APPEAL NO. 070867
FILED JULY 6, 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 (CCH) was held on March 29, 2007. The hearing officer resolved the disputed issue by deciding that the appellant (claimant) has a 2% impairment rating (IR) as a result of his compensable injury. The claimant appealed disputing the IR determination. The respondent (self-insured) responded, urging affirmance.

DECISION

Reversed and remanded.

The claimant sent a medical record dated May 3, 2007, to the Texas Department of Insurance, Division of Workers' Compensation (Division) for consideration. The medical record was received by the Division on May 9, 2007. Although the medical record was submitted separately from the claimant's appeal it was received within the statutory time period provided for an appeal. Documents submitted for the first time on appeal are generally not considered unless they constitute newly discovered evidence. *See generally*, Appeals Panel Decision (APD) 93111, decided March 29, 1993; Black v. Wills, 758 S.W. 2d 809 (Tex. App.-Dallas 1988, no writ). In determining whether new evidence submitted with an appeal requires remand for further consideration, the Appeals Panel considers whether the evidence came to the knowledge of the party after the hearing, whether it is cumulative of other evidence of record, whether it was not offered at the hearing due to a lack of diligence, and whether it is so material that it would probably result in a different decision. *See* APD 93536, decided August 12, 1993. Upon our review, we cannot agree that its admission on remand is so material that it would probably produce a different result. The new evidence submitted, therefore, will not be considered.

It was undisputed that the claimant sustained a compensable injury on _____, while moving a filing cabinet. The parties agreed that the claimant reached maximum medical improvement (MMI) on January 10, 2005. The only disputed issue at the CCH was the claimant's IR. In evidence was a prior CCH decision and order which noted that it was undisputed the claimant had a low back injury and determined that the claimant's _____, compensable injury includes an injury to the cervical spine and left shoulder. Division records indicate that the prior CCH decision was not appealed. There are certifications from both the designated doctor, Dr. P, and a carrier-selected required medical examination (RME) doctor, Dr. L, in evidence which assess an IR. There are three certifications from the designated doctor.

The designated doctor, Dr. P, initially certified on March 19, 2004, that the claimant was not at MMI. After the initial examination by the designated doctor, the claimant was examined by Dr. L, the RME doctor (on June 23, 2004), the results of

which will be discussed later in this decision. Dr. P (the designated doctor) examined the claimant again on October 11, 2004, and certified the claimant reached clinical MMI on June 1, 2004. Dr. P noted in her narrative report that she disagreed with the MMI date but was told that it had already been determined. Dr. P provided alternate ratings, one which included the cervical spine and one which did not. Both ratings were assessed 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. P assessed a 10% IR, placing the claimant in Diagnosis-Related Estimate (DRE) Lumbosacral Category III: Radiculopathy. Dr. P assessed an alternate rating of 15%, combining the 10% impairment assessed for the lumbar spine (DRE Lumbosacral Category III: Radiculopathy) and 5% impairment assessed for the cervical spine (DRE Cervicothoracic Category II: Minor Impairment).

Dr. P re-examined the claimant on April 4, 2005, and certified that the claimant reached MMI statutorily on January 10, 2005, with a 29% IR. The 29% IR consisted of the 10% impairment assessed for the lumbar spine (DRE Lumbosacral Category III: Radiculopathy), the 15% impairment assessed for the cervical spine (DRE Cervicothoracic Category III: Radiculopathy), and the 6% impairment for loss of range of motion of the shoulder[1]. In evidence are Dr. P's responses to a deposition on written questions. The deposition contained four questions regarding the significant signs of radiculopathy cited in the AMA Guides. Dr. P responded that her examination of the claimant on April 4, 2005, did not reveal measured unilateral atrophy of greater than 2 centimeters above or below the knee compared to measurements on the contralateral side at the same location and did not reveal loss of relevant lower extremity reflexes for the lumbar spine. Additionally, Dr. P responded that her examination of the claimant on April 4, 2005, did not find loss of relevant upper extremity reflexes for the cervical spine and did not find unilateral atrophy with greater than 2 centimeters decrease in circumference compared with the unaffected side measured at the same distance above or below the elbow. Citing these responses, the hearing officer found that a preponderance of the medical evidence is contrary to the 29% IR certified by Dr. P.

There are two certifications from Dr. L in evidence. Dr. L certified, based on an examination conducted June 23, 2004, that the claimant reached MMI on June 1, 2004, with a 0% IR, assessing 0% impairment for both the lumbar and cervical spine. Dr. L gave an alternative rating of 2% whole person impairment which included 4% upper extremity for loss of range of motion of the left shoulder, again assessing 0% impairment for both the lumbar and cervical spine.

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

[1] We note that the narrative report from Dr. P stated that the impairment for the left shoulder was assessed for loss of range of motion, but referenced the worksheet for the impairment value assessed. However, no worksheet was included in the evidence so the 6% impairment referenced above was determined by using the Combined Values Chart and the other impairment values assessed by Dr. P.

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* APD 040313-s, decided April 5, 2004, and APD 040514, decided April 28, 2004.

The hearing officer determined that the claimant's IR is 2% as assigned by Dr. L based on an MMI date of June 1, 2004. As previously noted, the parties agreed on the record at the CCH that the claimant reached MMI on January 10, 2005, as certified by Dr. P. Because Dr. L assigned an IR that was not based upon the claimant's condition on the agreed date of MMI, January 10, 2005, the 2% IR assigned by Dr. L cannot be adopted. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 2%.

Two of the three certifications from Dr. P (10% and 15% based on a June 1, 2004, MMI date) were based on a MMI date different than January 10, 2005, and therefore cannot be adopted. Additionally we note that the 10% IR certified by Dr. P did not rate the entire compensable injury and cannot be adopted because it did not include impairment for the cervical spine.

The only certification based on the agreed date of MMI is the 29% certified by Dr. P. As previously noted, Dr. P acknowledged that her examination did not find the significant signs specified in the AMA Guides for rating radiculopathy of the cervicothoracic or lumbosacral spine. *See* APD 030091-s, decided March 5, 2003, and APD 051456, decided August 16, 2005. We note that there are medical records in evidence from a referral doctor that document left upper extremity atrophy on February 17, 2005. The right mid forearm measured at 31 centimeters and the left arm measures at 27 centimeters. The same record notes that EMG studies show left C5-6 radiculopathy. Further, a medical record from the same referral doctor dated March 29, 2005, documents decreased deep tendon reflexes in the left upper extremity on physical examination when compared to the right. However, given that Dr. P acknowledged that the claimant did not exhibit any significant signs of cervical and lumbar radiculopathy on the date of the certifying examination of April 4, 2005; she did not acknowledge confirmation of objective clinical findings made by the claimant's referral doctor evidenced in the claimant's medical records; and the worksheets showing measurements taken to determine the exact impairment assessed for the left shoulder, if any, were not introduced into evidence, we cannot adopt the 29% IR assessed by Dr. P.

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 as of the agreed date of MMI of January 10, 2005, we remand this case back to the hearing officer. The

hearing officer is to determine whether Dr. P is still qualified and available to be the designated doctor, and if so, request that Dr. P rate the compensable injury of _____, based on the agreed MMI date of January 10, 2005. If Dr. P determines the claimant has cervical or lumbar radiculopathy, Dr. P must document the significant signs of radiculopathy according to the AMA Guides, DRE Cervicothoracic Category III: Radiculopathy (page 104) and/or the significant signs of radiculopathy according to the AMA Guides, DRE Lumbosacral Category III: Radiculopathy (page 102). Dr. P should assess an IR for the compensable injury of _____, which includes the cervical spine, lumbar spine, and left shoulder, based on the claimant's condition on January 10, 2005, in accordance with the AMA Guides. In determining the IR, Dr. P 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. P is no longer qualified 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 the claimant's cervical spine, lumbar spine, and left shoulder, based on the claimant's condition on the MMI date of January 10, 2005.

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

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

_____
Margaret L. Turner
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Veronica L. Ruberto
Appeals Judge