APPEAL NO. 051306-s
FILED AUGUST 3, 2005

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 May 4, 2005. The hearing officer determined that the appellant (claimant) reached maximum medical improvement (MMI) on January 22, 2004 (as stipulated by the parties) and that the claimant's impairment rating (IR) is 5% as assessed by the designated doctor (in his third report) whose report was entitled to presumptive weight.

The claimant appeals, contending that the hearing officer abused his discretion by not allowing the parties to agree in resolution of the case and that the hearing officer's determination that the claimant's IR is 5% is against the great weight of the evidence. The respondent (carrier) response, basically urges affirmance.

DECISION

Reversed and a new decision rendered.

The parties stipulated that the claimant sustained a compensable injury on _____, that the claimant reached MMI on January 22, 2004, and that (Dr. F) was the "[Texas Worker's Compensation Commission (Commission)]-selected designated doctor." The hearing officer comments that the claimant fell from a ladder and "sustained injuries to his face, his thoracic and lumbar spine, and his right hip." The designated doctor examined the claimant three times.

Addressing the claimant's Point of Error that the hearing officer abused his discretion in refusing to allow the parties to agree in resolution of the case, by reading the claimant's appeal and the carrier response on this point, it is obvious that there was a good deal of discussion on this matter at some time off the record. The Appeals Panel can only review the record of the proceedings and we are unaware of what transpired outside of the CCH record. At one point on the record the hearing officer asks what the carrier's position was and notes that the carrier's advocate of an IR prior to the date of MMI was "a somewhat untenable position." The following exchange is noted:

> [Carrier's attorney]: My difficulty, Your Honor, is that I believe that's the right percentage. I believe it was reached the wrong way at the time of MMI. And so I – if we agree to withdraw that issue –
>
> Are we agreeing to do that?
>
> [Claimant's attorney]: I have no problem with it.

> THE HEARING OFFICER: You can move to do it. And if both parties move to do it and y'all join a motion, bear in mind it's not binding on the hearing officer.
>
> Now, question: Is the Claimant receiving any income benefits at this point in time?

The hearing officer was not requested to make a ruling and did not err in not doing so. There was insufficient evidence of any kind of an agreement for resolution of the case and the hearing officer did not abuse his discretion. The claimant's argument on this point is without merit.

Dr. F first examined the claimant on February 27, 2003, and certified MMI on that date with a 10% IR utilizing 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 report indicates that the head, neck, thoracic and lumbar spine "(including the lower extremities)" were examined. Dr. F rated the facial injury as 0% impairment and diagnosed a "Thoracolumbar syndrome." However, Dr. F commented that the "thoracic and lumbar spine would be rated . . . as a DRE III with radiculopathy and this on Page 110, Table 72 assigns 10% impairment." We note that Table 72 on page 3/110 is for Diagnosis-Related Estimate (DRE) Lumbosacral Spine Impairments and a 10% impairment is for DRE Lumbosacral Category III; Radiculopathy.

The claimant forwarded some medical records regarding his hip treatment to the Commission. Subsequently the Commission, by letter dated January 6, 2004, requested clarification from Dr. F regarding a rating for the right hip. Dr. F replied that since the right hip has been held compensable reevaluation of the claimant would be appropriate.

Dr. F reexamined the claimant on January 22, 2004, and in a report of that date commented that his previous report had addressed only the lumbar spine and certified the January 22, 2004, date of MMI. Dr. F again assessed a 10% IR but after acknowledging that he had "previously assigned 10% but there has been an additional ruling. . . as to how the radiculopathy component needs to be rated" assessed a 5% DRE II "for the lumbar spine" in the "absence of frank radiculopathy, both clinically or on diagnostic studies." (It is fairly clear that Dr. F was rating claimant at DRE Lumbosacral Category II: Minor Impairment.) Dr. F also assessed a 3% impairment for the right hip using Table 64 on page 85 stating "[o]nly the component of trochanteric bursitis without abnormal gait is noted with the use of a cane can be rated and this assigns 3% impairment."[1] We read Dr. F's report to say that the claimant does not have an abnormal gait with the use of a cane and that if the claimant is not using a cane he would have an abnormal gait required by Table 64. Dr. F also assessed a 2% impairment from Table 40 Page 78 for loss of Range of Motion (ROM) combined with

[1] We note that under Table 64 page 85 for the hip there is a 3% whole person rating for "Throchanteric bursitis (chronic) with abnormal gait." (Emphasis added.)

the DRE II rating for 10% IR. (The Hearing Officer quotes Dr. F's report at some length in his decision.)

(Dr. C) (perhaps a referral doctor) in a letter report dated September 16, 2004, took issue with Dr. F's last report stating that he does not dispute "the most recent assessment of MMI." Dr. C goes on to state:

> We agree, based on the record, there is not sufficient evidence for radiculopathy that would place the patient in a DRE Category III but, because of continued symptomatology in the thoracic and lumbar spines, he would qualify for DRE Category II with each area of the spine rated separately, 5% per area, and we agree with the previous assignment of 5% for the right hip, which would place the patient at 15% impairment.

Based on this report the claimant requested additional clarification from Dr. F through the Commission. The Commission, by letter dated December 17, 2004, again queried Dr. F whether he had rated the thoracic spine in his last evaluation. Dr F reexamined the claimant again on January 4, 2005, and in a report of that date certified MMI on January 22, 2004, and assessed a 5% IR. Dr. F stated that he had evaluated the claimant's head, neck, thoracic and lumbar spine and right hip. Dr F assessed a 0% impairment for the hip "since it has normal ROM and no specific diagnosis that is ratable." Regarding the thoracolumbar spine Dr. F comments that "although I previously found [the claimant] to have a 10% impairment for radiculopathy, this is not born out on today's exam since knee jerk is present, there is no muscle wasting . . . and therefore no unequivocal neurologic change" and rates the back as DRE Thoracolumbar Category II: Minor Impairment. (Dr. F's reference to DRE II A is a description from Table 74 of minor impairment as "Clinical signs of thoracolumbar injury are present without radiculopathy or loss of motion segment integrity".) This results in a 5% impairment. Dr. F again finds the facial injury "not ratable" and comments that the claimant "has a bizarre presentation" not explained by the mode of injury, evaluations or diagnostic studies.

Subsequently (Dr. R) evaluated the claimant and in a report dated January 26, 2005, certified the January 22, 2004, MMI date and assessed an 18% IR based on 10% impairment for DRE Lumbosacral Category III: Radiculopathy, 5% impairment for DRE Thoracolumbar Category II: Minor Impairment and 3% impairment for "trochanteric bursitis" from Table 64, Page 85 (referenced previously).

The hearing officer comments that the designated doctor's report has presumptive weight, that DRE Thoracolumbar Category II is supported by the medical evidence and that the great weight of the other medical evidence is not contrary to Dr. F's clarification.

Although the hearing officer did a detailed and accurate recitation of the evidence we hold that Dr. F's last report of January 4, 2005, cannot be adopted. As of the stipulated date of MMI of January 22, 2004, Dr. F assessed a 5% impairment for the

right hip. Yet on the January 4, 2005, report Dr. F commented that the hip "receives 0% impairment, since it has normal ROM and no specific diagnosis, that is ratable." It appears obvious from this rating and Dr. F's January 4, 2005, comment regarding the exclusion of ratings of the hip, that he is rating the claimant as of January 4, 2005, rather than as of the MMI date of January 22, 2004. Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.1(c)(3) (Rule 130.1(c)(3)) provides that the "[a]ssignment 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." That rule has been interpreted to mean that the IR shall be based on the condition as of the MMI date and is not to be based on subsequent changes, including surgery. The preamble of Rule 130.1(c)(3) clarifies that IR assessments "must be based on the injured employee's condition as of the date of MMI." 29 Tex. Reg. 2337 (2004). *See also* Texas Workers' Compensation Commission Appeal No. 040313-s, decided April 5, 2004; Texas Workers' Compensation Commission Appeal No. 040583-s, decided May 3, 2004. Dr. F's January 4, 2005, IR cannot be adopted and we reverse the hearing officer's decision that the claimant's IR is 5%.

Section 408.125(c) provides that 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. Rule 130.6(i) provides that the designated doctor's response to a Commission request for clarification is considered to have presumptive weight as it is part of the doctor's opinion. Having ruled that Dr. F's January 4, 2005, report cannot be adopted, the question becomes whether the IR of one of the other doctors (or a prior report from Dr. F) can be adopted. The claimant urges that the 18% IR assessed by Dr. R on January 26, 2005, be adopted. Although Dr. R recites a January 22, 2004, MMI, and explains how he calculated the IR, Dr. R concludes that the IR "is accurate given todays presentation and examination of the patient considering all compensable areas of injury." This indicates to us that the IR was based on the claimant's condition at Dr. R's examination on January 26, 2005, rather than the MMI date of January 22, 2004.

The question also arises how individual aspects of the spine are rated in accordance with AMA Guides. We note that page 3/95 of the AMA Guides, regarding the spine examination, states:

> It is difficult to separate the cervical, thoracic, lumbar, and sacral spine regions functionally, because the signs related to the different regions commonly overlap. Upper lumbar spine impairments tend to behave more like those of the thoracic region than those of the lower lumber region, and the involved nerve plexuses expand the effects from the different levels.

* * * *

> With the injury or DRE Model, the main spine regions are termed the cervicothoracic, thoracolumbar, and lumbosacral regions.

The section goes on to say that the structural, neurologic, vascular, and other activities mediated by the spine regions overlap and are difficult to separate. That section concludes by saying that for the "purposes of this book" (AMA Guides), the cervical region may be considered to represent the cervicothoracic region, the thoracic region to represent the thoracolumbar region, and the lumbar region to represent the lumbosacral region. However Section 3.3(f) page 3/101 regarding specific procedures and directions (in paragraph No. 3) instructs the doctor to select the region primarily involved, that is, the lumbosacral, thoracolumbar, or cervicothoracic spine region and identify the patients most serious objective findings and refer to clinical differentiators if necessary. Paragraph No. 5 instructs if one spine region is primarily involved use the impairment table for that region while paragraph No. 8 instructs that if "more than one spine region is impaired, determine the impairment of the other region(s)" and combine the regional impairments using the Combined Values Chart. Consequently our reading of the AMA Guides would indicate that a doctor in the exercise of medical judgment, using the DRE model, in calculating how individual aspects of the spine are rated in accordance with the Guides, should select the region primarily involved and then rate that region. Applying the language from the bottom of page 3/95 of the AMA Guides, if the injury is primarily to the cervical spine the rating would be under part 3.3h, page 3/103 cervicothoracic spine impairment, if the injury was primarily to the thoracic area of the spine the rating would be under part 3.3i page 3/106 for thoracolumbar spine impairment and if the injury is primarily to the lumbar portion of the spine, the impairment would be under part 3.3g page 3/101 lumbosacral spine impairment. Pursuant to part 3.3f, page 3/101, paragraph 8, if more than one spine region is impaired, the doctor is to determine the impairment of the other regions and combine the regional impairments using the Combined Values Chart to express the patients total spine impairment.

In the instant case, although Dr. F at one time diagnosed a thoracolumbar syndrome he assessed a rating under lumbosacral impairment and subsequently had a clinical impression (in his January 22, 2004 report) of a lumbar syndrome and rated the injury as DRE Lumbosacral Category II: Minor impairment. We believe that Dr. F is correct in wanting to rate the spine as a "single entity" but was ambivalent whether it was the thoracic spine or the lumbar spine which was primarily involved, a fact that the AMA Guides recognize as "difficult to separate" as indicated on page 3/95.

We believe that Dr. F's January 22, 2004, rating can and should be adopted. Dr. F rated the facial injuries (with 0% impairment), the back injury, noted that an "MRI of the thoracic spine reportedly was negative" and included the hip injury. We reverse the hearing officer's determination that the claimant has a 5% IR and render a new decision that the claimant has a 10% IR as assessed by the designated doctor on the stipulated date of MMI and that the designated doctor's January 22, 2004, report is not contrary to the great weight of the other medical evidence.

The true corporate name of the insurance carrier is **LIBERTY INSURANCE CORPORATION** and the name and address of its registered agent for service of process is

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

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Robert W. Potts
Appeals Judge

_____
Margaret L. Turner
Appeals Judge