

APPEAL NO. 142524
FILED FEBRUARY 02, 2015

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 May 29, 2014, with the record closing on November 3, 2014, in San Antonio, Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issue by determining that the respondent's (claimant) impairment rating (IR) is 24%. The appellant (carrier) appeals the hearing officer's determination, contending that the IR adopted by the hearing officer includes a rating for cervical radiculopathy that is not supported by the evidence. The appeal file does not contain a response from the claimant.

DECISION

Reversed and remanded.

The parties stipulated that: (1) the claimant sustained a compensable injury on [Date of Injury], that includes left shoulder impingement, cervical disc displacement without myelopathy, and cervical radiculopathy; (2) the claimant reached maximum medical improvement (MMI) on April 3, 2013; and (3) r (Dr. B) was appointed as the designated doctor for the issues of MMI and IR.

Section 408.125(c) provides that the report of the designated doctor shall have presumptive weight, and the Texas Department of Insurance, Division of Workers' Compensation (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.

The hearing officer determined that the claimant's IR is 24% in accordance with an amended certification by Dr. B, the Division-appointed designated doctor to address MMI and IR. Dr. B examined the claimant on March 27, 2012, and August 14, 2012, and certified that the claimant had not reached MMI after each of those exams. She subsequently examined the claimant on July 9, 2013, and certified that the claimant reached MMI on April 3, 2013, with a 15% 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). Dr. B placed the claimant in Diagnosis-Related Estimate (DRE) Cervicothoracic Category III: Radiculopathy for a 15% impairment, but she failed to rate the left shoulder impingement, a compensable condition as stipulated by the parties. Following two letters of clarification asking Dr. B to rate and provide range of motion (ROM) measurements for the left shoulder, Dr. B re-examined the claimant on February 20, 2014. Dr. B assigned a 10% impairment for the left shoulder impingement based on ROM measurements. She combined the 10% impairment for the left shoulder with the previously assigned 15% impairment for cervical radiculopathy and awarded a 24% IR, which was adopted by the hearing officer.

The carrier contends that Dr. B did not document any significant signs of radiculopathy in her narrative reports in order to rate radiculopathy under the AMA Guides. We agree.

On page 3/104 of the AMA Guides DRE Cervicothoracic Category III: Radiculopathy has the following description and verification:

Description and Verification: The patient has significant signs of radiculopathy, such as (1) loss of relevant reflexes or (2) unilateral atrophy with greater than a 2-cm decrease in circumference compared with the unaffected side, measured at the same distance above or below the elbow. The neurologic impairment may be verified by electrodiagnostic or other criteria (differentiators 2, 3, and 4, Table 71, p. 109).

Dr. B, in her narrative report dated July 9, 2013, only stated that the neurologic exam reveals equal deep tendon reflexes in the upper extremities, but she did not describe any decrease in the upper extremity reflexes. Dr. B concluded that the claimant's rating was obtained using a diagnosis of cervicothoracic radiculopathy. There is no documentation by Dr. B of loss of relevant reflexes or unilateral atrophy in any of her narrative reports.

In Appeals Panel Decision (APD) 030091-s, decided March 5, 2003, the Appeals Panel held that the AMA Guides indicate that to find radiculopathy, doctors must look to see if there is a loss of relevant reflexes or unilateral atrophy to find radiculopathy. The Appeals Panel went on to state that the findings of neurologic impairment may be verified by electrodiagnostic studies but the AMA Guides do not state that electrodiagnostic studies showing nerve root irritation, without loss of reflexes or atrophy, constitutes undeniable evidence of radiculopathy. See also APD 110382, decided May 5, 2011, and APD 072220-s, decided February 5, 2008.

To clarify, we note that there may be a diagnosis of radiculopathy and/or an administrative determination by the Division that the compensable injury extends to radiculopathy; however, in order to rate radiculopathy under the AMA Guides, it is necessary for the certifying doctor to identify and document the “significant signs of radiculopathy” as provided in the appropriate category and as provided in Table 71 on page 3/109, such as loss of relevant reflexes and/or unilateral atrophy of 2 cm or greater.

The hearing officer erred in adopting Dr. B’s IR of 24% that placed the claimant in DRE Cervicothoracic Category III: Radiculopathy. Therefore, we reverse the hearing officer’s determination that the claimant’s IR is 24%.

Dr. B’s assigned IR of 15% likewise cannot be adopted because she placed the claimant in DRE Cervicothoracic Category III for cervical radiculopathy without documentation of significant signs of radiculopathy. Additionally, Dr. B’s 15% IR fails to rate the left shoulder impingement, a compensable condition as stipulated by the parties.

There are also two certifications from Dr. B dated March 27, 2012, and August 14, 2012, that determine the claimant had not reached MMI. As the parties have stipulated that the claimant reached MMI on April 3, 2013, they are not adoptable.

In evidence is a narrative report from (Dr. BI), a required medical examination doctor. Dr. BI examined the claimant on October 7, 2014, and in a narrative report of the same date, he determined that the claimant reached MMI on April 3, 2013, with a 15% IR using the AMA Guides. Dr. BI placed the claimant in DRE Cervicothoracic Category II for a 5% impairment and assigned an additional 10% impairment for the left shoulder based on ROM measurements. However, there is no Report of Medical Evaluation (DWC-69) in evidence from Dr. BI. Therefore, his IR determination cannot be adopted. See Rule 130.1(d)(1).

Because there is no assigned IR that can be adopted, we remand the IR issue to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

Dr. B is the designated doctor. On remand, the hearing officer is to determine whether Dr. B is still qualified and available to be the designated doctor. If Dr. B is no longer qualified or available to serve as the designated doctor, then another designated doctor is to be appointed to determine the claimant’s IR for the compensable injury of [Date of Injury].

The hearing officer is to advise the designated doctor that the compensable injury of [Date of Injury], includes left shoulder impingement, cervical disc displacement without myelopathy, and cervical radiculopathy, as stipulated by the parties. Additionally, the hearing officer is to advise the designated doctor that in order to rate radiculopathy under the AMA Guides, it is necessary for the certifying doctor to identify and document the "significant signs of radiculopathy" as provided in the appropriate category and as provided in Table 71 on page 3/109, such as loss of relevant reflexes and/or unilateral atrophy of 2 cm or greater.

The hearing officer is then to request that the designated doctor assign an IR for the claimant's compensable injury of [Date of Injury], based on the claimant's condition as of April 3, 2013, the stipulated date of MMI, using the AMA Guides and considering the claimant's medical record and the certifying examination and in accordance with 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 then to make a determination on IR supported by the evidence and 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 **NEW HAMPSHIRE 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 78701-3232.**

Cristina Beceiro
Appeals Judge

CONCUR:

Carisa Space-Beam
Appeals Judge

Margaret L. Turner
Appeals Judge