APPEAL NO. 130572
FILED APRIL 26, 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 was held on January 25, 2013, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that: (1) the appellant (claimant) reached maximum medical improvement (MMI) on August 4, 2011; and (2) the claimant's impairment rating (IR) is 12%.

The claimant appealed, disputing both the date of the MMI and the IR. The respondent (carrier) responded, urging affirmance of the disputed MMI and IR determinations.

DECISION

Reversed and rendered.

The parties stipulated that the claimant sustained a compensable injury on [date of injury], and that [Dr. B] was appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) as the designated doctor for determining MMI and IR. In evidence is a Notice of Disputed Issue(s) and Refusal to Pay Benefits (PLN-11) dated January 11, 2013, which states that the carrier accepts the diagnosis of left carpal tunnel syndrome (CTS) and left chronic regional pain syndrome (CRPS).

The medical records reflect that the claimant had physical therapy and underwent a left carpal tunnel release on April 9, 2010. The designated doctor, Dr. B, examined the claimant for the first time on July 8, 2010, and determined that the claimant had not yet reached MMI. The claimant had left stellate ganglion blocks in June, July, and September of 2010. The claimant had additional physical therapy in February and March of 2011. Dr. B examined the claimant again on June 9, 2011, and opined that the claimant had not yet reached MMI, noting that a spinal cord stimulator is being anticipated and he agreed that this may be of benefit for CRPS. On July 1, 2011, the claimant underwent an operative procedure to implant a spinal cord stimulator, and on August 4, 2011, the claimant underwent an operative procedure to implant a permanent cervical spinal cord stimulator.

A history of the medical records provided by the carrier-selected required medical examination doctor, [Dr. O], notes that on August 9, 2011, the claimant returned to the doctor who implanted the permanent cervical spinal cord stimulator, [Dr. S], and complained of burning pain over the lower incision generator site. The claimant returned for an office visit on August 18, 2011, with Dr. S noting the spinal cord

stimulator is working very well for the claimant's arm and neck pain. However, Dr. S noted that the claimant was bothered by the staples and that about half the staples were removed. In another office visit on August 25, 2011, according to Dr. O's history Dr. S removed an additional six staples with two staples left over the generator incision, and four staples left over the dorsal incision. Dr. O's history of the medical records further notes that on October 10, 2011, the doctor selected to act in place of the treating doctor, [Dr. H], noted that the spinal stimulator worked for three weeks and then quit working noting that the claimant needs a new spinal stimulator. Dr. O's history also documents that [Dr. W] noted on November 11, 2011, that the claimant had an excellent response to the spinal cord stimulator and her pain was 90% better for three weeks but the spinal cord stimulator failed to hold a charge and needed to be replaced. A pre-authorization of six sessions of physical therapy was requested until the claimant could get the spinal cord stimulator replaced.

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.

The record indicates that Dr. B examined the claimant on July 8, 2010, and June 9, 2011, and certified that the claimant had not yet reached MMI. Dr. H, a doctor selected by the treating doctor to act in place of the treating doctor, examined the claimant for purposes of determining MMI/IR on December 19, 2011. Dr. H certified that the claimant reached clinical MMI on August 4, 2011, with a 19% 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. H noted that the claimant had a

permanent cervical spinal cord stimulator implanted on August 4, 2011, and that at the time of his examination the "lower back generator" was not working and the stimulator was not holding a charge. Dr. H additionally noted that the claimant needed a replacement but it has been denied by the carrier. He stated he chose August 4, 2011, as the date of MMI because the claimant's condition reached a plateau after the permanent cervical spine stimulator was implanted on August 4, 2011. Dr. H stated the claimant has had no medical treatments since then. Dr. H assessed 14% upper extremity (UE) impairment for loss of range of motion (ROM) of the left wrist; 13% UE extremity impairment for the motor deficits of the median and ulnar nerves.

Dr. B examined the claimant again on February 2, 2012, and certified that the claimant reached MMI on that date with a 19% IR, using the AMA Guides. Dr. B assessed 11% UE impairment for the loss of ROM of the left wrist; 13% UE impairment for the sensory deficits of the median and ulnar nerves; and 12% UE impairment for the motor deficits of the median and ulnar nerves following the criteria set forth on page 3/56 of the AMA Guides for rating CRPS.

In a letter dated September 17, 2012, Dr. B wrote that per the Division letter dated September 12, 2012, statutory MMI is January 1, 2012. Dr. B noted that the medical records document that when the claimant was examined on December 19, 2011, the claimant had purplish discoloration of the distal forearm and hand and exquisite tenderness of the left elbow throughout the entire left forearm with limited ROM of the left wrist and decreased pinprick sensation. Dr. B stated that the claimant's condition was "still in process as of August 4, 2011, and her [MMI] would be statutory at January 1, 2012, rather than February 2, 2012, as noted in my final report." Dr. B provided a Report of Medical Evaluation (DWC-69) which certified that the claimant reached MMI on January 1, 2012, with a 19% IR.

Dr. O examined the claimant on February 24, 2012, and certified that the claimant reached MMI on "August 4, 2012," with a 12% IR, using the AMA Guides. We note that the DWC-69 certifies that the claimant reached MMI clinically on "August 4, 2012," although the narrative from Dr. O states that he agrees with the MMI date certified by Dr. H of August 4, 2011. Dr. O assessed 6% UE impairment for loss of ROM of the left wrist; 9% UE impairment for motor deficit of the ulnar nerve and 3% UE impairment for motor deficit of the median nerve.

The hearing officer adopted the MMI/IR certification of Dr. O. In the Background Information of the decision, the hearing officer notes that in a narrative report, Dr. O points out errors in Dr. B's calculations as well as the improper choice of the statutory date of MMI. The hearing officer additionally noted that the evidence preponderates in

accordance with the findings of Dr. O that the claimant reached MMI on August 4, 2011, with a 12% IR.

As previously noted the DWC-69 provided by Dr. O contains an incorrect date of August 4, 2012, rather than the August 4, 2011, date determined by the hearing officer. Dr. O noted in his explanation of the MMI date that an epidural stimulator was tried on July 1, 2011, but it was ineffective. Dr. O stated the stimulator only worked for three weeks and that once the claimant tried the epidural stimulator there was not really anything else to do. However, according to the history of the medical records provided by Dr. O and discussed above, on August 4, 2011, the claimant underwent a procedure to permanently implant a cervical spinal cord stimulator. The history of the medical records provided by Dr. O document that the claimant's symptoms greatly improved with the use of the cervical spinal cord stimulator and worsened when the stimulator ceased working. Further, the history of the records provided by Dr. O document that the claimant had staples from this procedure and that it took some time for the incision to heal.

Dr. B stated in his explanation of the MMI date that the claimant's condition was still improving on August 4, 2011, and the records document that on August 4, 2011, the claimant was still recovering from the procedure that permanently implanted the cervical spinal cord stimulator as treatment for the accepted condition of the CRPS. The records also note that the claimant's symptoms worsened when the stimulator ceased holding a charge and that a spinal cord stimulator in proper working condition was anticipated to bring about further material recovery from or lasting improvement to the claimant's CRPS.

The hearing officer's finding that the certification of MMI/IR by Dr. O is supported by a preponderance of the evidence is so against the great weight and preponderance of the evidence as to be clearly wrong and unjust. Accordingly, we reverse the hearing officer's determination that the claimant reached MMI on August 4, 2011, and render a new decision that the claimant reached MMI on January 1, 2012, as certified by the designated doctor.

Dr. O's assessment of 12% IR was based on a date of MMI of August 4, 2011, which has been reversed. For reasons discussed above, a new decision is rendered that the claimant's MMI is January 1, 2012. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 12%.

The only certification in evidence with the rendered date of MMI, January 1, 2012, was from the designated doctor, Dr. B. Dr. B assessed 11% UE impairment for

the loss of ROM of the left wrist;[1] 13% UE impairment for the sensory deficits of the median and ulnar nerves; and 12% UE impairment for the motor deficits of the median and ulnar nerves. Dr. O agreed that Dr. B properly applied the ROM figures he obtained to the figures in the AMA Guides and Dr. O assessed the same amount of UE impairment for motor loss of the median and ulnar nerves. Dr. O stated that assuming Dr. B's observation for sensory loss is correct, then Dr. B's rating follows the AMA Guides. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 12% and render a new decision that the claimant's IR is 19%.

SUMMARY

We reverse the hearing officer's determination that the claimant reached MMI on August 4, 2011, and render a new decision that the claimant reached MMI on January 1, 2012.

We reverse the hearing officer's determination that the claimant's IR is 12% and render a new decision that the claimant's IR is 19%.

[1] We note that Dr. B failed to round to the nearest 10° as instructed by the AMA Guides for radial deviation but that the whole person impairment assessed by Dr. B would not have changed whether Dr. B rounded up to 20° or down to 10°.

The true corporate name of the insurance carrier is **AMERICAN CASUALTY COMPANY OF READING, PENNSYLVANIA** and the name and address of its registered agent for service of process is

CT CORPORATION SYSTEM
350 NORTH ST. PAUL STREET
DALLAS, TEXAS 75201.

Margaret L. Turner
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Carisa Space-Beam
Appeals Judge