APPEAL NO. 072220-s
FILED FEBRUARY 5, 2008

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 August 13 and November 7, 2007. The issue at the CCH was whether the appellant (claimant) is entitled to supplemental income benefits (SIBs) for the first quarter, May 30 through August 28, 2007. The hearing officer resolved the disputed issue by deciding that because the claimant did not have an impairment rating (IR) of 15% or greater, she is not entitled to SIBs. The claimant appealed, contending that since the IR was not a specific issue before the hearing officer, that the hearing officer erred in determining the IR. The respondent (carrier) responded, urging affirmance.

DECISION

Reversed and remanded.

On appeal the claimant asserts that the hearing officer erred in making a determination of the claimant's IR because it was not a certified issue before her. We do not agree. Having an IR of 15% or greater is a statutory requirement for SIBs entitlement. Section 408.142(a)(1). In the absence of a stipulation by the parties, the claimant has the burden to establish all of the elements set out in Section 408.142(a) in order to show entitlement to SIBs. *See* Appeals Panel Decision (APD) 031275, decided July 3, 2003. In the instant case, there was no prior determination by the Texas Department of Insurance, Division of Workers' Compensation (Division) on an issue of the claimant's IR and the carrier refused to stipulate that the claimant had an IR of 15% or greater, so the burden was on the claimant to prove that she did have the required 15% or greater IR[1]. Entitlement to SIBs cannot be shown in the absence of a finding that the IR is 15% or greater.

The parties stipulated that the claimant sustained a compensable injury on _____. The Division-selected designated doctor examined the claimant on May 16, 2006, for the purpose of determining maximum medical improvement (MMI) and IR. The designated doctor certified that the claimant reached MMI on May 16, 2006, with an 18% IR, using 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 assessed 18% IR was comprised of 4% whole person impairment for the right shoulder (range of motion (ROM)); 5% whole person impairment for the cervical spine (Diagnosis-Related Estimate (DRE) Cervicothoracic Category II: Minor Impairment); and 10% whole person impairment for the lumbar spine (DRE Lumbosacral Category III: Radiculopathy). The

[1] In evidence is the carrier's Request for Benefit Review Conference disputing the findings of the designated doctor on MMI or IR (and explaining the dispute is on the designated doctor's IR) filed with the Division on August 10, 2007, which was 3 days before the first session of the CCH and prior to the end of the first quarter of SIBs, as that period is stated in the SIBs issue.

designated doctor noted in his physical findings that the claimant's left calf is approximately 2 centimeters smaller than the right, and that the claimant had radicular symptoms in the left lower extremity radiating down to the lateral left ankle. The designated doctor noted that this radiculopathy was not verified at the time of the examination. An addendum dated June 7, 2006, was included in his narrative report which stated he now had obtained an EMG/NCV dated May 26, 2006.

The designated doctor examined the claimant again on March 19, 2007, for the stated purpose of determining work ability and treatment needs. The designated doctor noted that the lower extremities do not show any atrophy or sensory loss. He additionally noted that "the right ankle jerk is reduced but present and that the left ankle jerk cannot be elicited well." Further, the designated doctor stated that, from his perspective, he considered the injury involved all of the areas that were rated and accepted as compensable and treated up until he certified the claimant's date of MMI and IR on May 16, 2006.

The first session of the CCH was conducted on August 13, 2007. At the conclusion of that session, the hearing officer specifically stated that she was not closing the record in the event she needed to write the designated doctor regarding his certification of MMI and IR. The hearing officer sent a letter of clarification dated August 21, 2007, which asked the designated doctor how he confirmed radiculopathy. The designated doctor replied in a response dated August 27, 2007, stating that the claimant does have a 2 centimeter reduction in the circumference of her left calf as compared to the right. He also referenced the EMG performed on May 26, 2006, stating he is not trained in EMG studies and cannot argue the specific numbers or interpretation of the test, and that he would go by the final summary of the person doing the test. The designated doctor stated that the May 2006 EMG of the leg "showed chronic denervation with reinnervation of muscle innervated by the S1-2 nerve roots." The designated doctor concluded that this was adequate to confirm radiculopathy and placement of the claimant in DRE Lumbosacral Category III. The letter of clarification and the response were sent to the parties and a second session of the CCH was scheduled for November 7, 2007.

At the second session of the CCH, the carrier offered into evidence a certification of MMI and IR of the claimant from a carrier-selected required medical examination doctor, Dr. G. Dr. G examined the claimant on October 9, 2007, and certified the claimant reached MMI on May 16, 2006, with a 7% IR, using the AMA Guides. The 7% IR was comprised of 2% whole person impairment of the right shoulder (ROM); 0% for the cervical spine (DRE Cervicothoracic Category I: Complaints or Symptoms); and 5% for the lumbar spine (DRE Lumbosacral Category II: Minor Impairment). With regard to the cervical spine, Dr. G explained that the claimant did not have spasms or guarding and did not have significant clinical findings or documentable neurological complaints. With regard to the lumbar spine, Dr. G's physical examination noted atrophy of the left calf, as compared to the right, of 2 centimeters. However, Dr. G went on to explain that the atrophy found on physical examination was not due to the occupational injury of _____. Dr. G stated that the claimant does not have a neurocompressive lesion

that reasonably would have led to a 2 centimeter loss of muscle mass in the left calf. Dr. G stated that the objective evidence (EMG and MRI) points to the fact that the occupational event of _____, was not the causal factor. Dr. G also specifically referenced the May 2006 EMG relied upon by the designated doctor for verification of the lumbar radiculopathy, noting the designated doctor specifically stated that he goes by the final summary of the person performing the test and does not look at the specific numbers or interpretation of the test. Dr. G explained that the actual test is indicative of an absence of radiculopathy rather than the presence of radiculopathy, noting that if the claimant had lumbar radiculopathy and any denervation of any significance, there would have been EMG abnormalities in the insertional activity, sharp waves, and fibrillation potentials. Dr. G concluded that the claimant has an unknown 2 centimeter difference between the left and right calves that cannot be attributable to the injury of 2004 based upon the absence of any traumatic injury to the low back and given the fact the MRI does not show a herniated disc that would compress the L5-S1 or S2 nerve root that would then manifest itself in muscular atrophy and circumferential change in the left calf. Both parties presented additional evidence and argument at the November 7, 2007, session of the CCH.

The hearing officer found that the claimant's compensable injury resulted in a 7% IR, making moot the issue of eligibility for SIBs. The claimant appealed this finding. The hearing officer noted that the date of MMI, May 16, 2006, which was certified by the designated doctor and Dr. G, was not in dispute. The hearing officer noted in the Background Information portion of the Decision and Order that "neither doctor found the difference to be more than 2 centimeters which is required before radiculopathy is to be confirmed by diagnostic testing." In APD 030091-s, decided March 5, 2003, the Appeals Panel held that "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." That decision goes on to state that the findings of neurologic impairment may be verified by electrodiagnostic studies, but that the AMA Guides do not state that electrodiagnostic studies, showing nerve root irritation, without loss of relevant reflexes or atrophy, constitutes undeniable evidence of radiculopathy. *See also* APD 050729-s, decided May 23, 2005; APD 051824, decided September 19, 2005; and APD 051456, decided August 16, 2005.

The specific description of DRE Lumbosacral Category III: Radiculopathy found at page 3/102 of the AMA Guides states:

> Description and Verification: the patient has significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of greater than 2 cm above or below the knee, compared to measurements on the contralateral side at the same location. The impairment may be verified by electrodiagnostic findings. *See* Table 71, p. 109, differentiators 2, 3, and 4.

Differentiator number 3 in Table 71, page 3/109 of the AMA Guides discusses "Decreased circumference, atrophy." This differentiator clarifies that the atrophy must be spine-injury-related and that the measurements "show loss of girth of 2 cm or more" above or below the knee. In Table 71, differentiator number 3 further states that the atrophy cannot be explained by non-spine-related problems.

It is clear from the hearing officer's discussion that she based her determination of the claimant's IR solely on the fact that the atrophy found by both the designated doctor and Dr. G was exactly 2 centimeters rather than greater than 2 centimeters, based on prior interpretation of the AMA Guides requirement for a rating of radiculopathy given by the Appeals Panel. In closing argument, the ombudsman pointed out that differentiator 3 in Table 71 notes circumferential measurements show loss of girth of 2 centimeters or more above or below the knee.

Where a conflict exists between the general directions and the figures in the AMA Guides, the general directions control. *See* APD 022504-s, decided November 12, 2002. However, in the instant case, the general directions for rating lumbosacral radiculopathy specifically refer to the differentiator 3 in Table 71, which gives a further description of "Decreased circumference, atrophy." The description in Table 71, differentiator 3 and the description and verification of DRE Lumbosacral Category III: Radiculopathy contain a minor inconsistency regarding the amount of atrophy required to show significant signs of radiculopathy which are ratable under the AMA Guides. Further, we note that on page 3/100 of the AMA Guides, first column, under Section 3.3e relating to "General Approach and Directions" the AMA Guides state that "[a] series of differentiators (Table 71, p. 109) describes clinical criteria that correlate with serious physiologic dysfunction or structural change, which the physician should use to help define the patient's impairment." We also note that the Texas Supreme Court stated in Albertson's, Inc. v. Sinclair, 984 S.W.2d 958 (Tex. 1999) that "we liberally construe workers' compensation legislation to carry out its evident purpose of compensating injured workers and their dependents." Consequently, to clarify any inconsistency we hold that to receive a rating for radiculopathy the claimant must have significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of 2 centimeters or more above or below the knee, compared to measurements on the contralateral side at the same location. The atrophy or loss of relevant reflex must be spine-injury-related for radiculopathy to be rated.

As explained by the hearing officer, her determination of the IR was based solely on the fact that the atrophy found was not greater than 2 centimeters but rather 2 centimeters exactly. Therefore, we reverse the hearing officer's determination that because the claimant did not have an IR of 15% or greater, she is not entitled to SIBs and remand this case back to the hearing officer to make a determination of IR and SIBs entitlement 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 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 **FIDELITY & GUARANTY INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
701 BRAZOS STREET, SUITE 1050
AUSTIN, TEXAS 78701.

_____
Margaret L. Turner
Appeals Judge

CONCUR:

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Thomas A. Knapp
Appeals Judge

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Veronica L. Ruberto
Appeals Judge