APPEAL NO. 130633
FILED APRIL 24, 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 February 13, 2013, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the sole disputed issue by deciding that the appellant's (claimant) impairment rating (IR) is 5%. The claimant appealed, disputing the hearing officer's IR determination. The respondent (self-insured) responded, urging affirmance of the disputed IR determination.

DECISION

Reversed and remanded.

The parties stipulated that on [date of injury], the claimant sustained a compensable injury of bilateral carpal tunnel syndrome (CTS); the Texas Department of Insurance, Division of Workers' Compensation (Division) appointed [Dr. P] to determine maximum medical improvement (MMI) and IR; Dr. P determined that the claimant reached MMI on February 24, 2012, with an IR of 12%; [Dr. K], a post-designated doctor required medical examination (RME) doctor certified that the claimant reached MMI on February 24, 2012, with an IR of 5%. We note that in the decision the hearing officer mistakenly identified the date of MMI as statutory MMI in Finding of Fact 1.G. A review of the record reflects that the parties agreed the date of MMI is February 24, 2012, but did not identify that date as the statutory date. The medical records reflect that the claimant underwent a left carpal tunnel release on April 28, 2011, and a right carpal tunnel release on December 1, 2011.

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. P examined the claimant on July 17, 2012, and initially certified that the claimant reached MMI on February 24, 2012, with a 0% IR. Dr. P's narrative report noted that the claimant's range of motion (ROM) for his bilateral upper extremities was

within normal limits and that the claimant's sensory and motor testing of the bilateral upper extremities was within normal limits.

Dr. P subsequently amended his report, noting that an EMG performed on July 27, 2012, originally indicated a normal study; however, the performing physician amended those results stating the EMG on July 27, 2012, revealed bilateral CTS; left ulnar cubital tunnel syndrome; and distal motor sensory neuropathy. Upon reading the amended test results, Dr. P certified the claimant reached MMI on February 24, 2012, with a 12% 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. P assessed 10% upper extremity impairment for left CTS and 10% upper extremity impairment for right CTS using Table 16, page 3/57 of the AMA Guides. Dr. P noted that the claimant had a mild ulnar nerve entrapment at the left and right wrist. Dr. P then converted the upper extremity impairment for each wrist to whole person and combined the whole person impairment for the left and right wrist to assess a 12% impairment.

The hearing officer found that Dr. P's assigned IR is not supported by a preponderance of the evidence and was not performed in accordance with the AMA Guides. In the Background Information section of the decision, the hearing officer stated that the designated doctor utilized Table 16 in determining the claimant's IR for the compensable injury and that this is improper, citing to Appeals Panel Decision (APD) 111965, decided February 24, 2012. The hearing officer quoted from Page 3/46 of the AMA Guides in part as follows:

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

We note that both the quoted language of the AMA Guides and APD 111965, *supra,* apply when impairment based on loss of ROM is assessed in addition to impairment assessed under Section 3.1k, which includes Table 16. In the instant case the designated doctor, Dr. P, did not combine impairment assessed under Table 16 with any other impairment but rather rated the claimant's bilateral CTS solely on Table 16. The AMA Guides provide on page 3/56 that "[i]mpairment of the hand and upper extremity secondary to entrapment neuropathy may be derived by measuring the sensory and motor deficits as described in preceding parts of this section." The AMA Guides provide that an alternative method is provided in Table 16 and states that the

evaluator should not use both methods. As previously noted, Dr. P did not combine the impairment he assessed under Table 16 with impairment based on ROM or any sensory or motor deficits. The example provided in the AMA Guides for entrapment neuropathy on page 3/56 specifically utilizes Table 16 and describes the impairment as due to mild residual CTS. The hearing officer rejected the report of the designated doctor in error based on his belief that the doctor could not use Table 16 to rate CTS.

The hearing officer found that the assigned IR from Dr. K, the post-designated doctor RME doctor, is supported by a preponderance of the evidence and was performed in accordance with the AMA Guides. We disagree. In his narrative report, Dr. K stated, "[a]ccording to the [AMA Guides] [T]able 11 due to pain and sensory [the claimant] is an [a]2 with a permanent physical impairment of 4% of the upper extremity and on the [T]able 12, he has no motor deficits, no impairment so therefore he has both a right and left problems of 4% of the upper extremity even though he has no sensory changes." Dr. K does not identify the specific grade he used in Table 11. Grade a2 provides a range of 1-25. To apply [T]able 11 the AMA Guides provide that the first step is to identify the area of involvement; identify the nerve that innervates the area; grade the severity of the sensory deficit using Table 11, and then multiply the severity of the sensory deficit by the maximum impairment value to obtain the upper extremity impairment for each structure involved. While Dr. K identified the grade of classification he would place the claimant in for sensory deficit using Table 11, he failed to specifically identify the grade he would use to multiply by the maximum impairment value using Table 15 and failed to identify the maximum value used under Table 15. Further, 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. Dr. K combined the upper extremity impairment for both the right and left upper extremity and then converted the upper extremity impairment to whole person. Dr. K noted that 4% of the upper extremity right and left is equal to 8% of the upper extremity. Dr. K then used Table 3, converting 8% impairment of the upper extremity to 5% impairment of the whole person.

However, if you follow the directions in the AMA Guides you should calculate the impairment for the right upper extremity (4%) to whole person impairment using Table 3 (2%) and then combine that with the impairment assessed for the left upper extremity, which using Dr. K's figures would also be 2%. Combining 2% with 2% would result in 4% not the 5% assessed by Dr. K. Dr. K failed to: (1) identify the specific grade, as opposed to a range, for sensory deficit; (2) identify the maximum impairment value for the structure involved using Table 15; and (3) properly combine impairment assessed for both the right and left upper extremity. We agree with the claimant that it was error for the hearing officer to adopt the 5% IR. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 5%.

As previously discussed, there are two remaining certifications of impairment with the stipulated date of MMI, both from the designated doctor. Consequently, we do not consider it appropriate to simply render a decision regarding the claimant's IR. We remand the IR issue to the hearing officer to make a decision based on the remaining certifications in evidence.

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 **[a self-insured governmental entity]** and the name and address of its registered agent for service of process is

[NAME]
[ADDRESS]
[CITY, TEXAS ZIP].

Margaret L. Turner
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Carisa Space-Beam
Appeals Judge