APPEAL NO. 132911
FILED FEBRUARY 18, 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 was held on October 25, 2013, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that: (1) the first certification of maximum medical improvement (MMI) and assigned impairment rating (IR) from [Dr. O] on March 21, 2013, did not become final under Section 408.123 and 28 TEX. ADMIN. CODE § 130.12 (Rule 130.12); (2) the respondent (claimant) reached MMI on November 19, 2012; and (3) the claimant's IR is 32%. The appellant (self-insured) appeals the hearing officer's determination of the MMI date and IR of 32%, contending that the certification from Dr. O is not adoptable as a matter of law. The self-insured argues that Dr. O failed to follow 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 appeal file does not contain a response from the claimant. The hearing officer's determination that the first certification of MMI and assigned IR from Dr. O on March 21, 2013, did not become final under Section 408.123 and Rule 130.12 was not appealed and has become final pursuant to Section 410.169.

DECISION

Affirmed in part and reversed and remanded in part.

The parties stipulated that on [date of injury], the claimant sustained a compensable injury and that Dr. O was appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) as the designated doctor for MMI and IR. The medical reports in evidence reflect that the claimant was injured when lifting milk cartons. The claimant testified that she injured her right shoulder, left ankle, and cervical spine. On March 12, 2012, the claimant underwent an anterior cervical diskectomy and fusion at C5-6 and C6-7.

MMI

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.

Dr. O examined the claimant on March 21, 2013, and stated in his narrative report that it appeared the claimant had reached a plateau in her recovery and that the last date of physical therapy was on October 16, 2012. Dr. O further states the claimant was released by her treating doctor and surgeon on November 19, 2012. Dr. O certified that the claimant reached MMI on November 19, 2012. The hearing officer found in part that the preponderance of the other medical evidence is not contrary to the designated doctor's opinion on MMI. That portion of the hearing officer's finding is supported by sufficient evidence and is affirmed. We affirm the hearing officer's determination that the claimant reached MMI on November 19, 2012.

IR

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. 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 record indicates that the designated doctor examined the claimant on March 21, 2013, and certified that the claimant reached MMI on November 19, 2012, and assigned a 32% IR, using the AMA Guides. Dr. O assessed 0% impairment for the claimant's left ankle, finding no range of motion (ROM) deficits; 9% impairment for the claimant's right shoulder, based on ROM deficits; and 25% impairment for the claimant's cervical spine, placing the claimant in Diagnosis-Related Estimate (DRE) Cervicothoracic Category IV: Loss of Motion Segment Integrity or Multilevel Neurologic Compromise.

Dr. O assessed 9% impairment for the claimant's right shoulder based on the following ROM measurements, after rounding to the nearest 10°: flexion 110° (5% upper extremity (UE) impairment); extension 35° (1% UE impairment); abduction 100° (4% UE impairment); adduction 30° (1% UE impairment); internal rotation 25° (4% UE impairment); external rotation 30° (1% UE impairment). Dr. O stated the ROM deficits combined to a total whole person impairment of 15% UE, which converts to 9% whole person.

We note that the AMA Guides provide on page 3/45 that to determine impairments due to abnormal motions of the shoulder joint you should first determine the impairments of the UE that are contributed by abnormal shoulder motions including flexion and extension, abduction and adduction, and internal and external rotation. The

AMA Guides further provide that because the relative value of each shoulder functional unit has been taken into consideration in the impairment charts, the impairment values for loss of each shoulder motion are added to determine the impairment of the UE. Adding the ROM measurements obtained by Dr. O results in 16% UE rather than the 15% UE impairment Dr. O assessed because he combined the measurements. Converting 16% UE impairment results in 10% whole person impairment rather than 9% whole person impairment assessed by Dr. O.

Dr. O assessed 25% impairment for the claimant's cervical spine placing the claimant in DRE Cervicothoracic Category IV based on loss of ROM of the cervical spine.

Dr. O stated in his narrative report that the claimant did not specifically meet the criteria for DRE Cervicothoracic Categories II, III, or IV. Dr. O noted that the claimant does not meet the criteria for DRE Cervicothoracic Category II: Minor Impairment, because due to the surgical procedure, she will be subject to accelerated degenerative disc and joint processes, life-long losses of her ranges of motion, compromise in her ability to seek certain types of potential gainful employment, prolonged and continuing pain and adverse residual effects, and other such adverse affects. Dr. O stated the claimant does not fit into DRE Cervicothoracic Category III: Radiculopathy, because she does not meet the criteria of greater than 2.0 cm of atrophy or a loss of the relevant reflex. Dr. O further stated the claimant does not fit into DRE Cervicothoracic Category IV: Loss of Motion Segment Integrity or Multilevel Neurologic Compromise, because she does not have more than 3.5 mm/5.0 mm of vertebral translation or bilateral or multi-level radiculopathy. There is no indication in his report that Dr. O was contemplating which of two or more DRE categories to place the claimant in based on his clinical findings of no radiculopathy or loss of motion segment integrity.

In Appeals Panel Decision (APD) 030288-s, decided March 18, 2003, the Appeals Panel held that although there are instances when the ROM Model may be used, such as if none of the categories of the DRE Model are applicable, the use of the DRE Model is not optional and is to be used unless there is a specific explanation why it cannot be used. In that case, the Appeals Panel referenced the AMA Guides on page 3/94 that states "[t]he evaluator assessing the spine should use the [DRE Model], if the patient's condition is one of those listed in Table 70 ([page]108)." The Appeals Panel also referenced page 3/112 that states the "[ROM] Model should be used only if the [DRE] Model is not applicable, or if more clinical data on the spine are needed to categorize the individual's spine impairment." The Appeals Panel held that unless there is a specific explanation why the DRE Model cannot be used, a comment that the evaluator merely prefers to use the model that he or she feels is most appropriate is insufficient justification for not using the DRE Model.

The AMA Guides on page 3/100 state that the Injury Model "relies especially on evidence of neurologic deficits and uncommon, adverse structural changes, such as fractures, dislocations, and loss of motion segment integrity. Under this model, DREs are differentiated according to clinical findings that are verifiable using standard medical procedures."

In APD 022509-s, decided November 21, 2002, the Appeals Panel explained when the ROM Model may also be used as a differentiator. That case referenced the AMA Guides on page 3/99 that stated:

> If the physician cannot decide into which DRE category the patient belongs, the physician may refer to and use the ROM Model, which is described in Section 3.3j [p.112]. Using the procedures of that model, the physician combines an impairment percent based on the patient's diagnosis with a percent based on the patient's spine motion impairment and a percent based on neurologic impairment, if it is present. The physician uses the estimate determined with the ROM Model to decide placement within one of the DRE categories. The proper DRE category is the one having the impairment percent that is closest to the impairment percent determined with the ROM Model.

In APD 042543, decided December 2, 2004, the Appeals Panel stated that simply because the claimant had spinal surgery was not sufficient justification for using the ROM Model rather than the DRE Model. In that case, the designated doctor stated, "'there was no DRE category that specifically addresses spinal surgery post injury. However, the ROM Model specifically rates spinal surgery.'" The Appeals Panel stated that "'[i]t is clear from his response, that the designated doctor did not use the DRE Model to assess impairment not because of any factor specific to the claimant's condition and treatment but simply because he had spinal surgery." Spinal surgery in and of itself is not an appropriate reason to use the ROM Model to assess an impairment. In this case, the only justification provided by Dr. O for placing the claimant in DRE Cervicothoracic Category IV was that because of the claimant's spinal surgery, he anticipated that she will have problems in the future and was not based on her actual physical condition as of the MMI date. It is clear from Dr. O's report that he did not use the ROM Model as a differentiator as provided by the AMA Guides, but rather he placed the claimant in a DRE category that was in closest proximity to the 20% IR she would have received under the ROM Model. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 32%.

The only other certification in evidence with the affirmed MMI date of November 19, 2012, is from [Dr. B], the claimant's treating doctor. Dr. B examined the claimant on

November 19, 2012, and certified that the claimant reached MMI on that date and did not have any permanent impairment as a result of the compensable injury. Although there is a medical report from Dr. B dated November 19, 2012, it does not document specific laboratory or clinical findings or even identify the specific conditions considered in assessing no impairment nor does it discuss the two level cervical fusion the claimant underwent on March 12, 2012. The certification from Dr. B that the claimant did not have any permanent impairment as a result of the compensable injury cannot be adopted.

There is another certification from Dr. B in evidence that certifies the claimant reached MMI on November 13, 2012, with no permanent impairment. There is no narrative attached to the certification that specifies the conditions considered in the assessing no permanent impairment and there is no documentation of any specific laboratory or clinical findings to support the assessment of no permanent impairment. As previously noted, the hearing officer's determination that the claimant reached MMI on November 19, 2012, has been affirmed. Accordingly, the certification from Dr. B that the claimant reached MMI on November 13, 2012, with no permanent impairment cannot be adopted.

There is a certification from [Dr. Os] in evidence, the self-insured-selected required medical examination doctor. Dr. Os examined the claimant on June 18, 2013, and certified that the claimant reached MMI on November 13, 2012, with a 7% IR. However, as previously noted, the hearing officer's determination that the claimant reached MMI on November 19, 2012, has been affirmed. Accordingly, the certification from Dr. Os that the claimant reached MMI on November 13, 2012, with a 7% IR cannot be adopted.

There is no other certification in evidence. Accordingly, we remand the IR issue to the hearing officer for further action consistent with this decision.

SUMMARY

We affirm the hearing officer's determination that the claimant reached MMI on November 19, 2012.

We reverse the hearing officer's determination that the claimant's IR is 32% and remand the IR issue to the hearing officer for further action consistent with this decision.

REMAND INSTRUCTIONS

Dr. O is the designated doctor in this case. On remand, the hearing officer is to determine whether Dr. O is still qualified and available to be the designated doctor. If

Dr. O 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 it has been administratively determined that the claimant reached MMI on November 19, 2012. The hearing officer is to request that the designated doctor rate the entire compensable injury in accordance with the AMA Guides based on the claimant's conditions as of the date of MMI (November 19, 2012), considering the medical record, the certifying examination and the rating criteria in the AMA Guides, which includes pages 3/45 and 3/101. 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.

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 **(a self-insured governmental entity)** and the name and address of its registered agent for service of process is

SUPERINTENDENT
[ADDRESS]
[CITY], TEXAS [ZIP CODE].

Margaret L. Turner
Appeals Judge

CONCUR:

Cristina Beceiro
Appeals Judge

Carisa Space-Beam
Appeals Judge