APPEAL NO. 030091-s
FILED MARCH 5, 2003

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 December 3, 2002. The hearing officer determined that the impairment rating (IR) of respondent (claimant) is 15% in accordance with the report of the treating doctor. Appellant (carrier) appealed this determination, contending the hearing officer erred in rejecting the report of the Texas Workers' Compensation Commission (Commission)-selected designated doctor. Claimant responded that the Appeals Panel should affirm the hearing officer's decision and order.

DECISION

We reverse and remand.

The issue in this case concerned the claimant's IR. The subissue is: does claimant have radiculopathy shown by the objective evidence so that DRE category III applies under 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 treating doctor found a 15% IR under DRE category III of the AMA Guides. The designated doctor thought claimant did not have radiculopathy and gave him 5% from DRE category II. The hearing officer rejected the report of the designated doctor and found that the great weight of the medical evidence supports the 15% IR certified by the treating doctor.

Section 408.125(e) provides that the report of the designated doctor has presumptive weight, and the Commission shall base its determination as to an employee's IR on that report "unless the great weight of the other medical evidence is to the contrary." The presumption afforded the designated doctor's report and certification of IR is not rebutted "absent a substantial basis to do so." Texas Workers' Compensation Commission Appeal No. 950561, decided May 22, 1995, citing Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993. A mere difference of medical opinion is not enough to overcome the presumption afforded the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 960034, decided February 5, 1996. Whether the party challenging a designated doctor's report has produced the great weight of other medical evidence contrary to the report and whether the presumption afforded to the report is rebutted is a question of fact for the hearing officer. Appeal No. 950561, *supra*.

In a January 16, 2001, evaluation report, (Dr. T) stated that claimant's motor, sensory, and reflex examinations were all within normal limits. He did not note whether there was any atrophy, though he noted that claimant was a "well-developed, well-nourished male." It appears that Dr. T did not find any evidence of loss of reflexes or atrophy. This report was written before claimant's surgery.

In a September 21, 2000, report, Dr. (RA) stated that he found no muscle atrophy and that he found "inhibition of both biceps jerk; otherwise no evidence of other reflex abnormality." This report is dated before claimant's surgery. There is no report from Dr. RA regarding whether claimant had muscle atrophy or loss of reflexes after his surgery. In two reports, dated September 21, 2000, and May 28, 2002, Dr. RA indicated that needle electrodiagnostic testing on both those dates were suggestive of bilateral C6 nerve root irritation.

In a May 14, 2002, report, Dr. (Y), the treating doctor, stated that he found mild atrophy. The difference in girth between claimant's forearms was noted to be only one centimeter. The treating doctor appeared to state that claimant's reflexes were normal, although he noted that there was some sensory loss. In an October 22, 2002, report, Dr. Y stated that claimant was placed in DRE category III because he had a positive EMG and radiculopathy. Dr. Y certified a 15% IR, which the hearing officer adopted.

In an October 23, 2002, letter to carrier, Dr. (B) stated that he reviewed the electrodiagnostic studies provided. He said: (1) the abnormalities are only in one muscle; therefore, one cannot say it is a radiculopathy based on one muscle; (2) the paraspinals were "clean" and would not indicate a radiculopathy diagnosis; and (3) if there were a C6 radiculopathy, there would be changes in paraspinals, deltoids, biceps, brachioradialis, and pronator teres. It is not clear what studies Dr. B reviewed, though his report is written after both studies by Dr. RA were done.

In his March 6, 2002, report and April 16, 2002, letter, the designated doctor indicated that there is no evidence of testing suggesting radiculopathy and there is no atrophy of the muscles. The designated doctor did not note any loss of reflexes. However, it is not clear that the designated doctor saw the electromyography report from Dr. RA dated May 28, 2002, which was performed after the August 7, 2001, C5-6 diskectomy surgery claimant underwent. In his April 16, 2002, report, the designated doctor acknowledged that Dr. RA had previously found nerve root irritation before claimant's August 2001 surgery. However, the designated doctor then stated that "there is no documentation following the surgery of an EMG suggesting radiculopathy or other test suggesting radiculopathy." The Commission apparently contacted the designated doctor after he wrote his initial report, but it is not clear whether Dr. RA's May 28, 2002, test results showing continuing nerve root irritation were sent to the designated doctor. It is also not clear whether the designated doctor thought that an electromyography report showing nerve root irritation constituted evidence of radiculopathy.

The hearing officer determined that: (1) medical records confirm some radicular component to claimant's injury before surgery; (2) some irritation is still noted in the more recent EMG; (3) the designated doctor confirmed that the medical records before surgery showed evidence of bilateral nerve root irritation and radiculopathy; (4) the designated doctor is not appropriately applying the AMA Guides and has refused to change his rating in spite of acknowledging the radicular component; (5) writing the designated doctor again would be futile; (6) the treating doctor properly examined

claimant and applied the correct version of the AMA Guides; and (7) the great weight of the medical evidence supports the 15% IR certified by the treating doctor.

We first note that when finding that a designated doctor's certification of IR is contrary to the great weight of the medical evidence, the hearing officer should "clearly detail the evidence relevant to his or her consideration and clearly state why the other evidence is to the contrary." Texas Workers' Compensation Commission Appeal No. 950317, decided April 13, 1995. In this case, the hearing officer did not detail all of the relevant evidence in rejecting the designated doctor's report. We next note that the hearing officer said that the AMA Guides state on page 3-100 that, "when utilizing the Injury Model to rate an impairment, surgery to treat an impairment does not modify the original impairment estimate as they remain the same even if there are changes of symptoms that may follow surgery." The hearing officer appears to then state that if there was *ever* a diagnosis of radiculopathy, then claimant must be rated under DRE category III, even if he no longer has radiculopathy at the time the designated doctor examines him. However, impairment has to be "permanent" to be included in an IR. Section 401.011(23). *See also* AMA Guides 2-9; 3-94; 3-101 (regarding permanent impairment). Therefore, it follows that a claimant's IR may not be based on impairment that the claimant no longer has at the time of the designated doctor's IR examination. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.1(c)(2) (Rule 130.1(c)(2)) states that "a doctor who certifies that an employee has reached [maximum medical improvement] shall assign an [IR] for the current compensable injury using the rating criteria contained in the appropriate edition of the [AMA Guides]." However, despite the wording on page 3-100 of the AMA Guides, the AMA Guides do not control over our applicable rules and the 1989 Act and only permanent impairment may be rated.

The hearing officer erred in stating that the designated doctor acknowledged a radicular component to claimant's impairment. The designated doctor noted that there were "nonverifiable radicular complaints," but said there is *no evidence* of radiculopathy. The designated doctor did acknowledge evidence of bilateral C6 nerve root irritation, but noted that this was diagnosed before claimant's surgery. The designated doctor also noted that "there is no documentation following the surgery of an EMG suggesting radiculopathy or other test suggesting radiculopathy."

Page 109 of chapter 3 the AMA Guides is instructive regarding what is the relevant evidence to detail regarding whether there is true radiculopathy. This is evidence regarding: (1) loss of reflexes; (2) atrophy greater than two centimeters above or below the elbow; and (3) unequivocal electrodiagostic evidence of acute nerve root compromise. On 3-104 of the AMA Guides, it states:

> DRE Cervicothoracic category III: Radiculopathy
>
> Description and verification: The patient has significant signs of radiculopathy, such as (1) loss of relevant reflexes or (2) unilateral atrophy with greater than a 2-cm decrease in circumference compared with the unaffected side, measured at the same distance above or below the elbow.

> The neurologic impairment may be verified by electrodiagnostic or other criteria (differentiators 2, 3, 4, Table 71, p. 109).

We are concerned that the hearing officer appears to be equating nerve root irritation with radiculopathy for the purposes of finding radiculopathy under DRE category III. However, the AMA Guides indicate that to find radiculopathy, doctors must look to see if there is a loss of relevant reflexes or unilateral atrophy with greater than a two centimeter decrease in circumference compared with the unaffected side, measured at the same distance above or below the elbow. The AMA Guides state that such findings of neurologic impairment may then be *verified* by electrodiagnostic studies. The AMA Guides do not state that electrodiagnostic studies showing nerve root irritation, without any loss of reflexes or atrophy, constitutes undeniable evidence of radiculopathy.

Even the treating doctor does not appear to have documented a loss of reflexes or the level of atrophy mentioned by the AMA Guides. Even if the test results showing nerve root irritation are some evidence of radiculopathy, there appears to be a lack of neurological findings regarding loss of reflexes and/or atrophy which, according to the AMA Guides, would show radiculopathy. The reports from other doctors do not show that they found atrophy or loss of reflexes, except for the September 21, 2000, report of Dr. RA stating that he found "inhibition of both biceps jerk." We note that the treating doctor did not note a similar reflex loss and stated that the "biceps reflexes are 2+ and equal bilaterally."

It does not appear that the designated doctor in this case had all of the relevant records before him in that it appears that he did not have Dr. RA's May 28, 2002, report. We must remand this case for the hearing officer to seek clarification from the designated doctor. The hearing officer should send Dr. RA's May 28, 2002, report to the designated doctor and ask the designated doctor whether Dr. RA's findings affect his IR determination. The hearing officer should also send the operative report to the designated doctor.[1]

After clarification is obtained from the designated doctor, the hearing officer should reconsider the IR issue. In reconsidering this case, the hearing officer should:

1. detail and consider all of the evidence relevant to her consideration, including all the evidence regarding atrophy, loss of reflexes, and radiculopathy;

2. clearly state why the other evidence is contrary to the report of the designated doctor;

3. note that the impairment for claimant's injury must be *permanent* impairment, despite what is written on page 100 of the AMA Guides; and

[1] The parties said at the hearing the designated doctor has seen the second EMG and the operative report, but this is not reflected in the record.

4. note that a mere difference of medical opinion is not enough to overcome the presumption afforded the designated doctor's report.

We reverse the hearing officer's determination that claimant's IR is 15% and remand this case for further consideration 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 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 **HARTFORD UNDERWRITERS INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CT CORPORATION SYSTEM
350 NORTH ST. PAUL, SUITE 2900
DALLAS, TEXAS 75201.

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Judy L. S. Barnes
Appeals Judge

CONCUR:

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Chris Cowan
Appeals Judge

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Thomas A. Knapp
Appeals Judge