APPEAL NO. 132851
FILED FEBRUARY 12, 2014

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 September 30, 2013, in [City 1], 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 lumbosacral neuritis/radiculopathy, lumbar facet arthropathy, L4-5 disc bulge with desiccation, and right foraminal disc herniation at L5-S1; (2) the appellant (claimant) reached maximum medical improvement (MMI) on October 25, 2012; (3) the claimant's impairment rating (IR) is five percent; and (4) the claimant had disability from March 10, 2012, and continuing through the date of the CCH on September 30, 2012.

The claimant appealed the hearing officer's extent-of-injury determination, arguing that the evidence established the compensability of the claimed conditions. The claimant also appealed the hearing officer's MMI and IR determinations, arguing that the MMI/IR certification adopted by the hearing officer is defective because the MMI/IR certification is contradictory as to whether the certifying doctor gave a rating for radiculopathy, and because it did not include a range of motion (ROM) worksheet referenced in the narrative report. The appeal file does not contain a response from the respondent (carrier) to the claimant's appeal.

The hearing officer's determination that the claimant had disability from March 10, 2012, and continuing through the date of the CCH on September 30, 2012, has not been appealed. The date of the CCH was September 30, 2013. The hearing officer found in Finding of Fact No. 5 that from March 10, 2012, and continuing through the date of the CCH on September 30, 2013, the claimant was unable to obtain and retain employment at wages equivalent to his preinjury wage as a result of the [date of injury], compensable injury. However, the hearing officer determined that the claimant sustained disability from March 10, 2012, and continuing through September 30, 2012. Pursuant to Section 410.206, the Texas Department of Insurance, Division of Workers' Compensation (Division) may revise a decision in a CCH on a finding of clerical error. The hearing officer's disability determination presents such a clerical error. Therefore, we revise the hearing officer's decision to reflect that the claimant had disability from March 10, 2012, and continuing through the date of the CCH on September 30, 2013. Because the hearing officer's disability has not been appealed, this determination, as revised, has become final pursuant to Section 410.169.

DECISION

Affirmed in part and reversed and remanded in part.

The parties stipulated that the claimant sustained a compensable lumbar contusion and lumbar sprain/strain injury on [date of injury], and that [Dr. C] was appointed as the designated doctor by the Division to determine MMI and IR. The claimant testified he was injured after falling backwards and landing on his back on pointed iron while making a mold on the date of injury.

EXTENT OF INJURY

The hearing officer's determination that the compensable injury of [date of injury], does not extend to lumbosacral neuritis/radiculopathy, lumbar facet arthropathy, L4-5 disc bulge with desiccation, and right foraminal disc herniation at L5-S1 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 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 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 reached MMI on October 25, 2012, with a five percent IR per Dr. C, the designated doctor.

Dr. C examined the claimant on February 8, 2013, and certified that the claimant reached MMI on October 25, 2012, with a five percent IR. In an attached narrative report Dr. C noted a diagnosis of lumbar radiculopathy. Dr. C placed the claimant in Diagnosis-Related Estimate Lumbosacral Category II: Minor Impairment. Dr. C stated that the claimant's IR was based on his injury to his lumbar spine, and that the claimant had symptoms of radiculopathy but no objective evidence of atrophy. However, we

have affirmed the hearing officer's determination that the compensable injury does not extend to lumbosacral radiculopathy. Dr. C has considered a condition that has been determined not to be a part of the compensable injury. *See* Appeals Panel Decision (APD) 110463, decided June 13, 2011, and APD 101567, decided December 20, 2010. Additionally, Dr. C did not discuss in his narrative report a lumbar contusion or a lumbar sprain/strain, which are conditions accepted by the carrier, and therefore Dr. C did not consider the entire compensable injury. Accordingly, we reverse the hearing officer's determination that the claimant reached MMI on October 25, 2012, with a five percent IR.

The claimant also argued that Dr. C did not receive all of the medical records prior to his examination. In Dr. C's narrative February 8, 2013, Dr. C stated that "[the] [c]laimant was apparently seen at [Hospital] E.R. in [City 2] though no medical records were provided."

Section 408.0041(c) provides in pertinent part that the treating doctor and the insurance carrier are both responsible for sending to the designated doctor all of the injured employee's medical records relating to the issue to be evaluated by the designated doctor that are in their possession.

Rule 127.10(a)(1) provides in pertinent part that the treating doctor and insurance carrier shall provide to the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor. Rule 127.10(a)(3) provides in pertinent part that the treating doctor and the insurance carrier shall ensure that the required records and analyses, if any, are received by the designated doctor no later than three working days prior to the date of the designated doctor examination, and if the designated doctor has not received the medical records or any part thereof at least three working days prior to the examination, the designated doctor shall report this violation to the Division within one working day of not timely receiving the records.

Rule 127.10(b) provides that before examining an injured employee, the designated doctor shall review the injured employee's medical records, including any analysis of the injured employee's medical condition, functional abilities and return to work opportunities provided by the insurance carrier and treating doctor in accordance with subsection (a) of this section, and any materials submitted to the doctor by the Division. Rule 127.10(b) further provides that the designated doctor shall also review the injured employee's medical condition and history as provided by the injured employee, any medical records provided by the injured employee, and shall perform a complete physical examination of the injured employee. The designated doctor shall

give the medical records reviewed the weight the designated doctor determines to be appropriate.

The evidence established that Dr. C did not have all of the claimant's medical records for his examination before making a determination on MMI and IR, the issues Dr. C was appointed to determine. *See* APD 132258, decided November 20, 2013. This is another reason why Dr. C's MMI/IR certification cannot be adopted.

There is one other MMI/IR certification in evidence, which is also from Dr. C. Dr. C initially examined the claimant on August 9, 2012, and certified that the claimant had not reached MMI but was expected to do so on or about November 9, 2012. In an attached narrative report Dr. C noted that the claimant had clinical and radiological evidence of radiculopathy and was pending surgical consultation. However, as discussed above, the hearing officer's determination that the compensable injury does not extend to lumbosacral radiculopathy has been affirmed. Additionally, Dr. C did not discuss in his narrative report a lumbar contusion or a lumbar sprain/strain, which are conditions accepted by the carrier, and therefore Dr. C did not consider the entire compensable injury. We also note, as argued by the claimant, that Dr. C's August 9, 2012, narrative report also states that "[the] [c]laimant was apparently seen at [Hospital] E.R. in [City 2] though no medical records were provided." The evidence established that Dr. C did not have all of the claimant's medical records for his examination. For these reasons, Dr. C's certification that the claimant has not reached MMI cannot be adopted.

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

SUMMARY

We affirm the hearing officer's determination that the compensable injury of [date of injury], does not extend to lumbosacral neuritis/radiculopathy, lumbar facet arthropathy, L4-5 disc bulge with desiccation, and right foraminal disc herniation at L5-S1.

We reverse the hearing officer's determinations that the claimant reached MMI on October 25, 2012, with a five percent IR, and we remand the issues of MMI and IR to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

Dr. C is the designated doctor in this case. On remand, the hearing officer is to determine whether Dr. C is still qualified and available to be the designated doctor. If Dr. C 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 the claimant's MMI and IR.

The hearing officer is to advise the designated doctor that the compensable injury extends to lumbar contusion and lumbar sprain/strain as stipulated to by the parties. The hearing officer is also to advise the designated doctor that the compensable injury does not extend to lumbosacral neuritis/radiculopathy, lumbar facet arthropathy, L4-5 disc bulge with desiccation, and right foraminal disc herniation at L5-S1 as administratively determined. The hearing officer is then to request the designated doctor to give an opinion on the claimant's MMI and rate the entire compensable injury, in accordance with 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) considering the medical record and the certifying examination.

On remand, the hearing officer should ensure that the treating doctor and the carrier shall send to the designated doctor all of the claimant's medical records that are in their possession relating to the issues to be evaluated by the designated doctor, which is MMI and IR.

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 MMI and IR that is supported by the evidence.

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 **THE INSURANCE COMPANY OF THE STATE OF PENNSYLVANIA** 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 78701-3218.

Carisa Space-Beam
Appeals Judge

CONCUR:

Cristina Beceiro
Appeals Judge

Margaret L. Turner
Appeals Judge