APPEAL NO. 061908
FILED NOVEMBER 27, 2006

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). The disputed issues were actually litigated in a contested case hearing (CCH) on August 14, 2006. The hearing officer resolved the disputed issues by deciding that the respondent (claimant) reached maximum medical improvement (MMI) on December 22, 2004, with a 24% impairment rating (IR) per Dr. P report. The appellant (carrier) appealed the hearing officer's MMI and IR determinations, arguing that the designated doctor's, Dr. T, amended report that states that the claimant reached MMI on July 29, 2004, with a 14% IR has presumptive weight. The carrier only disputes the rating for the cervical spine, it did not dispute the rating for the left knee or the lumbar spine. The claimant responded, urging affirmance of the hearing officer's determinations.

DECISION

Reversed and rendered.

FACTUAL SUMMARY

The parties stipulated that on _____, the claimant sustained a compensable left knee, low back, and neck injury while in the course and scope of her employment. The medical evidence indicates that on September 25, 2003, and September 29, 2003, respectively, the claimant had an EMG to her upper extremities that reflected radiculopathy at left C6, and an EMG of the lower extremities that reflected radiculopathy at right S1. It is undisputed that on March 24, 2004, the claimant underwent spinal surgery at L4-5 and L5-S1.

It is undisputed that 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) applies to this case. On July 29, 2004, the designated doctor, Dr. T, examined the claimant and he certified that the claimant reached MMI on that same date. Dr. T's narrative report reflects that he assigned two separate IRs: 4% IR for the left knee only; and 27% IR for the left knee, cervical spine, and lumbar spine. Dr. T explained in his narrative report that he assigned two separate IRs because the carrier informed him that the left knee was the only compensable injury; however, "per the medical records submitted by the treating physician and/or insurance carrier as well as the patient's indication of his/her injury modality at the time of examination" he assigned a separate IR for the left knee, cervical spine, and lumbar spine. Dr. T's narrative report indicates that he assessed a 27% IR based on 4% whole person impairment for the left knee, 15% impairment for Diagnosis-Related Estimate (DRE) Cervicothoracic Category III: Radiculopathy, and 10% impairment for DRE Lumbosacral Category III: Radiculopathy.

A letter of clarification dated September 15, 2004, was sent to the designated doctor by the Texas Department of Insurance, Division of Workers' Compensation (Division) requesting that he explain the discrepancies between the assigned IRs and that he provide a Report of Medical Evaluation (DWC-69) that included an IR for "all the [compensable] body parts." In an undated response, Dr. T referenced the letter of clarification dated September 15, 2004, and he stated that after reviewing his IR evaluation, the IR of the left knee and lumbar spine remained the same; however, he was amending the IR of the cervical spine from 15% to 0% because the claimant did not have "any complaints of her cervical region." Dr. T amended his report to reflect a 14% IR based on 4% whole person impairment for the left knee, 10% impairment for DRE Lumbosacral Category III: Radiculopathy for the lumbar spine, and 0% impairment for the cervical spine. In another undated response, Dr. T referenced a letter of clarification dated March 24, 2005, and he explained that he assessed 0% impairment for the cervical spine because the claimant "has no loss of reflex or unilateral atrophy of greater than 2 cm compared to the contralateral side." Dr. T explained that there was an error on the previous report regarding the cervical spine in which he assessed a 15% IR, and that he corrected his error to reflect a 0% IR for the cervical spine. In a response dated June 21, 2005, Dr. T stated that the claimant's IR remained the same. Dr. T provided a DWC-69 that reflects that the claimant reached MMI on July 29, 2004, with a 14% IR.

In a report dated September 23, 2004, the carrier's peer review doctor, Dr. C, indicated that the designated doctor's IR for the cervical spine was incorrect because the designated doctor had noted that there were "no complaints of symptoms and full range of motion" that would justify a 15% IR under DRE Cervicothoracic Category III: Radiculopathy.

In evidence is a narrative report from Dr. P, acting in place of the treating doctor, that states he examined the claimant on December 22, 2004, certifying that the claimant reached MMI on that date with a 24% IR. Dr. P assessed a 24% IR based on 0% impairment for the left knee, 15% impairment for DRE Cervicothoracic Category III: Radiculopathy, and 10% impairment for DRE Lumbosacral Category III: Radiculopathy. In worksheets attached to the certification, Dr. P noted that "evidence of radiculopathy is present (positive EMG findings)" for the cervical and lumbar spine. The narrative report from Dr. P does not document loss of reflexes or atrophy for the cervical or lumbar spine.

The hearing officer found that the "credible evidence establishes that [Dr. T's] change of opinion regarding the Claimant's cervical impairment was not due to an error, but instead was due to his change of opinion based on his review of a peer review report done by [Dr. C] at the Carrier's request." (Finding of Fact No. 9). The hearing officer determined that the preponderance of the medical evidence is contrary to the designated doctor's report on the issues of MMI and IR, therefore the designated doctor's report does not have presumptive weight (Finding of Fact No. 11 and Finding of Fact No. 13). Therefore, the hearing officer adopted the report of another doctor, Dr. P, and determined that the claimant reached MMI on December 22, 2004, with a 24% IR per Dr. P's report.

The carrier appealed the hearing officer's MMI and IR determinations arguing that the designated doctor's amended report in which he assigned a 14% IR has presumptive weight, because the designated doctor properly corrected his report to reflect that there were no significant signs of radiculopathy in the cervical spine as required for that rating by the AMA Guides. We note that the carrier did not dispute the 4% whole person impairment for the left knee, or the 10% impairment for DRE Lumbosacral Category III: Radiculopathy for the lumbar spine assigned by designated doctor. The carrier argues that the IR assessed must be based on a permanent condition at the time the designated doctor determined that the claimant reached MMI. The carrier requests that Dr. T's amended report which reflects a 14% IR, based on 4% whole person impairment for the left knee, 10% impairment for DRE Lumbosacral Category III: Radiculopathy for the lumbar spine, and 0% impairment for the cervical spine, be adopted.

MMI AND IR

Section 408.1225(c) provides that the report of the designated doctor has presumptive weight, and the Division shall base its determination of whether the employee has reached MMI on the report of the designated doctor unless the preponderance of the other medical evidence is to the contrary. Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the 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. Both Sections 408.1225(c) and 408.125(c) apply to this case because the CCH was held on or after September 1, 2005. 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, the amended report of Dr. T, the designated doctor, is entitled to presumptive weight and should be adopted unless the preponderance of the medical evidence is to the contrary. The hearing officer erred in determining that the preponderance of the medical evidence is contrary to Dr. T's report on the issues of MMI and IR and adopting the report of Dr. P. With regard to MMI, the hearing officer noted in her discussion of the evidence that the credible medical evidence showed that the claimant's condition "had not plateaued as of July 29, 2004," and the claimant had significant spinal complaints that could be expected to improve with further treatment that was being requested by a referral doctor, Dr. Mc. In a medical report dated July 27, 2004, Dr. Mc noted he thought the claimant needed additional diagnostic testing but noted that the claimant did not want the additional testing. The designated doctor, Dr. T, noted in his narrative report which certified MMI on July 29, 2004, that he did not believe further treatment would likely improve the claimant's condition. In an undated response, Dr. T referred to a letter of clarification dated March 24, 2005. Dr. T stated that he reviewed additional information from the treating doctor and concluded that he had no changes to make to his original MMI assessment. In a subsequent response

dated June 21, 2005, to an additional letter of clarification, Dr. T noted that unless there are new findings, the claimant's MMI date would remain the same. The medical evidence indicates that there were no new findings after Dr. T's certification of MMI. Based on the definition of MMI, in Section 401.011(30), the evidence supports Dr. T's certification that the claimant reached MMI on July 29, 2004. We hold that the hearing officer's determination that the preponderance of the medical evidence is contrary to Dr. T's report on the issue of MMI is not supported by the medical evidence.

With regard to IR, the hearing officer specifically found that the preponderance of the medical evidence establishes that the claimant has a permanent impairment relative to her cervical spine as a result of her _____, injury. We note that Dr. P's report does not document loss of reflexes or atrophy for the cervical or lumbar spine, and that he assigned an IR for the cervical and lumbar spine based on "positive EMG findings." A positive EMG is not enough to rate radiculopathy under the AMA Guides. Appeals Panel Decision (APD) 050729-s, decided May 23, 2005, APD 051456, decided August 16, 2005, and APD 051824, decided September 19, 2005, all reference APD 030091-s, decided March 5, 2003, which held that to find radiculopathy the 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 to the unaffected side, measured at the same distance above or below the elbow. Such findings of neurologic impairment may then be verified by diagnostic studies. In this case, Dr. P's narrative report cannot be adopted because it does not comply with the AMA Guides.

The hearing officer's finding that "the preponderance of the medical evidence is contrary to [the designated doctor's] report on the issue of MMI and, therefore, [the designated doctor's] report does not have presumptive weight and is not adopted" is reversed. The hearing officer's finding that "the preponderance of the medical evidence is contrary to [the designated doctor's] report on the issue of IR and, therefore, [the designated doctor's] report does not have presumptive weight and is not adopted on the issue of IR" is reversed. Therefore, the hearing officer's determination that the claimant reached MMI on December 22, 2004, with a 24% IR per Dr. P's report is reversed.

The designated doctor, Dr. T, amended his report to reflect that he corrected the IR for the cervical spine based on the claimant's condition on the date of MMI. Dr. T's narrative report dated July 29, 2004, states that "[i]n regards to the cervical spine, she shows no signs or symptoms. The examinee has no complaints or symptoms, and has full range of motion of the cervical spine." Dr. T noted that he observed that range of motion of the cervical spine was within normal limits. Rule 130.1(c)(3) provides that the assignment of an IR for the current compensable injury shall be based on the injured employee's condition as of the MMI date considering the medical record and the certifying examination. As previously mentioned, the designated doctor's responses to the Division's letters of clarification state that he amended his narrative report after "reviewing his IR evaluation" and that he corrected his error to reflect a 0% IR for the cervical spine. Dr. T amended his narrative report to reflect a 14% IR for the compensable injuries based on the claimant's condition as of the MMI date. Therefore the hearing officer's finding that "the credible evidence establishes that [the designated

doctor's] change of opinion regarding the Claimant's cervical impairment was not due to an error, but instead was due to his change of opinion based on his review of a peer review report done by [Dr. C] at the Carrier's request" is reversed.

We reverse the hearing officer's determination that the claimant reached MMI on December 22, 2004, with a 24% IR per Dr. P's report and render a new determination that the claimant reached MMI on July 29, 2004, with a 14% IR per Dr. T's, the designated doctor, amended report.

The true corporate name of the insurance carrier **AMERICAN HOME ASSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
800 BRAZOS, SUITE 750
AUSTIN, TEXAS 78701.

_____
Veronica L. Ruberto
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Margaret L. Turner
Appeals Judge