APPEAL NO. 132388
FILED DECEMBER 9, 2013

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 23, 2013, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that: (1) the [date of injury], compensable injury does not extend to disc herniations at C3-4 and C6-7, cervical spinal stenosis from C3 through C6, cervical facet syndrome, cervical facet hypertrophy at C2-3 and C6-7, cervical radiculopathy, thoracic radiculopathy, disc bulges at L5-S1, reflex sympathetic dystrophy (RSD), lumbosacral spondylosis without myelopathy, or spinal stenosis of the lumbar region; (2) the respondent/cross-appellant (claimant) reached maximum medical improvement (MMI) on June 20, 2012; (3) the claimant's impairment rating (IR) is 11%; and (4) the claimant had disability from September 24, 2012, through the date of the CCH.

The appellant/cross-respondent (self-insured) appealed the hearing officer's determination that the claimant's IR is 11%. The claimant responded, urging affirmance of the hearing officer's IR determination. The claimant filed an untimely cross-appeal on the hearing officer's extent of injury determination. The hearing officer's determinations that the claimant reached MMI on June 20, 2012, and that the claimant had disability from September 24, 2012, through the date of the CCH were not appealed, and because the hearing officer's determination that the [date of injury], compensable injury does not extend to disc herniations at C3-4 and C6-7, cervical spinal stenosis from C3 through C6, cervical facet syndrome, cervical facet hypertrophy at C2-3 and C6-7, cervical radiculopathy, thoracic radiculopathy, disc bulges at L5-S1, RSD, lumbosacral spondylosis without myelopathy, or spinal stenosis of the lumbar region, has not been timely appealed, those determinations have become final pursuant to Section 410.169.

DECISION

Reversed and rendered.

The parties stipulated that the claimant sustained a compensable injury on [date of injury], that extends to bilateral wrist sprains, a cervical strain, a left knee contusion, a right knee meniscus tear, a right elbow strain, and a right thumb strain, and [Dr. L] is the designated doctor appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) for MMI and IR. The claimant testified she was injured when the wheels of the chair in which she was sitting caught on torn carpet and caused the chair to overturn.

UNTIMELY CROSS-APPEAL

Although the claimant's response was timely as a response, it was untimely as a cross-appeal. The deemed date of receipt of the hearing officer's decision was September 16, 2013, and a timely appeal must have been filed by Monday, October 7, 2013. The claimant's response/cross-appeal was sent by facsimile transmission to the Division on October 23, 2013, and was received by the Division on that date. Accordingly, insofar as the claimant's response is considered a cross-appeal, the cross-appeal, not having been filed or mailed by October 7, 2013, is untimely as a cross-appeal. *See* 28 TEX. ADMIN. CODE § 143.3(d), 102.5(d), 102.3(a)(3) and 102.3(b) (Rules 143.3(d), 102.5(d), 102.3(a)(3), and 102.3(b)). The claimant's response was timely and was considered.

FINDING OF FACT NO. 5 REFORMED

We note that the hearing officer found in Finding of Fact No. 5 that "[d]isc herniations at C3-4 and C6-7; cervical spinal stenosis from C3 through C6; cervical facet syndrome; cervical facet hypertrophy at C2-3 and C6-7; cervical radiculopathy; thoracic radiculopathy; disc bulges at L5-S1; RSD; lumbosacral spondylosis without myelopathy; and spinal stenosis of the lumbar region, did arise out of or naturally flow from the compensable injury of [date of injury]." However, in Conclusion of Law No. 3 and in the decision portion the hearing officer determined that the compensable injury does not extent to those conditions. The hearing officer's Background Information section makes clear that the evidence did not establish the compensable injury included those conditions. We therefore reform the hearing officer's Finding of Fact No. 5 to state that disc herniations at C3-4 and C6-7, cervical spinal stenosis from C3 through C6, cervical facet syndrome, cervical facet hypertrophy at C2-3 and C6-7, cervical radiculopathy, thoracic radiculopathy, disc bulges at L5-S1, RSD, lumbosacral spondylosis without myelopathy, and spinal stenosis of the lumbar region did not arise out of or naturally flow from the compensable injury of [date of injury], to conform to the evidence, Conclusion of Law No. 3, and to the decision.

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. 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.

The hearing officer determined that the claimant's IR is 11% per Dr. L, the designated doctor appointed to determine MMI and IR.

Dr. L examined the claimant on August 22, 2012, and in a Report of Medical Evaluation (DWC-69) of that date certified the claimant reached clinical MMI on June 20, 2012, with an 11% IR. Dr. L's 11% IR is based on Diagnosis-Related Estimate (DRE) Cervicothoracic Category I: Complaints or Symptoms for 0% impairment; DRE Lumbosacral Category I: Complaints or Symptoms for 0% impairment; range of motion (ROM) measurements of the left knee for 0% left lower extremity (LE) impairment, and ROM measurements of the claimant's right knee for 20% right LE impairment, which converts to a whole person impairment (WPI) of 8% for the LE; ROM measurements of the claimant's left wrist for 0% left upper extremity (UE) impairment; and ROM measurements of the claimant's right elbow, wrist, and hand. Dr. L noted in his attached narrative report that the combined impairments due to sensory loss, loss of motion, and other disorders resulted in 13% impairment for the claimant's right thumb. Combining the right elbow, wrist, and hand resulted in a 5% right UE impairment, which converts to a WPI of 3% for the right UE.

We note that in assessing 13% impairment for the claimant's right thumb, Dr. L measured 2 centimeters lack of adduction and, using Figure 14 on page 3/28 of 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), assessed 10% impairment for the claimant's lack of thumb adduction.

The directions for assessing impairment for thumb adduction are on page 3/28 of the AMA Guides. The AMA Guides provide in part that the certifying doctor is to:

Measure and record the smallest possible distance in centimeters from the flexor crease of the thumb IP joint to the distal palmar crease over the MP joint of the little finger (Fig. 14, below). The normal range is from 8 to 0 cm.

Consult Table 5 (right) to determine the percent of thumb impairment contributed by adduction lack or ankylosis.

These directions make clear that while the certifying doctor is to refer to Figure 14 on page 3/28 when measuring a claimant's thumb adduction, the certifying doctor is to actually use Table 5 on page 3/28 to assess thumb impairment due to lack of thumb adduction. In the case on appeal, Dr. L used Figure 14 on page 3/28 to assess 10%

impairment for the claimant's lack of thumb adduction, when according to the directions on page 3/28 he should have used Table 5 on page 3/28. Using Table 5, the 2 centimeters lack of adduction measured by Dr. L would result in 1% impairment, not 10% impairment as assessed by Dr. L.

The Appeals Panel has previously stated that, where the certifying doctor's report provides the component parts of the rating that are to be combined and the act of combining those numbers is a mathematical correction which does not involve medical judgment or discretion, the Appeals Panel can recalculate the correct IR from the figures provided in the certifying doctor's report and render a new decision as to the correct IR. *See* APD 041413, decided July 30, 2004; APD 100111, decided March 22, 2010; and APD 131670, decided August 29, 2013.

In this case, Dr. L's IR is incorrect because he applied Figure 14 on page 3/28 rather than Table 5 on page 3/28 to reach 10% impairment of the claimant's right thumb adduction. Under the facts of this case we consider Dr. L's IR a mathematical error that can be corrected without involving the exercise of medical judgment in correcting that error. We can apply the 2 centimeters lack of adduction measured by Dr. L to Table 5 on page 3/28 to arrive at 1% impairment for lack of adduction in the right thumb. Combining Dr. L's 3% impairment for the claimant's IP and MP joints of the right thumb and the 1% impairment for lack of adduction of the claimant's right thumb results in 4% impairment for the claimant's right thumb. Using Table 1 on page 3/18, 4% impairment for the claimant's right thumb results in 2% impairment of the claimant's right hand. Combining 2% right hand impairment with the 0% impairment assessed for both the claimant's right elbow and wrist results in 2% right UE impairment. Combining 2% right UE impairment with the 0% left UE impairment results in 2% UE impairment. Using Table 3 on page 3/20, 2% UE impairment converts to 1% WPI, rather than the 3% WPI assessed by Dr. L.

Combining 0% for the cervical spine, 0% for the lumbar spine, 1% for the UE, and 8% for the LE, results in 9% WPI, rather than the 11% WPI assessed by Dr. L. The hearing officer found that the preponderance of the other medical evidence is not contrary to Dr. L's opinion on MMI and IR, and after a mathematical correction, that finding is supported by the evidence. Accordingly, we reverse the hearing officer's determination that the claimant's IR is 11% and we render a new decision that the claimant's IR is 9%.

The true corporate name of the insurance carrier is **[SELF-INSURED]** and the name and address of its registered agent for service of process is

SUPERINTENDENT
[ADDRESS]
[CITY], TEXAS [ZIP CODE].

Carisa Space-Beam
Appeals Judge

CONCUR:

Cristina Beceiro
Appeals Judge

Margaret L. Turner
Appeals Judge