APPEAL NO. 071872
FILED DECEMBER 20, 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 commenced on August 8, 2006, in (City 1), Texas, with (the first hearing officer) presiding as hearing officer. In that proceeding the first hearing officer found good cause to add the issue of "Should the [Texas Department of Insurance, Division of Workers' Compensation (Division)] appoint a new designated doctor?" That proceeding was continued in order to research who the employer was. The respondent/cross-appellant (claimant) did not have the assistance of an ombudsman at that proceeding. Subsequently, a CCH was reconvened on January 11, 2007, in (City 1), Texas with (second hearing officer) presiding as the hearing officer. The record was closed on September 18, 2007. With regard to the two issues before her, the hearing officer determined that the claimant's impairment rating (IR) is 14% and that the compensable injury of _____, does include the "disc pathology at L3 through S1 and diagnosed radiculopathy."

The appellant/cross-respondent (carrier) appealed, contending among other matters, that the hearing officer erred by failing to address the issue added at the August 2006 proceeding of whether to appoint a new designated doctor and that the hearing officer abused her discretion in the appointment of Dr. S as the second designated doctor. On appeal, the carrier states that it accepts that the _____, compensable injury includes the right protrusion at L5-S1 with radiculopathy, but not the annular tear at L5-S1 or any other disc pathology or radiculopathy at L3-4 or L4-5. The hearing officer's determination that the compensable injury includes a right protrusion at L5-S1 with radiculopathy has not been appealed and has become final pursuant to Section 410.169. The carrier also appeals the IR contending that the claimant's IR should be 5% as assessed by Dr. JP, the first designated doctor, in his initial report. The claimant appeals the 14% IR contending a new (third) designated doctor should be appointed. Both parties responded to the other party's appeal.

DECISION

Affirmed in part and reversed and rendered in part.

The claimant sustained his injury in a fall from a ladder. The parties stipulated that: (1) the claimant sustained a compensable injury in the form of a head contusion, neck sprain, right rib contusion, lumbar sprain/strain, right shoulder bursitis and tendonitis and right kidney contusion, on _____; (2) the claimant reached maximum medical improvement (MMI) on May 23, 2002; (3) the Division-selected designated doctor is Dr. JP; (4) on December 13, 2004, Dr. JP, assigned a 5% IR; (5) on December 27, 2005, Dr. JP amended his certification and assigned a 14% IR; (6) on November 4, 2006, Dr. P, the carrier-selected required medical examination (RME) doctor, assigned a 10% IR; and (7) 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 4th edition) is the correct edition of the AMA Guides to be used in this case.

After the claimant's fall on _____, the claimant was initially treated conservatively for strains and contusions until September/October 2000 when spinal surgery was recommended. The surgery was never performed as the claimant was incarcerated from November 2000 until November 2004.

EXTENT OF INJURY

The hearing officer's determination that the compensable injury of _____, includes disc pathology at L3-4 and L4-5 and diagnosed radiculopathy is supported by sufficient evidence and is affirmed.

THE 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.

Dr. JP assigned the first IR on December 13, 2004.[1] Dr. JP certified that the claimant reached MMI statutorily on May 23, 2002, the stipulated date of MMI, with a 5% IR on a Report of Medical Evaluation (DWC-69). Dr. JP indicated he used the AMA Guides 4th edition to assess the IR. How Dr. JP arrived at the 5% IR is not evident in his narrative report and Dr. JP only listed as diagnoses lumbar muscle ligamentous strain and lumbar myofascitis. Dr. JP does note range of motion (ROM) measurements for the cervical spine, right shoulder and lumbar spine. This report cannot be adopted because it fails to specify how the 5% IR was calculated. The doctor evaluating permanent impairment must consider the entire compensable injury. Appeals Panel Decision (APD) 043168, decided January 20, 2005.

In a letter of clarification (LOC) dated November 22, 2005, the Division requested that Dr. JP provide an IR using the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides 3rd edition). In a response dated December 27, 2005, Dr. JP states that: (1) he reexamined the claimant; (2) the claimant "reached (statutory) MMI on 5/21/2002"; (3) he used the AMA Guides 3rd edition; and (4) he assigned a 14% IR

[1] There are two versions of the December 13, 2004, report in evidence, one is incomplete and therefore we consider the other.

(based on 7% impairment for the lumbar spine and 7% impairment for the right shoulder). The attached DWC-69 indicates that Dr. JP checked the box for statutory MMI, but failed to provide a date, and assigned a 14% IR. Also, Dr. JP checked the box that he assessed an IR using the AMA Guides 3rd edition. As previously stated, the parties stipulated that the AMA Guides 4th edition is the correct edition of the AMA Guides to be used in this case. Therefore, Dr. JP's 14% IR cannot be adopted because it is based on the AMA Guides 3rd edition. Rule 130.1(c)(2)(C) provides that IRs assigned using the wrong edition of the AMA Guides shall not be considered valid.

In another LOC Dr. JP was sent an undated letter from Dr. L, the treating doctor. Dr. JP responded by letter dated March 14, 2006, commenting on Dr. L's report, the confusion regarding which edition of the AMA Guides to use and suggesting that the claimant was doctor shopping for a higher IR. Dr. JP provided another DWC-69 that noted the claimant reached statutory MMI but did not provide a date, and assessed a 14% IR, indicating that the AMA Guides 4th edition was used. Dr. JP concluded:

> In any event there is no change in the IR. I used the ROM model and the IR is still the same whether you use the 3rd or 4th edition of the A.M.A Guide.
>
> I feel [DWC] should provide finality to this case. I will not provide any more reports or clarifications and request withdrawal from this case.

Dr. JP did not explain why the ROM Model was used in rating spine impairment under the AMA Guides 4th edition. *See* APD 061529-s, decided September 26, 2006, which explains that if the designated doctor uses the ROM Model in the AMA Guides 4th edition to assign spine impairment, the designated doctor must explain why the ROM Model should be used and why the Diagnoses-Related Estimate (DRE) Model cannot be used. Dr. JP's 14% IR (indicating the AMA Guides 4th edition was used) cannot be adopted because of the uncertainty as to whether the 14% is based on the AMA Guides 3rd edition or the AMA Guides 4th edition pursuant to his response to the LOC and, if the AMA Guides 4th edition was used, the absence of an explanation for using the ROM Model to assess spine impairment.

After the January 11, 2007, CCH the hearing officer wrote the parties stating that there was not a valid IR to adopt, and that since Dr. JP had withdrawn from the case she was reopening the record and appointing a new designated doctor. Although the hearing officer did not make any determination in her decision on the issue of whether a second designated doctor should be appointed, in view of Dr. JP's withdrawal, and the subsequent appointment of Dr. S as the second designated doctor, we will infer determinations that a second designated doctor should be appointed and that the Division did not abuse its discretion in the appointment of Dr. S. Dr. S examined the claimant on March 12, 2007, and in a report of that date certified that the claimant reached MMI statutorily on May 21, 2002 (not the stipulated MMI date of May 23, 2002) with a 14% IR using the AMA Guides 4th edition. Dr. S stated that he used the ROM

Model to determine the low back rating because "there is a dispute between several physicians concerning this assessment using the DRE Category." Dr. S assessed a 7% impairment for the lumbar "region" plus 2% impairment for lumbar loss of ROM "allowing a 9% overall impairment." Dr. S concluded this was closest to DRE Lumbosacral Category III: Radiculopathy and therefore rated the claimant with 10% impairment for the low back. In addition, Dr. S rated a loss of ROM of the right shoulder for a 7% upper extremity (UE) impairment. Dr. S converted the 7% UE rating to a 4% whole person rating (Table 3 of the AMA Guides) and combined the ratings to arrive at the 14% IR.

The hearing officer, in a LOC dated July 24, 2007, wrote Dr. S advising him that the IR must be assigned as of the date the claimant "reached statutory [MMI]" and "[t]hat date is May 27, 2002" (also not the stipulated May 23, 2002, date of MMI). The hearing officer also questioned Dr. S about his use of ROM as a differentiator referring to page 101 of the AMA Guides 4th edition and asked about loss of (relevant) reflexes or atrophy in placing the claimant in "DRE Category III." Dr. S replied, amending the DWC-69 to reflect that the claimant reached MMI statutorily on May 27, 2002, and explaining:

> The ROM model was used because there was dispute between two doctors concerning impairment from CAT II or CAT III of the Lumbosacral DRE. The ROM model gave 9% which is closest to 10%. The EMG issue is a separate issue and I wrote several reports stating that the EMG study should not be used to award CAT III unless PE signs of radiculopathy were present before any appeals panels were available. Since we have two examiners who cannot agree and who have chosen between CAT II and CAT III the range of motion model was (and rightly so) used as the final differentiator.
>
> There will be no change in the impairment of 14% WP.

The hearing officer found that the 14% IR assigned by Dr. S is supported by a preponderance of the evidence and concluded that the claimant's IR is 14%. We hold in this case that Dr. S's IR cannot be adopted because Dr. S did not assess the IR as of the stipulated May 23, 2002, MMI date.

Dr. P, the carrier RME doctor, examined the claimant on November 4, 2006, and in a report of that date certified MMI on the stipulated May 23, 2002, date of MMI and assessed a 10% IR using the AMA Guides 4th edition. The 10% IR is based on DRE Lumbosacral Category III: Radiculopathy. Dr. P discussed the other compensable body parts and explained why he determined only a 0% impairment for those body parts or why they were not ratable. Dr. P addresses the shoulder complaints, and states that the ROM of the shoulder was not accurate, and finds a 0% impairment for ROM loss. Dr. P in discussing the lower extremities states that the "examination reveals 1 + deep tendon reflexes." A peer review doctor testified that since the reflexes were the same bilaterally that was considered normal, referencing the reports of two other doctors. Dr. JS, in a report dated April 17, 2006, notes that the claimant's "deep tendon reflexes are

bilaterally present but depressed at the patella and the Achilles." The other doctor, Dr. C, in a report dated October 6, 2005, found the right lower extremity deep tendon reflexes at the patella and Achilles tendon are 1 + and the left lower extremity deep tendon reflexes at the patella and Achilles tendon are 2 + indicating a loss of lower extremity deep tendon reflexes on the right.

Dr. P, in his review of Dr. JP's December 2004 report, commented that "EMG's were subsequently obtained which suggested right L5 and S1 nerve root radiculopathy, with acute and chronic changes." Dr. P concluded in his discussion of the lumbar spine that the claimant "has disc protrusion with radicular-type symptoms" and therefore "he would be entitled to a Category III or radiculopathy which entitles [the claimant] to a 10% whole person [IR]." The hearing officer, in the Background Information, discusses Dr. P's assessment, stating that while Dr. P had rated all the compensable body parts, he assigned the claimant an IR for radiculopathy based solely on the EMG findings and that the EMG findings do not appear to be supported by physical findings. We disagree. The EMG performed on September 30, 2005, found lumbar radiculopathy involving the right L5 and S1 nerve roots. The description of DRE Lumbosacral Category III: Radiculopathy requires that the patient has significant signs of radiculopathy, such as loss of relevant reflexes which may be verified by electrodiagnostic findings. (Page 3/102 and Table 71 page 3/109 of the AMA Guides.) Dr. P found loss of reflexes, which is supported by Dr. C's finding of loss of reflexes on the right, and is verified by the EMG findings of lumbar radiculopathy involving the right L5 and S1 nerve roots. The hearing officer's comment that the EMG does not appear to be supported by physical findings is not supported by the evidence.

We reverse the hearing officer's determination that the IR is 14% (as assessed by Dr. S) and render a new decision that the claimant's IR is 10% as assessed by Dr. P.

SUMMARY

We affirm the hearing officer's determination that the compensable injury of _____, includes disc pathology at L3-4 and L4-5 and diagnosed radiculopathy. We reverse the hearing officer's determination that the claimant's IR is 14% and render a new decision that the claimant's IR is 10%, as assessed by Dr. P.

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

RUSSELL R. OLIVER, PRESIDENT
6210 HIGHWAY 290 EAST
AUSTIN, TEXAS 78723.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Veronica L. Ruberto
Appeals Judge

_____
Margaret L. Turner
Appeals Judge