APPEAL NO. 090692-s
FILED JULY 14, 2009

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 February 9, 2009, and concluded on April 13, 2009. With regard to the two disputed issues before him, the hearing officer determined that the respondent (claimant) reached maximum medical improvement (MMI) on January 29, 2008, and that the claimant's impairment rating (IR) is 19%.

The appellant (carrier) appeals, asserting that the designated doctor's date of MMI is not supported by the evidence. The carrier also asserts that the designated doctor (and the hearing officer) have misapplied 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 appeal file does not contain a response from the claimant.

DECISION

Affirmed in part and reversed and remanded in part.

The parties stipulated that the claimant sustained a compensable chest contusion, left thigh contusion, nondisplaced lateral tibia fracture of the left leg, nondisplaced fracture of the fibula head of the left leg, partial tear of the anterior cruciate ligament (ACL) of the left knee, and low back strain injury on _____, and that (Dr. B), was appointed as the designated doctor by the Texas Department of Insurance, Division of Workers' Compensation (Division) to evaluate the date of MMI and assess an IR.

MMI

The hearing officer's determination that the claimant reached MMI on January 29, 2008, as certified by the designated doctor, is supported by sufficient evidence and is affirmed.

IR

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 § 130.1(c)(3) (Rule 130.1(c)(3)) provides that the assignment 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.

It is undisputed that the claimant underwent arthroscopic surgery of the left knee on February 7, 2007. Dr. B, the designated doctor, initially examined the claimant on July 27, 2007, and certified that the claimant was not at MMI. Dr. B re-examined the claimant on January 29, 2008, and certified that the claimant reached clinical MMI on that date with a 26% IR. The 26% IR was based on Diagnosis-Related Estimate (DRE) Lumbosacral Category III: Radiculopathy for 10% impairment; and loss of range of motion (ROM) of the claimant's left knee for 4% impairment and 14% impairment for flexion and flexion contracture respectively, using Table 41, page 3/78 of the AMA Guides.

(Dr. C), a carrier-selected required medical examination doctor examined the claimant on April 29, 2008, and certified that the claimant reached clinical MMI on October 31, 2007, with a 12% IR, based on 8% impairment for loss of ROM of the claimant's left knee and 4% impairment for atrophy. Dr. C rated the low back injury as DRE Lumbosacral Category I: Complaints or Symptoms, 0% impairment. Dr. C criticized Dr. B's application of the AMA Guides regarding the left knee ROM measurements. Dr. C opined that the claimant could not receive a 4% rating under Table 41, page 3/78 of the AMA Guides for flexion and a 14% rating under the same table for flexion contracture.

Dr. C's report was sent to Dr. B in a letter of clarification (LOC) dated July 17, 2008. Dr. B responded, after re-examining the claimant on August 6, 2008. Dr. B again certified that the claimant reached MMI on January 29, 2008, with a 26% IR. However, the 26% IR was based on 10% impairment for DRE Lumbosacral Category III: Radiculopathy; 14% impairment for loss of ROM of the claimant's left knee, flexion contracture, using Table 41, page 3/78 of the AMA Guides; 2% impairment for abnormal left hip motion; and 1% impairment because he felt "the impairments suggested by the [AMA] Guides do not adequately reflect [the claimant's] compensable injuries and associated impairment."

Another LOC was sent to Dr. B and in a response dated December 9, 2008, Dr. B stated he re-examined the claimant and certified that the claimant reached MMI on January 29, 2008, with a 21% IR. The 21% IR was based on 5% impairment for DRE Lumbosacral Category II: Minor Impairment; 14% impairment for loss of ROM of the claimant's left knee (flexion contracture) using Table 41, page 3/78 of the AMA Guides; 2% impairment for abnormal left hip motion; and 1% impairment "because the AMA [G]uides allows an adjustment [1%-3%] for lack of treatment, page [2/9]." Dr. B stated that the claimant was not given the treatment for his ACL injury/surgery as recommended by the Official Disability Guidelines-Treatment in Workers' Compensation published by Work Loss Data Institute (ODG). Dr. B noted the rehabilitation process following surgery involves six months of very intense therapy and the claimant was returned to unrestricted work duty less than eight weeks after the ACL repair surgery.

After the first session of the CCH on February 9, 2009, the hearing officer wrote a LOC to Dr. B asking Dr. B specifically how he arrived at the 21% IR which included a rating for the left hip and 1% impairment for lack of treatment. Dr. B declined to change the 21% IR previously assigned. The hearing officer sent another LOC to Dr. B, informing him that the claimant had specifically indicated that he is not alleging a left hip injury and therefore the left hip should not be included. The hearing officer also asked for additional information regarding the 1% impairment assessed by Dr. B for "lack of treatment." Dr. B responded, stating the claimant did not have appropriate postoperative treatment therefore he deserved an additional impairment and gave alternative ratings including and excluding the left hip. Dr. B certified that the claimant reached MMI on January 29, 2008, and assessed a 19% IR, which excluded an impairment for the left hip. The 19% IR was based on 5% impairment for DRE Lumbosacral Category II: Minor Impairment; 14% impairment for loss of ROM of the claimant's left knee (flexion contracture); and 1% impairment "because the AMA [G]uides allows an adjustment [1%-3%] for lack of treatment, page [2/9]." The hearing officer determined that the claimant's IR for the compensable injury of _____, is 19%.

In all but his first report certifying an IR (certifying a 26% IR), Dr. B assigned 1% impairment for "lack of treatment" referencing page 2/9 of the AMA Guides. The AMA Guides provide in part on page 2/9, as follows:

> **Adjustments for Effects of Treatment or Lack of Treatment**
>
> In certain instances, the treatment of an illness may result in apparently total remission of the patient's signs and symptoms. Examples include the treatment of hypothyroidism with levothyroxine and the treatment of type I diabetes mellitus with insulin. Yet it is debatable as to whether the patient has regained the previous status of normal good health. In these instances, the physician may choose to increase the impairment estimate by a small percentage (eg, 1% to 3%), combining that percent with any other impairment percent by means of the Combined Values Chart (p. 322).
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> In some instances, as with the recipients of transplanted organs who are treated with immunity-suppressing pharmaceuticals or persons treated with anticoagulants, the pharmaceuticals themselves may lead to impairments. In such an instance, the physician should use the appropriate parts of the *Guides* to evaluate the impairment related to the pharmaceutical. If information in the *Guides* is lacking, the physician may combine an estimated impairment percent, the magnitude of which would depend on the severity of the effect, with the primary organ system impairment, by means of the Combined Values Chart.
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> A patient may decline treatment of an impairment with a surgical procedure, a pharmacologic agent, or other therapeutic approach. The

> view of the *Guides* contributors is that if a patient declines therapy for a permanent impairment, that decision should neither decrease nor increase the estimated percentage of the patient's impairment. However, the physician may wish to make a written comment in the medical evaluation report about the suitability of the therapeutic approach and describe the basis of the patient's refusal.

The portion of the AMA Guides relied upon by Dr. B to assess 1% impairment for "lack of treatment" is not applicable in the claimant's circumstances. There was no evidence that the claimant was taking medication which resulted in apparent total remission of his condition. Dr. B opined that the claimant did not receive as much physical therapy as called for by the ODG, justifying his increase of the claimant's impairment by 1% for "lack of treatment." However, not having the requisite number of physical therapy sessions is not contemplated by the AMA Guides for assessing additional impairment under the section relied upon by Dr. B. Dr. B clearly believed that the claimant had reached MMI clinically and consistently found the same date for MMI for numerous re-examinations of the claimant. Dr. B did assess an impairment for loss of ROM of the claimant's left knee. We hold that the AMA Guides do not allow for assessment of additional impairment under the facts presented. The hearing officer erred in adopting Dr. B's assessment of a 19% IR.

In his initial certification certifying an IR, Dr. B certified that the claimant reached MMI on January 29, 2008, with a 26% IR based on DRE Lumbosacral Category III: Radiculopathy for 10% impairment; and loss of ROM of the claimant's left knee for 4% impairment and 14% impairment for flexion and flexion contracture respectively, using Table 41, page 3/78 of the AMA Guides. In reports subsequent to his initial certification, Dr. B does not rate the claimant's lumbar spine for radiculopathy noting measurements of the claimant's lower extremities did not reflect a 2 cm or greater difference in atrophy. No other doctor who examined the claimant and assessed an IR found significant signs of radiculopathy that was ratable. Additionally, Dr. B's subsequent reports do not note loss of ROM for flexion. Based on the evidence presented in this case, the preponderance of the other medical evidence is contrary to the 26% IR assessed by Dr. B and on remand the hearing officer cannot adopt the 26% IR initially assessed by Dr. B because to do so would be so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust.

Also, in evidence was a certification from Dr. B in which he certified that the claimant reached MMI on January 29, 2008, with a 21% IR. However, the 21% IR includes 2% impairment for loss of ROM of the left hip, which is not part of the compensable injury and 1% impairment based on page 2/9, of the AMA Guides, for "lack of treatment." Dr. B's 21% IR based on the December 9, 2008, re-examination cannot be adopted because he improperly assigned 1% impairment for "lack of treatment" and an IR for the left hip.

All the other certifications in evidence, except those assessed by Dr. B, certify a different date of MMI than the one determined by the hearing officer and affirmed herein, and therefore cannot be adopted. *See* Rule 130.1(c)(3).

Accordingly, we reverse the hearing officer's determination that the claimant's IR is 19% as that IR is not in accordance with the AMA Guides. We remand the case to the hearing officer to determine whether Dr. B is still qualified and available and is willing to comply with the AMA Guides. On remand, the hearing officer should inform Dr. B that the AMA Guides do not allow a 1% assessment for "lack of treatment" under the evidence presented. If it is determined that Dr. B is unwilling or refuses to apply the AMA Guides as directed then another designated doctor is to be appointed pursuant to Rule 126.7(h) to determine the claimant's IR as of the January 29, 2008, date of MMI.

SUMMARY

We affirm the hearing officer's determination that the claimant reached MMI on January 29, 2008. We reverse the hearing officer's determination that the claimant's IR is 19% and remand the IR issue to the hearing officer, 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* Appeals Panel Decision 060721, decided June 12, 2006.

The true corporate name of the insurance carrier is **ZURICH AMERICAN 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.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Veronica L. Ruberto
Appeals Judge

_____
Margaret L. Turner
Appeals Judge