

Designated Doctor  
Case-Based Webinar  
Module 2

**Spine MMI IR EOI**

## Disclaimer

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Do not cite the webinar information.

The only things that are authoritative are the adopted AMA Guides, 4<sup>th</sup> Edition, the APDs and the Texas Administrative Code.

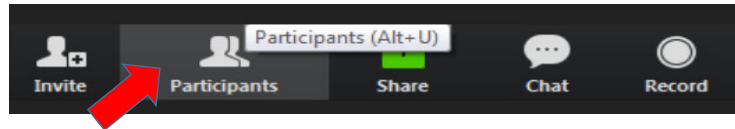
These cases “cherry pick” certain details in the records. Your cases may not be as obvious.

**It is your responsibility** (not your scheduling company) to add in pertinent details from the records,

ESPECIALLY those that are temporally related to the DOI in your record review. Failure to do so will lead to a legally insufficient report.

# Housekeeping

At the bottom of your screen, click to turn on the participant list:



Ensure your name (not phone # or initials) is shown on the Participant List for CME and attendance purposes. If not, do the following to rename:

Hover over your current sign in and two boxes appear

Click on the Rename box

Type in your first and last name

Make sure your name shows correctly in the Participant list.

# Asking questions

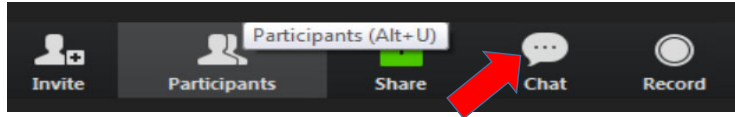
Please mute your phone/VOIP audio connection

All attendees will be muted during the presentation and submit questions via Chat

Attendees may be unmuted at the request of the monitor or instructor for clarification or further discussion

## Asking questions

You will find the Chat feature to the right of the participants list.



As the instructor goes through the course they will ask for questions via chat at the end of a case, or after a concept has been explained.

You may type your questions into Chat. The Chat monitor may answer your question in Chat, or have the instructor answer the question verbally.

# Spine Maximum Medical Improvement / Impairment Rating (MMI/IR)

## Combined Values for Impairment Rating

Each organ system/body area should be expressed as a whole person impairment, then

- Whole person impairments should be **combined** using the Combined Values Chart (pp. 322 – 324)
- “Combining” assures that the impairment can’t exceed 100%. It reduces the remaining portion of the whole person that is available for the second impairment
- Example 40% c/w 40% (of the remaining 60%) = 64%



## Combining 3 or More Impairment Values

“If three or more impairment values are to be combined, select any two and find their combined value as above. Then use that value and the third value to locate the combined value of all. This process can be repeated indefinitely, the final value in each instance being the combination of all the previous values. In each step of this process, the larger impairment value must be identified at the **side** of the chart.” (page 322)

## **Combining 3 or More Impairment Values**

**Best practice - combine the largest %  
with the second largest %, then  
combine with third largest %, etc**

## **Conflict between DWC Statutes/Rules and *AMA Guides***

**Be aware of when DWC  
Statutes/Rules  
take precedence**

## Spine MMI/IR Case 1

- 62-year-old female veterinarian assistant began having low back pain after lifting 100-lb. dog at work
- Initial pain drawing showed left lumbosacral pain
- X-rays on date of injury showed a well healed compression fracture with less than 25% loss of anterior height of L1 vertebral body

## Spine MMI/IR Case 1

- Developed pain in left leg in patchy distribution approximating L5-S1 on left which persisted
- Lumbar MRI at six weeks demonstrated 2 mm right paracentral protrusion at
  - L5-S1
    - no edema in any vertebral body

# Spine MMI/IR Case 1

## At MMI

- Right lumbar list
- Deviation to the right with lumbar flexion
- Limitation of right side bend with increased left lumbosacral pain
- Able to walk on heels and toes and squat without evidence of weakness
- Achilles DTRs absent bilaterally
- 1+ patellar DTRs bilaterally

# Spine MMI/IR Case 1

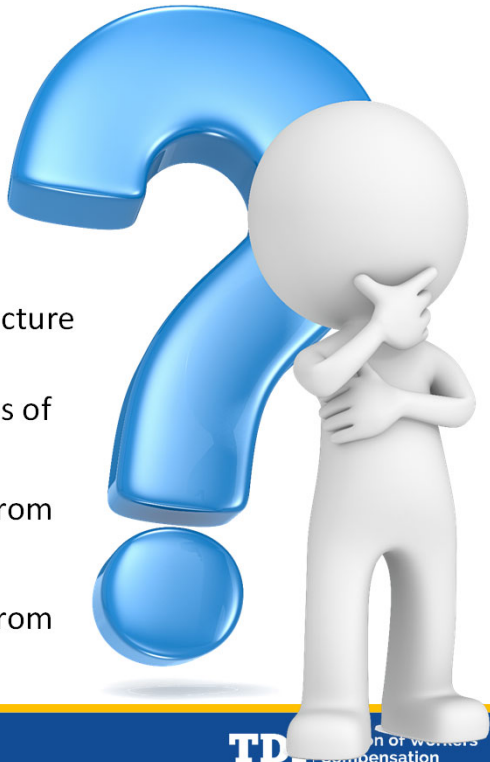
## At MMI (cont'd)

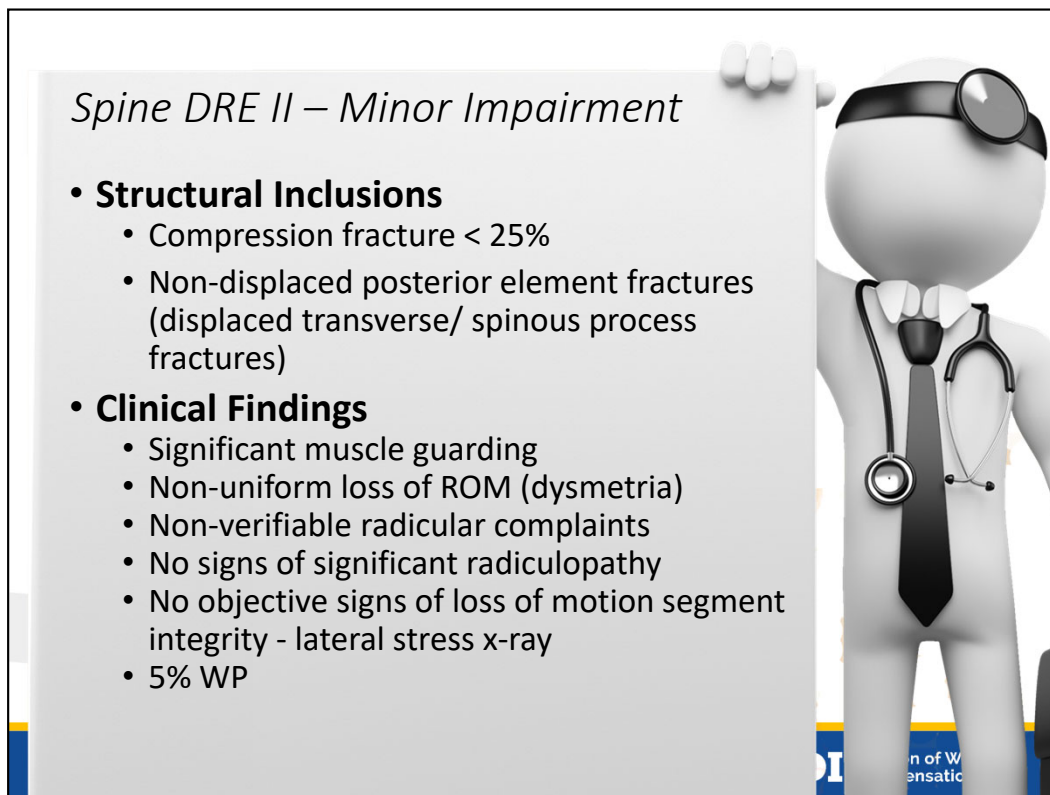
- Symmetric LE girth
- Complaints of decreased sensation left shin and lateral foot
- LE strength 5/5
- Left SLR 54° with increased LBP, increased with ankle dorsiflexion
- Right SLR 70° limited by hamstring tightness

## Spine MMI/IR Case 1

On date of MMI, what is appropriate lumbosacral DRE category and why?

- A. DRE II: Due to compression fracture at L1
- B. DRE II: Due to non-uniform loss of range of motion
- C. DRE III: Due to radiculopathy from loss of sensation
- D. DRE III: Due to radiculopathy from loss of relevant reflex





*Spine DRE II – Minor Impairment*

- **Structural Inclusions**
  - Compression fracture < 25%
  - Non-displaced posterior element fractures (displaced transverse/ spinous process fractures)
- **Clinical Findings**
  - Significant muscle guarding
  - Non-uniform loss of ROM (dysmetria)
  - Non-verifiable radicular complaints
  - No signs of significant radiculopathy
  - No objective signs of loss of motion segment integrity - lateral stress x-ray
  - 5% WP

SPASM is mentioned in Table 71 but not in text for DRE II.

While 4th Edition states “history of“, Rule 130.1 states that you rate the condition at MMI.


So, rating history of spasm would be like rating a “History of” misaligned fracture acutely that then healed in appropriate alignment after treatment.

There is no APD ruling on this, so you must make your determination and defend by explaining in your narrative report.

DISCUSS what is “Non-uniform loss of ROM (dysmetria)” In the context of a symptomatic DISC, what would you expect?

Worse with FF and dependent on location of disc (Paracentral, subarticular, foraminal) potentially bending same side or opposite side.

Does “Non-verifiable radicular complaints” mean global extremity pain or pain that is not at least partially dermatomal or pain that does not correlate with the MRI?



**Spine MMI/IR Case 1**

- 5% from DRE II non-uniform loss of motion
- Explain what this means to you and how it is appropriate to use in this case
- L1 compression fracture pre-exists injury (imaging inconsistent with acute L1 compression fx)
- There are no significant signs of radiculopathy
  - Loss of relevant reflex(es)
  - Unilateral atrophy  $\geq 2$  cm

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TD Compensation

# R SB Increased pain, right list that increased with FF = consistent with symptomatic disc

#T2 and especially STIR (Short Tau Inversion Recovery) for spine or T2 PD (Proton Density) for extremity sequences are used to enhance ability to visualize.

Explain this in your report - that based on imaging the compression fracture IS NOT acute! If you don't the ALJ may assume that you did not consider that in your report.

#SIGNIFICANT SIGNS: The reflex loss is BILATERAL in a 64 year old. Sensory changes are to the wrong side to the MRI changes.

# Questions About Spine MMI/IR Case 1?



## Spine MMI/IR Case 2

- 25-year-old painter fell off a ladder sustaining fracture of inferior right L5 facet
- Non-contrast lumbar CT and lumbar MRI showed acute right L5 facet fracture, no displacement of fracture into spinal canal
- Initial exam demonstrated
  - Decreased sensation in right L5 distribution
  - Weakness right hip abductors, tibialis anterior, EHL
  - Absent right medial hamstring DTR

What would the usual mechanism be for a facet Fracture? It would usually be Axial load plus extension.

Be sure you know your neuroanatomy!

Weak TFL (L4L5S1), TA (L4L5), EHL (L5S1). Unilateral decreased or absent medial HS reflex in the face of adequate relaxation is consistent with L5 radiculopathy.

## Spine MMI/IR Case 2

### At MMI

- EMG/NCS at 6 weeks post injury interpreted to show “acute right L5 radiculopathy”
- LE DTRs symmetrically decreased
- Right SLR 60° with increased LBP and posterior thigh pain increased with ankle dorsiflexion
- Left SLR 70° limited by hamstring tightness
- Decreased sensation in L5 dermatome

EMG – It may take 3 weeks (arm), to 4 weeks (leg) for findings to fully evolve, even if objective weakness or reflex changes occur before that.

# Improvement of reflex. #True dural tension sign. But, still with signs of CLINICAL radiculopathy.

## Spine MMI/IR Case 2

On date of MMI, what is  
the whole person IR?



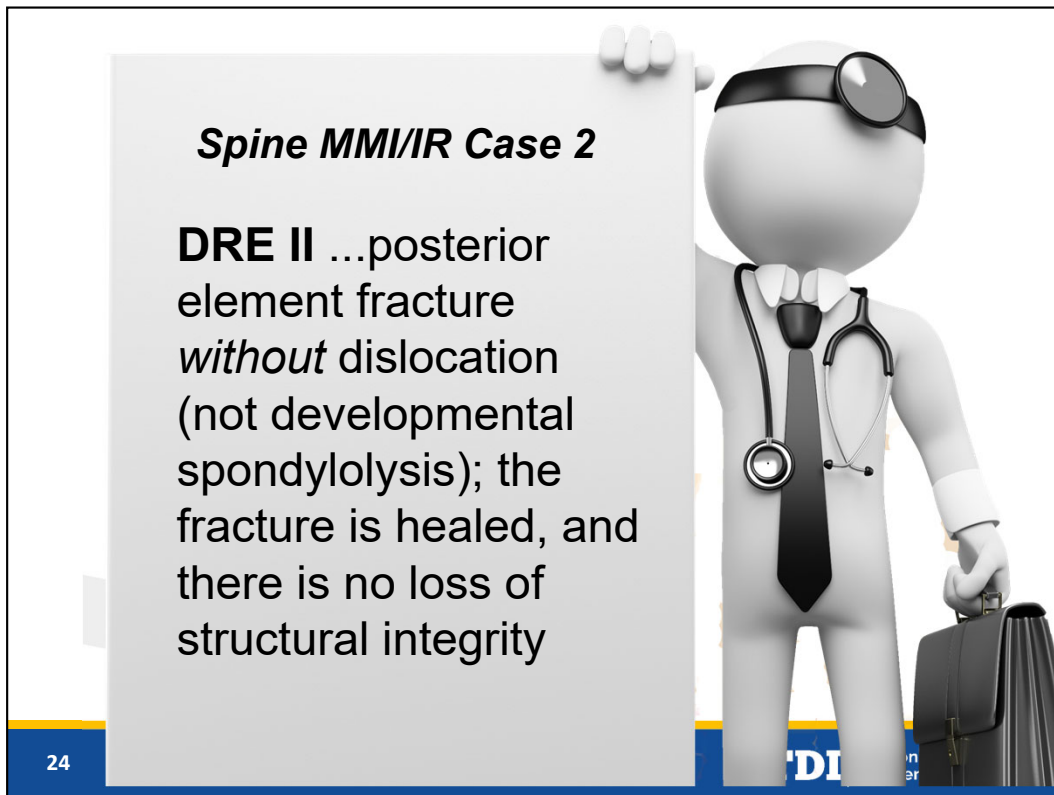
## Spine MMI/IR Case 2

On the date of MMI,  
what is the whole  
person IR?

- A. DRE I = 0%
- B. DRE II = 5%
- C. DRE III = 10%
- D. DRE IV = 20%



Correct answer is B. DRE II.



Were there any other differentiators? The IE still had a clinical radiculopathy so the category is DRE II for NON-VERIFIABLE RADICULAR COMPLAINTS. The IE Did NOT meet the criteria / have the differentiators required for DRE III.

### DRE Lumbosacral Category II: Minor Impairment

*Description and Verification:* The clinical history and examination findings are compatible with a specific injury or illness.

The findings may include significant intermittent or continuous muscle guarding that has been observed and documented

by a physician, nonuniform loss of range of motion (dysmetria, differentiator 1, Table 71, p. 109), or non-verifiable radicular

complaints. There is *no* objective sign of radiculopathy and *no* loss of structural integrity. See Table 71, differentiator 1


(p. 109).

*Structural Inclusions:* (1) Less than 25% compression of one vertebral body; (2) posterior element fracture *without* dislocation

(not developmental spondylolysis) ; the fracture is healed, and there is no loss of motion segment integrity. A spinous or transverse

process fracture with displacement without a vertebral body fracture is a category II impairment because it does not disrupt the spinal canal.

*Impairment:* 5% whole-person impairment.



**Spine MMI/IR Case 2**

**Not DRE III** for radiculopathy

- no significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of greater than (or equal to) 2 cm above or below the knee on date of MMI

**Not DRE III** for posterior element fracture

- no displacement disrupting the spinal canal, healed without loss of structural integrity.

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You are rating the condition at MMI – NOT based on the early clinical status. Reflexes symmetric. Not enough atrophy, despite sensory changes in dermatome.

### DRE Lumbosacral Category III: Radiculopathy

*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.

*Structural Inclusions:* (1) 25% to 50% compression of one

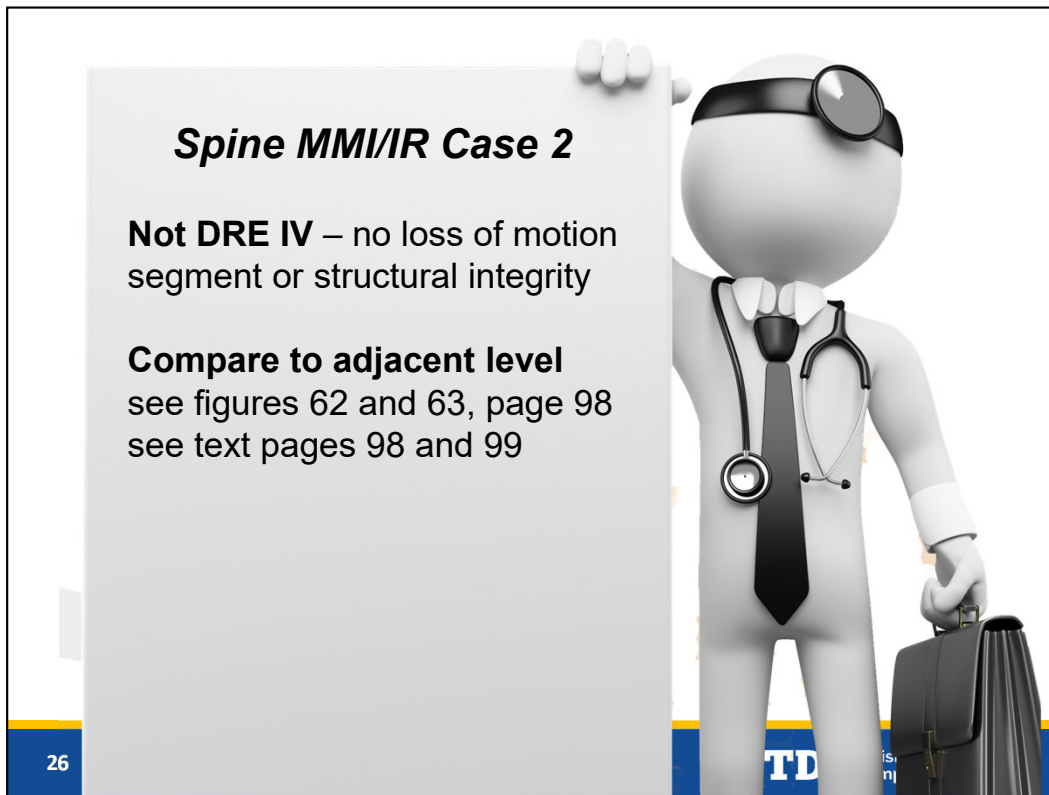
vertebral body; (2) posterior element fracture, but *not* fracture of transverse or spinous process, *with* displacement disrupting the spinal canal, healed with out loss of structural integrity.

Radiculopathy may or may not be present.

Differentiation from congenital and developmental conditions may be accomplished by examining preinjury roentgenograms

or a bone scan performed after onset of the condition.

*Impairment:* 10% whole-person impairment.



Should have x-rays proximate to the date of MMI to determine.

#### DRE Lumbosacral Category IV: Loss of Motion Segment Integrity

*Description and Verification:* The patient has loss of motion segment integrity (differentiator 5, Table 71, p. 109).

Loss of motion segment or structural integrity is defined as at least 5 mm of translation of one vertebra on another, or angular motion at the involved motion segment that is  $11^{\circ}$  more than that at an adjacent motion segment (Figs. 62 and 63, p. 98).

Loss of structural integrity at the lumbosacral joint is defined as at least  $15^{\circ}$  more angular motion than at the L4 and L5 motion segment. A documented history of muscle guarding and pain is present. Neurologic abnormalities need not be present.

If they are present, the examiner should consider using category V.

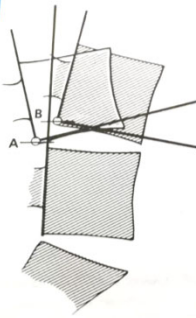
*Structural Inclusions:* (1) Greater than 50% compression of one vertebral body without residual neurologic compromise;

(2) multilevel spine segment structural compromise, as with fractures or dislocations, without residual neurologic motor compromise.

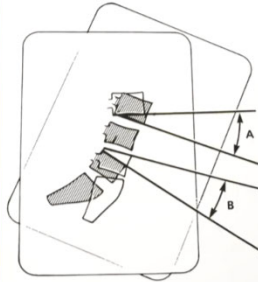
*Impairment:* 20% whole-person impairment.

# Impairment Rating – Spine Loss of Motion Segment Integrity

**Figure 62.** Loss of Motion Segment Integrity:  
Translation.

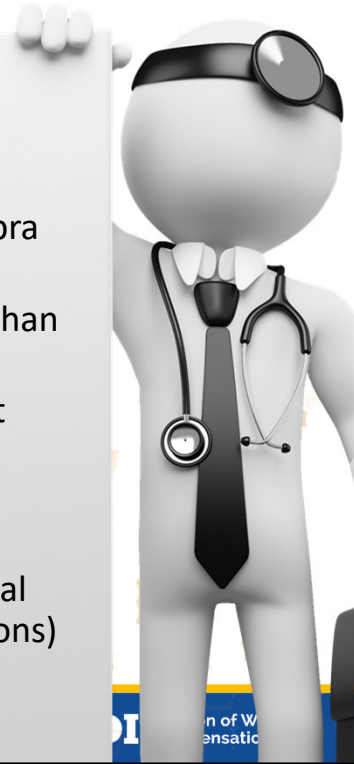


**Figure 63.** Loss of Motion Segment Integrity:  
Angular Motion.



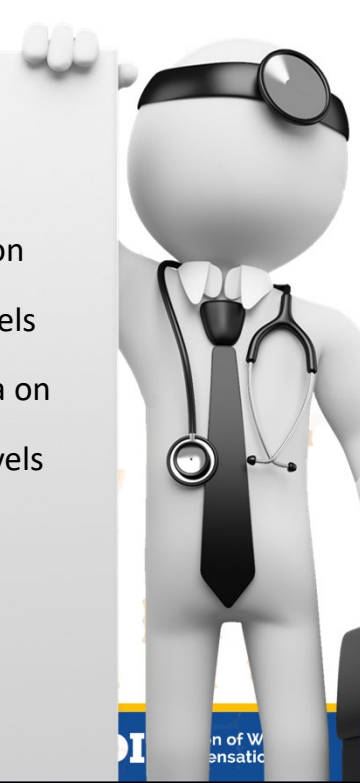
## *Spine DRE IV - Lumbar*

- **Loss of Motion Segment Integrity**
  - Lumbar
    - > 5mm translation of one vertebra on another
    - >15° of excess motion at L5/S1 than L4/L5
    - >11° angular motion at adjacent levels
- **Structural Inclusions**
  - Compression fracture >50%
  - Multi-level spine segment structural compromise (fractures & dislocations)
- **Lumbosacral = 20% WP**



*Spine DRE IV – Cervicothoracic and Thoracolumbar*

- **Loss of Motion Segment Integrity**
  - Thoracic
    - $\geq 5$ mm translation of one vertebra on another
    - $>11^{\circ}$  angular motion at adjacent levels
  - Cervical
    - $>3.5$  mm translation of one vertebra on another
    - $>11^{\circ}$  angular motion at adjacent levels
- **Structural Inclusions**
  - Compression fracture  $>50\%$
  - Multi-level spine segment structural compromise (fractures & dislocations)
- **Bilateral or Multi-level Radiculopathy**
- **Cervicothoracic = 25% WP**
- **Thoracolumbar = 20% WP**



So, the main differences are lumbar is  $>$  or  $= 5$  mm and cervical and thoracic are  $> 3.5$  mm, **within the DRE descriptions.**

**But, Table 71, on Pg. 109 specifies that for Lumbar, Thoracic and Cervical the amount of translation must be equal to or greater than the measurement provided, to meet the criteria of DRE IV**

L5/S1 is  $> 15$  degrees compared to L4/L5 and ALL OTHER are 11 degrees compared to adjacent.

The other way to get there is BILATERAL or MULTILEVEL RADIC. READ THE TEXT on pages 102, 104, 106.

Although used for ROM model, don't forget Table 83 with the nerve root values.

Non-traumatic radiculopathies, such as due to a complication of treatment

## Questions About Spine MMI/IR Case 2?



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 C. |   
 rson

What IF the Right L5 reflex was still decreased >>>> DRE III.

Practice L5 reflex EVERY exam so that you get proficient at it.

Only in ~ 10 – 20 % of individuals, but most lumbar radiculopathies are L5 so it is important to know the technique.

## Spine MMI/IR Case 3

- 45-year-old carpenter began having right low back and right lower extremity pain after lifting lumber at work
- Lumbar MRI showed 8 mm right posterolateral L4/5 herniated disc compressing the right L5 nerve root
- Lumbar ESI x 3 and PT with improvement
- EMG interpreted by neurologist to be positive for right L5 radiculopathy
- Does not want to pursue surgery, ESI or further treatment

## Spine MMI/IR Case 3

### At MMI

- History left knee ACL reconstruction
- Complains of intermittent low back and right buttock, posterior thigh and lateral calf pain
- Worsened with cough/sneeze, sitting, lifting and other activities involving trunk flexion
- Achilles DTRs 2+ bilaterally
- Patellar DTRs 1+ left, 2+ right
- Unable to elicit hamstring reflexes on either side

“Worsened with cough/sneeze, sitting, lifting and other activities involving trunk flexion” is c/w discogenic pain generator.

## Spine MMI/IR Case 3

- Lumbar ROM

Lumbar Flexion 35°	Extension 25°
RLF 20°	LLF 10°

- Right SLR 55° which produces right low back, buttock, posterior thigh and calf pain
- Further worsened with ankle dorsiflexion and hip internal rotation/adduction
- Left SLR 70° limited by hamstring tightness
- 4/5 strength of right EHL and hip abductors
- Symmetric LE girth

Is that ROM non-uniform? Is it consistent with a discogenic source of pain for paracentral herniated disc?

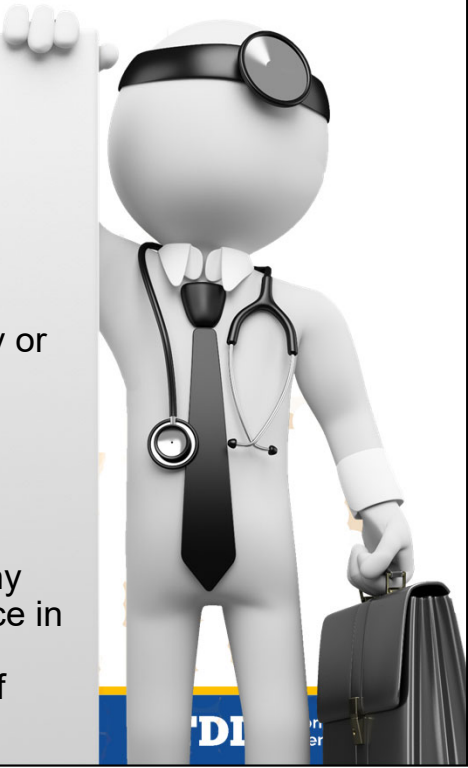
## Spine MMI/IR Case 3

On date of MMI, what is the whole person IR?

- A. DRE I: 0%
- B. DRE II: 5%
- C. DRE III: 10%
- D. DRE IV: 20%



Answer is B. DRE II



**Spine MMI/IR Case 3**

DRE II

- Non-verifiable radicular complaints
- Non-uniform loss of motion

**Not** DRE III

- **Not** 2 cm or greater atrophy or loss of relevant DTR

What about L5? (C8? T1?)

- ROM Model??
- Rarely used and requires significant explanation why DRE is not applicable or why more data is needed to place in IE correct DRE
- Also used as differentiator if used

The reflex loss is WRONG side and level (L4 NOT L5) and is due to prior ACL reconstruction.

DIFFERENTIATOR means that you use it to JUSTIFY the DRE III, NOT use the # obtained.

## *Spine DRE III Radiculopathy & Others*

### **Structural Inclusions**

- Compression Fracture > 25% and < 50%
- Displaced posterior element fractures (not spinous or trans-verse process) that disrupt spinal canal

### **Clinical Findings**

- Loss of relevant reflex(es)
- 2 cm or greater atrophy with circumferential measurements of relevant extremity

Cervicothoracic & Thoracolumbar = 15% WP

Lumbosacral = 10% WP



### ***Spine DRE III Radiculopathy & Others***

**Radiculopathy** may be an accepted/compensable condition with corresponding clinical findings, but may *not* be ratable as DRE III

Must have “significant signs” of radiculopathy

- Loss of reflex(es) – includes decreased and absent relevant reflex(es)
- 2 cm or greater atrophy with circumferential measurements of relevant extremity



RADICULOPATHY is just the NAME for a DRE III. Clinical radiculopathy DOES NOT always EQUAL a RATABLE radiculopathy.

Nerve Root	Weakness (Atrophy)	Deep Tendon Reflex
C5	Deltoid, Biceps (upper arm)	Biceps
C6	Biceps (upper arm), wrist extensors (forearm)	Brachioradialis
C7	Triceps(upper arm), wrist flexors (forearm), finger extensors (forearm)	Triceps
C8	Hand intrinsic (difficult to measure)	
T1	Hand intrinsic (difficult to measure)	
L4	Quadriceps (thigh)	Patellar or "knee jerk"
L5	Gluteus medius (difficult to measure), tibialis anterior (lower leg) and extensor hallucis longus (difficult to measure)	Medial hamstring (difficult to obtain)
S1	Gastrocnemius, soleus (lower leg/calf)	Achilles or "ankle jerk"

These are reflexes commonly tested

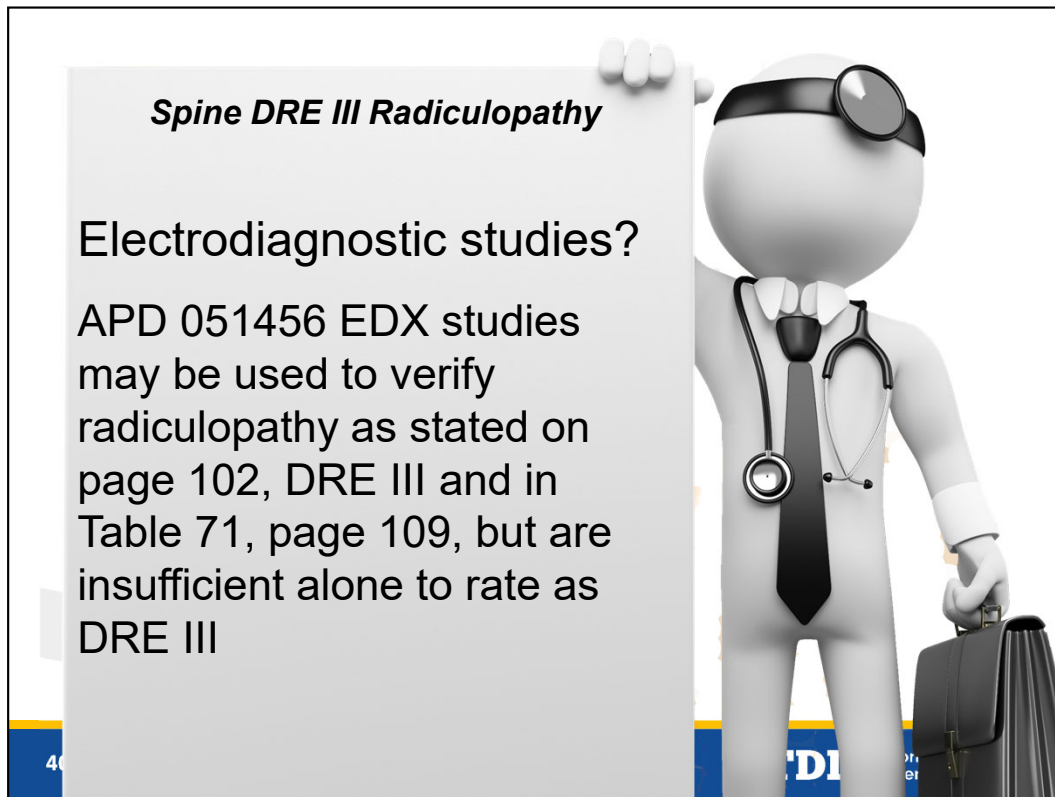
Pronator Teres can also be used to test C6 and C7.

Lateral HS can be used for S1 for the elderly or below knee amputees.

### ***Spine DRE III Radiculopathy & Others***

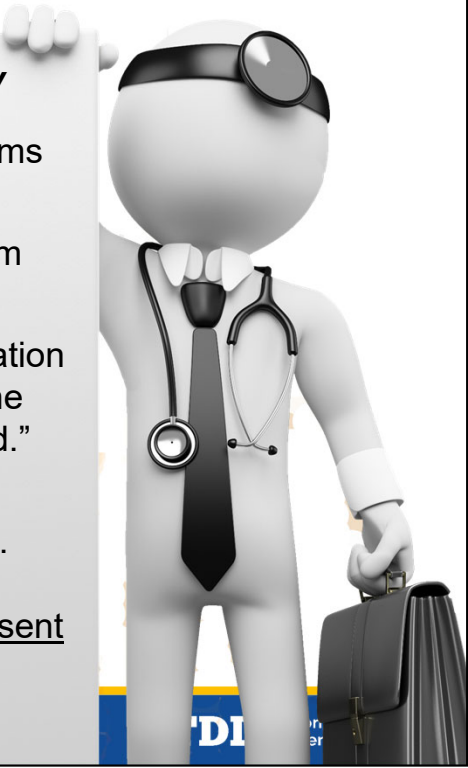
- Appeal Panel Decisions (APDs) 040924, 091039, 111710 - Loss of relevant reflex(es) includes ***decreased*** and ***absent*** reflexes
- APD 030091-s Radiculopathy requires >2 cm of atrophy and/ or loss of relevant reflex(es)
- APD 072220-s clarified that DRE III radiculopathy was for atrophy of 2 cm or more





EDX abnormalities can persist even after RESOLUTION of clinical symptoms or adequate decompression.

EDX in past is not rating the condition at MMI.



**Spine DRE III Radiculopathy**

- What about MRI, CT, Discograms and other X-ray findings?
- History and other physical exam findings?
- There should be clinical correlation “...plausible and relate to the Impairment being evaluated.” page 8, Guides
- Surgery? (page 100 Guides vs. DWC law and rules)
  - Rate impairment that is present at MMI

Implication of the last one could be >>> spondylolisthesis that RESOLVES with surgical fusion.

## Questions About Spine MMI/IR Case 3?

Check out the article,  
"**Nomenclature and  
Classification of Lumbar Disc  
Pathology**" at  
[http://hbtinstitute.com/files/SPINE  
2001\\_Disk\\_Nomenclature.pdf](http://hbtinstitute.com/files/SPINE_2001_Disk_Nomenclature.pdf)



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Remember the higher levels above IV. There may be DD Test questions on these DREs. Be aware of where to look in Guides to help you determine your answers.  
T

When you take the test, that should not be the first time you look at these pages.

If you are a DC and the records reveal B/B involvement, you should contact DWC to redesignate the exam.

It could happen that Non-MSK conditions are only revealed to you at the time of the exam, and you find you are not qualified by rule to conduct the exam/provide MMI/IR..

Call the division.

If spinal cord injury is a condition, only NEURO / PM&R are qualified, but in some counties, other MDs may be asked to see if they are the most qualified physician available there. The division should notify you when the exam is assigned that you are the most qualified. Call the division if you have questions.

# Questions About Spine MMI/IR?



## Spine - MMI, IR, EOI Case

You receive a Presiding officer Directive address MMI/IR and EOI and provide multiple certifications

- **NOTICE – Effective 6/5/2023:** DDs are no longer required to provide multiple certifications when a DWC-032 requests MMI/IR and EOI in a single exam.
- Multiple certifications are only to be provided when ordered by the division via a POD

The directions in the following slides are for a hypothetical POD request. The issues of MMI, IR and EOI will usually be requested on a POD requesting multiple certifications, but that could vary.

As of 6/5/2023 DDs will only provide multiple certifications when ordered by the division in a Presiding Officer's Directive (POD).

The Administrative Law Judge will provide directions to the DD on the certifications required (what injuries to include for each certification).

## Spine MMI/IR/EOI Case

- 45-year-old male warehouse worker with acute onset low back pain after lifting 150-lb. toolbox four months ago
- Medical records document low back pain on date of injury with left buttock, posterior thigh and calf radicular pain five days later
- Physical exam 2 weeks post injury
  - Left leg weakness
  - Slightly decreased ankle DTR
  - Left SLR positive for increased left leg symptoms

Is this consistent with Clinical Radiculopathy? Dermatomal?

## Spine MMI/IR/EOI Case

- Lumbar x-rays show L5/S1 spondylosis
- Lumbar MRI shows L5/S1 disc degeneration, ligamentum flavum and facet hypertrophy L5/S1; 6 mm left posterolateral disc protrusion left L5-S1 with impingement exiting left S1 nerve root
- Signs and symptoms persist despite 10 visits of PT, NSAIDS, muscle relaxants and narcotic pain medication
- ESI and surgery denied because extent of injury beyond a lumbar sprain/strain disputed

Are the clinical findings consistent with imaging?

## Spine MMI/IR/EOI Case

DD Exam 4 Months Post Injury for

MMI, IR and EOI and multiple certifications:

- **Certification 1** - for carrier accepted injuries,
- **Certification 2** - for carrier accepted plus all disputed, and
- **Certification 3** – for the DD’s opinion of the compensable injury if different from the first two certifications.
- The POD notes the insurance carrier accepted injury as “lumbar sprain/strain”

## Spine MMI/IR/EOI Case

### DD Exam 4 - Months Post Injury for MMI, IR and EOI (cont'd)

- On the POD, the ALJ lists the injuries (diagnoses/body parts/conditions) in question, claimed to be caused by, or naturally resulting from accident or incident as:
  - Facet hypertrophy at L5/S1
  - Ligamentum flavum hypertrophy L5/S1
  - Disc dessication at L5/S1 lumbar spine
  - L5-S1 disc protrusion with impingement on exiting left S1 nerve root

## Spine MMI/IR/EOI Case

- You define the compensable injury for certifying MMI and IR
  - **Lumbar sprain/strain** (from POD list of Carrier accepted injuries)
  - **L5-S1 disc protrusion** with impingement on exiting left S1 nerve root (from POD list of disputed conditions)
  - **Left S1 radiculopathy** (not included in POD)
- Explain in report basis in medical records and certifying exam that led to conclusion

Assume that your exam is consistent / similar to that at 2 weeks after the DOI.

Explain the MOI and whether or not it is consistent with a mechanism that would cause / aggravate a disc protrusion.

Were subjective complaints and clinical findings consistent with a RAUMATIC radiculopathy?

Are the clinical findings consistent with the IMAGING? What about EBM?

Know what the counter evidence is, and what about THIS CASE's evidence you included or did not include.

## Spine MMI/IR/EOI Case

You address ***Extent of Injury***, with causation analysis, that injury ***does not*** extend to these additional claimed injuries listed in Box 31C

- Facet hypertrophy and at L5/S1
- Ligamentum flavum hypertrophy L5/S1
- Disc desiccation at L5/S1 lumbar

WHY were these not included?

Ligamentum flavum is extremely durable and takes fracture / dislocations to injure. Very Tough!

What kind of mechanism would aggravate facet joints? How do you aggravate disc desiccation?

## Spine MMI/IR/EOI Case

You address ***Extent of Injury***, with causation analysis, injury ***does*** extend to

- L5-S1 disc protrusion with impingement on exiting left S1 nerve root

## Spine MMI/IR/EOI Case

- Multiple certifications of MMI/IR, as directed in the POD, each with DWC Form-069, all explained in your report
  - Certification 1
  - Certification 2
  - Certification 3

## Spine MMI/IR/EOI Case

### Certification 1

MMI/IR for injury Noted in POD as ***injury accepted as compensable by insurance carrier*** as “lumbar sprain/strain”

# Certification 1

DWC069

**Texas Department of Insurance**  
Division of Workers' Compensation  
7551 Metro Center Drive, Suite 100 • M5-94  
Austin, TX 78744-1645  
(800) 252-7031 phone • (512) 490-1047 fax

Complete if known:  
DWC Claim # \_\_\_\_\_  
Carrier Claim # \_\_\_\_\_

**Report of Medical Evaluation**

**I. GENERAL INFORMATION**

1. Injured Employee's Name (Print, Middle, Last)	4. Date of Injury	6. Social Security Number	9. Certifying Doctor's Name and License Type
2. Workers' Compensation Insurance Carrier	5. Date of Exam	7. Employee's Phone Number	10. Certifying Doctor's License Number and Jurisdiction
3. Employer's Name	8. Employer's Address (Street or PO Box, City, State, Zip)	11. Certifying Doctor's Phone and Fax Numbers (Ph) (Fax)	12. Certifying Doctor's Address (Street or PO Box, City, State, Zip)

**II. DOCTOR'S ROLE**

13. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMI/impairment and file this report (28 Texas Administrative Code (TAC) §136.1 governs such authorization):

Treating Doctor  Doctor selected by Treating Doctor acting in place of the Treating Doctor  Designated Doctor selected by DWC  
 Insurance Carrier-selected RME Doctor approved by DWC to evaluate MMI and/or permanent impairment after a Designated Doctor examination

NOTE: If you are not authorized by 28 TAC §136.1 to file this report, you will not be paid for this report or the MMI/impairment examination.

**III. MEDICAL STATUS INFORMATION**

14. Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
15. Diagnosis Codes: **S33.5XXA S39.012A**

16. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions:

Clinical MMI: Clinical Medical Improvement (Clinical MMI) is the earliest date after which, based upon reasonable medical probability, further material recovery or lasting improvement to an injury is no longer reasonably anticipated.

Statutory MMI: Statutory MMI is the later of: (1) the end of the 104-week period after the date that temporary income benefits (TIBs) began to accrue; or (2) the date that the employee's TIBs were extended by DWC pursuant to Texas Labor Code §403.104.

a)  Yes, I certify that the employee reached  CLINICAL or  STATUTORY /  CLINICAL (mark one) MMI on \_\_\_\_/\_\_\_\_/\_\_\_\_ (may not be the same as the date of the last examination and documentation relating to this certification in the attached narrative. - OR -  
b)  No, I certify that the employee has NOT reached Clinical or Statutory MMI but is expected to reach MMI on or about \_\_\_\_/\_\_\_\_/\_\_\_\_. The reason the employee has not reached Clinical or Statutory MMI is documented in the attached narrative.

NOTE: The fact that an employee has not reached Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits.

**IV. PERMANENT IMPAIRMENT**

17. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury. "Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impairment exists must be made based upon objective clinical or laboratory findings meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.

a)  I certify that the employee does not have any permanent impairment as a result of the compensable injury. - OR -  
b)  I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is \_\_\_\_\_%, which was determined in accordance with the requirements of the Texas Labor Code and Texas Administrative Code. The attached narrative provides explanation and documentation used for the calculation of the impairment rating assigned using the appropriate tables, figures, or worksheets from the following edition of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association (AMA):  
 fifth edition, 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, or 4<sup>th</sup> printing, including corrections and changes issued by the AMA prior to May 16, 2000. - OR -  
 fourth edition, 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, or 4<sup>th</sup> printing, including corrections and changes issued by the AMA prior to May 16, 2000.

NOTE: A finding of no impairment is not equivalent to a 0% impairment rating. A doctor can only assign an impairment rating, including a 0% rating, if the doctor performed the examination and testing required by the AMA Guides.

**V. DOCTOR'S CERTIFICATION**

18. I HEREBY CERTIFY THAT THIS REPORT OF MEDICAL EVALUATION is complete and accurate and complies with the Texas Labor Code and applicable rules. If an impairment rating has been assigned, I certify that I have completed the required training and testing and have a current certification by DWC to assign impairment ratings in the Texas workers' compensation system or have received specific permission by DWC to certify MMI and assign an impairment rating. I understand that making a misrepresentation about a workers' compensation claim or myself is a crime that can result in fines and/or imprisonment and notification of this report.

Signature of Certifying Doctor: \_\_\_\_\_ Date of Certification: \_\_\_\_\_

**VI. TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION**


19. Treating Doctor's Name and License Type: \_\_\_\_\_  
 I AGREE /  DISAGREE with the certifying doctor's certification of MMI.

20. Treating Doctor's License Number and Jurisdiction: \_\_\_\_\_  
 I AGREE /  DISAGREE with the certifying doctor's finding of no impairment. - OR -  
 I AGREE /  DISAGREE with the impairment rating assigned by the certifying doctor.

21. Treating Doctor's Phone and Fax Numbers (Ph) (FAX): \_\_\_\_\_

24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Treating Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

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To presenter: Animation will complete this 69 with info from previous slide, codes for Lumbar sprain/strain


## Spine MMI/IR/EOI Case

### **Certification 2**

MMI/IR for what the carrier has accepted ***plus all conditions listed on POD as disputed:***

- Lumbar sprain/strain
- Facet hypertrophy at L5/S1
- Ligamentum flavum hypertrophy L5/S1
- Disc dessication at L5/S1 lumbar spine
- L5-S1 disc protrusion with impingement on exiting left S1 nerve root

# Certification 2



**Texas Department of Insurance**  
 Division of Workers' Compensation  
 7551 Metro Center Drive, Suite 100 • MS-94  
 Austin, TX 78744-1645  
 (800) 252-7031 phone • (512) 490-1047 fax

DWC069

Complete if known:  
 DWC Claim # \_\_\_\_\_  
 Carrier Claim # \_\_\_\_\_

**Report of Medical Evaluation**

<b>I. GENERAL INFORMATION</b>		<b>II. DOCTOR'S ROLE</b>	
1. Injured Employee's Name (First, Middle, Last)	2. Certifying Doctor's Name and License Type	3. Workers' Compensation Insurance Carrier	4. Date of Injury
5. Employer's Name	6. Social Security Number	7. Employer's Phone Number	8. Certifying Doctor's License Number and Jurisdiction (City, State)
9. Employer's Address (Street or PO Box, City, State, Zip)	10. Employee's Address (Street or PO Box, City, State, Zip)	11. Certifying Doctor's Phone and Fax Numbers (City, State)	12. Certifying Doctor's Address (Street or PO Box, City, State, Zip)

**III. MEDICAL STATUS INFORMATION**

13. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMI/impairment and file this report (28 Texas Administrative Code (TAC) §130.1 governs such authorization):  
 Treating Doctor     Doctor selected by Treating Doctor acting in place of the Treating Doctor     Designated Doctor selected by DWC  
 Insurance Carrier-selected RME Doctor approved by DWC to evaluate MMI and/or permanent impairment after a Designated Doctor examination  
 NOTE: If you are not authorized by 28 TAC §130.1 to file this report, you will not be paid for this report or the MMI/impairment examination.

14. Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_    15. Diagnosis Codes: **S33.5XXA, S39.012A, M54.17, M51.27, M51.37**

16. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions:  
**Medical Maximum Medical Improvement (Clinical MMI)** is the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to the injury is no longer reasonably to be anticipated.  
**Statutory MMI** is the later of: (1) the employee's 16th week after the date that temporary income benefits (TIBs) began to accrue, or (2) the date that the employee's MMI was extended by DWC pursuant to Texas Labor Code §405.104

a)  I certify that the employee reached STATUTORY /  CLINICAL (mark one) MMI on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
 b)  No, I certify that the employee has not reached MMI but is expected to reach MMI on or about \_\_\_\_/\_\_\_\_/\_\_\_\_.  
 The reason the employee has not reached MMI is documented in the attached narrative.  
 NOTE: The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits.

**IV. PERMANENT IMPAIRMENT**

17. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury.  
 "Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impairment exists must be based upon objective clinical or laboratory findings meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.

a)  I certify that the employee does not have any permanent impairment as a result of the compensable injury. - OR -  
 b)  I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is \_\_\_\_%, which was determined in accordance with the requirements of the Texas Labor Code and Texas Administrative Code. The attached narrative provides explanation and documentation used for the calculation of the impairment rating assigned using the appropriate tables, figures, or worksheets from the following edition of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association (AMA):  
 third edition, second printing, February 1989 - OR -  
 fourth edition, 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, or 4<sup>th</sup> printing, including corrections and changes issued by the AMA prior to May 16, 2000.  
 NOTE: A finding of no impairment is not equivalent to a 0% impairment rating. A doctor can only assign an impairment rating, including a 0% rating, if the doctor performed the examination and testing required by the AMA Guides.

**V. DOCTOR'S CERTIFICATION**

18. I HEREBY CERTIFY THAT THIS REPORT OF MEDICAL EVALUATION is complete and accurate and complies with the Texas Labor Code and applicable rules. If an impairment rating has been assigned, I certify that I have completed the required training and testing and have a current certification by DWC to assign impairment ratings in the Texas workers' compensation system or have received specific permission by DWC to certify MMI and assign an impairment rating. I understand that making a misrepresentation about a workers' compensation claim or myself is a crime that can result in fines and/or imprisonment and notification of this report.

Signature of Certifying Doctor: \_\_\_\_\_ Date of Certification: \_\_\_\_\_

**VI. TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION**


19. Treating Doctor's Name and License Type

20. Treating Doctor's License Number and Jurisdiction

21. Treating Doctor's Phone and Fax Numbers (City, State)

22. I AGREE /  I DISAGREE with the certifying doctor's certification of MMI.  
 I AGREE /  I DISAGREE with the certifying doctor's finding of no impairment. - OR -  
 I AGREE /  I DISAGREE with the impairment rating assigned by the certifying doctor.

24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.  
 Signature of Treating Doctor: \_\_\_\_\_ Date: \_\_\_\_\_



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To Presenter: Animation will complete this 69 with the info from the previous slide, adding codes for:

## Spine MMI/IR/EOI Case

### **Certification 3**

MMI/IR for what you defined injury to be

- Lumbar sprain/strain
- Left S1 radiculopathy
- L5-S1 disc protrusion with impingement on exiting left S1 nerve root

# Certification 3

**Texas Department of Insurance**  
 Division of Workers' Compensation  
 7551 Metro Center Drive, Suite 100 • MS-04  
 Austin, TX 78744-1643  
 (800) 252-7031 phone • (512) 490-1047 fax

DWC069

Complete if known:  
 DWC Claim # \_\_\_\_\_  
 Carrier Claim # \_\_\_\_\_

**Report of Medical Evaluation**

<b>I. GENERAL INFORMATION</b>		<b>4. Injured Employee's Name</b> (Print, Middle, Last)		<b>8. Certifying Doctor's Name and License Type</b>	
<b>1. Workers' Compensation Insurance Carrier</b>		<b>5. Date of Injury</b>		<b>9. Certifying Doctor's License Number and Jurisdiction</b>	
<b>2. Employer's Name</b>		<b>6. Social Security Number</b>		<b>10. Certifying Doctor's Phone and Fax Numbers</b> (Print)	
<b>3. Employer's Address</b> (Street or PO Box, City, State, Zip)		<b>7. Employer's Phone Number</b>		<b>11. Certifying Doctor's Address</b> (Street or PO Box, City, State, Zip)	
		<b>8. Employer's Address</b> (Street or PO Box, City, State, Zip)		<b>12. Certifying Doctor's Address</b> (Street or PO Box, City, State, Zip)	

**III. DOCTOR'S ROLE**

13. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMI/impairment and file this report (28 Texas Administrative Code (TAC) §130.1 governs such authorization):

Treating Doctor     Doctor selected by Treating Doctor acting in place of the Treating Doctor     Designated Doctor selected by DWC  
 Insurance Carrier-selected RME Doctor approved by DWC to evaluate MMI and/or permanent impairment after a Designated Doctor examination

NOTE: If you are not authorized by 28 TAC §130.1 to file this report, you will not be paid for this report or the MMI/impairment examination.

**III. MEDICAL STATUS INFORMATION**

14. Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_    15. Diagnosis (Codes): **S33.5XXA, S39.012A, M54.17, M51.27**

16. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions:

**Clinical Maximum Medical Improvement (Clinical MMI)** is the earliest date after which, based upon reasonable medical probability, further material gain from or lasting improvement to the injury can no longer reasonably be anticipated.

**Statutory MMI** is the later of: (1) the date that 104th week after the date that temporary income benefits (TIBs) began to accrue, or (2) the date that MMI was extended by DWC pursuant to Texas Labor Code §408.104.

Yes, I certify that the employee reached **STATUTORY** /  **CLINICAL (mark one)** MMI on \_\_\_\_/\_\_\_\_/\_\_\_\_.

No, I certify that the employee has not reached MMI but is expected to reach MMI on or about \_\_\_\_/\_\_\_\_/\_\_\_\_. - OR -  
 The reason the employee has not reached MMI is documented in the attached narrative.

NOTE: The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits.

**IV. PERMANENT IMPAIRMENT**

17. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury.

"Impairment" means any anatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impairment exists must be made based upon objective clinical or laboratory findings, meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee.

I certify that the employee does not have any permanent impairment as a result of the compensable injury. - OR -  
 I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is \_\_\_\_%, which was determined in accordance with the requirements of the Texas Labor Code and Texas Administrative Code. The attached narrative provides explanation and documentation used for the calculation of the impairment rating assigned using the appropriate tables, figures, or worksheets from the following edition of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association (AMA):  
 third edition, second printing, February 1998 - OR -  
 fourth edition, 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, or 4<sup>th</sup> printing, including corrections and changes issued by the AMA prior to May 18, 2000.

NOTE: A finding of no impairment is not equivalent to a 0% impairment rating. A doctor can only assign an impairment rating, including a 0% rating, if the doctor performed the examination and testing required by the AMA Guides.

**V. DOCTOR'S CERTIFICATION**

18. I HEREBY CERTIFY THAT THIS REPORT OF MEDICAL EVALUATION is complete and accurate and complies with the Texas Labor Code and applicable rules. If an impairment rating has been assigned, I certify that I have completed the required training and testing and have a current certification by DWC to assign impairment ratings in the Texas workers' compensation system or have received specific permission by DWC to certify MMI and assign an impairment rating. I understand that making a misrepresentation about a workers' compensation claim or myself is a crime that can result in fines and/or imprisonment and nullification of this report.

Signature of Certifying Doctor: \_\_\_\_\_ Date of Certification: \_\_\_\_\_

**VI. TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION**

<b>19. Treating Doctor's Name and License Type</b>		<b>22. I AGREE / <input type="checkbox"/> DISAGREE</b> with the certifying doctor's certification of MMI.	
<b>20. Treating Doctor's License Number and Jurisdiction</b>		<b>23. I AGREE / <input type="checkbox"/> DISAGREE</b> with the certifying doctor's finding of no impairment. - OR -	
<b>21. Treating Doctor's Phone and Fax Numbers</b> (Print)		<b>I AGREE / <input type="checkbox"/> DISAGREE</b> with the impairment rating assigned by the certifying doctor.	

24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature of Treating Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

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to presenter: Animation completes this 69 per the pervious slide information,

Questions  
About Multiple  
Certifications of  
MMI/IR under  
the current rule?



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**TDI** Division of  
Transportation

Remember, only provide multiple certifications when the POD directs you to do so, and follow the directions in the POD

## EOI – Connect the Dots

accident/incident

+

claimed injury

+

claimant's medical history and treatment

+

evidence based medicine, where applicable

+

appropriate legal terms

Not enough just to include the terms... accident/incident, claimed injury, claimant's medical history and treatment, evidence-based medicine, where applicable... to make it legally sufficient. This is just the skeleton. Put some meat on the bones in the form of evidence from the records and EBM.

# Extent of Injury Template

## Extent of Injury Analysis Section of a Designated Doctor Report

In addition to the basic requirements of a designated doctor narrative report in 28 TAC Rule 127.220, a narrative on extent of injury may include the following information:

### I. Injury in Question (Box 31C of the DWC Form-032)

*State injuries in question as listed in Box 31C, and define and describe each injury in medical terms.*

Note: Extent of Injury is a specific question as to a specific injury as listed in Box 31C. Failure to use the exact terms as listed in Box 31C to refer to the injury may result in a letter of clarification, or a report not being adopted. If there are other medical terms used in the report to refer to the injury in question as listed in Box 31C, explain or clarify that to the reader by stating these terms are synonyms, one is inclusive of the other, etc. If there are injuries that can be grouped together as the same, or part of the same medical process, explain such grouping.

# Extent of Injury Template

## II. Accident/Incident (Mechanism of Injury)

Describe the accident/incident (mechanism of injury). Include any account described and who gave it. (i.e. Claimant told me during the exam, or treating doctor describes in the notes on 1/1/2023.)

## III. Clinical Findings and Timeline in Support of Causation Analysis

*Provide the relevant findings contained in the medical records, history and physical exam. Where applicable, detail symptom onset relative to the timeline of the medical history.*

In your review and detail of the above, pay particular attention to the following in relation to the injury in question (Box 31C):

- a. Did the injury in question exist prior to the work-related accident or incident (mechanism of injury)?
- b. Was the injury in question present during the physical examination?

# Extent of Injury Template

## IV. Analysis of Clinical Findings and Timeline

*Provide an analysis based on the findings from Sections II and III above, and any other relevant supporting factors to explain the basis for the opinion regarding the injury in question (Box 31C).*

Pay particular attention to the following in relation to the causation analysis for the injury in question (Box 31C), and explain all that are applicable:

- a. Consider whether the timeline of symptom onset was consistent with the work-related injury, including relevant medical records prior to the injury, proximate to the time of injury, as well as post-injury treatment and testing.
- b. Is this type of work-related accident/incident (mechanism of injury) consistent or inconsistent with the injury in question?

If evidence-based medicine is available, then explain how it supports that the work-related accident/incident (mechanism of injury) caused or did not cause the injury in question (Box 31C).

# Extent of Injury Template

## v. Medical/Legal Causation Opinion Statement

### *SAMPLE CONCLUSION TEXT*

"Based on the above referenced reasons, it is my medical opinion, based upon my education, training, and experience, and within reasonable medical probability that (the work-related accident/incident/ mechanism of injury) caused or did not cause the injury in question (Box 31C). I find that the compensable injury of (mm/dd/yyyy) was/ was not a substantial factor in bringing about the additional claimed injury or condition (Box 31C), and without it, the additional injury or condition (Box 31C) would not have occurred. Specifically, it does or does not extend to include (Box 31C)."

\*\*DWC does not require use of this form, and additionally, this form is not applicable in all cases. DDs must adhere to all applicable rules regarding reporting requirements and this form is neither a substitute nor an addendum to those requirements. This form is an example of expert causation analysis where extent of injury is an issue, and is not a comment on whether expert testimony is required to establish causation as to this, or any other specific injury. Whether expert testimony is required to establish causation for an injury is a determination that is made at the hearings level on a case by case basis.

Many DDs are just using this statement. THIS IS NOT LEGALLY SUFFICIENT!

Lack of symptoms before and now symptoms. NOT verifiable! This is a conclusory opinion.

## Spine MMI/IR/EOI Case

- What about “aggravation”?
- EBM for lumbar spine,
- herniated disc, etc.



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**TDI** Workers Compensation

Aggravation is “ADDITIONAL INJURY OR HARM” and should be objective. State what the evidence is that allows you to say there was aggravation.

## Any Other Questions?

Remember to check out the article, "**Nomenclature and Classification of Lumbar Disc Pathology**" at [http://hbtinstitute.com/files/SPI\\_NE2001\\_Disk\\_Nomenclature.pdf](http://hbtinstitute.com/files/SPI_NE2001_Disk_Nomenclature.pdf)



## Any Other Questions?

Remember to check out the article, "**Nomenclature and Classification of Lumbar Disc Pathology**" at [http://hbtinstitute.com/files/SPI\\_NE2001\\_Disk\\_Nomenclature.pdf](http://hbtinstitute.com/files/SPI_NE2001_Disk_Nomenclature.pdf)



## Spine MMI/IR/Extent Of Injury (MMI/IR/EOI)

**Remember :** The requirement of providing multiple certifications when addressing MMI/IR and EOI in a single exam has been removed effective **6/5/2023**.

The **§127.1-127.25 and §180.23** rules can be viewed at:  
<https://www.tdi.texas.gov/wc/rules/2023rules.html>  
scroll down to: Designated Doctor Procedure and Requirements

The new rules require that multiple certifications are only be done when ordered by the division

For an exam ordered by a DWC 32 for MMI/IR, and EOI you should provide one certification that is your opinion.

Thank you