APPEAL NO. 051277
FILED AUGUST 1, 2005

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 May 9, 2005. The two disputed issues were the respondent's (claimant) impairment rating (IR) and entitlement to supplemental income benefits (SIBs) for the first quarter. The hearing officer resolved the disputed issues by deciding that the claimant's IR is 16% as reported by the second designated doctor, and that the claimant is not entitled to SIBs for the first quarter. The appellant (carrier) appeals the hearing officer's determination that the claimant's IR is 16%, contending that the claimant's IR is 5%. The claimant requests affirmance. There is no appeal of the hearing officer's determination that the claimant is not entitled to SIBs for the first quarter.

DECISION

Reversed and rendered.

The claimant testified that he injured his lower back lifting computer monitors on _____, and it is undisputed that the claimant sustained a compensable injury on _____. An initial medical record states that the claimant had low back pain radiating into the right leg, and that the claimant had previously had a fusion of L4-S1 in 1985. X-rays showed a solid fusion of L4-S1 and degenerative changes at L3-4. In February 2002, the claimant had electrodiagnostic testing (nerve conduction studies and electromyography (EMG)) done for his complaint of low back pain into the right leg and the report of that testing stated that there was no evidence of an acute motor radiculopathy affecting the right lower extremity or paraspinal muscles, and that the EMG was negative. In a report dated May 21, 2002, the doctor who was then treating the claimant reported that epidural steroid injections had not helped, that the claimant was still complaining of back and leg pain and was walking with a cane, that examination showed significant psychosocial overlay with positive Waddell findings, and that motor and sensory functions were intact. The doctor stated that he had nothing further to offer to the claimant that would be of benefit and that the claimant may be at maximum medical improvement (MMI).

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 4th edition) applies to this case. *See* Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.1(c)(2)(B) (Rule 130.1(c)(2)(B)). The first designated doctor appointed by the Texas Workers' Compensation Commission (Commission) examined the claimant on October 24, 2002, and in a Report of Medical Evaluation (TWCC-69) certified that the claimant reached MMI on May 21, 2002, with a 5% IR. The 5% IR was under Diagnosis-Related Estimate (DRE) Lumbosacral Category II: Minor Impairment. The first designated doctor reported that no IR was assigned for any mental health condition because the

documentation did not relate any such condition to the compensable injury, that lower extremity reflexes were normal and equal bilaterally, that there was no atrophy of the lower extremities, and that lower extremity motor functions were normal.

The Commission requested the first designated doctor to review a medical report from a chiropractor in November 2002, and in response to that request, the first designated doctor wrote that he found no reason in that report to amend his MMI/IR report. Various medical reports refer to the fact that the claimant had a lumbar spinal fusion at L3-4 on January 14, 2003, although the operative report is not in evidence. The Commission sent the L3-4 operative report to the first designated doctor for his review in February 2003, and in response, the first designated doctor wrote that the operative report would not change the IR. The Commission sent the first designated doctor additional medical records in September 2003, and in response, the first designated doctor wrote in September 2003, that the 5% IR would not change, but that because of the claimant's January 2003 L3-4 surgery, the MMI date would need to be amended. The first designated doctor noted that the Commission had informed him that the statutory date of MMI would be December 4, 2003, and that is the date he anticipated that the claimant would reach clinical MMI.

The Commission appointed a second designated doctor because the first designated doctor was not available to reexamine the claimant. In Texas Workers' Compensation Commission Appeal No. 042669-s, decided December 2, 2004, the Appeals Panel rendered a decision that the Commission properly appointed the second designated doctor.

The second designated doctor examined the claimant and in a TWCC-69 certified that the claimant reached statutory MMI with a 16% IR. The second designated doctor's report reflects that the claimant did not have atrophy, that lower extremity reflexes were normal, and that motor and sensory functions were normal. The second designated doctor stated an impression of lumbar post-laminectomy syndrome, erectile dysfunction, depression, and chronic pain. The second designated doctor stated as follows in the discussion section of his report:

> The patient is at statutory [MMI] since it has been two years from his initial injury. Therefore, I will give him an [IR]. Referring to Table 72 on page 110 of the [AMA Guides 4th edition], he is in the DRE Impairment Category III with evidence of radiculopathy and this results in a 10% impairment of the whole person. Secondarily, referring to page 4/142, Table 3, under Behavioral Disorders, he is in the Mild category with a range of 0 to 14%. I will give him a 7% for the behavioral disorder, which includes erectile dysfunction and depression. Then, combining the 10% and 7% in the back of the [AMA Guides], he has a combined whole person impairment of 16%.

The parties stipulated that the second designated doctor assigned the claimant a 16% IR.

In another TWCC-69, dated December 15, 2003, the second designated doctor certified that the claimant reached statutory MMI on December 4, 2003, with a 12% IR. In the narrative report attached to this TWCC-69 the second designated doctor noted that at this time he had all the records; that based on the review of the medical records and physical examination, he was assigning the claimant a 5% IR under DRE Lumbosacral Category II, because although the claimant had low back pain with radicular pain, he had "no clinical signs of radiculopathy." The second designated doctor added that the claimant has significant signs, symptoms, and a clinical history of depression and that in referring to Table 3 on page 4/142 (of the AMA Guides 4th edition), the claimant is in the mild category with a 7% IR for the behavioral disorder. The second designated doctor combined the 5% impairment with the 7% impairment for a 12% whole person IR.

A peer review doctor reviewed the second designated doctor's 16% IR report at the request of the carrier and wrote that the IR is not in accordance with the AMA Guides, explained his opinion, and noted that the claimant's IR should be 5% under DRE Lumbosacral Category II: Minor Impairment.

Apparently in response to a letter from the Commission, the second designated doctor wrote in March 2004, that:

> I have reviewed the chart once again on [claimant] and I do not wish to change my [IR]. I feel there is adequate documentation in the chart of the patient having a radiculopathy and depression.
>
> Once again, I do not wish to change my [IR], and if there are any questions, please call my office.

A carrier-selected required medical examination (RME) doctor evaluated the claimant on May 14, 2004, for MMI and IR. In a TWCC-69 dated May 14, 2004, the RME doctor certified that the claimant reached statutory MMI on December 4, 2003, with a 5% IR. The RME doctor assigned the claimant 5% impairment under DRE Lumbosacral Category II: Minor Impairment. The RME doctor stated that he found only differentiator 1 (Guarding) from Table 71 of the AMA Guides 4th edition present. With regard to the 10% impairment the second designated doctor assigned under DRE Lumbosacral Category III: Radiculopathy, the RME doctor stated:

> In specifically reviewing [second designated doctor's report], it is noted that he placed the claimant into the DRE Category III with evidence of radiculopathy. Based on this he assigned a 10% impairment. However, the claimant did not have any evidence of radiculopathy. Namely, this is loss of the relevant reflexes and atrophy of the extremity. The claimant however, did not have any of these findings and [second designated doctor] did not document any of these findings. When we review the actual narrative on page 101, we find that the DRE Category III states that the patient must have significant signs of radiculopathy such as loss of the

> relevant reflex or measured unilateral atrophy of greater than 2 cms above or below the knee. The claimant does not have any of these. Therefore, the claimant cannot be placed into the DRE Category III and as such the impairment for the lumbar spine assigned by [second designated doctor] is not accurate.

With regard to the 7% IR the second designated doctor assigned for behavioral disorder, the RME doctor stated:

> [Second designated doctor] also additionally assigned impairment for what he termed were "behavioral disorders." He referenced Table 3 on page 142. It would be incorrect to use this Table however, in this case, as this Table applies only to individuals who have behavioral disorders secondary to brain injury. In other words, it can only be used if there has been a head trauma. I would refer you to the narrative on page 140, Section 4.1 where the emotional or behavioral impairments used by [second designated doctor] are discussed as being represented of cerebral dysfunction resulting from disorders of the forebrain. Since this individual has not had this type of injury, the use of Table 3, page 142 would be inappropriate. Thus, the 7% assigned by [second designated doctor] for brain injury would not be applicable in this case.
>
> The claimant related subjective complaints of erectile dysfunction. However, this is not ratable unless there is objective documentation of such. The subjective complaints of such a problem are not ratable according to the AMA Guides.

Several reports from a doctor who treated the claimant in 2004 are in evidence and they note impressions of chronic intractable pain secondary to post-laminectomy syndrome, right leg radiculopathy, and depression/irritability.

Section 408.125(c) provides as follows:

> (c) 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. If the great weight of the medical evidence contradicts the [IR] contained in the report of the designated doctor chosen by the commission, the commission shall adopt the [IR] of one of the other doctors.

Rule 130.6(i) provides in pertinent part that the designated doctor's response to a commission request for clarification is considered to have presumptive weight as it is part of the doctor's opinion.

Rule 130.1(c)(1) provides that an IR is the percentage of permanent impairment of the whole body resulting from the current compensable injury. Rule 130.1(c)(2)

provides that a doctor who certifies that an injured employee has reached MMI shall assign an IR for the current compensable injury using the rating criteria contained in the appropriate edition of the AMA Guides.

The AMA Guides, Chapter 3, page 102, provides in pertinent part as follows:

DRE Lumbosacral Category III: Radiculopathy

> *Description and Verification*: The patient has significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of greater than 2 cm above or below the knee, compared to measurements on the contralateral side at the same location. The impairment may be verified by electrodiagnostic findings. See Table 71, p. 109, differentiators 2, 3, and 4.

The hearing officer determined that the 16% IR assigned by the second designated doctor was not contrary to the great weight of the other medical evidence and concluded that the claimant's IR is 16%. The carrier contends that there are no clinical findings by the second designated doctor, or by any other doctor, to support placing the claimant in DRE Lumbosacral Category III: Radiculopathy. In the instant case, in assigning the claimant a whole person IR of 16%, the second designated doctor improperly assigned the claimant 10% impairment utilizing DRE Lumbosacral Category III: Radiculopathy because there are no findings that the claimant has significant signs of radiculopathy, such as loss of relevant reflexes, or measured unilateral atrophy of greater than 2 cm above or below the knee, compared to measurements on the contralateral side at the same location. In addition, the electrodiagnositic testing was negative for radiculopathy. The second designated doctor himself reported in one report that the claimant has no clinical signs of radiculopathy and in another report noted that leg reflexes were normal and did not find any atrophy. Those findings are consistent with the RME doctor's findings of no significant signs of radiculopathy as provided by the AMA Guides 4th edition.

The extent of the compensable injury was not an issue. In the TWCC-69 in which a 16% whole person IR was assigned, the second designated doctor referenced both depression and erectile dysfunction in assessing a 7% impairment for behavioral disorders, but in the TWCC-69 in which a 12% whole person IR was assigned, the second designated doctor referenced only depression in rating the behavioral disorder. The designated doctor's TWCC-69 assigning a 16% IR cannot be adopted because the second designated doctor improperly assigned 10% impairment under DRE Lumbosacral Category III for radiculopathy when the great weight of the medical evidence reflects that the claimant did not have significant signs of radiculopathy as set forth in the AMA Guides 4th edition.

With regard to the 7% impairment the second designated doctor assigned the claimant for depression in the TWCC-69 in which he assigned a 12% IR, we note that Chapter 14 of the AMA Guides 4th edition, which is entitled "Mental and Behavioral

Disorders," does not provide impairment percentages for mental and behavioral disorders, and this is also true for Chapter 14 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing dated February 1989, published by the AMA (AMA Guides 3rd edition), which is also entitled "Mental and Behavioral Disorders." Chapter 4 of both the AMA Guides 3rd edition and the AMA Guides 4th edition is entitled "The Nervous System." In discussing mental and behavioral impairment under the AMA Guides 3rd edition, the Appeals Panel stated: "[t]he Appeals Panel has previously rejected the argument that the AMA Guides cannot be used to assess mental and emotional impairment, or that the Tables in Chapter 4 of the AMA Guides cannot be used to calculate impairment percentages." Texas Workers' Compensation Commission Appeal No. 960420, decided, April 11, 1996. In another decision involving the AMA Guides 3rd edition, the Appeals Panel determined that it was not improper for a designated doctor to look to Chapter 4 of the AMA Guides 3rd edition to assess a claimant's impairment for her psychological injury. Texas Workers' Compensation Commission Appeal No. 002007, decided October 10, 2000. As to whether an IR for depression can be given under the AMA Guides 4th edition, the Appeals Panel previously affirmed a determination in which a designated doctor assigned 15% impairment for depression under the AMA Guides 4th edition. Texas Workers' Compensation Commission Appeal No. 031423, decided July 24, 2003. We note that Chapter 4, page 142, of the AMA Guides 4th edition states that "[t]he criteria for evaluating these disturbances (Table 3, below) relate to the criteria for mental and behavioral impairments (Chapter 14, p. 291).

We recognize that the parties stipulated that the second designated doctor assigned the claimant a 16% IR. The 16% IR cannot be adopted because the great weight of the medical evidence reflects that the claimant does not have significant signs of radiculopathy and thus the assignment of a 10% impairment under DRE Lumbosacral Category III: Radiculopathy was not proper. However, as previously noted, in the CCH record is another TWCC-69 from the second designated doctor that assigns the claimant a 12% IR, consisting of 5% impairment under DRE Lumbosacral Category II: Minor Impairment, and 7% impairment for depression, and the 12% IR is not contrary to the great weight of the other medical evidence.

We reverse the hearing officer's decision that the claimant's IR is 16% and we render a new decision that the claimant's IR is 12%.

The true corporate name of the insurance carrier is **AMERICAN HOME ASSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
800 BRAZOS, SUITE 750, COMMODORE 1
AUSTIN, TEXAS 78701.

_____
Robert W. Potts
Appeals Judge

CONCUR:

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Thomas A. Knapp
Appeals Judge

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Margaret L. Turner
Appeals Judge