APPEAL NO. 111364
FILED NOVEMBER 18, 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 was held on August 22, 2011. With regard to the only issue before him the hearing officer determined that the respondent's (claimant) impairment rating (IR) is 25%. The appellant (carrier) appealed, contending there was insufficient evidence to support the 25% IR and that the 10% IR from the designated doctor should be adopted. The claimant responded, urging affirmance.

DECISION

Reversed and a new decision rendered.

It is undisputed that the claimant's date of maximum medical improvement (MMI) was January 19, 2010. The parties stipulated that: (1) the claimant sustained a compensable injury to his lumbar spine on (date of injury); (2) (Dr. T) was appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) to determine the IR; (3) Dr. T examined the claimant on April 19, 2010; and certified that the claimant reached MMI on January 19, 2010, with an IR of 10%; and (4) the treating doctor, (Dr. R) certified that the claimant reached MMI on January 19, 2010, with an IR of 25%.

In the hearing officer's Background Information, the hearing officer discusses the reports of Dr. T, of (Dr. C), a board certified radiologist, and of Dr. R. The hearing officer further commented that:

> The doctors disagree, however, the more persuasive evidence was the opinions of [Dr. R] and [Dr. C] that placed the [c]laimant in [Diagnosis-Related Estimates (DRE) Lumbosacral Category V: Radiculopathy and Loss of Motion Segment Integrity of 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)] resulting in an [IR] of 25%.

The hearing officer found Dr. R's IR was made in accordance with the AMA Guides and is supported by a preponderance of the evidence.

In evidence is Dr. R's Report of Medical Evaluation (DWC-69) dated August 22, 2011, with an exam date of February 12, 2010, certifying statutory MMI on January 19, 2010, with a 25% IR. However, there is no narrative report from Dr. R attached to his DWC-69. Elsewhere in the exhibits is a DWC-69 from (Dr. B) with a date of certification of February 12, 2010, exam date of February 12, 2010, certifying statutory MMI on September 20, 2009, with a 25% IR. The narrative which accompanies Dr. B's DWC-69 has a September 20, 2009, date of MMI and is signed by Dr. B. The claimant testified and his response indicates that both Dr. B and Dr. R are his treating doctors.

28 TEX. ADMIN. CODE § 130.1(d)(1) (Rule 130.1(d)(1)) states that a certification of MMI and assignment of an IR requires completion, signing and submission of the DWC-69 and a narrative report. The evidence does not contain a narrative report signed by Dr. R. We further note that Rule 130.1(c)(3) requires that the doctor assigning the IR shall:

(A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury;

(B) document specific laboratory or clinical findings of an impairment;

(C) analyze specific clinical and laboratory findings of an impairment;

(D) compare the results of the analysis with the impairment criteria and provide the following:

(i) A description and explanation of specific clinical findings related to each impairment, including zero percent (0%) [IRs]; and

(ii) A description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained.

(E) assign one whole body [IR] for the current compensable injury.

As previously indicated, there is no narrative signed by Dr. R. The narrative signed by Dr. B, certifying a different date of MMI, cannot be substituted as a narrative for Dr. R.

The AMA Guides, Table 71 on page 3/109 for Loss of Motion Segment Integrity requires "[f]lexion and extension comparison roentgenograms show significant injury-related anterior-to-posterior translation of two adjacent vertebral bodies of 5 mm or more in the lumbar . . . ." The narrative signed by Dr. B does not give the flexion and extension comparison the AMA Guides require for an assignment of loss of motion

segment integrity and does not explain why the claimant meets the criteria for DRE Lumbosacral Category V: Radiculopathy and Loss of Motion Segment Integrity. *See* pages 3/102 and 3/109 of the AMA Guides. Dr. R's IR cannot be adopted because it does not contain a narrative from Dr. R and is not in conformance with the AMA Guides and Rule 130.1(d)(1). Dr. B's IR cannot be adopted because Dr. B certifies an MMI date differing from that stipulated to by the parties and because the narrative does not conform with the requirements of the AMA Guides on loss of motion segment integrity.

Dr. C, identified as a board certified radiologist, in a report dated June 14, 2011, described the records that he had reviewed and his measurements for motion segment integrity-annular motion. Dr. C stated that the "observed measurements at both L3-4 and L5-S1 exceed 5 mm translation, meeting the criteria for loss of motion segment integrity on the basis of translation." However, Dr. C's report does not contain a DWC-69. *See* Rule 130.1(d)(1). Also in evidence is a report dated September 13, 2009, from Dr. Stephen Cyr (Dr. SC) which documents loss of motion segment integrity but there is no DWC-69 certifying MMI/IR. Because there is no certification of MMI/IR by Dr. R, Dr. B, Dr. C or Dr. SC that can be adopted and the hearing officer based his Conclusion of Law on Dr. R's IR, we reverse the hearing officer's determination that the claimant's IR is 25%.

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.

In evidence is the report of Dr. T, the designated doctor. In a report dated April 19, 2010, with an exam that same date, Dr. T certified statutory MMI on September 20, 2009, with a 10% IR. Dr. T stated that he used the DRE Injury Model, recited evidence of decreased patellar reflex and ankle jerk to justify left lower extremity radiculopathy and assigned a DRE Lumbosacral Category III: Radiculopathy based on Table 72, page 3/110 of the AMA Guides. In a letter of clarification dated June 14, 2010, Dr. T was asked to review additional medical records and was advised that the correct date of statutory MMI was January 19, 2010. In a response dated June 16, 2010, Dr. T replied that he would amend his DWC-69 to reflect the correct statutory MMI date of January 19, 2010. Dr. T also stated he had reviewed the lumbar x-ray report of the lumbar spine dated January 16, 2009, and it did not warrant a change in the IR. An amended DWC-69 reflecting the statutory MMI date of January 19, 2010, is attached to the response. We hold that the preponderance of the other medical evidence is not contrary to the designated doctor's amended report.

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). We reverse the hearing officer's determination that the claimant's IR is 25% as being so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust. We render a new decision that the claimant's IR is 10% as assessed by the designated doctor's report which is not contrary to the preponderance of the other medical evidence.

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

CORPORATION SERVICE COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701-3232.

Thomas A. Knapp
Appeals Judge

CONCUR:

Cynthia A. Brown
Appeals Judge

Margaret L. Turner
Appeals Judge