APPEAL NO. 051456
FILED AUGUST 16, 2005

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 commenced on December 9, 2004, and concluded on March 17, 2005, with the record closing on May 18, 2005.

The hearing officer determined that the respondent (claimant) reached maximum medical improvement (MMI) on May 30, 2004, with a 24% impairment rating (IR) as assessed by the designated doctor whose report was entitled to presumptive weight.

The appellant (carrier) appealed, contending that the IR was improperly assessed citing Appeals Panel decisions and that the MMI date should be August 22, 2003, as originally assessed by the designated doctor. The file does not contain a response from the claimant.

DECISION

Reversed and a new decision rendered.

The parties stipulated that the claimant sustained a compensable injury on _____. The hearing officer recites that the claimant sustained multiple injuries including rib fractures, shoulder, neck, mid-back, low back and right leg pain. (Dr. R), the claimant's then treating doctor in a Report of Medical Evaluation (TWCC-69) and a report dated November 26, 2002, certified MMI on that date with a 10% IR. Dr. R utilized 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), commented that the claimant "will continue improving" and assessed Diagnosis-Related Estimate (DRE) Lumbosacral Category III: Radiculopathy which "will include the fractures of the ribs and the fractured scapula."

The parties stipulated that (Dr. P) was the designated doctor. Dr. P first saw the claimant on April 11, 2003, and at that time certified that the claimant was not at MMI. Various medical reports reference a magnetic resonance imaging (MRI) performed on June 25, 2003, (not in evidence) which either shows a disc herniation or disc protrusion at L4-5 depending on the report. Dr. P saw the claimant again on August 22, 2003, and certified MMI on that date with a 10% IR. Dr. P stated that he recommended that the claimant return for range of motion (ROM) testing for the cervical and thoracic spine "as well as for an EMG/NCV of the bilateral upper and lower extremities to rule our [sic out] radiculopathy." Dr. P went on to comment that the claimant's attorney indicated that the claimant "would not return for the appropriate diagnostic testing" and rated the claimant at DRE Lumbosacral Category II: Minor Impairment (5% impairment) and DRE Cervicothoracic Category II: Minor Impairment (5% impairment).

Electrodiagnostic studies were done on September 22, 2003, which indicated an abnormal study stating "electrodiagnostic evidence is most consistent with a chronic lumbar radiculopathy primarily affecting the right L5 nerve root with mild ongoing denervation" and "also a chronic cervical radiculopathy affecting the left C5 nerve root with mild ongoing denervation." (Dr. G), the claimant's current treating doctor, in a rebuttal letter dated December 10, 2003, requested "reconsideration" of the claimant's MMI date and IR, contending that the claimant was not at MMI. Dr. G also noted the September 2003 electrodiagnostic studies and opined:

> If the patient were to be found at maximum medical improvement, based on the results of the electrodiagnostic study results, claimant would qualify for DRE lumbosacral category III: radiculopathy, 10% as well as DRE cervicothoracic category III: radiculopathy, 15%. This would place his whole person impairment rating at 24%.

In an undated letter of clarification, referring to a letter dated January 22, 2004, forwarding "new medical reports," Dr. P replied:

> At the time of my examination on 08-22-2003, I requested an EMG/NCV be performed on the claimant, however his attorney informed the office he would not be attending the requested testing. There was no clinical evidence of radiculopathy at the time of my examination and he was not rated for it. As stated in my report the patient had reached MMI as all conservative treatments had been received. I have no changes to make to my original assessment.

Subsequently, Dr. G in another letter dated August 30, 2004, did a detailed review of the medical evidence, reasserted that the claimant had a 24% IR, based on his calculations in his December 10, 2003, letter, criticized Dr. P's IR and concluded that he believed that Dr. P's "evaluation should be found invalid." In a report dated October 4, 2004, Dr. G stated that the claimant reached "statutory MMI" (*See* Section 401.011(30)(B)) on May 13, 2004, and assessed a 27% IR. Dr. G commented:

> By EMG, the patient has left C5 and right L5 radiculopathy. This would qualify for DRE category III for the cervicothoracic spine for 15% whole person impairment and DRE category III for the lumbosacral spine for 10% whole person impairment.

In addition Dr. G assessed a total 3% whole person impairment for loss of ROM for the right and left upper extremities.

A CCH was commenced on December 9, 2004, and the various medical reports were discussed (there was apparently another hearing where the recorder was not working). The hearing officer states, and the record supports, that an Order to Reopen the Record Sua Sponte was signed on December 29, 2004, for the claimant to return to Dr. P, the designated doctor, for ROM and additional testing as necessary. At some

time there was apparently a dispute whether the cervical spine was part of the compensable injury and the designated doctor was told that the cervical spine was not part of the compensable injury. Dr. P saw the claimant again on January 14, 2005, and prepared another report with two IR's (a 10% IR for the right shoulder and lumber spine and a 24% IR for the cervical and lumbar spine) with a May 30, 2004, statutory MMI date. The 10% IR was assessed based on DRE Lumbosacral Category III: Radiculopathy and the 24% IR was based on combining 15% impairment for DRE Cervicothoracic Category III: Radiculopathy with the 10% impairment for DRE Lumbosacral Category III: Radiculopathy, citing the September 22, 2003, EMG/NCV study. The report was provided to the parties and the claimant responded in an undated note (hearing officer exhibit 12) suggesting, among other things, improper contact with the designated doctor by the carrier.

Another CCH was scheduled on March 17, 2005, at which time the hearing officer asked whether the parties wished to add the issue of an extent of injury. The parties did not wish to add an extent-of-injury issue and it was subsequently determined that the claimant's treating doctor had contacted the designated doctor on the extent of injury matter. The carrier filed a motion requesting, among other things, that the record be left open to obtain further clarification from the designated doctor regarding the change of MMI and the "clinical basis" to support the "change from DRE II to DRE III using the defined DRE criteria." Another letter of clarification was requested and the designated doctor replied referring to his prior reports (Hearing Officer's Exhibits 6 and 7).

Another letter, dated April 11, 2005, was sent to Dr. P, again requesting the reasons for changing the date of the MMI and the basis for placing the claimant in DRE Category III. The hearing officer states that Dr. P's response was admitted as hearing officer's Exhibit No. 9, however there is no exhibit marked Hearing Officer Exhibit No. 9. An exhibit, 1 of 2 exhibits marked as "Hearing Officer Exhibit 10," appears to respond to the questions raised by the hearing officer. Dr. P stated that he changed the MMI date "from 08-22-2003 to 05-30-2004 because of additional treatment" to include "extensive physical therapy." Dr. P also states that changing the claimant to DRE Category III had "no clinical basis but is based on diagnostics, i.e. the EMG."

The hearing officer, in her Background Information section, commented:

> There was no indication during the first hearing that the cervical complaints were not part of the compensable injury, and it did not appear that Carrier was denying that the cervical injury was compensable at the time of the second hearing. The parties would not agree to return to a benefit review conference to fully develop the evidence. [i.e. regarding the extent of injury.]
>
> Based upon evidence as presented, the May 30, 2004, date of MMI and 24% IR from Dr. P are adopted. The first impairment rating and date of

> MMI were equivocal because the designated doctor wanted Claimant to return for ROM measurements and additional testing.

The carrier appealed, briefly summarizing the facts, and contending that Dr. P did not give any specifics regarding the additional physical therapy that he used to change the MMI date and challenging the basis for changing the ratings from DRE II: Minor Impairment to DRE III: Radiculopathy, citing an Appeals Panel case. The carrier does not challenge that the proper rating includes both the cervical and lumbar spine.

On page 3/102 of the AMA Guides, DRE Lumbosacral Category III: Radiculopathy has as its description and verification:

> *Description and Verification:* The patient has significant signs of radiculopathy, such as loss of relevant reflex (es), or measured unilateral atrophy of greater than 2 cm above or below the knee, compared to measurements on the contralateral side at the same location. The impairment may be verified by electrodiagnostic findings. *See* Table 71, p. 109 differentiators 2, 3, and 4.

Page 3/104 DRE Cervicothoracic Category III: Radiculopathy has the following description and verfication:

> *Description and Verification:* The patient has significant signs of radiculopathy, such as (1) loss of relevant reflexes or (2) unilateral atrophy with greater than a 2-cm decrease in circumference compared with the unaffected side, measured at the same distance above or below the elbow. The neurologic impairment may be verified by electrodiagnostic or other criteria (differentiators 2, 3, and 4, Table 71, p. 109).

Dr. P, in citing evidence of radiculopathy cites only the September 22, 2003, EMG as electrodiagnostic evidence consistent with chronic lumbar radiculopathy and chronic cervical radiculopathy to support his DRE III ratings. There is no mention of testing or measurements of loss of relevant reflexes or unilateral atrophy. The description/verification criteria only mentions that the impairment "may be verified by electrodiagnostic testing." In Texas Workers' Compensation Commission Appeal No. 030091-s, decided March 5, 2003, the Appeals Panel held that "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 two centimeter decrease in circumference compared with the unaffected side" to find radiculopathy. Appeal No. 030091-s goes on to state that the findings of neurologic impairment may be verified by electrodiagnostic studies but that the AMA Guides do not state that electrodiagnostic studies showing nerve root irritation, without loss of reflexes or atrophy, constitutes undeniable evidence of radiculopathy. In the instant case the designated doctor points to no clinical basis for his opinion regarding radiculopathy other than the cited EMG. We hold that the evidence is insufficient to uphold a finding of radiculopathy for the purpose of assigning impairment under the AMA Guides and that Dr. P's January 14,

2005, report and rating is contrary to the AMA Guides requirement for radiculopathy for cervicothoracic and/or lumbosacral DRE III.

Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Texas Workers' Compensation Commission (Commission) shall base the 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 IR contained in the report of the designated doctor chosen by the Commission, the Commission shall adopt the IR of one of the other doctors. Rule 130.6(i) provides that the designated doctor's response to a Commission request for clarification is considered to have presumptive weight as it is part of the doctor's opinion. We hold that Dr. P's report of January 14, 2005, is contrary to the great weight of the other medical evidence because it does not comply with the AMA Guides on verifying the rating for radiculopathy. However Dr. P's report of August 22, 2003, where Dr. P certified MMI on that date with a 10% IR based on a 5% impairment for DRE Lumbosacral Category II: Minor Impairment and a 5% impairment for DRE Cervicothoracic Category II: Minor Impairment is supported by the evidence and is not contrary to the great weight of the other medical evidence.

Accordingly we reverse the hearing officer's determination that the claimant reached MMI on May 30, 2004, with a 24% IR as certified by Dr. P and render a new decision that the claimant reached MMI on August 22, 2003, with a 10% IR as certified by Dr. P.

The true corporate name of the insurance carrier is **LIBERTY MUTUAL FIRE INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CT CORPORATION SYSTEMS
350 NORTH ST. PAUL, SUITE 2900
DALLAS, TEXAS 75201.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Robert W. Potts
Appeals Judge

_____
Margaret L. Turner
Appeals Judge