APPEAL NO. 061787
FILED OCTOBER 30, 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 convened on March 1, 2006. After a joint motion for continuance the case was continued to May 9, 2006. At that time some issues were added and an issue withdrawn and the case was continued to allow the parties time to prepare to litigate the added issues. The hearing was reconvened on July 12, 2006, with the record held open until July 24, 2006, to allow the respondent (claimant) to respond to the appellant's (carrier) hearing briefs. The record was closed on July 25, 2006.

With regard to the nine issues before him, the hearing officer determined that: 1) the carrier did not waive the right to contest compensability of a cervical injury by not contesting compensability in accordance with Section 409.021; 2) the extent of injury and/or impairment rating (IR) have not become final pursuant to 28 TEX. ADMIN. CODE § 130.102(g) (Rule 130.102(g)); 3) the compensable injury of _____, extends to include the cervical spine; 4) the claimant reached maximum medical improvement (MMI) on August 15, 2004; 5) the claimant's IR is 15%; 6) the claimant is entitled to supplemental income benefits (SIBs) for the first quarter; 7) the claimant is entitled to SIBs for the second quarter; 8) the claimant is entitled to SIBs for the third quarter; and 9) the carrier is not entitled to a reduction of the claimant's impairment income benefits and/or SIBs based on contribution from an earlier compensable injury. The determination regarding the issues of finality of the extent of injury and/or IR under Rule 130.102(g) and carrier waiver have not been appealed and have become final pursuant to Section 410.169.

The carrier appeals the contribution issue, contending it is entitled to a 67% contribution due to a 1992 injury and the MMI and IR issues. The carrier also asserts error in the extent-of-injury issue asserting it is *res judicata* based on a prior CCH. The carrier also appeals the SIBs determinations. The claimant responds, urging affirmance.

DECISION

Affirmed in part and reversed and remanded in part.

STIPULATIONS

The parties stipulated that the claimant sustained a compensable injury on _____; that IIBs have not been commuted; that Dr. D was appointed as the designated doctor and that the claimant had sustained a prior compensable injury on (prior date of injury), for which he had received a 7% IR for the lumbar spine. The parties also stipulated to the qualifying periods for the first, second and third quarters of SIBs.

BACKGROUND

The claimant sustained the stipulated compensable injury on _____, and had his initial doctor visit on July 23, 2002. The claimant subsequently changed treating doctors and received various treatments and evaluations. The claimant was referred to Dr. C for an IR by the claimant's treating doctor. Dr. C in a report dated January 8, 2003, certified the claimant at MMI on that date and assessed a 10% IR based on 5% impairment for Diagnosis-Related Estimate (DRE) Cervicothoracic Category II: Minor Impairment and 5% impairment for DRE Lumbosacral Category II: Minor Impairment utilizing 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). Medical records indicate that the claimant continued to have complaints and continued to receive treatment and medication. The designated doctor noted that the claimant received "an epidural" on April 9, 2003. A required medical examination (RME) doctor noted that another doctor had documented some improvement in July 2003 and "that the claimant had had three epidurals." The designated doctor indicated that he saw the claimant on January 14, 2004, and certified him not to be at MMI (that report is referred to but is not in evidence). The claimant continued to complain of pain, and other diagnostic tests were performed. The RME doctor evaluated the claimant on August 3, 2004, and stated that he believed the claimant to have reached MMI "at least by 01/14/04" (the date the designated doctor stated the claimant was not at MMI) and assessed the claimant with 5% impairment for DRE Lumbosacral Category II: Minor Impairment. The RME doctor concluded "I do not find that any impairment is applicable to any other body areas" and assessed a 5% IR.

The designated doctor, Dr. D, saw the claimant (again) on October 20, 2004, certified a statutory MMI date of August 15, 2004, with a 15% IR based on 5% impairment for DRE Cervicothoracic Category II: Minor Impairment and 10% impairment for DRE Lumbosacral Category III: Radiculopathy. Dr. D recites that the claimant "shows clinical evidence of lumbosacral injury with bilateral L4/L5 radiculopathy." (Claimant's Exhibit No. 5). In another report, also dated and based on the October 20, 2004, examination Dr. D only rates the lumbar injury and certifies the August 15, 2004, MMI date with a 10% IR based on DRE Lumbosacral Category III: Radiculopathy.

EXTENT OF INJURY

The prior 2004 CCH did not address the cervical spine and the extent of injury to the cervical spine was not an issue before the hearing officer at the 2004 CCH. The hearing officer's determination on the extent-of-injury issue (that the compensable injury extends to include the cervical spine) is supported by the evidence and is affirmed.

MMI

The hearing officer's determination that the claimant reached MMI on August 15, 2004, is supported by the evidence and is affirmed.

IR

As previously noted in the Background Information portion of this decision Dr. C, a referral doctor, first certified MMI on January 8, 2003, and assessed a 10% IR. That IR cannot be adopted in that we have affirmed the hearing officer's determination that the claimant reached MMI on August 15, 2004, therefore Dr. C's IR was not based on the claimant's condition as of the MMI date. (*See* Rule 130.1(c)(3)).

The RME doctor evaluated the claimant on August 3, 2004, and certified MMI on January 14, 2004, with a 5% IR. That IR cannot be adopted for the same reason that Dr. C's IR cannot be adopted. Further the RME did not rate the cervical injury, which we affirmed was part of the compensable injury.

Dr. D, the designated doctor, certified MMI on the affirmed MMI date of August 15, 2004, and assessed two ratings, one which included, and another which excluded, the cervical spine. However, it is Dr. D's assessment of a 10% impairment for DRE Lumbosacral Category III: Radiculopathy that is problematic. The description and verification of DRE Lumbosacral Category III: Radiculopathy states:

> 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.

Dr. D recites that the claimant "shows clinical evidence of a lumbosacral injury with bilateral L4/L5 radiculopathy."

Dr. B, in performing the contribution assessment based on a review of medical records, in a report dated January 31, 2006 (Carrier's Exhibit M pg. 6) states:

> There was specific competent, objective and independently confirmable medical evidence of a verifiable radiculopathy. Therefore this would be assigned as a DRE III or 10% whole person impairment rating as per Table 72. [Dr. D] correctly assigned this impairment rating.

However, neither Dr. D nor Dr. B reference testing which indicates loss of relevant reflexes or unilateral atrophy. Dr. B in reviewing the medical evidence from the 1992 injury comments:

> I was able to go through the supporting documentation [for the 1992 injury] and noted that there was an electrodiagnostic assessment completed on July 10, 1992 by [another doctor]. A verifiable Radiculopathy was objectified with that assessment.

> Therefore, had the 1992 injury been assigned an impairment rating as per the AMA Guides to the Evaluation of Permanent Impairment, 4th edition, then this would have been a DRE III for 10% whole person impairment rating.

Dr. MT, in a peer review report dated May 4, 2006 (Carrier's Exhibit J) references "abnormal results on electrodiagnostic testing [of] July 10, 1992, for the [1992] work related injury" and electrodiagnostic studies performed by Dr. O on April 23, 2003. Dr. MT states he did not have the April 23, 2003, EMG performed by Dr. O (and it is not in evidence) but because the July 10, 1992, and April 23, 2003, studies found similar abnormal results "it is clear that if an abnormality is present in the testing, it is not the result of the reported _____ injury."

Dr. MT in the report dated May 4, 2006, comments that Dr. D did not perform strength and sensory testing and two other doctors "did not document any physical exam findings compatible with radiculopathy." The carrier in its appeal references the requirement of the AMA Guides for rating radiculopathy and asserts that none of the medical records show significant signs of lumbar radiculopathy. Our review of the record confirms that there is no documented loss of relevant reflexes or unilateral atrophy in the medical records. Rule 130.1(c)(3) provides in part that the doctor assigning the IR shall "(B) document specific laboratory or clinical findings of an impairment." In Appeals Panel Decision (APD) 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." APD 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 relevant reflexes or atrophy, constitutes undeniable evidence of radiculopathy. In the instant case Dr. D points to no significant signs of radiculopathy, as described in the AMA Guides, for his opinion regarding radiculopathy. In that Dr. D's assessment of a 15% IR includes a 10% impairment for DRE Lumbosacral Category III: Radiculopathy, which is contrary to the AMA Guides and which is not supported by the evidence, we reverse the hearing officer's determination that the claimant's IR is 15%.

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, the Division shall adopt the IR of one of the other doctors. 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 that we have reversed the hearing officer's determination of Dr. D's 15% IR and there is no other doctor's report which can be adopted, we remand the case back to the hearing officer for further action as described in the summary.

SIBs

Eligibility criteria for SIBs entitlement are set forth in Section 408.142 and includes, among other things, an IR of 15% or more. In that we have reversed the hearing officer's determination that the claimant's IR is 15%, we must also reverse the hearing officer's determinations that the claimant is entitled to SIBs for the first, second and third quarters. The determination regarding the SIBs quarters at issue is remanded pending a determination on remand of whether the claimant has an IR of 15% or more.

CONTRIBUTION

Contribution is provided for in Section 408.084 and is based on the documented impairment from earlier compensable injuries, in this case the 1992 injury. In that we have reversed the hearing officer's determination that the claimant's IR is 15% we must also reverse the hearing officer's determination on contribution because a determination has not been made regarding the IR due to the _____, injury.

SUMMARY

We affirm the hearing officer's determinations on the extent of injury and MMI issues. We reverse the hearing officer's determination that the claimant's IR is 15% as being contrary to the AMA Guides and remand the case to the hearing officer. The hearing officer is to determine whether Dr. D is still qualified and available to be the designated doctor, and if so, request that Dr. D document the significant signs of radiculopathy based on page 102 of the AMA Guides relating to DRE Lumbosacral Category III and if he chooses, to reexamine the claimant to assess an IR for the compensable lumbar and cervical injury of _____, based on the claimant's condition as of the August 15, 2004, MMI date considering the medical records and the certifying examination. If Dr. D is no longer qualified to serve as the designated doctor then another designated doctor is to be appointed pursuant to Rule 130.5(d)(2) to determine the claimant's IR, which would include both a lumbar and cervical injury, based on the claimant's condition as of August 15, 2004, date of MMI, considering the medical records and certifying examination. The hearing officer is to provide the designated doctor's response to the parties and allow the parties an opportunity to respond and then make a determination regarding the IR. After the hearing officer has determined the IR he is to consider the claimant's eligibility for SIBs for the first, second and third quarters and make a determination regarding those quarters. When the IR determination has been made the hearing officer is to consider the contribution issue and make a determination on that issue.

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 92642, decided January 20, 1993.

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

CT CORPORATION SYSTEM
350 NORTH ST. PAUL STREET
DALLAS, TEXAS 75201.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Veronica L. Ruberto
Appeals Judge

_____
Margaret L. Turner
Appeals Judge