. O, and affirmed by this decision.

Because there are no other certifications of IR in evidence that can be adopted, we remand the IR issue to the hearing officer for further action consistent with this decision.

SUMMARY

We affirm the hearing officer's determination that the claimant's MMI date is August 1, 2011.

We reverse the hearing officer's determination that the claimant's IR is 21% and we remand the issue of IR back to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

Dr. H is the designated doctor in this case. On remand, the hearing officer is to determine whether Dr. H 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, as accepted by the carrier: (1) left knee tear lateral meniscus, chronic patellas tendinitis, chondral defect patellofemoral joint; (2) status post-left knee partial lateral meniscectomy, debridement of patellar tendon, chondroplasty patellofemoral joint; (3) right wrist sprain/strain; (4) status post-right carpal tunnel release; (5) status post-right elbow CTR (cubital tunnel release); (6) sprain/strain left shoulder; and (7) loss of central incisor teeth.

The hearing officer is to request the designated doctor to rate the entire compensable injury based on the claimant's condition as of the August 1, 2011, date of MMI based on the medical records (as the claimant is deceased no reexamination is possible).

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 **AMERISURE MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

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IRVING, TEXAS 75039-3711.

Thomas A. Knapp
Appeals Judge

CONCUR:

Carisa Space-Beam
Appeals Judge

Margaret L. Turner
Appeals Judge