APPEAL NO. 111244
FILED OCTOBER 3, 2011

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 July 15, 2011. The hearing officer resolved the disputed issues by deciding that the appellant (claimant) reached maximum medical improvement (MMI) on November 9, 2010, with a five percent impairment rating (IR) and that the claimant had disability from November 10, 2010, through the date of the CCH. The claimant appealed the hearing officer's determinations on MMI and IR. The respondent (carrier) responded, urging affirmance.

The hearing officer's determination that the claimant had disability from November 10, 2010, through the date of the CCH, July 15, 2011, was not appealed and has become final pursuant to Section 410.169.

DECISION

Reversed and rendered.

The parties stipulated that on (date of injury), the claimant sustained a compensable injury. It was undisputed that the claimant, a hospice nurse's aide, slipped in water and fell on a wet floor, hitting her head, neck and lower back. At the CCH, the claimant's attorney in her opening statement argued that the claimant sustained cervical and lumbar spine injuries as part of the compensable injury, which had been diagnosed and treated from the date of her work injury. The carrier's attorney waived opening statement. The claimant testified that she injured her neck and lower back at work on (date of injury), when she slipped and fell on a wet floor while assisting a patient to the shower. Also in evidence are the records of her medical diagnoses and treatment of the cervical and lumbar spine following her fall at work. During closing argument, the claimant's attorney argued that the designated doctor's certification of MMI/IR could not be adopted because the designated doctor did not have all of the claimant's medical records and the designated doctor did not rate the entire compensable injury, which included the lumbar spine. The claimant's attorney contended that the designated doctor failed to assign an impairment for the lower back (which could have included a zero percent impairment). The claimant's attorney further argued that there was never an extent-of-injury dispute by the carrier and that cervical and lumbar spine injuries were sustained by the claimant at work. The carrier in its closing argument contended that the claimant was at MMI for the cervical and lumbar spine injuries because the claimant underwent cervical surgery, which improved and stabilized her neck condition, and because the lumbar spine complaints had resolved.

The carrier argued that at the time of the certifying exam, the designated doctor found that the claimant had full lumbar range of motion (ROM) and negative straight leg raises. We note that the carrier never disputed or litigated at the CCH that the lumbar spine was not part of the compensable injury of (date of injury).

The claimant testified that she was initially treated at (Healthcare Provider). In evidence is a medical record dated (date of injury), from Dr. C at (Healthcare Provider), who diagnosed the claimant with bilateral cervical sprain/strain, bilateral lumbar sprain/strain, contusion of hip, post-concussion syndrome and "[h]ead [i]njury NOS," without skull fracture. In that report, Dr. C documents decreased ROM as well as muscle spasms for the cervical and lumbar spine. Additional records in evidence of Dr. C during March of 2010, indicate that a CAT scan and MRI of the brain were normal. A letter dated March 16, 2010, indicates that Dr. C referred the claimant to (Dr. B), for the claimant's cervical spine. Dr. B performed an anterior cervical discectomy and fusion at C3-4 and C4-5 with placement of anterior cervical plate on May 5, 2010, and continued with follow-up care on the claimant's cervical spine post-surgery.

The claimant testified that, subsequent to Dr. C, her follow-up care at (Healthcare Provider) was with (Dr. HH). A review of Dr. HH's medical records in evidence dated from April 15 through August 6, 2010, reveal that while the claimant presented to her with complaints of cervical pain and decreased ROM with a full ROM for the lumbar spine with resolved muscle spasms and tenderness, Dr. HH's continued diagnoses included bilateral cervical sprain/strain and bilateral lumbar sprain/strain. Then in a medical report dated July 13, 2010, Dr. HH noted increased pain, muscle spasm and tenderness as well as decreased ROM in the lumbar spine. Dr. HH continued her diagnosis of a bilateral lumbar sprain/strain, but requested a lumbar MRI as medically necessary, and ordered physical therapy to include the cervical and lumbar spine. In her last August 6, 2010, medical report, Dr. HH noted that the claimant's symptoms are increasing, ROM in the lumbar spine had decreased on all planes, and there was radiating pain in the lumbar spine although the straight leg testing was negative. Dr. HH continued the orders for physical therapy for the lumbar spine because of decreased strength and there was still a pending request for a lumbar MRI.

The claimant testified that she then changed treating doctors and was referred to (Dr. O) for the lumbar spine. Dr. O in a medical report dated August 24, 2010, diagnosed the claimant with lumbar strain with radiculitis and stated that most of the claimant's therapy for her work injury had been directed towards the neck and the claimant had received "very little treatment for her low back, just some therapy." In a medical report dated September 10, 2010, Dr. O stated that "[w]ork comp has denied therapy for her low back. [The claimant] was able to get the initial visit and none additional before she had to stop."

The claimant was examined on November 9, 2010, by (Dr. L), the designated doctor appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) to address MMI/IR and return to work. Dr. L certified on his Report of Medical Evaluation (DWC-69) and in his narrative report that the claimant reached MMI on that date with a five percent IR for Diagnosis-Related Estimate Cervicothoracic Category II: Minor Impairment, 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).

Section 401.011(30)(A) defines MMI as "the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated." 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. 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. P), a doctor selected by the treating doctor in place of the treating doctor, examined the claimant on January 17, 2011, and provided a DWC-69 and narrative report dated that same date, certifying that the claimant had not yet reached MMI with no assignment of IR. In Dr. P's narrative report, he states that "[t]he patient has not received proper diagnostics for the lumbar spine. The lumbar MRI [has] been requested numerous times and denied. The patient is presenting with symptoms of a possible [herniation] of the lumbar spine. The patient's treatment focus for the past year has been on the cervical spine and the lumbar spine has essentially been ignored. The patient should at least be afforded the proper diagnostics."

In evidence is an MRI of the claimant's lumbar spine dated January 31, 2011, which revealed a protrusion/herniation at L3-4, L4-5 and L5-S1, which indented the thecal sac. Also in evidence is an EMG dated February 21, 2011, which revealed abnormalities suggestive of bilateral L5 and bilateral S1 radiculopathy. In evidence is a letter from the carrier to the claimant's treating doctor, (Dr. H), in which the carrier approved six physical therapy visits for the cervical and lumbar spine. In a hand-written

statement dated May 10, 2011, Dr. H stated, "[i]n my opinion, there is definitely a reasonable degree of probability that the herniations described [in the lumbar MRI dated January 31, 2011] occurred due to the injury of [(date of injury)]. The mechanism of the injury can lead to protrusions of that degree. [The claimant] reported that there was no pain or discomfort in her lower back prior to the injury." On May 13, 2011, the claimant received a lumbar epidural steroid injection (ESI) at L4-5 and testified that she had another scheduled after the date of the CCH. The claimant further testified that depending on the outcome of the second injection, her doctor might consider lumbar surgery.

In reviewing a "great weight" challenge, we must examine the entire record to determine if: (1) there is only "slight" evidence to support the finding; (2) the finding is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust; or (3) the great weight and preponderance of the evidence supports its nonexistence. *See* Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

The claimant contended in part at the CCH and in her appeal that she has not yet reached MMI and that Dr. L failed to rate the entire compensable injury. We agree. The designated doctor, Dr. L, certified an MMI date based only as to the claimant's cervical spine and only gave the claimant an IR for the cervical spine, without assigning a specific impairment for the claimant's lumbar spine as described in the AMA Guides. The hearing officer found that the November 9, 2010, date of MMI and five percent IR certified by Dr. L is not contrary to the preponderance of the evidence. That finding is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. Accordingly, we reverse the hearing officer's determination that the claimant reached MMI on November 9, 2010, with a five percent IR.

There is only one other certification of MMI/IR in evidence. The certification is from Dr. P, as discussed above, who examined the claimant on January 17, 2011, and certified that the claimant had not yet reached MMI and assigned no IR as a result of the compensable injury. Because the preponderance of the medical evidence established, based on a reasonable medical probability, that further material recovery from or lasting improvement to the lumbar spine injury could reasonably be anticipated subsequent to Dr. L's certified MMI date as shown by the claimant's treating doctors' medical records as to her subsequent diagnostic testings, the lumbar ESIs, and the additional physical therapy for the lumbar spine as approved by the carrier, Dr. P's certification of MMI/IR can be adopted.

We reverse the hearing officer's decision and render a new decision that the claimant has not yet reached MMI and the assignment of an IR is premature.

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

CORPORATION SERVICE COMPANY
211 EAST 7TH STREET, SUITE 620
AUSTIN, TEXAS 78701-3218.

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Cynthia A. Brown
Appeals Judge

CONCUR:

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Thomas L. Knapp
Appeals Judge

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Margaret L. Turner
Appeals Judge