APPEAL NO. 131804
FILED OCTOBER 3, 2013

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 January 4, 2013, with the record closing on June 24, 2013, in [City], Texas, with [hearing officer] presiding as hearing officer. With regard to the five issues before her, the hearing officer determined that: (1) the compensable injury of [date of injury], extends to disc protrusions/"excursions" at L3-4 and L4-5, mild lumbar stenosis at L2-3, and bilateral nerve root and thecal sac compression (we note that the actual condition reported out of the Benefit Review Conference (BRC) report and agreed to by the parties was "extrusions," not "excursions" as identified by the hearing officer in the decision); (2) [Dr. K] was appointed as the designated doctor in accordance with Section 408.041 and 28 TEX. ADMIN. CODE § 127.5 (Rule 127.5); (3) the respondent/cross-appellant (claimant) reached maximum medical improvement (MMI) on June 18, 2011; (4) the claimant's impairment rating (IR) is 5%; and (5) the claimant had disability beginning June 19, 2011, and continuing through the date of the CCH.

The appellant/cross-respondent (carrier) appealed the hearing officer's extent-of-injury determination, contending that the evidence was insufficient to establish causation between the compensable injury and the extent-of-injury conditions found compensable by the hearing officer. The claimant cross-appealed the hearing officer's MMI/IR determination, contending that the evidence established he has not yet reached MMI. The claimant also cross-appealed the hearing officer's determination that Dr. K was appointed as the designated doctor in accordance with Section 408.041 and Rule 127.5, contending that Dr. K was not qualified to perform the MMI/IR examination because the carrier did not properly complete the Request for Designated Doctor Examination (DWC-32). The appeal file does not contain a response from the claimant to the carrier's appeal. The hearing officer's determination that the claimant sustained disability from June 19, 2011, and continuing through the date of the CCH has not been appealed and has become final pursuant to Section 410.169.

DECISION

Reformed in part, affirmed in part, and reversed and remanded in part.

The parties stipulated that the claimant sustained a compensable injury on [date of injury], at least in the form of a lumbar sprain/strain. The claimant testified that he injured his back when he slipped on ice and fell down a flight of stairs.

EXTENT OF INJURY

The hearing officer determined that the compensable injury extends to disc protrusions/"excursions" at L3-4 and L4-5. However, we note that the extent-of-injury issue reported out of the BRC report lists that condition as disc protrusions/extrusions at L3-4 and L4-5, and that the parties agreed to the extent-of-injury issue to include that condition. We therefore reform the hearing officer's decision to strike all references to protrusions/excursions at L3-4 and L4-5 to read protrusions/extrusions at L3-4 and L4-5.

The hearing officer's determination that the compensable injury extends to disc protrusions/extrusions at L3-4 and L4-5, mild lumbar stenosis at L2-3, and bilateral nerve root and thecal sac compression is supported by sufficient evidence and is affirmed.

DESIGNATED DOCTOR APPOINTMENT

The hearing officer's determination that Dr. K was appointed as the designated doctor in accordance with Section 408.041 and Rule 127.5 is supported by sufficient evidence and is affirmed.

MMI/IR

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 Texas Department of Insurance, Division of Workers' Compensation (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.

The hearing officer determined that the claimant reached MMI on June 18, 2011, with a 5% IR per Dr. K, the designated doctor.

Dr. K initially examined the claimant on June 18, 2011, and in a Report of Medical Evaluation (DWC-69) dated that same date, certified that the claimant reached clinical MMI on June 18, 2011, with a 5% IR. In his narrative report Dr. K stated that "I feel that [the claimant] has significant pathology in his lumbosacral spine, but most of

this is probably pre-existing." Dr. K stated that the claimant had been given adequate conservative therapy and treatment. Dr. K noted that the claimant had pain and spasm during the examination and "significant changes that are not related in his lumbosacral spine. Therefore, I do not see any surgery needed related to his work injury." Dr. K placed the claimant in Diagnosis-Related Estimate (DRE) Lumbosacral Category II: Minor Impairment for 5% impairment. We note that in evidence are operative reports dated May 12, 2011, and June 23, 2011, for a right L4 transforaminal epidural steroid injection. Also in evidence is an operative report dated September 20, 2011, for decompressive laminectomies at L2, L3, L4, and L5, and bilateral foraminotomies at L2-3, L3-4, and L4-5.

On January 22, 2013, the hearing officer sent Dr. K a letter of clarification asking him that, in the event the hearing officer finds the compensable injury extends to disc protrusions/extrusions at L3-4 and L4-5, lumbar stenosis at L2-3, and bilateral nerve root and thecal sac compression, would Dr. K's June 18, 2011, date of MMI and 5% IR change. Dr. K responded on March 22, 2013, stating:

> It would change the date of the impairment and that would add on; but, to say, it would be hard without evaluating the percentages if he did have these included. . . . So my answer to the question is yes, it will change, but I cannot give you a day and I cannot give you an [IR].

Dr. K reexamined the claimant on March 23, 2013, and in a DWC-69 and narrative report again certified that the claimant reached clinical MMI on June 18, 2011, with a 5% IR. Dr. K noted that the claimant had had surgery on his lower back about four or five days after the June 18, 2011, examination and that according to the claimant "the pain went from 10/10 to almost nothing, 1/10." Dr. K stated that "[s]ince I find nothing different other than what I saw on [June 18, 2011], I have to opine that [the claimant] had been at [MMI] from the injury as of that date and an [IR] of 5% whole person impairment." We note that Dr. K did not include measurements or objective clinical findings to support his 5% IR.

Rule 130.1(c)(3) provides in pertinent part that the assignment of an IR shall be based on the injured employee'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;
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> (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 [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)]. The doctor's inability to obtain required measurements must be explained.

In this case, Dr. K failed to comply with the requirements of Rule 130.1(c)(3) because he did not include any information in his narrative report to establish how he arrived at his assessment of impairment for the claimant's compensable injury. *See* Appeals Panel Decision (APD) 111924, decided February 22, 2012. Furthermore, we note that Dr. K does not discuss or mention what diagnoses he considered and rated in his certification of MMI and IR. We reverse the hearing officer's determination that the claimant reached MMI on June 18, 2011, with a 5% IR.

There are two other MMI/IR certifications in evidence. The first is from [Dr. M], a doctor selected by the treating doctor to act in the treating doctor's place. Dr. M examined the claimant on September 5, 2012, and in a DWC-69 dated that same date, certified that the claimant reached MMI on January 8, 2012, with a 10% IR. In an attached narrative report, Dr. M listed diagnoses of lumbar strain/sprain and lumbar radiculopathy. Dr. M placed the claimant in DRE Lumbosacral Category III: Radiculopathy for 10% impairment "[b]ased on his exam today which demonstrated minor neurologic impairment and a mild right sided atrophy. . . ." Dr. M noted that "it would be useful to have electrodiagnostic studies which have been recommended but not obtained. . . ."

In 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. 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; APD 072220-s, decided February 5, 2008. Dr. M's MMI/IR certification is not adoptable because the clinical findings do not support a DRE Lumbosacral Category III: Radiculopathy.

The only other MMI/IR certification in evidence is from [Dr. Ka], the post-designated doctor required medical examination doctor. Dr. Ka examined the claimant on September 14, 2012, and in a DWC-69 dated September 25, 2012, certified that the claimant reached clinical MMI on June 18, 2011, with a 5% IR. Dr. Ka noted in his narrative report that "the carrier accepted as compensable only lumbar strain and disputed all other diagnoses as being unrelated to the compensable injury," and listed impressions of "[s]tatus post lumbar sprain/strain evolving into chronic pain syndrome with no objective findings of radiculopathy" and "[s]tatus post decompressive laminectomy at L2, L3, L4, and L5 with bilateral foraminotomies at L2-3, L3-4, and L4-5. . . ." Dr. Ka stated that he agreed with the MMI date of June 18, 2011, as certified by Dr. K, the designated doctor, and noted that the documentation supported that the compensable injury resulted in lumbar sprain/strain. Dr. Ka placed the claimant in DRE Lumbosacral Category II: Minor Impairment for 5% impairment. Dr. Ka makes clear in his narrative report that he did not consider and rate the extent-of-injury conditions found compensable by the hearing officer and affirmed in this decision, and as such his MMI/IR certification cannot be adopted. *See* APD 110267, decided April 19, 2011, and APD 043168, decided January 20, 2005.

As there is no MMI/IR certification in evidence that can be adopted, we remand the issues of MMI and IR to the hearing officer for further action consistent with this decision.

SUMMARY

We reform the hearing officer's decision to strike all references to protrusions/excursions at L3-4 and L4-5 to read protrusions/extrusions at L3-4 and L4-5.

We affirm the hearing officer's determination that the compensable injury extends to disc protrusions/extrusions at L3-4 and L4-5, mild lumbar stenosis at L2-3, and bilateral nerve root and thecal sac compression.

We affirm the hearing officer's determination that Dr. K was appointed as the designated doctor in accordance with Section 408.041 and Rule 127.5.

We reverse the hearing officer's determination that the claimant reached MMI on June 18, 2011, with a 5% IR, and we remand the issues of MMI and IR to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

Dr. K is the designated doctor in this case. On remand, the hearing officer is to determine whether Dr. K is still qualified and available to be the designated doctor. If Dr. K 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 MMI and IR for the [date of injury], compensable injury.

The hearing officer is also to take a stipulation from the parties on the date of statutory MMI. If the parties are unable to stipulate to the date of statutory MMI, the hearing officer is to make a determination of the date of statutory MMI. The hearing officer is to advise the designated doctor that the compensable injury extends to lumbar sprain/strain as stipulated to by the parties, as well as disc protrusions/extrusions at L3-4 and L4-5, mild lumbar stenosis at L2-3, and bilateral nerve root and thecal sac compression as administratively determined. The hearing officer is also to advise the designated doctor the date of statutory MMI. The hearing officer is to request the designated doctor to give an opinion on the claimant's date of MMI and rate the entire compensable injury in accordance with the AMA Guides considering the medical records and the certifying examination.

The parties are to be provided with the designated doctor's new MMI/IR certification and are to be allowed an opportunity to respond. The hearing officer is then to make a determination on 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 **EMPLOYERS ASSURANCE 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.

Carisa Space-Beam
Appeals Judge

CONCUR:

Veronica L. Ruberto
Appeals Judge

Margaret L. Turner
Appeals Judge