APPEAL NO. 032336-s
FILED OCTOBER 27, 2003

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 30, 2003. The hearing officer resolved the disputed issue by deciding that the respondent's (claimant) impairment rating (IR) is 30% as reported by Dr. A, the designated doctor chosen by the Texas Workers' Compensation Commission (Commission). The appellant (carrier) appeals, contending that the claimant's IR is 10% as reported by Dr. C, a peer review doctor, and that the hearing officer erred in not addressing the extent of the compensable injury. No response was received from the claimant.

DECISION

Reversed and remanded.

The parties stipulated that the claimant sustained a compensable injury on ______________, and that he reached maximum medical improvement (MMI) on May 7, 2002. It is undisputed that 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) is the appropriate edition of the AMA Guides to use to assign an IR in this case. For a claim for workers' compensation benefits based on a compensable injury that occurs before June 17, 2001, Section 408.125(e) provides that if the designated doctor is chosen by the Commission, the report of the designated doctor shall have presumptive weight, and the Commission shall base the IR on that report unless the great weight of the other medical evidence is to the contrary.

It is undisputed that the claimant injured his low back while performing his job duties on _______________, and that he underwent a left L4-5 discectomy and a left L5-6 discectomy on July 13, 2001, as a result of his compensable injury (records reflect that the claimant has a "transitional vertebra numbered L6).

The carrier contends that the hearing officer erred in failing to resolve an issue on extent of injury, that being whether the claimant has cauda equina syndrome and, if so, whether it is related to the compensable injury, and also contends that the claimant failed to meet his burden of proof on that issue. The only disputed issue in the benefit review conference report and agreed to by the parties at the CCH was "what is the claimant's [IR]?" The carrier contended at the CCH that as a result of his compensable injury, the claimant has radiculopathy, and not cauda equina syndrome, and thus the peer review doctor's IR of 10% under Diagnosis-Related Estimates (DRE) Lumbosacral Category III: Radiculopathy, is correct and the designated doctor's 30% IR under DRE Lumbosacral Category VI: Cauda Equina-like Syndrome Without Bowel or Bladder Signs, is incorrect. The claimant contended that the designated doctor's IR is correct.

Under the particular facts of this case, where the only issue was the claimant's IR, it was undisputed that the claimant sustained a compensable low back injury, and the doctors were providing IRs for the low back injury, we do not view the case as being one involving a true extent-of-injury issue, rather it is a case involving a dispute as to which DRE category the claimant should be rated under. Consequently, we do not consider the hearing officer's failure to make an explicit fact finding on whether the claimant has cauda equina syndrome to be error.

DRE Lumbosacral Category VI: Cauda Equina-like Syndrome Without Bowel or Bladder Signs provides as follows:

> *Description and Verification*: Patients in this category have a cauda equina-like syndrome with objectively demonstrated, permanent, partial loss of lower-extremity function bilaterally. They may or may not have loss of motion segment integrity. They do *not* have objectively demonstrated bowel or bladder impairment.
>
> *Structural Inclusion*: None
>
> *Impairment*: 40% whole-person impairment.

An August 2000 EMG report, which was done before the claimant's July 2001 back surgery, assessed left S1 radiculopathy and findings suggestive of L5-S1 discogenic pain. A December 2001 EMG report, which was done after the claimant's surgery, noted an impression of electrodiagnostic evidence of chronic, resolving left L5-S1 radiculopathy.

The designated doctor examined the claimant on May 7, 2002, and determined that the claimant reached MMI on that date. The designated doctor reported that:

> Upon review of the medical records and physical examination, the examinee shows [sic] was surgically treated in the lumbar spine at L4/5 and L5/6 with residual cauda equina like syndrome in the left lower extremity without bladder or bowel problems. Based on Table 72, DRE Category VI, page 110, he is assigned a whole person impairment of 30% due to this condition.

In the neurological examination section of the report, the designated wrote:

> Neurological Exam: Neurological examination of the lower extremities revealed evidence of absent patellar and Achilies reflexes bilaterally. There is severe weakness of plantar flexion, especially on the left, with muscle strength of about 4/5 on the left gastrocnemius and muscle strength of about 4.5/5 on the right gastroc. There is inability of the examinee to walk on his heels as well with weakness of dorsiflexers on

> the left. The examinee has decreased pinprick sensation in the S1 dermatome on the left.

The designated doctor concluded the supplemental information portion of his report as follows:

> Date of MMI: It is my opinion that this examinee has, based on The Guides to the Evaluation of Permanent Impairment, Fourth Edition, reached MMI as of today, May 7, 2002 and has [IR] of 30%. This is according to Table 72, page 110 Category VI involves cauda equina like syndrome without bladder or bowel impairment. The maximum is 40%, but in view that this examinee has some involvement only on the left lower extremity with mild involvement of the right lower extremity, the impairment of 30% is awarded.

Dr. B reviewed the designated doctor's report, apparently at the carrier's request, and concluded that DRE "Category III" would be the appropriate category to rate the claimant's impairment and stated that the IR would be 15%. It appears that in evaluating the designated doctor's report and opining on the appropriate DRE category, Dr. B was referring to the criteria of the thoracolumbar spine DRE categories, and not the lumbosacral DRE categories. It appears that Dr. B did not examine the claimant.

The Commission sent Dr. B's report to the designated doctor who responded:

> Based on my extensive experience as a neurosurgeon, it is very clear that this individual has partial cauda equina syndrome. I awarded him a 30% whole person impairment from Table 72, DRE Category VI, page 110 and I stand by this assessment.

At the carrier's request, Dr. C reviewed the claimant's medical records as well as the designated doctor's report and opined that the claimant has a radiculopathy and should be placed in DRE Lumbosacral Category III for a 10% IR. Dr. C also opined that the claimant does not have cauda equina syndrome. Dr. C did not examine the claimant. Dr. C provided the same opinions in his testimony at the CCH. Dr. C also said that cauda equina syndrome is a bilateral condition with multilevel motor weakness, multilevel sensory loss, saddle anesthesia, and can include bowel or bladder incontinence.

The Commission sent Dr. C's report to the designated doctor who responded by stating that:

> The cauda equina is the bundle of nerves that originates at the conus medullaris of the lower spinal cord and innervates the lower extremities, as well as perineum, bladder, bowel, etc." It provides sensory and motor functions. When there is an injury to the cauda equina, there are several degrees. Severe is when there is paraplegia as a result of the injury to the

> cauda equina in which there is no motor function, no sensory function and no bowel or bladder function below the level of the lesion. There are milder degrees of cauda equina syndrome in which there is partial loss of the motor and sensory functions. It could be with or without bowel and bladder control. It could be with sensory deficit to the perineum or motor deficit and sensory deficit in the lower extremities. One extremity could be affected more than the other.

The designated doctor then noted his findings on physical examination of the claimant and stated:

> This means there are bilateral changes of weakness on both gastrocs right and left. There is inability of the examinee to walk on his heels, as well as weakness of dorsiflexors on the left. The examinee has decreased pinprick sensation S1 dermatome on the left. Therefore, based on the clinical fact that the patient does have weakness on both gastrocnemuis and his inability to do toe walking and his inability to do heel walking, that means he has weakness of his dorsiflexors of both feet, especially the left. Since the involvement is more severe on one side than the other and the claimant is still able to ambulate, although with difficulty, that is why I gave impairment of 30% whole person impairment as opposed to the full 40% from Table 72, DRE Category VI, page 110. I continue to stand by my appropriate assessment of this claimant.

Dr. C responded to the designated doctor's letter of clarification by stating that the evidence was not compatible with cauda equina-like syndrome, that there does not appear to be evidence that the claimant has permanent bilateral loss of lower extremity function, and that the documentation is commensurate with a left-sided radiculopathy. Dr. C also noted that the AMA Guides do not allow for a doctor to simply pick a number between two DRE categories in assigning an IR.

The Commission sent Dr. C's second report to the designated doctor who responded that he had based his opinion on the claimant's examination, review of the medical records, and his extensive experience as a neurosurgeon for 30 years, and that he stands by his assessment.

There are references in the testimony and in the exhibits to another doctor, who may have been a referral doctor, who assigned the claimant a 25% IR, however, that doctor's IR report is not in evidence.

The carrier points out in its appeal that the designated doctor assigned an IR that is not provided for in the AMA Guides because DRE Lumbosacral Category VI for cauda equina-like syndrome without bowel or bladder signs provides for a 40% IR. The carrier states that the designated doctor's "unilateral reduction" of the Category VI IR to 30% is tantamount to an admission that the claimant's condition does not warrant a rating under that category.

In Texas Workers' Compensation Commission Appeal No. 031133, decided June 12, 2003, the Appeals Panel disagreed with a designated doctor's opinion that he was permitted to interpolate between two DRE categories, specifically between DRE Lumbosacral Category III providing for a 10% IR and DRE Lumbosacral Category IV providing for a 20% IR, to arrive at a 15% IR. The Appeals Panel stated:

> Table 70 sets out certain qualitative criteria that must be met to place an examinee into each of the DRE categories. Unless the qualitative criteria are met for a DRE category, an examinee cannot be placed in that DRE category. Table 71 provides some additional criteria to assist the examiner in placing an examinee into the proper DRE category when it is unclear whether or not the examinee meets the qualitative criteria listed in Table 70. However, if an examinee clearly does not meet the qualitative criteria set out for a DRE category in Table 70, the examiner may not place the examinee in that DRE category. In the present case, it was undisputed that the claimant did not meet all the criteria set out for DRE Category IV. Dr. R [designated doctor] recognized that the claimant did not have loss of motion segment integrity. Absent meeting the criteria for Category IV, the examiner could not place the claimant in DRE Category IV or use the impairment value for DRE Category IV found in Table 72 to rate the claimant's impairment. *See* Texas Workers' Compensation Commission Appeal No. 022509-s, decided November 21, 2002.

In the case presently under consideration, the designated doctor did what the Appeals Panel rejected in Appeal No. 031133, that is, he chose an IR that is between the IRs provided for in the DRE categories. In other words, if the claimant meets the criteria for DRE Lumbosacral Category VI, the AMA Guides provide for assigning a 40% IR, not a 30% IR. We are unaware of any provision in the AMA Guides that would allow for an IR less than 40% to be assigned for a DRE Lumbosacral Category VI.

While we are well aware that the designated doctor has already been asked for clarification three times, we hesitate to simply render a decision that the claimant has a 40% IR given the designated doctor's obvious reluctance to assign more than a 30% IR to the claimant, and the fact that no doctor that has examined the claimant has assigned a 40% IR. We believe that the better course is to remand the case to the hearing officer for the hearing officer to inform the designated doctor that the Appeals Panel has decided that under the AMA Guides, if a doctor determines that an examinee meets the criteria to be placed in a particular DRE category, then the appropriate impairment percentage to be assigned to the examinee by the doctor for the spine region being rated is the impairment percentage set out in the AMA Guides for that particular DRE category. The designated doctor would then decide whether the claimant actually meets the criteria for DRE Lumbosacral Category VI as described on page 103 of the AMA Guides, and if he does so decide, then the IR to be assigned by the designated doctor would be 40%, not 30%. If the designated doctor were to determine that the claimant does not meet the criteria for DRE Lumbosacral Category VI, then the designated doctor would not rate the claimant under that DRE category, but would

determine what DRE category is applicable to the claimant's condition (*see* AMA Guides page 101 which provides that if the criteria of one impairment category cannot be met, then compare the findings in the patient with the criteria of other categories). If the designated does not comply with the AMA Guides in assigning the IR, the hearing officer may consider the appointment of a second designated doctor. *See* Texas Workers' Compensation Commission Appeal No. 030174, decided March 10, 2003. We note that the designated doctor has examined the claimant, but that the carrier peer review doctors have not examined the claimant. In Texas Workers' Compensation Commission Appeal No. 941640, decided January 13, 1995, the Appeals Panel stated:

> We believe that the 1989 Act and Commission rules contemplate that an injured employee's IR will be based on the IR of a doctor who has examined the employee, whether the doctor is a treating doctor, a designated doctor, or a doctor other than a treating doctor or designated doctor. Thus, when the great weight of the other medical evidence is contrary to the IR assigned by a designated doctor and the hearing officer adopts the IR of one of the other doctors under Section 408.125(e), the IR adopted should be based at least in part on the examination of the employee by the doctor who assigned the IR.

We reverse the hearing officer's decision that the claimant has a 30% IR and we remand the case to the hearing officer for the hearing officer to further consider and develop the evidence 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 Commission's Division of Hearings, pursuant to Section 410.202, as amended effective June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of time in which a request for appeal or a response must be filed.

The true corporate name of the insurance carrier is **AMERICAN ZURICH INSURANCE COMPANY** and the name and address of its registered agent for serviced of process is

GARY SUDOL
9330 LBJ FREEWAY SUITE 1200
DALLAS, TEXAS 75243.

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Robert W. Potts
Appeals Judge

CONCUR:

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Chris Cowan
Appeals Judge

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Edward Vilano
Appeals Judge