

APPEAL NO. 033213
FILED FEBRUARY 4, 2004

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 November 5, 2003. The hearing officer determined that the appellant (claimant) reached maximum medical improvement (MMI) on June 25, 2002, with an impairment rating (IR) of 0% as a result of her _____, compensable injury as certified by the Texas Workers' Compensation Commission (Commission)-selected designated doctor. The claimant appeals on a sufficiency of the evidence basis. The appeal file does not contain a response from the respondent (carrier).

DECISION

Reversed and rendered.

The parties stipulated that the claimant sustained a compensable injury on _____, and that Dr. L was appointed to serve as the designated doctor. The claimant testified that she was an animal handler and sustained her injury when a large dog, which she had on a leash, "yanked" her to the left. The claimant testified that she immediately felt a "ripped" and burning sensation on her left side, and that by the next day her left leg was numb. The claimant testified that although she has received some treatment for her injury, the carrier has denied treatment which has been recommended by her doctors. Dr. T testified that he has treated the claimant for her compensable injury since July of 2002. He disagreed with Dr. L's certification of MMI and IR. Dr. T testified that during the course of his treatment of the claimant, he has seen ongoing muscle guarding; that the diagnostics show that the claimant needs continued management of her condition through the use of injections; that the injections would improve the claimant's functional abilities; that the claimant had not had a complete work-up of her condition at the time of the designated doctor exam; and that due to the claimant's radicular symptoms, Dr. L should have ordered an EMG, pain management consultation, surgical consultation, and functional capacity evaluation prior to issuing his certification.

A review of the medical records in evidence reveals that the claimant underwent a lumbar MRI on April 15, 2002, which revealed degenerative changes at L3-4, L4-5, L5-S1 with minimal narrowing at L3-4 and L4-5. On April 23, 2002, the claimant saw Dr. S. His report indicates that the claimant was complaining of pain radiating down her left leg into her foot. Dr. S notes muscle spasms and reduced range of motion (ROM). Dr. S's impression was lumbar strain/radiculopathy, left lumbar facet disease, left SI joint dysfunction, myofascial pain syndrome, and possible disc pathology (herniation). In an undated letter, Dr. S disagreed with Dr. L's certification of MMI. Dr. S stated that the claimant was in need of additional diagnostic and therapeutic procedures, such as injection therapy. On April 26, 2003, the claimant saw Dr. W for a chiropractic evaluation and therapy application. Dr. W notes a complaint of numbness and tingling

in the left leg and foot. On physical examination, Dr. W noted muscle spasms and reduced ROM. Part of his impression included lumbar radiculopathy. Dr. W recommended two weeks of physical therapy, with reevaluation at that time.

The claimant was seen by Dr. L for a designated doctor examination on June 25, 2002, about two and a half months after the _____, date of injury. Dr. L placed the claimant at MMI as of that date with a 0% IR. Dr. L's report indicates that he reviewed the April 15, 2002, MRI; that there were no significant clinical findings; no muscle guarding or history of muscle guarding; no documented neurologic impairment; and that the claimant demonstrated 5 out of 5 Waddell's signs. On July 23, 2002, the claimant saw Dr. B who certified that the claimant was not at MMI, but that her IR would be 15%. Upon physical examination, Dr. B noted muscle spasms; decreased lumbar and thoracic ROM; decreased deep tendon reflexes on the left; and a sensory dermatomal deficit of the left leg "consistent with an L5 nerve root." On September 23, 2002, the claimant saw Dr. O. Dr. O notes that there is an NCV/EMG which revealed evidence of L5 nerve root irritation. He notes that the injection therapy, which was recommended, was not approved. Dr. O's clinical findings included "obvious" muscle spasms and reduced lumbar ROM. Dr. O diagnosed lumbar radicular syndrome and opined that the claimant may need a lumbar myelogram. The claimant saw Dr. O again on October 7, 2002, and he again noted muscle spasms and reduced lumbar ROM. At that visit, Dr. O determined that the claimant would need at least two more weeks of physical therapy and would require a lumbar myelogram. Both reports note the claimant's complaints of left lower extremity problems.

On October 11, 2002, the Commission sent Dr. L a letter of clarification and attached records from Dr. S, Dr. O, and Dr. B. Dr. L was requested to review the records and determine whether they changed his opinion and whether the claimant needed to be reexamined. On October 16, 2002, Dr. L responded by stating that his opinion remained unchanged. On October 28, 2002, a lumbar myelogram and CT scan were performed. The myelogram revealed "subtle peripheral underfilling of the left L5 nerve root sleeve." The CT scan revealed:

1. Small broad-based left posterolateral foraminal protusion of L4-5 intervertebral disc contacts the emanating left L4 nerve root. Protusion is shallow, extending just a couple of millimeters into the neural.
2. Minimal bilateral facet arthropathy at L4-5 level, not contributory to foraminal restriction.
3. Subtle unilateral underfilling of the left L5 nerve root sleeve, likely a filling phenomenon in the absence of any mechanical impingement of the left L5 nerve root on postmyelogram lumbar CT.

On November 11, 2002, the claimant saw Dr. T for a pain management consultation. Dr. T notes a history of radicular pain to the left leg. On physical examination, Dr. T notes reduced ROM, moderate muscle spasms, diminished sensation at the left L4 and L5 dermatome, and left leg raising is positive for radicular leg pain. Dr. T's assessment

included lumbar radiculopathy with left L4-5 nerve root irritation. Dr. T recommended a lumbar epidural steroid injection (ESI) and post-injection physical therapy.

On December 12, 2002, the claimant saw Dr. D with complaints of low back pain radiating into the left lower extremity. Dr. D indicated that the claimant had received a lumbar injection approximately a week prior to his examination. On physical examination, Dr. D noted muscle rigidity, severe tenderness, restricted ROM, left leg weakness, and that the claimant was positive for left radiculopathy. Dr. D diagnosed lumbar radiculitis, and referred her for physical therapy. He additionally referred the claimant for an orthopedic consultation. On January 15, January 29, April 2, and April 30, 2003, the claimant saw Dr. MO. Dr. MO noted “gross” lumbar spasms and diminished deep tendon reflexes in the left lower extremity. One of the assessments made by Dr. MO was lumbar radiculopathy and he ordered a series of three ESIs. As of Dr. MO’s report of April 30, 2003, the ESIs had not yet been performed. On June 13, 2003, the claimant saw Dr. MA for an assessment of MMI and IR. Dr. MA certified that the claimant was at MMI as of that date and awarded her a 10% IR pursuant to 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) Table 72, Diagnosis-Related Estimate (DRE) Category III due to radiculopathy.

On June 25, 2003, the Commission sent Dr. L a second letter of clarification and enclosed a December 3, 2002, operative report (ESI) from Dr. T and a copy of the myelogram and CT scan the claimant had undergone. On June 30, 2003, Dr. L responded stating that his opinion remained unchanged. Dr. L stated that the MRI findings are not “clearly abnormal” and that the myelogram and CT scan also do not clearly document a significant injury. Dr. L stated “[m]y view of these findings therefore is that they are not clearly indicative of a pathologic problem related to the compensable injury.” On August 7, 2003, Dr. D responded to Dr. L’s letter. Dr. D points out that the physical examinations performed by all of the doctors [except for Dr. L] confirm the claimant’s complaints. Dr. D states that the “entire clinical picture indicates that [the claimant] does, in fact, have left lumbar radiculopathy.”

Sections 408.122(c) and 408.125(c) provides that if the designated doctor is chosen by the Commission, the report of the designated doctor shall have presumptive weight, and the Commission shall base MMI and IR on that report unless the great weight of the other medical evidence is to the contrary, and that, if the great weight of the medical evidence contradicts the date of MMI and the IR contained in the report of the designated doctor chosen by the Commission, the Commission shall adopt the date of MMI and IR of one of the other doctors. In the instant case, we find that the great weight of the other medical evidence is contrary to the designated doctor’s certification of MMI and IR, and that the hearing officer erred in giving it presumptive weight. Every doctor that examined the claimant, except Dr. L, found clinical signs of spasms and radiculopathy (we note that Dr. MA found radiculopathy, but did not mention spasms). Dr. L examined the claimant only once, and that examination occurred just 10 weeks post-injury. In order for the claimant to be placed in DRE Category I, there would have

had to be no significant clinical findings. Dr. L is the only examining doctor that found none. We hold that the hearing officer's decision is not supported by the evidence and that the great weight of other medical evidence, as recited herein, is contrary to the designated doctor's opinion. As the only other certification of MMI and IR in the record is Dr. MA's, we find that Dr. MA's certification is supported by the great weight of the medical evidence in this case, we adopt Dr. MA's certification that the claimant reached MMI on June 13, 2003, with a 10% IR.

The hearing officer's decision that the claimant reached MMI on June 25, 2002, with a 0% IR is reversed and a new decision is rendered that the claimant reached MMI on June 13, 2003, with a 10% IR as certified by Dr. MA.

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

**MR. RUSSELL R. OLIVER, PRESIDENT
221 WEST 6TH STREET
AUSTIN, TEXAS 78701.**

Thomas A. Knapp
Appeals Judge

CONCUR:

Judy L. S. Barnes
Appeals Judge

Gary L. Kilgore
Appeals Judge