APPEAL NO. 061529-s
FILED SEPTEMBER 26, 2006

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 June 12, 2006. The hearing officer determined that the date of statutory maximum medical improvement (MMI) is May 10, 2005 (and it is undisputed that the respondent (claimant) reached MMI on that date by operation of law pursuant to Section 401.011(30)(B)) and that the claimant's impairment rating (IR) is 29%. The MMI date was stipulated and has not been appealed thereby becoming final. Section 410.169.

The appellant (carrier) appealed, contending that the designated doctor's 29% IR was contrary to the direction in 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) and that the 29% IR was incorrect as a matter of law. The file does not contain a response from the claimant.

DECISION

Reversed and a new decision rendered.

The parties stipulated that the claimant sustained a compensable injury on _____; that Dr. N was the designated doctor; and that the date of statutory MMI was May 10, 2005. The medical records indicate that the claimant sustained a low back injury while holding a jackhammer. The claimant was diagnosed with a lumbar herniated disc at L5-S1 with Grade I spondylolisthesis. Lumbar spine x-rays, performed on March 28, 2003, show bilateral spondylolisthesis at L5-S1. The claimant had spinal surgery in the form of a lumbar laminectomy, discectomy, and posterior lumbar interbody fusion with instrumentation at L5-S1 on August 19, 2003. The treating doctor, a chiropractor, referred the claimant to Dr. H for an evaluation on IR.

Dr. H in a Report of Medical Evaluation (DWC-69) and narrative dated May 10, 2005, certified the claimant at MMI on that date and assessed a 21% IR. Dr. H commented that using the procedures and protocols listed in "Table 70 (p. 108) and 71 (p. 109)," the claimant's injury meets the criteria of Diagnosis-Related Estimate (DRE) Lumbosacral Category III: Radiculopathy, discussing the verification for radiculopathy, including "evidence of unilateral atrophy of greater than 2 cm above or below the knee as compared to the contralateral side" reciting measurements. Dr. H goes on to state:

> However, the DRE Category does not accurately reflect [the claimant's] true impairment. Therefore the range of motion [ROM] model will be implemented to identify a more accurate [IR].

Dr. H then assessed a 10% impairment from Table 75 (p. 113), Subsection II E, validated loss of ROM, and assessed 12% impairment for loss of ROM combined to arrive at the 21% IR. No impairment was assessed for motor or sensory loss.

Dr. N, the designated doctor, in a report of October 23, 2004, had certified that the claimant was not at MMI pending additional physical therapy at that time. Dr. N re-examined the claimant on June 24, 2005, and in a DWC-69 and narrative of that date certified the claimant at MMI on the stipulated MMI date of May 10, 2005. Dr. N reviewed the medical records and assessed a 10% IR based on DRE Lumbosacral Category III: Radiculopathy.

Dr. H wrote the treating doctor in a letter dated August 29, 2005, in which he referenced "TWCC [now DWC] Advisory 2003-10B" signed February 24, 2004, and stated:

> It is my opinion that [the claimant's] fusion was far from "uncomplicated" and that a 5% or even a 10% is far from an accurate impairment rating. The DD states that [the claimant's] lumbar ROM "decreased with submaximal effort," however, there are no actual measurements included in the report indicating any inconsistencies in lumbar ROM. Further, Advisory 2003-10B (2.) states, "Health care providers may utilize the [ROM] or other methodology if indicated (as with any condition in the 4th Edition Guides) that most accurately reflects the [IR] evident for each injured worker." Therefore, in this particular case, given that hardware remains in [the claimant's] back and that has resulted in a marked lack of lumbar ROM, the Lumbosacral DRE Category III is still not an accurate reflection of [the claimant's] true impairment. In my opinion the [ROM] model gave a more accurate and true [IR] than the DRE method.

Dr. H requested that the Texas Department of Insurance, Division of Workers' Compensation (Division) seek clarification from the designated doctor, Dr. N, regarding whether "spinal measurement using dual inclinometers" was performed, whether the claimant's surgery "was 'uncomplicated,'" whether "Lumbosacral DRE Category III is an accurate reflection of [the claimant's] true impairment" and if using the "ROM model is warranted to determine a more accurate, true impairment for [the claimant]." Dr. N, replied in a letter dated December 14, 2005, that he had received a letter regarding the claimant's "MMI/IR" from the Division; that he had reviewed the information which included Dr. H's August 29, 2005, letter disputing the IR and "Advisory 2003-10B"; and that "[a]fter careful review of the above information the patient needs to [be] re-examined to get an [IR] using the [ROM] model." The claimant was reexamined on February 3, 2006. Dr. N certified the statutory MMI date and assessed a 29% IR. Dr. N assessed a 12% impairment using "specific spine disorders page 113, IV D 1e, single level fusion with or without decompression with residual signs or symptoms," and 19% impairment for loss of ROM, combined to get the 29% IR.

A carrier peer review doctor, in a report dated June 1, 2006, and who testified at the CCH, was of the opinion that the ROM model should not have been used, that there was no explanation why Dr. N had used the ROM model and that the ROM model should principally be used as a differentiator.

The hearing officer cites the quoted language from Dr. H's August 29, 2005, letter as the explanation for the use of the ROM model and attributes that reasoning to Dr. N, the designated doctor, who said that he wanted to reexamine the claimant using the ROM model.

Section 408.124(a) provides that an award of an impairment income benefit must be based on an IR determined using the IR guides described by that section and the appropriate edition of the AMA Guides, which, in this case, is the fourth edition. Regarding evaluation of the spine, page 94 of the AMA Guides instructs:

> "The evaluator assessing the spine should use the Injury Model, [also known as the DRE model] if the patient's condition is one of those conditions listed in Table 70 (p. 108). That model, for instance, would be applicable to a patient with a herniated lumbar disk and evidence of nerve root irritation. If none of the eight categories of the Injury Model is applicable then the evaluator should use the [ROM] Model.

That section goes on to state that if disagreement exists about the category of the DRE model in which the impairment belongs, then the ROM model may be applied to provide evidence on the question. Page 99 of the Guides describes how to use the ROM model as a differentiator and states that if the physician cannot decide into which DRE category the patient belongs, the physician may refer to and use the ROM model "to decide placement within one of the DRE categories." In discussing use of the ROM model, page 112 of the AMA Guides states:

> The [ROM] model should be used only if the Injury [DRE] model is not applicable, or if more clinical data on the spine are needed to categorize the individual's spine impairment.

In Appeals Panel Decision (APD) 022509-s, decided November 21, 2002, the Appeals Panel discussed the use of the Injury (DRE) Model and how the ROM Model could be used as a differentiator or if none of the eight categories of the Injury Model is applicable. In APD 030288-s, decided March 18, 2003, the Appeals Panel rejected the premise that the "evaluating physician has the leniency to use the Model that he or she feels most appropriate." APD 030288-s, *supra*, concluded:

> In summary, although there are instances when the ROM Model may be used, such as if none of the categories of the DRE Model are applicable, or as a differentiator, 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. 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.

In APD 032737, decided December 8, 2003, the Appeals Panel held that the treating doctor, in assessing an IR using the ROM Model "made no effort to use the DRE model or explain how the ROM model was used as a differentiator, other than say the DRE model, in his opinion, does not accurately assess the claimant's impairment. The treating doctor's assessment does not meet the requirements of the AMA Guides."

In the instant case, Dr. N, the designated doctor, in his February 3, 2006, report gives no reason whatsoever for using the ROM Model rather than the DRE Model. The hearing officer comments that Dr. N did provide an explanation for his use of the ROM Model when he referred to Dr. H's August 29, 2005, letter and Advisory 2003-10B thereby imputing Dr. H's reasoning to Dr. N. However, Dr. N only acknowledges receipt of Dr. H's letter and Advisory 2003-10B stating that he would need to reexamine the claimant "to get an [IR] using the [ROM] model." That does not constitute a specific explanation why the DRE Model could not be used. The reasons given by Dr. H were that the claimant's spinal surgery fusion "was far from 'uncomplicated'" that "hardware remains in [the claimant's] back and that has resulted in a marked lack of lumbar ROM" and that "Lumbosacral DRE Category III is still not an accurate reflection of [the claimant's] true impairment." We hold that Dr. H's opinion that the claimant's surgery "was far from uncomplicated," that hardware remains in the claimant's back and that in Dr. H's opinion Lumbosacral DRE Category III is not an accurate reflection of the claimant's true impairment is insufficient to justify use of the ROM Model instead of the preferred DRE Model by Dr. N.

Dr. H and the hearing officer both reference Advisory 2003-10B as providing an explanation or justification for use of the ROM Model. The pertinent part of Advisory 2003-10B is in paragraph 2 which states:

c. Health care providers may utilize the [ROM] or other methodology if indicated (as with any condition in the 4th Edition Guides) that most accurately reflects the [IR] evident for each injured worker.

We read that provision to harmonize with the guidance in the AMA Guides. In other words, the ROM methodology may be used in accordance with the 4th Edition Guides to accurately reflect the IR. In APD 042543, decided December 2, 2004, Advisory 2003-10B, Section 2c regarding ROM was noted. In reversing the hearing officer's decision, the Appeals Panel noted that the designated doctor, in that case, "did not indicate why the [ROM] most accurately reflected the claimant's impairment other than the fact he had spinal surgery." Similar reasoning is applied here in that the reasons set out by Dr. H, and imputed to Dr. N by the hearing officer, had to do with Dr. H's opinion that the ROM Model was more accurate than the DRE Model.

In APD 061455, decided September 13, 2006, the Appeals Panel addressed a similar situation where a designated doctor had attempted to use the ROM Model

instead of the DRE Model because the injured worker had undergone multi-level cervical fusion surgery. In that case, the Appeals Panel concluded that spinal surgery in and of itself is not an appropriate reason to use the ROM Model to assess an impairment and that the designated doctor had failed to "provide an explanation as to why he felt the DRE Model could not be used to assess that claimant's IR."

For CCH's which are held on or after September 1, 2005, 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 § 130.6(i) (Rule 130.6(i)) provides that the designated doctor's response to a Division request for clarification is considered to have presumptive weight as it is part of the doctor's opinion. In this case, after being sent a letter seeking clarification, Dr. N acknowledged that he had received the letter, had reviewed the information, which included Dr. H's opinion, and had received a copy of Advisory 2003-10B. Dr. N stated that after careful review of the information the claimant needed to be reexamined using the ROM Model. Dr. N gives no other explanation why the ROM Model should be used and more importantly why he felt the DRE Model could not be used to assess the claimant's IR.

We reverse the hearing officer's decision that the claimant's IR is 29% as not being in accordance with the AMA Guides, and is contrary to the preponderance of the medical evidence, and we render a new decision that the claimant's IR is 10% pursuant to DRE Lumbosacral Category III: Radiculopathy as assessed by Dr. N in his report of June 24, 2005, which is supported by a preponderance of the medical evidence.

The true corporate name of the insurance carrier is **PACIFIC EMPLOYERS INSURANCE COMPANY** and the name and address of its registered agent for service of process is

ROBIN M. MOUNTAIN
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IRVING, TEXAS 75063-2732.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

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Veronica L. Ruberto
Appeals Judge

_____
Margaret L. Turner
Appeals Judge