APPEAL NO. 022509-s
FILED NOVEMBER 21, 2002

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 5, 2002. The hearing officer resolved the disputed issue by deciding that the respondent's (claimant) impairment rating (IR) is 25% as certified by the designated doctor chosen by the Texas Workers' Compensation Commission (Commission). The appellant (self-insured) appealed and the claimant responded.

DECISION

The hearing officer's decision is reversed and the case is remanded to the hearing officer.

It is undisputed that the claimant sustained a compensable back injury on _____, and 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 determine the claimant's IR (all page number references are to the AMA Guides, fourth edition, 4th printing October 1999). The only issue at the CCH was the claimant's IR. The benefit review conference (BRC) report states that "the parties do not dispute maximum medical improvement [MMI] was reached on January 4, 2002." The hearing officer did not ask for a stipulation on MMI and the parties did not stipulate as to MMI at the CCH.

As a result of his compensable injury, the claimant had surgery performed in April 2001. The preoperative and postoperative diagnoses were disc herniation at L4-5, spinal stenosis at L4-5, lumbosacral radiculities, and degenerative joint disease. The operative procedure was a lumbar decompression of L4-5, including decompression of the L4 and L5 roots bilaterally, and a posterior and anterior fusion at L4-5, with instrumentation. Lumbar spine x-rays were taken on March 14, 2000, the day after the claimant's injury, and a doctor noted that those x-rays did not show gross bony abnormality, with the exception of some baseline osteopenia. The claimant underwent a myelogram, CT scan, and discogram prior to his surgery and those tests demonstrated a herniated disc at L4-5. Lumbar spine x-rays were taken after the claimant's surgery, and the surgeon reported that they did not show hardware failure.

On January 4, 2002, the claimant underwent a required medical examination (RME) by a doctor at the self-insured's request and the RME doctor certified that the claimant reached MMI on January 4, 2002, with a 10% IR under Table 72, DRE (Diagnosis-Related Estimates) lumbosacral spine impairment category III, which is described in Table 72 as "radiculopathy; evidence of radiculopathy is present."

The designated doctor chosen by the Commission examined the claimant on March 4, 2002, and certified that the claimant reached MMI on March 4, 2002, with a 25% IR under DRE lumbosacral category V, which is described in Table 72 as "Radiculopathy and loss of motion segment integrity."

The self-insured's RME doctor reexamined the claimant on May 3, 2002, and again certified that the claimant reached MMI on January 4, 2002, with a 10% IR under DRE lumbosacral category III.

The self-insured had three peer review doctors review the designated doctor's report. Two of those doctors opined that DRE lumbosacral category III (10% IR) was the appropriate impairment category for rating the claimant's impairment, and one doctor opined that, at most, the claimant's IR would be 10%.

The carrier's RME doctor and the carrier's three peer review doctors were of the opinion that there were no lumbar flexion and extension x-rays to document loss of motion segment integrity and thus the claimant would not qualify for impairment under lumbosacral categories IV or V.

The self-insured asked the Commission to write to the designated doctor and to attach to the letter a report from the RME doctor and a report from one of the peer review doctors. Apparently the Commission wrote to the designated doctor, but that letter is not in evidence. The designated doctor provided a written response, in which he concluded that the 25% IR under lumbosacral category V is accurate.

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, and that, 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. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.6(i) (Rule 130.6(i)) provides in part that the designated doctor shall respond to any Commission requests for clarification not later than the fifth working day after the date on which the doctor receives the Commission's request, and that the doctor's response is considered to have presumptive weight as it is part of the doctor's opinion. Rule 130.1(c)(3) provides:

> (3) Assignment of an [IR] for the current compenable injury must be based on the employee's medical record and the certifying examination. The doctor assigning the [IR] shall:
>
> (A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury;
>
> (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 the specific clinical findings related to each impairment, including zero percent (0%) [IRs]; and

(ii) A description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained.

The hearing officer determined that the designated doctor's IR certification of 25% had not been overcome by the great weight of contrary medical evidence and that the claimant has a 25% IR as a result of his compensable injury. The self-insured appeals, contending that there is insufficient evidence to support the designated doctor's determination that the claimant has loss of motion segment integrity; that if the designated doctor used the Range of Motion (ROM) Model as a differentiator, he did not do it in conformity with the AMA Guides and gave no rationale that would justify using the ROM Model as a differentiator; that the great weight of the medical evidence is contrary to the designated doctor's assignment of a 25% IR; that the claimant's IR is 10%; and that an MMI date must be established. The claimant's response requests affirmance of the hearing officer's decision; notes that MMI was not an issue at the CCH and that the BRC report states that the parties do not dispute that MMI was reached on January 4, 2002; and states that if the carrier insists that MMI be decided, then the MMI date should be March 4, 2002, as certified by the designated doctor.

With regard to spine impairment, the fourth edition of the AMA Guides uses the Injury Model, also called the DRE Model, and the ROM Model. (p. 94). The evaluator assessing the spine should use the Injury Model, if the patient's condition is one of those listed in Table 70 (p. 108). (p. 94). If none of the eight categories of the Injury Model is applicable, then the evaluator should use the ROM Model. (p. 94). If disagreement exists about the category of the Injury Model in which a patient's impairment belongs, then the ROM Model may be applied to provide evidence on the question. (p. 94). A motion segment of the spine is defined as two adjacent vertebrae, an intercalcated disk, and the vertebral facet joints. (p. 98). Loss of motion segment or structural integrity is defined as abnormal back-and-forth motion (translation) or abnormal angular motion of a motion segment with respect to an adjacent motion segment. (p. 98). Definitions regarding loss of integrity are found on p. 98. Motion of the spine segments is evaluated with flexion and extension roentgenograms. (p. 98).

According to DORLAND'S ILLUSTRATED MEDICAL DICTIONARY (27th ed.), a "roentgenogram" is "a film produced by roentgenography; radiograph," and "roentgenography" is defined as "the making of a record (roentgenogram) of internal structures of the body by passage of x-rays through the body to act on specially sensitized film." Webster's New World Dictionary of the American Language (1972), simply defines a "roentgenogram" as "a photograph taken with x-rays."

In using the Injury Model, the physician or examiner may use certain clinical procedures or determinations in placing the patient's impairment in the proper category. (p. 99). These "differentiators" are described in Table 71 (p. 109). (p. 99). No differentiator is required to place a patient in any impairment category. (p. 99). However, if a differentiator is present, it provides important evidence as to the category in which the patient belongs. (p. 99). 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). (p. 99). 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. (p. 99). The physician uses the estimate determined with the ROM Model to decide placement within one of the DRE categories. (p. 99). The proper DRE category is the one having the impairment percent that is closest to the impairment percent determined with the ROM Model. (p. 99).

Certain spine fracture patterns may lead to significant impairment and yet not demonstrate any of the findings involving the differentiators. (p. 99). Therefore, with the Injury Model, "structural inclusions" are included in some of the DRE categories. (p. 99). If the patient has a condition that meets the definition of a category that includes a structural inclusion, the physician need not determine if the other criteria for that category are present. (p. 99).

Specific procedures and directions are in Section 3.3f. No. 6 provides that if the physician cannot place the patient into an impairment category, or if disagreement exists about which of two or three categories to use for the patient, the physican should use the ROM Model as a differentiator, as explained in Section 3.3b (p. 99, "Differentiators"). (p. 101). If spine motion examinations under the ROM Model do not meet validity standards, then only a percent in Table 75 (p. 113), which provides estimates based on diagnoses under the ROM Model should be used. (p. 101). If no diagnosis in Table 75 is applicable, the ROM Model should not be used. (p. 101). Instead, the patient should be placed in the lowest of the DRE categories in question. (p. 101). When the ROM Model is used as a differentiator, the impairment percent assigned to the patient under the Injury Model should not be lower than that of the lowest category of the Injury Model in question nor higher than that of the highest category in question. (p. 101).

With the Injury Model, surgery to treat an impairment does not modify the original impairment estimate, which remains the same in spite of any changes in signs or

symptoms that may follow the surgery and irrespective of whether the patient has a favorable or unfavorable response to treatment. (p. 100).

It is not disputed on appeal that the claimant's condition qualifies for impairment under DRE lumbosacral category III: Radiculopathy (10% IR). As to DRE lumbosacral categories IV and V, p. 102 describes those categories as follows:

> **DRE Lumbosacral Category IV: Loss of Motion Segment Integrity**
>
> *Description and Verification:* The patient has loss of motion segment integrity (differentiator 5, Table 71, p. 109). Loss of motion segment or structural integrity is defined as at least 5 mm of translation of one vertebra on another, or angular motion at the involved motion segment that is 11º more than that at an adjacent motion segment (Figs. 62 and 63, p. 98). Loss of structural integrity at the lumbosacral joint is defined as at least 15º more angular motion than at the L4 and L5 motion segment.
>
> A documented history of muscle guarding and pain is present. Neurologic abnormalities need not be present. If they are present, the examiner should consider using category V.
>
> *Structural Inclusions:* (1) Greater than 50% compression of one vertebral body without residual neurologic compromise; (2) multilevel spine segment structural compromise, as with fractures or dislocations, without residual neurologic motor compromise.
>
> *Impairment:* 20% whole-person impairment.
>
> **DRE Lumbosacral Category V: Radiculopathy and Loss of Motion Segment Integrity**
>
> *Description and Verification:* The patient meets the criteria of DRE lumbosacral category III and DRE lumbosacral category IV, that is, both radiculopathy and loss of motion segment integrity are present (Table 71, differentiators 2, 3, 4, and 5, p. 109). Significant lower-extremity impairment is indicated by atrophy or loss of reflex(es), numbness with an anatomic basis, or electromyographic findings as in lumbosacral category III *and* loss of spine motion segment integrity as in lumbosacral category IV.
>
> *Structural Inclusions:* Structural compromise is present, as is documented neurologic or motor compromise.
>
> *Impairment:* 25% whole-person impairment.

Differentiator 5, Table 71, p. 109, which is noted in the above descriptions of DRE lumbosacral categories IV and V, states:

> **5. * Loss of motion segment integrity**
>
> Flexion and extension comparison roentgenograms show significant injury-related anterior-to-posterior translation of two adjacent vertebral bodies of 5 mm or more in the lumbar or thoracic spine, or of 3.5 mm or more in the cervical spine; or the roentgenograms show 15º more angular motion in the sagittal plane of L5 and S1 than at L4 and L5, or 11º more angular motion in the sagittal plane of a motion segment above L5 than in the adjacent motion segment. See Figs. 62 and 63 (p. 98).

Section 3.3j, the ROM Model, states in part at page112:

> Determining the [ROM] of a patient's spine is a clinically useful procedure, and it is the second of the two methods recommended in the *Guides* for evaluating spine impairment. This approach uses a diagnosis-based component, based on Table 75 (p. 113), a method for determining the [ROM] of the impaired spine region described in this section, and a component based on any spinal nerve deficit (Section 3.1k, p. 46).
>
> The [ROM] Model should be used only if the Injury Model is not applicable, or if more clinical data on the spine are needed to categorize the individual's spine impairment.

In his report, the designated doctor set out part of the description for DRE lumbosacral category V and stated that based on that description, the claimant was given a 25% IR. The designated doctor's report has ROM measurements, but the ROM worksheet references the third edition of the AMA Guides. The designated doctor does not state a ROM impairment. The designated doctor states a diagnosis of "lumbar disc displacement 722.10," but does not relate that diagnosis to any Table in the AMA Guides. The designated doctor's narrative report does not reference any flexion and extension roentgenograms upon which loss of motion segment integrity could be documented, nor does it indicate that the ROM Model was used as a differentiator. The designated doctor's report does not indicate any structural inclusions. The designated doctor's report does not provide a basis for determining loss of motion segment integrity.

The designated doctor's response to the Commission letter that is not in evidence, states:

> As you know, I evaluated [claimant] on 03/04/2002, and I found him to have a 25% [IR]. This was done with Category V in the DRE motion segments. As you know, we did flexion and extension testing on him. He was nowhere near normals. In these particular areas I saw no need to

> document motion which I found lacking on x-rays at the time. The changes do show 15 degrees or perhaps even more regulation changes in terms of the flexion and extension, particularly on check and recheck, or if not, very close. I think this meets the criteria. I stand by my findings. I think anyone would say that a fusion would give you loss of motion and integrity, particularly in flexion and extension. I think his rating is accurate. Thank you.

In arriving at her decision, the hearing officer wrote that "In reviewing [the designated doctor's] opinion and comparing it with the applicable portions of the Guides, it appears that although [the designated doctor's] explanation of his method was somewhat lacking in detail, he did arrive at his decision in conformity with the Guides, which indicate that when it is difficult to assign a patient a particular DRE category, the examining physican may use the [ROM] model described in Section 3.3j of the Guides to assist in making his decision."

The hearing officer erred in affording presumptive weight to the 25% IR assigned by the designated doctor under DRE lumbosacral category V for the following reasons:

1. It appears that the designated doctor failed to base his assessment of loss of motion segment integrity on flexion and extension roentgenograms. Motion of the spine segments is evaluated with flexion and extension roentgenograms (p. 98 and Table 71, No. 5, p.109). According to the CCH record, flexion and extension roentgenograms may not have been taken and the claimant has already had surgery (p. 100).

2. The designated doctor appears to be substituting findings on ROM testing for an evaluation of loss of motion segment integrity with flexion and extension roentgenograms, and the AMA Guides do not provide for that.

3. If the designated doctor is attempting to use the ROM Model as a differentiator, which is provided for in the AMA Guides (p. 99 and 101), he has not provided an explanation for doing so, and he has not followed the ROM Model in Section 3.3j.

4. If the designated doctor is attempting to assign impairment based on structural inclusions, he has not identified and documented what those structural inclusions are or described how his findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. Rule 130.1(c)(3).

We reverse the hearing officer's decision and remand the case to the hearing officer for the hearing officer to request the designated doctor to provide an IR report that is in compliance with Commission rules, with particular emphasis on Rule 130.1(c)(3), and the AMA Guides, fourth edition. The hearing officer should ask the designated doctor if a reexamination of the claimant is necessary to complete his report.

The hearing officer should provide the parties with a copy of any amended report of the designated doctor and allow the parties an opportunity to respond to any such report.

On remand, the hearing officer should ask the parties if they will stipulate to an MMI date. If no stipulation of MMI is made, then the hearing officer should make the Commission letter appointing the designated doctor a hearing officer exhibit in order to determine whether the designated doctor was appointed to determine both MMI and IR or just the IR. If a party requests that an MMI issue be added to the statement of disputes, then the hearing officer should determine whether good cause exists to add that issue. Rule 142.7(e).

The hearing officer's decision that the claimant has a 25% IR is reversed and the case is remanded to the hearing officer for further consideration and development of the evidence consistent with this opinion. Section 410.203(b)(3).

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 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* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **(a certified self-insured)** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY.
800 BRAZOS
AUSTIN, TEXAS 78701.

_____
Robert W. Potts
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Veronica Lopez
Appeals Judge