APPEAL NO. 070782
FILED JUNE 25, 2007

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 April 11, 2007. The hearing officer resolved the sole disputed issue by deciding that the appellant's (claimant) impairment rating (IR) is 10%, per the required medical examination (RME) doctor, Dr. L. The claimant appealed the hearing officer's determination arguing that the Texas Department of Insurance, Division of Workers' Compensation (Division)-selected designated doctor, Dr. V, properly assigned an IR of 26% and that IR should be adopted. The respondent (self-insured) responded, urging affirmance.

DECISION

Reversed and remanded.

FACTUAL SUMMARY

The parties stipulated that the claimant injured her neck, low back and left wrist as a result of the compensable injury of _____, and that the claimant reached maximum medical improvement (MMI) on August 17, 2006. The designated doctor, Dr. V, examined the claimant on August 17, 2006, and certified that the claimant reached MMI on that same date with a 26% IR. Dr. V assigned a 15% IR for Diagnosis-Related Estimate (DRE) Cervicothoracic Category III: Radiculopathy for the cervical spine, 5% IR for DRE Lumbosacral Category II: Minor Impairment for the lumbar spine, and 8% IR for the left wrist using 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). Dr. V noted in her "Physical Examination" section of her report that the claimant's "[r]eflexes were normal." However, in her "Recommendation/Discussion" section of her report she states that:

> The numbness in her forearm, the forearm flexion, the grip and interosseous strength decreases are not felt to be due to the wrist fracture. They are felt to be due to a residual radiculopathy from the cervical strain. There is no anatomical way to explain the weakness and the sensory deficits based on wrist pathology. The pathology has to come from the cervical spine. Since the patient did have a cervical strain and at one time was diagnosed with a cervical radiculopathy, we feel the radiculopathy persists.

Dr. V's report does not document significant signs of cervical radiculopathy, such as loss of relevant reflexes or unilateral atrophy with greater than a two centimeter decrease in circumference compared with the unaffected side, measured at the same

distance above or below the elbow, in accordance with the AMA Guides, Chapter 3, page 104.

In response to a letter of clarification dated September 13, 2006, Dr. V stated that "[t]he reason for the [cervical] radiculopathy [IR] was [that] there was a decrease in strength, decrease in motor function and a decrease in sensation in a dermatome specific distribution as noted in my narrative report." In a second response to a letter of clarification dated September 27, 2006, Dr. V stated that "based on the findings of my physical examination, upper extremity motor function loss, sensory loss and other neurologic alterations, this would be best described as a DRE III [Cervicothoracic Category III: Radiculopathy.] That would be a 15% whole person [IR]. Therefore, I do not see any reason to alter the [IR] assigned."

In evidence is an EMG/NCV study dated October 5, 2006, that states "[n]o electrophysiological evidence of cervical radiculopathy, brachial plexopathy, or distal mononeuropathy was recorded in these electrodiagnostic studies of the upper extremites." Dr. L, the RME doctor, examined the claimant on November 14, 2006, and certified that the claimant reached MMI on that same date with a 10% IR. Dr. L assigned a 5% IR for DRE Cervicothoracic Category II: Minor Impairment for the cervical spine and 5% IR for DRE Lumbosacral Category II: Minor Impairment for the lumbar spine. Dr. L described in the Physical Examination section of his report that "[d]eep tendon reflexes in the upper extremities measured 0 to a trace equally with 1+ in the lower limbs" and "[t]he right forearm measured 3/8 inch more in circumference than the left." We note that 3/8 inch converts to 0.95 centimeter.[1] Although Dr. L's report indicates that he documented loss of reflexes, it also reflects that the EMG/NCV study was reviewed, which did not indicate cervical radiculopathy, and Dr. L concluded in his narrative report that "[t]here are no findings of cervical radiculopathy." Dr. L testified that there was no ratable condition for the left wrist because the range of motion of both left and right wrists were normal.

On December 20, 2006, the Division sent a letter of clarification to Dr. V requesting that she review Dr. L's report. In a response dated December 29, 2006, Dr. V opined that the IR assigned by her "addressed the wrist, cervical and lumbar spine injuries." Dr. V reviewed Dr. L's report and commented in support of the 15% IR for cervical radiculopathy that:

> While [Dr. L] noted no cervical radiculopathy, the physical examination [report] indicated deep tendon reflexes of "0 to a trace" with the conventional standard being 2+. Additionally, right forearm circumference was 3/8 inch difference in this lady. Pain, reflex changes, unilateral upper extremity atrophy and exacerbation of degenerative changes equate to a verifiable radiculopathy in my opinion.

[1] Conversion from inches to centimeters: 3/8 inch=0.375 inch; 1 inch=2.54 centimeters; 0.375 inch x 2.54 centimeters=0.95 centimeter.

The hearing officer found that the findings of the designated doctor with regard to the IR are not supported by the preponderance of the other medical evidence and adopted the 10% IR assigned by the RME doctor, Dr. L, which is based on the November 14, 2006, MMI date certified by Dr. L, and not the stipulated date of MMI of August 17, 2006, certified by Dr. V.

IR

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. 28 TEX. ADMIN. CODE § 130.1(c)(3) (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. The preamble of Rule 130.1(c)(3) clarifies that IR assessments "must be based on the injured employee's condition as of the date of MMI." 29 Tex. Reg. 2337 (2004). *See* Appeals Panel Decision (APD) 040313-s, decided April 5, 2004.

In APD 040514, decided April 28, 2004, the hearing officer adopted the IR assigned by the treating doctor that was based on an MMI date different from the stipulated date of MMI. In that case, the Appeals Panel reversed the hearing officer's IR determination because the treating doctor's certification of IR was not based upon the claimant's condition on the stipulated date of MMI, therefore the certification could not be adopted. In the instant case, the hearing officer determined that the claimant's IR is 10% as assigned by Dr. L based on an MMI date of November 14, 2006. As previously mentioned, the parties stipulated that the date of MMI was August 17, 2006. Because Dr. L assigned an IR that was not based upon the claimant's condition on the stipulated date of MMI, August 17, 2006, the 10% IR assigned by Dr. L cannot be adopted. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 10%.

Review of the record indicates that there are two other certifications of MMI/IR. Dr. T, the doctor acting in place of the treating doctor, examined the claimant on August 10, 2006, and certified that the claimant reached MMI on that same date with a 15% IR, for the left wrist and lumbar spine. Dr. T did not provide a rating for the cervical spine. Dr. T's certification cannot be adopted because the MMI date is different from the stipulated date of August 17, 2006, and he did not rate the entire compensable injury. The designated doctor, Dr. V, certified that the claimant reached MMI on August 17, 2006 (the stipulated date of MMI) with a 26% IR, however, as the hearing officer correctly concluded, Dr. V's assigned IR cannot be adopted because it does not comply with the AMA Guides in rating cervical radiculopathy. In APD 030091-s, decided March 5, 2003, the Appeals Panel stated 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, measured at the same distance above or below the elbow. The AMA Guides state that such findings of neurologic impairment may then be verified by electrodiagnostic studies. Dr. V's report based on the claimant's condition on the stipulated date of MMI of August 17, 2006, does not document loss of relevant reflexes or atrophy in accordance with the AMA Guides. Since the hearing officer's IR determination has been reversed and there is no other certification of MMI/IR that rates the entire compensable injury in accordance with the AMA Guides as of the stipulated date of MMI of August 17, 2006, we remand this case back to the hearing officer.

The hearing officer is to determine whether Dr. V is still qualified and available to be the designated doctor, and if so, request that Dr. V rate the compensable injury (left wrist, cervical spine and lumbar spine) of _____, based on the stipulated date of MMI, August 17, 2006. If Dr. V determines that the claimant has cervical radiculopathy, Dr. V is to document the significant signs of cervical radiculopathy according to the AMA Guides, DRE Cervicothoracic Category III: Radiculopathy (page 104). Dr. V should assess an IR for the compensable injury of _____, which includes the left wrist, cervical spine, and lumbar spine, based on the claimant's condition at the stipulated date of MMI, August 17, 2006, in accordance with the AMA Guides. In determining the IR, Dr. V should consider the medical records and the certifying examination of the claimant. 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. If Dr. V is no longer qualified and available to serve as the designated doctor then another designated doctor is to be appointed pursuant to Rule 126.7(h) to determine the claimant's IR, which would include left wrist, lumbar and cervical injury, based on the claimant's condition on the stipulated date of MMI August 17, 2006.

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 **(a certified self-insured governmental entity)** and the name and address of its registered agent for service of process is

SUPERINTENDENT
(ADDRESS)
(CITY), TEXAS (ZIP CODE).

_____
Veronica L. Ruberto
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Margaret L. Turner
Appeals Judge