

APPEAL NO. 120613
FILED MAY 21, 2012

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 February 29, 2012, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that: (1) the compensable injury of [date of injury], does not extend to L3-4 1mm disc bulge with slight effacement of ventral thecal sac, L4-5 1-2 mm disc bulge/protrusion which in the foraminal distributions contributes to mild foraminal narrowing with facets at this level thought mildly hypertrophic and (bulging disc) may abut the exiting nerve root in left lateral foraminal to far lateral distribution, and L5-S1 mild bilateral facet arthropathy with diffuse 3-4 mm disc bulge/protrusion with mild bilateral neural foraminal narrowing, slight inferior extension of protrusion in the midline, subtle annular rent noted within the posterior aspect of the annulus near the midline and foraminal narrowing moderate on the right and mild leftward; (2) since further improvement and material recovery can reasonably be anticipated, the respondent (claimant) is not yet at maximum medical improvement (MMI); and (3) since the claimant is not yet at MMI, there can be no impairment rating (IR) at this time. The appellant (carrier) appeals the hearing officer's MMI and IR determinations. The claimant responds, urging affirmance of the MMI and IR determinations. The hearing officer's determination that the compensable injury of [date of injury], does not extend to L3-4 1mm disc bulge with slight effacement of ventral thecal sac, L4-5 1-2 mm disc bulge/protrusion which in the foraminal distributions contributes to mild foraminal narrowing with facets at this level thought mildly hypertrophic and (bulging disc) may abut the exiting nerve root in left lateral foraminal to far lateral distribution, and L5-S1 mild bilateral facet arthropathy with diffuse 3-4 mm disc bulge/protrusion with mild bilateral neural foraminal narrowing, slight inferior extension of protrusion in the midline, subtle annular rent noted within the posterior aspect of the annulus near the midline and foraminal narrowing moderate on the right and mild leftward was not appealed and has become final pursuant to Section 410.169.

DECISION

Reversed and remanded.

The parties stipulated that: (1) the claimant sustained a compensable injury on [date of injury]; (2) the Texas Department of Insurance, Division of Workers' Compensation (Division) appointed [Dr. A] as the designated doctor to address MMI and IR; (3) Dr. A certified that the claimant reached MMI on March 21, 2011, with five percent IR; (4) on July 22, 2010, [Dr. H] was initially appointed by the Division as the designated doctor to address MMI, IR, and the claimant's ability to return to work; and

(5) the carrier has accepted an [date of injury], compensable injury in the form of a lumbar sprain/strain.

The evidence establishes that Dr. H was initially appointed as the designated doctor with the subsequent appointment of Dr. A as the designated doctor on August 8, 2011.

There are two certifications of MMI and IR in evidence.

Dr. H, the first designated doctor, examined the claimant on April 25, 2011, and certified on May 4, 2011, that the claimant had not yet reached MMI, because the claimant was awaiting lumbar fusion surgery at the L5-S1 level, with no assignment of IR.

Dr. A, the second designated doctor, examined the claimant on August 26, 2011, and certified that the claimant reached MMI on March 21, 2011, after the last epidural steroid injection (ESI) was performed (with minimal relief) with five percent IR, 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) and placing the claimant in Diagnosis-Related Estimate (DRE) Lumbosacral Category II: Minor Impairment.

The hearing officer found that “[t]he March 21, 2011, date of MMI and [five percent] IR certified by [Dr. A] is contrary to the preponderance of the other medical evidence.” Further, the hearing officer found that “[r]ecover and material improvement could reasonably be anticipated in [the] [c]laimant’s lumbar spine compensable injury as a result of post-surgical recovery and medical care.”

The operative report dated November 23, 2011, is in evidence and states that the pre-operative and post-operative diagnosis is “[d]egenerative disc disease at L5-S1 with intractable back and some leg pain.”

The hearing officer in the Background Information section of her decision stated that “[i]n the instant case, [the] [c]laimant underwent a lumbar fusion which, from records in evidence, was pre-authorized. [The] [c]laimant has offered into evidence a medical opinion from his surgeon, [Dr. M], who stated that as of December 29, 2011, ‘[the claimant] is early in the post-operative phase after an anterior lumbar interbody fusion.’” The hearing officer’s Finding of Fact No. 6 states that “[r]ecover and material improvement could reasonably be anticipated in [the] [c]laimant’s lumbar spine compensable injury as a result of post-surgical recovery and medical care.”

The hearing officer determined that the claimed extent-of-injury conditions (which included the disc pathology at the L5-S1 level revealed by the lumbar MRI) were not part of the compensable injury of [date of injury]. The carrier contends in its appeal that the hearing officer erred in her MMI/IR determinations because she considered the November 23, 2011, surgery (anterior lumbar interbody fusion with placement of intervertebral fusion cage and anterior instrumentation at L5-S1), which was performed for a condition not part of the compensable injury and, furthermore, the hearing officer erred in not adopting the certification of MMI/IR by Dr. A for the compensable injury of lumbar sprain/strain.

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 in pertinent part that the assignment of an IR shall be based on the injured worker’s condition as of the MMI date considering the medical record and the certifying examination and 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 [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.

The evidence reflects that Dr. A examined the claimant on August 26, 2011, to address MMI and IR. The Report of Medical Evaluation (DWC-69) by Dr. A certifies that the claimant reached MMI on March 21, 2011, with five percent IR. In his narrative report attached to the DWC-69, Dr. A states under the section "Assessment" a history of facet syndrome, history of lower back pain, history of lumbosacral disc degeneration, and history of obesity but does not list in his narrative report, or on his DWC-69, a diagnosis for the claimant's compensable injury of [date of injury]. In his narrative report, Dr. A further states:

[The claimant] in my opinion reached MMI on March 21, 2011, after the last ESI injection with minimal relief. [The claimant] does not meet [Official Disability Guides (ODG)] indications for surgery. He had MRI done on May 24, 2010, that showed broad-based disc protrusion at L3-4, L5-S1 with bilateral neural foraminal narrowing. No unilateral muscle atrophy noted. No reported disc rupture or lateral recess stenosis reported. No evidence of radiculopathy or loss of structural integrity noted on physical examination, EMG or MRI. I will recommend continued pain management and exercises. [The claimant] meets a DRE Lumbosacral [C]ategory II minor impairment of [five percent] of a whole person impairment.

The March 21, 2011, date of MMI and five percent IR certified by Dr. A is contrary to the preponderance of the other medical evidence. Dr. A states he is certifying the claimant's MMI date based on the last ESI injection done on March 21, 2011, without explaining if ESI injections were treatment, based on reasonable medical probability, that further material recovery from or lasting improvement to a lumbar sprain/strain could be reasonably anticipated. Dr. A does not indicate in his narrative report that he considered the compensable injury of lumbar sprain/strain and excluded the claimed extent-of-injury conditions (which included L5-S1 disc pathology) determined by the hearing officer to not be part of the compensable injury. Furthermore, Dr. A does not provide objective findings, document, or analyze his clinical findings with the impairment criteria of the AMA Guides in placing the claimant in DRE Lumbosacral Category II: Minor Impairment as provided in Rule 130.1(c)(3). Therefore, Dr. A's certification of MMI/IR cannot be adopted.

The only other certification of MMI/IR in evidence is by Dr. H, which the hearing officer adopted. On his DWC-69, Dr. H provided the diagnosis codes for displacement of lumbar intervertebral disc disorder (IVD) without myelopathy, thoracic IVD with myelopathy, and lumbar sprain. Dr. H in his narrative report stated that the claimant

was not at MMI because “[the claimant] remains very symptomatic from his lower back injury. [The claimant] is awaiting approval for [Dr. HE] to perform lumbar fusion L5-S1.” Although not appointed to address extent of injury, Dr. H stated “[l]ower back pain. Exacerbation of underlying degenerative disc disease particularly L5-S1.”

The hearing officer erred in adopting Dr. H’s opinion that the claimant was not at MMI because Dr. H considered in part conditions determined by the hearing officer to not be part of the compensable injury. Further, in Finding of Fact No. 6, the hearing officer stated “[r]ecover and material improvement could reasonably be anticipated in [the] [c]laimant’s lumbar spine compensable injury as a result of post-surgical recovery and medical care.” The hearing officer determined that the claimant is not yet at MMI due to the lumbar fusion surgery at the L5-S1 level (disc pathology determined not part of the compensable injury and regardless of pre-authorization of the surgery) rather than based on a lumbar sprain/strain.

There is no other certification of MMI/IR in evidence that can be adopted.

Accordingly, we reverse the hearing officer’s determinations that since further improvement and material recovery can reasonably be anticipated, the claimant is not yet at MMI and since the claimant is not yet at MMI, there can be no IR at this time and remand the issues of MMI and IR to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

Dr. A is the designated doctor in this case. On remand, the hearing officer is to determine whether Dr. A is still qualified and available to be the designated doctor. If Dr. A is no longer qualified or available to serve as the designated doctor, then another designated doctor is to be appointed pursuant to Rule 127.5(c) to determine MMI and IR for the compensable injury of [date of injury], in the form of a lumbar sprain/strain.

The hearing officer is to advise the designated doctor that the compensable injury of [date of injury], includes a lumbar sprain/strain. The hearing officer is to advise the designated doctor that the compensable injury of [date of injury], does not extend to L3-4 1 mm disc bulge with slight effacement of ventral thecal sac, L4-5 1-2 mm disc bulge/protrusion which in the foraminal distributions contributes to mild foraminal narrowing with facets at this level thought mildly hypertrophic and (bulging disc) may abut the exiting nerve root in left lateral foraminal to far lateral distribution, and L5-S1 mild bilateral facet arthropathy with diffuse 3-4 mm disc bulge/protrusion with mild bilateral neural foraminal narrowing, slight inferior extension of protrusion in the midline, subtle annular rent noted within the posterior aspect of the annulus near the midline and foraminal narrowing moderate on the right and mild leftward.

The hearing officer is then to request the designated doctor to provide a certification of MMI and IR for the claimant's compensable injury. The assignment of an IR is required to be based on the claimant's condition as of the MMI date considering the medical record and the certifying examination and according to the rating criteria of the AMA Guides and the provisions of Rule 130.1(c)(3).

The parties are to be provided with the hearing officer's letter to the designated doctor and the designated doctor's response. The parties are to be allowed an opportunity to respond. The hearing officer is to determine the issues of MMI and IR consistent with this decision.

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 060721, decided June 12, 2006.

The true corporate name of the insurance carrier is **ACCIDENT FUND INSURANCE COMPANY OF AMERICA** and the name and address of its registered agent for service of process is

**CT CORPORATION SYSTEM
350 NORTH ST. PAUL STREET
DALLAS, TEXAS 75201.**

Cynthia A. Brown
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Margaret L. Turner
Appeals Judge

