APPEAL NO. 061455
FILED SEPTEMBER 13, 2006

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 held on July 27, 2005, with the record closing on May 26, 2006. The hearing officer resolved the disputed issues by deciding that: (1) the compensable injury of _____, does not extend to include the loss of any maxillary left teeth or trigeminal neuralgia of the left jaw; (2) the appellant (carrier) has not waived the right to contest compensability of trigeminal neuralgia of the jaw by not timely contesting the injury in accordance with Section 409.021; and (3) the respondent (claimant) reached maximum medical improvement (MMI) on November 14, 2004, with a 25% impairment rating (IR). The carrier appealed the hearing officer's IR determination and requested that the designated doctor's assessment of a 5% IR be adopted. The appeal file does not contain a response from the claimant. The hearing officer's carrier waiver and extent-of-injury determinations were not appealed and have become final. Section 410.169.

DECISION

Reversed and rendered.

BACKGROUND INFORMATION

The parties stipulated that the claimant sustained a compensable injury on _____, and that the claimant reached MMI on November 14, 2004. It is undisputed that the claimant underwent a two-level cervical fusion at C4-5, C5-6 on August 19, 2003, and a one-level cervical fusion at C6-7 on June 9, 2004. 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) apply to this case. The designated doctor, Dr. Silver (Dr. S), examined the claimant on December 2, 2004, and he assessed 25% IR under Diagnosis-Related Estimate (DRE) Cervicothoracic Category IV: Loss of Motion Segment Integrity or Multilevel Neurologic Comprise based on Advisory 2003-10 signed July 22, 2003, and Advisory 2003-10b signed February 24, 2004 (advisories). It is undisputed that Dr. S incorrectly relied on the advisories to assess a 25% IR based on the claimant's spinal fusion surgeries because preoperative flexion/extension x-rays were performed prior to each cervical fusion.

Given that Dr. S incorrectly relied on the advisories to assess a 25% IR as explained above, the hearing officer requested a new Report of Medical Evaluation (DWC-69) and narrative report from the designated doctor to determine the claimant's IR. The evidence reflects that from October 2005, through January 2006, the hearing officer sent several letters of clarification (LOCs) to Dr. S: (1) informing him that the advisories may not be used in this case; (2) asking him whether the claimant had radiculopathy; (3) asking him if the range of motion (ROM) Model was used, rather than

the Injury Model (also known as DRE Model), and to provide an explanation of why he used the ROM Model; and (4) asking him to provide an IR without the use of the advisories or the ROM Model. The evidence reflects that Dr. S responded to all the hearing officer's LOCs and provided the hearing officer with alternative IRs. The evidence reflects that Dr. S assessed three alternative IRs: (1) a 26% IR using the ROM Model; (2) a 25% IR under DRE Cervicothoracic Category IV using the ROM Model as a differentiator; and (3) a 10% IR under DRE Cervicothoracic Category II: Minor Impairment.

With regard to the 26% IR, Dr. S indicates in his response that he assessed a 26% IR using the ROM Model, however he concluded that he stood by his 25% IR under DRE IV. Dr. S did not provide a DWC-69 or a narrative report assessing a 26% IR using the ROM Model. With regard to the 10% IR, Dr. S indicates in his response that he assessed a 10% IR under DRE Cervicothoracic Category II. The evidence indicates that Dr. S provided a DWC-69 and a narrative report assessing a 10% IR under DRE Cervicothoracic Category II. The carrier states in its appeal that the 10% IR under DRE II is in error and that the hearing officer sent a LOC to Dr. S informing him that an IR under DRE Cervicothoracic Category II results in a 5% IR, rather than 10% IR. The carrier states that Dr. S responded that the IR should be corrected from a 10% IR to 5% IR. The hearing officer states in his discussion that Dr. S certified a 5% IR, after a clerical correction.[1]

IR

The hearing officer found that Dr. S had provided a sufficient explanation, involving facts specific to the claimant's condition and treatment of why he did not use the DRE Model but instead used the ROM Model as a differentiator to place the claimant in DRE category IV for a 25% IR. The hearing officer relied on Dr. S's response dated December 13, 2005, in which he stated that he assessed a 26% IR based on the ROM Model and that because of the nature of the claimant's cervical fusions at C4-5, C5-6, and C6-7 on two separate occasions, that "placement in a lower level DRE category would not be sound and indeed would be clinically inappropriate. Therefore with the leeway allotted by the [AMA Guides], using the ROM Model in this case is entirely justified." The hearing officer stated in his discussion that the designated doctor's explanation was arguably not as extensive as some of the explanations found to be sufficient in some Appeal Panel Decisions (APD), but that the explanation involved factors specific to the claimant's condition and treatment. The hearing officer determined that Dr. S's 25% IR, under Cervicothoracic DRE Category IV, was supported by the preponderance of the evidence. We disagree.

In APD 030288-s, decided March 18, 2003, the Appeals Panel held that although there are instances when the ROM Model may be used, such as if none of the

[1] We note that although the response to the LOC which corrected the IR from a 10% to a 5% was not marked as a hearing officer's exhibit, it is clear from the hearing officer's discussion in his decision and order that it was considered. Additionally, it is clear that the parties were sent a copy of both the LOC inquiring about the 10% IR as well as Dr. S's response that acknowledged his error of impairment assessed for Cervicothoracic DRE II as 10% IR, rather than 5% IR, as provided in the AMA Guides.

categories of the DRE Model are applicable, the use of the DRE Model is not optional and is to be used unless there is a specific explanation why it cannot be used. In that case, the Appeals Panel referenced the AMA Guides on page 3/94 that states "[t]he evaluator assessing the spine should use the [DRE Model], if the patient's condition is one of those listed in Table 70 (p.108)." The Appeals Panel also referenced page 3/112 that states the "[ROM] Model should be used only if the [DRE] Model is not applicable, or if more clinical data on the spine are needed to categorize the individual's spine impairment." The Appeals Panel held that unless there is a specific explanation why the DRE Model cannot be used, a comment that the evaluator merely prefers to use the model that he or she feels is most appropriate is insufficient justification for not using the DRE Model.

In the instant case, Dr. S indicated in his responses that there was an absence of radiculopathy, that there was no loss of motion segment integrity, and that a 25% IR under DRE IV was appropriate based on the claimant's spinal surgeries. There is no indication in Dr. S's reports or responses that he was contemplating which of two or more DRE categories to place the claimant in based on his clinical findings of no radiculopathy or loss of motion segment integrity. Rather his response dated November 10, 2005, specifically states that "[n]either clinical nor electrodiagnostic evidence of radiculopathy was present and therefore no [IR] was awarded for this" and that the "flexion and extension films were done prior to 06-09-2004 and showed no evidence of loss of motion segment integrity." This response does not indicate that the claimant belongs in Cervicothoracic DRE Category III: Radiculopathy or Cervicothoracic DRE Category IV: Loss of Motion Segment Integrity or Multilevel Neurological Compromise. The AMA Guides on page 3/100 state that the Injury Model "relies especially on evidence of neurological deficits and uncommon, adverse structural changes, such as fractures, dislocations, and loss of motion segment integrity. Under this model, DRE's are differentiated according to clinical findings that are verifiable using standard medical procedures."

In APD 022509-s, decided November 21, 2002, the Appeals Panel explained when the ROM Model may also be used as a differentiator. That case referenced the AMA Guides on page 3/99 that stated:

> If the physician cannot decide into which DRE category the patient belongs, the physician may refer to and use the ROM Model, which is described in Section 3.3j [p.112]. Using the procedures of that model, the physician combines an impairment percent based on the patient's diagnosis with a percent based on the patient's spine motion impairment and a percent based on neurologic impairment, if it is present. The physician uses the estimate determined with the [ROM] Model to decide placement within one of the DRE categories. The proper DRE category is the one having the impairment percent that is closest to the impairment percent determined with the [ROM] Model.

In this case, the only justification provided by Dr. S for placing the claimant in Cervicothoracic DRE Category IV was that because of the claimant's spinal surgery, placement in a lower level category would not be sound. Although Dr. S states in his response dated December 13, 2005, that he used the ROM Model as a differentiator, the statement "placement in a lower level DRE category would not be sound and indeed would be clinically inappropriate" because the claimant had spinal surgery indicates otherwise given the clinical findings of no radiculopathy and no loss of motion segment integrity. It is clear from the designated doctor's response that he did not use the ROM Model as a differentiator as provided by the AMA Guides, but rather he placed the claimant in a DRE category that was in proximity to the 26% IR using the ROM Model. In APD 042543, decided December 2, 2004, the Appeals Panel noted that "Advisory 2003-10B specifically provides for assessment of impairment utilizing the DRE [M]odel and allows use of the ROM [M]odel to assess impairment only when a doctor indicates it more accurately reflects impairment in an individual case." However, the Appeals Panel stated that simply because the claimant had spinal surgery was not sufficient justification for using the ROM Model rather than the DRE Model. In that case, the designated doctor stated, "there was no DRE category that specifically addresses spinal surgery post injury. However, the ROM Model specifically rates spinal surgery." The Appeals Panel stated that "[I]t is clear from his response, that the designated doctor did not use the DRE Model to assess impairment not because of any factor specific to the claimant's condition and treatment but simply because he had spinal surgery." In the instant case, the designated doctor's response indicates that he used the ROM Model to rate the cervical fusions, rather than use the ROM Model as a differentiator to determine placement within one of the DRE categories as provided by the AMA Guides. Spinal surgery in and of itself is not an appropriate reason to use the ROM Model to assess an impairment.

We distinguish this case from APD 032317-s, decided October 2, 2003, in which the Appeals Panel reversed and rendered a new determination that the claimant's IR was 20%, which had been calculated by the designated doctor using the ROM Model as a differentiator after the designated doctor determined that the claimant's IR that had been determined under the DRE Model did not accurately reflect the true nature of his impairment from the compensable injury. In that case, the claimant had a fusion and the designated doctor contemplated placing the claimant in Lumbosacral DRE Category III or IV based on his clinical findings. The designated doctor explained in his LOC that he did not believe that Lumbosacral DRE Category III rating reflected the true nature of the claimant's impairment that resulted from the compensable injury and used the ROM Model as a differentiator to place the claimant in Lumbosacral DRE Category IV. In the instant case, Dr. S does not indicate in his reports or responses that he could not decide into which DRE category the claimant belonged, and then used the ROM Model as a differentiator to decide placement within one of the DRE categories. Accordingly, we reverse the hearing officer's determination that the designated doctor's IR of 25% is supported by the preponderance of the evidence.

For CCH's which are held on or after September 1, 2005, Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the

Texas Department of Insurance, Division of Workers' Compensation (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 § 130.6(i) (Rule 130.6(i)) provides that the designated doctor's response to a Division request for clarification is considered to have presumptive weight as it is part of the doctor's opinion. In this case, on January 23, 2006, the hearing officer sent a LOC to Dr. S requesting an IR without the use of the advisories or the ROM Model. In addition, the hearing officer asked the designated doctor that if he wished "to add to the explanation, contained in your letter of December 13, 2005, of why you felt the DRE Model could not be used to calculate IR, please do so." On January 29, 2006, Dr. S responded that "after careful review," he had changes to make to the IR and stated that without the use of the advisories and the ROM Model, he assessed a 10% IR under Cervicothoracic DRE Category II. Dr. S did not provide an explanation as to why he felt the DRE Model could not be used to assess that claimant's IR. In a letter dated May 10, 2006, Dr. S corrected his clerical error to state that the IR under Cervicothoracic DRE Category II should be 5%, not 10%, per the AMA Guides.

We reverse the hearing officer's determination that the IR is 25% and render a new determination that the IR is 5%.

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
DALLAS, TEXAS 75201.

_____
Veronica L. Ruberto
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Margaret L. Turner
Appeals Judge