Appeals Panel Decisions (APDs) for Designated Doctors

As of November 16, 2017

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.
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	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).
022509-s	Spine	In the event the evaluating doctor must choose between two or more DRE categories that may apply, the 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.
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

APD#	Subject	Relevancy
		feels is most appropriate" is insufficient justification for using the ROM rather than the DRE Model."
051306-s	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 CVC to express the total spine impairment.
080966-s	Spine Guarding	Table 71, AMA Guides, p. 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	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.
151158-s 160851	Resection Arthroplasty of the Distal Clavicle	The language contained on page 3/58 is ambiguous, whereas the language on page 3/62 provides more clear 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 3/37, 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.
061569-s	Upper Extremity	Upper extremity impairments for a limb are combined using the Combined Value Chart (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.

APD#	Subject	Relevancy
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.
110741 132734	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.
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.
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.
072253-s 130849	Hernia	To assess an impairment for a hernia-related injury under Table 7 "Classes of Hernia-related Impairment", page 10/247 of the AMA Guides, there must be a palpable defect in the supporting structures of the abdominal wall.
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.
060949	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 219) to determine visual system impairment." Step 5 is to convert the visual system impairment to a whole person IR.
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

APD#	Subject	Relevancy
		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.
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.
090692-s	IR Adjustments	Adjustments to IR for effects of treatment or lack of treatment.
121131-s	Lifetime Income Benefits (LIBs)-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.
043168 110267	Compensable Injury	The doctor evaluating permanent impairment must consider the entire compensable injury.

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.