APPEALS PANEL DECISION SUMMARIES

(171273 – )

*Don’t rely on the summaries for your arguments. Make sure the decision applies to your case. My summaries focus on why the decision was overturned. I don’t go into great depth so any decision may say more than what I write/cut/paste from the AP decision. About 95% of what is here is just cut and paste from the decisions. I try to hit what I think are the highlights, even if there are other reasons the hearing officer’s decision was overturned. My original contributions are limited to the comment giving a summary of the summary. Anything that can be construed as my opinion is just that, my opinion and does not reflect the opinion of the Division. Ken Wrobel*

171273 – Finality, verifiable delivery - In her discussion of the evidence the hearing officer noted that based upon the claimant’s testimony, the report from Dr. S was deemed received by the claimant late in 2015. The hearing officer found that at least by December 31, 2015, the claimant received notification by verifiable means of the September 4, 2015, certification report by Dr. S. The claimant testified that he did not remember the exact date he received the certification of MMI/IR from Dr. S but knew he got it in 2015. The claimant never testified that he received the documents on December 31, 2015, and there is no evidence that December 31, 2015, is the date of receipt by verifiable means. We hold that the claimant’s testimony in this case does not constitute acknowledged receipt by the claimant on December 31, 2015.

171296 – Bona fide offer of employment, third party vendor - (Ms. T), a safety compliance manager for the employer, testified ff the employer determines that the injured employee’s restrictions cannot be accommodated the employer looks to outside sources that would accept the injured employee on the employer’s behalf. The adjuster contacted RE, and gave them the claimant’s restrictions and the employer’s offered rate of pay. As noted above RE sent both offers to the claimant. The hearing officer stated that Rule 129.6 does not provide for the use of a third-party vendor, and “[a]s the [Rule 129.6] is strictly construed, the two letters sent to [the] [c]laimant by [RE] do not comply with Rule 129.6, and thus are not valid BFOEs in accordance with Rule 129.6.” Under the facts of this case we disagree. The evidence established that the offers were sent by RE at the request of Ms. T on behalf of the employer to find work that would accommodate the claimant’s restrictions. The evidence also established that the employer would pay the claimant $15.00 per hour to work at RMH, and that this position would accommodate the claimant’s restrictions. We hold that in this case the offers sent by RE on behalf of the employer are considered offers from the employer.

171412 – DWC-69 has to be signed - Dr. Pe assigned an IR of five percent pursuant to Table 72, Lumbosacral Diagnosis-Related Estimate (DRE) Category II for the lumbar sprain/strain using the Guides to the Evaluation of Permanent Impairment, fourth edition. Dr. Pe’s IR cannot be adopted, however, because his Report of Medical Evaluation (DWC-69) was not signed.

171429 – MMI/impairment rating certification has to rate the entire compensable injury - Dr. B’s IR cannot be adopted, however, because he also evaluated and assigned an IR of 0% under DRE Category I for a thoracic spine injury, which the parties had expressly agreed was not part of the (date of injury), compensable injury. Furthermore, Dr. B failed to evaluate a left chest wall strain, a condition which the parties agreed was a part of the

compensable injury. For such reason, the hearing officer’s decision that the claimant’s IR is 14% as determined by Dr. B is reversed.

171476 - MMI/impairment rating certification has to rate the entire compensable injury - Dr. Y considered and rated post-concussion syndrome, vertigo, cervical sprain/strain, left shoulder sprain/strain, left shoulder tear, right knee contusion (rather than a right knee sprain), and right knee tear. As previously noted the parties stipulated that the carrier has accepted as compensable a scalp laceration. Dr. Y did not consider or rate a scalp laceration. Because Dr. Y did not rate the entire compensable injury his certification of MMI and IR cannot be adopted.

171530 – Finality, verifiable means proven by green card - We note the USPS return receipt tracking number listed in the preceding Activity Note entry is the same as the tracking number listed on Carrier’s Exhibit D, page 1, a copy of a USPS certified mail receipt addressed to the claimant, and in Carrier’s Exhibit D, page 2, a copy of a USPS return receipt “green card” addressed to the claimant and signed by her acknowledging receipt of certified mail on May 21, 2016. The hearing officer’s determination that Dr. P’s certification was not delivered to the claimant through verifiable means on a date certain, is so against the great weight and preponderance of the evidence as to be clearly wrong and unjust. According to the facts presented in this case, Dr. P’s certification of MMI and assignment of IR was delivered to the claimant on May 21, 2016, as evidenced by the carrier’s Activity Notes which reflect that Dr. P’s certification was sent to the claimant on May 13, 2016, by certified mail bearing tracking number 7015 0640 0001 5080 9983, and the USPS return receipt “green card” bearing the same tracking number signed by the claimant on May 21, 2016.

171586 – Designated Doctor cannot contact Employer, has to go through Division - The evidence reflects that Dr. S examined the claimant on February 6, 2017. In his narrative report, in a section titled analysis of clinical findings and timeline, Dr. S stated that he telephoned the claimant’s employer. As a result of that telephone call, the employer submitted two statements from co-workers who were eyewitnesses to the claimant’s work-related incident. Dr. S used information from the co-workers’ statements in part to justify his opinion that the compensable injury does not extend to several of the disputed extent-of-injury conditions. Section 408.125(d) provides, in part, that to avoid undue influence on a person selected as a designated doctor, only the injured employee or an appropriate member of the staff of the Division may communicate with the designated doctor about the case regarding the injured employee’s medical condition or history before the examination of the injured employee by the designated doctor. After that examination is completed, communication with the designated doctor regarding the injured employee’s medical condition or history may be made only through appropriate Division staff members. We hold that under the facts of this case, Dr. S’ contact with the claimant’s employer after he examined the claimant was improper and contrary to Section 408.125(d) and Rule 127.15(a)(2).

171766 – Designated Doctor made a mathematical error in rating the ankle - Dr. D combined impairment for two planes of motion for ankle motion impairment provided in Table 42 on page 3/78 of the AMA Guides and both planes of motion for hindfoot impairment provided in Table 43 on page 3/78 of the AMA Guides. However, Dr. D’s 2% for the claimant’s right ankle contains a mathematical error. In his narrative report Dr. D noted 30° of ankle plantar flexion results in 0% impairment; 20° of inversion results in 1% impairment; 10° of eversion results in 1% impairment; and neutral dorsiflexion results in 0% impairment. Table 42 provides that neutral dorsiflexion results in 3% impairment, not 0% impairment as assigned by Dr. D.

171843 – Disability, there has to be evidence to support the period in dispute - The ALJ determined that the claimant has had disability resulting from the compensable injury of (date of injury 1), from (date of injury 2), through the date of the CCH, April 13, 2017. At the CCH, the claimant testified that she continued to work with restrictions from the date of the injury until November 28, 2015, and that she has not worked thereafter; however, there is no evidence in the record concerning the claimant’s earnings during the period beginning (date of injury 2) through November 28, 2015, when the claimant ceased working. The ALJ’s determination that the compensable injury was a cause of the claimant’s inability to obtain and retain employment at wages equivalent to her pre-injury wages for the period beginning on (date of injury 2), and continuing through November 28, 2015, is against the great weight and preponderance of the evidence as there is no evidence in the record that the wages earned by the claimant during this period were not equivalent to her pre-injury wage.

171882 – Compensable injury, Lyme Disease - The evidence in the instant case established the claimant was diagnosed with Lyme disease on July 1, 2016. In evidence is a medical narrative dated April 11, 2017, from (Dr. E). Dr. E opined that the tick bites sustained on (date of injury), brought forth the bacteria Borrelia burgdorferi that caused Lyme disease because the claimant’s symptoms after the tick bites improved while on treatment for Lyme disease. Dr. E pointed out that the claimant denied previous exposure or tick bites, which further supported her opinion that the tick bites on (date of injury), were the cause of the Lyme disease. Dr. E stated that the mechanism of injury of tick bites is consistent with the bacteria Borrelia burgdorferi that causes Lyme disease. Dr. E further stated that being bitten by infected ticks is the only way a human is infected, and that Lyme disease is not detectable until four or more months after the injurious exposure and symptoms can take weeks, months, or even longer to appear. However, as in APD 93885, *supra*, there was no evidence to establish the type of tick to which the claimant was exposed or that the tick or ticks carried the bacteria that causes Lyme disease. Dr. E assumed that because the claimant was bitten by ticks those ticks transmitted Lyme disease. Her opinion merely suggests a bare possibility of how the claimant was exposed to Lyme disease.

171936 – Course & scope, MVA - Evidence in the record reveals that the decedent arrived at the workplace and began his workday at approximately 6:58 a.m. on (date of injury); that he left the workplace at 7:03 a.m. to return to his residence to retrieve a laptop computer, owned by his employer and used in the performance of his duties, which he had forgotten to bring with him to work that morning; and that, while traveling back to the office, he was involved in the motor vehicle accident that resulted in his death. We hold in this case that the decedent was not simply traveling to or from work but had begun his workday at 6:58 a.m. on (date of injury), when he arrived at his office and that, since the travel which resulted in his death occurred after he had begun work, such travel did not fall within the coming and going rule. While the decedent’s supervisor testified that the decedent did not need his laptop to connect to the company network and that the decedent could access such information from another computer at the workplace, he also indicated that the decedent would need his laptop to access information stored on its hard drive. The decedent obviously believed it necessary to have access to his assigned computer at work that day as there is no evidence of any personal or other purpose which was furthered by his travel back to his residence after beginning his workday on (date of injury). Under the specific facts of this case, the decedent’s workday began when he accessed the workplace on (date of injury), at 6:58 a.m. His travel to and from his residence after having begun his workday was for the purpose of retrieving his assigned laptop computer which he deemed necessary for the performance of his duties at work that day. Such travel was not simply transportation to and from the place of employment but was travel that both furthered the employer’s business and originated in such business.

172017 – D&O cannot find not at MMI when stat MMI is passed - Based upon the evidence in this case, it appears the date of statutory MMI may have passed; however, we do not have sufficient evidence of that date. The Appeals Panel has previously held that it is legal error to determine a claimant has not reached MMI in a Decision and Order dated after the date of statutory MMI.

172119 – MMI - The ALJ correctly determined that neither the certification of Dr. K nor the certification of Dr. KM could be adopted because neither of these physicians rated the entire compensable injury. Furthermore, both Dr. K and Dr. KM determined that the claimant reached MMI on the statutory date; however, each doctor certified MMI on a date that is not the correct date of statutory MMI. The ALJ instead determined that the claimant reached MMI on November 20, 2015, with a 46% IR in accordance with the certification of Dr. D and in her Finding of Fact No. 6, states that Dr. D’s certification of MMI and IR is supported by the preponderance of the evidence. We disagree. Evidence in the record reflects that requests for occupational therapy to address the claimant’s left elbow contracture were denied by the carrier in December 2015, and

in January 2016; and that the claimant had fallen at least three times as of October 2015, due to difficulties with his prosthetic leg. Furthermore, in an affidavit dated July 12, 2017, the claimant’s treating doctor, (Dr. M), stated several reason why Claimant was not at MMI as of November 20, 2015.

172128 – MMI/impairment rating dispute has to had a Designated Doctor - Although the evidence in the record indicates that (Dr. A) was appointed by the Division to act as designated doctor to address extent of the compensable injury, there has not been a designated doctor appointed in this case to address MMI/IR. In both APD 142008 and APD 132423, the Appeals Panel reversed the ALJ’s decision and remanded for a designated doctor to be appointed on the issues of MMI and IR.

172396 – Newly discovered evidence - We agree that the documents submitted by the carrier for the first time on appeal meet the requirements for newly discovered evidence. A review of the record reveals that the carrier requested authorization from the claimant to obtain pertinent medical records on May 2, 2017, shortly after the claim was filed, and again on August 2, 2017, 2 days following the benefit review conference in this matter. Having received no medical authorization from the claimant, the carrier requested a subpoena on August 14, 2017, ordering production of the offered records. A subpoena was issued by the Texas Department of Insurance, Division of Workers’ Compensation (Division) on August 21, 2017, and served on Hospital on or about August 24, 2017. In its Supplemental Request for Review, the carrier indicates the requested records were received from the hospital on October 6, 2017, one month following the CCH. We accordingly find that the evidence came to the knowledge of the carrier after the hearing, that it is not cumulative of the other evidence in the record and that the carrier’s failure to offer the evidence at the CCH was not due to a lack of diligence on its part. We further note that the medical records submitted with the carrier’s appeal could result in a different decision by the ALJ.

172403 - MMI/impairment rating certification has to rate the entire compensable injury – There were five certifications in evidence and none rated the entire compensable injury.

172430 – Extent of injury, ALJ exceeded scope of issue as certified - The ALJ’s decision correctly states the extent-of-injury issue as revised by agreement of the parties; however, his Finding of Fact No. 4, Conclusion of Law No. 4, Decision and the first paragraph of the Decision and Order address bilateral shoulder tendinosis, a condition that was not included in the extent-of-injury issue and was not part of the dispute before him. We note further that the ALJ’s decision fails to determine whether the compensable injury extends to bilateral shoulder tendonitis, a disputed condition that was made a part of the extent-of-injury issue by agreement of the parties. Because the ALJ failed to make a determination on each of the conditions made a part of the extent-of-injury issue before him, and because he exceeded the scope of his authority by making a determination on a condition that was not before him, we reverse that portion of the ALJ’s determination that the compensable injury of (date of injury), does not extend to bilateral shoulder tendinosis and we remand the extent-of-injury issue to the ALJ to make a determination consistent with this decision.

172459 – SIBs, number of searches defined by start of quarter - The ALJ stated that the claimant received an initial Application for [SIBs] (DWC-52) from the carrier for the sixth quarter that noted the required number of weekly work search efforts was five. As previously mentioned, the parties stipulated that the required number of weekly work search efforts changed from five to seven in January of 2017; that the qualifying period for the sixth quarter began on March 30, 2017; and that the claimant received notice of the changed number of weekly work search efforts from five to seven weekly searches on April 17, 2017. In its response the carrier contends that once the claimant became aware that the correct number of job searches was seven instead of five, the claimant then had a duty to make seven job contacts for the remainder of the qualifying period. The carrier concedes that the DWC-52 sent to the claimant initially for the sixth quarter contained the incorrect number of job searches required. Rule 130.102(f) provides, in part, that if the required minimum number of work search contacts changes during a qualifying period, the lesser number of work search contacts shall be the required minimum number of contacts for that period. In the instant case the parties agreed that the change in work search contacts occurred prior to the beginning of the qualifying period at issue but that the carrier provided the wrong number of work search contacts to the claimant prior to the beginning of the qualifying period. The rules do not contemplate having two different numbers of minimum weekly work search contacts during the same qualifying period.

172482 – SIBS, no ability to work does not require a single narrative - In evidence are letters from (Dr. P) and (Dr. G), dated April 17, 2017, and May 18, 2017, respectively, which were offered to serve as narrative reports to explain how the compensable injury caused a total inability to work. In her discussion of the evidence the ALJ stated that the claimant “failed to provide a single ‘narrative report’ which explained how the compensable injury caused a total inability to work during the qualifying period for the [1st] quarter.”

The Appeals Panel has held that reports from different doctors cannot be read together to create a narrative report. The narrative report must come from one doctor. In APD 002724, decided January 5, 2001, the Appeals Panel stated that in determining whether the requirements of Rule 130.102(d)(4) (now found in Rule 130.102(d)(1)(E)) for a doctor's narrative report are met, the following will be considered: amendments; supplements, including CCH testimony from the doctor; information incorporated in the report by reference; or information from a doctor's medical records in evidence that can be reasonably incorporated in the doctor's narrative report by inference based on some connection between the report and the information in the medical records. *See also* APD 033152, decided January 16, 2004, and APD 130821. Rule 130.102(d)(1)(E) does not require a single narrative report to establish a total inability to work. We hold that the ALJ has applied an incorrect standard in requiring a single narrative report to establish a total inability to work for purposes of SIBs.

172488 – Impairment rating, Designated Doctor combined incorrectly - Dr. T assessed 19% whole person impairment for the right upper extremity based on loss of range of motion, motor loss, and sensory loss. Dr. T assessed 14% whole person impairment for PTSD. Dr. T then combined the 14% impairment for the PTSD with the 19% impairment for the claimant’s right upper extremity using the combined value chart of the AMA Guides, assessing 31% impairment. However, when using the combined values chart, combining 14% with 19% results in 30% impairment not 31% impairment.

172502 – SIBS, direct result has to be for compensable injury - The carrier argues on appeal that the claimant’s unemployment was not a direct result of his impairment from the compensable injury. In evidence is a signed Benefit Dispute Agreement (DWC-24) which states that the compensable injury of (date of injury), does not extend to a left shoulder rotator cuff tear, cervical radiculopathy, carpal tunnel syndrome of the left hand/wrist, subacromial impingement syndrome, left shoulder glenohumeral synovitis, and left shoulder acromioclavicular impingement syndrome. The DWC-24 was approved by a Division ALJ on May 4, 2015. In evidence is a narrative report from a designated doctor who examined the claimant on October 24, 2015, and opined that, with regard to the compensable injuries only, there is no disability from June 7, 2015, to the present for the lumbar strain, left shoulder strain, and left hand contusion. Further, in evidence is a Work Status Report (DWC-73) dated July 22, 2015, from the claimant’s treating doctor which stated the claimant was allowed to return to work without restrictions as of July 22, 2015. A DWC-73 dated April 25, 2017, reflects the claimant was taken completely off work from April 25 through May 5, 2017. The diagnoses listed on the DWC-73 taking the claimant off work were complete rotator cuff tear and “other specified postproced [sic].” The report accompanying that DWC-73 reflects that the rotator cuff tear was to the left shoulder. As previously noted, the left shoulder rotator cuff tear was not part of the compensable injury as agreed to by the parties.

172503 – Attorney fees - Effective January 30, 2017, the maximum hourly rates increased from $150.00 an hour to $200.00 for attorneys, and from $50.00 an hour to $65.00 an hour for legal assistants.

172522 – Compensable injury and mechanism of injury - The claimant, a school bus driver for the self-insured, claims to have sustained an injury while in the course and scope of her employment on (date of injury), when she stopped at a railroad crossing and pulled out a *lever that turns on the hazard lights* of the school bus she was driving and felt a “pop” in her left hand with pain radiating into her left elbow. The ALJ stated in the Discussion section of his Decision and Order that the claimant “testified that she was returning after delivering the kids to schools, and she stopped at a railroad crossing and had *to pull a lever to open the door*, and she felt a pop in her left hand which caused pain shooting to the outside of her elbow.” The claimant did not testify or argue that she sustained an injury while opening the door of the bus but rather while pulling the hazard light lever located on the left side of the steering column. We view the ALJ’s misstatement of the evidence as a material misstatement of fact. (Emphasis added.)

172543 – Finality, verifiable delivery by email - The ALJ found that Dr. B’s MMI and IR certification was provided to the claimant by verifiable means on October 28, 2016. In evidence is a copy of an e-mail dated October 28, 2015, to the claimant that states the designated doctor’s examination report is attached. The claimant acknowledged her e-mail address was the one shown on the e-mail, but she testified that she never received the report through e-mail. The carrier presented a copy of the e-mail that indicates the report was sent; however, there was no evidence of delivery to the claimant. Simply verifying a correct e-mail address does not establish that the report from the designated doctor was delivered. Consequently, the ALJ’s finding that Dr. B’s MMI and IR certification was provided to the claimant by verifiable means on October 28, 2016, is in error and is stricken. We note that the finding contained in Finding of Fact No. 7 that is being stricken referenced 2016 rather than 2015.

172543 – Finality, mailed to last correct address given by Claimant - The evidence also shows the report was mailed to the claimant by certified mail return receipt requested on November 4, 2015, and was returned to the carrier on November 24, 2015, as being undeliverable as of November 6, 2015. The ALJ further noted that the claimant testified it was sent to an incorrect address but also testified she failed to let either the carrier or the Texas Department of Insurance, Division of Workers’ Compensation (Division) know about the change of address. In evidence is a Dispute Resolution Information System (DRIS) note dated March 31, 2017, that states, in part, that the claimant said she never received the certification by certified mail and never signed the green card. The DRIS note reflects that the claimant notified the Office of Injured Employee Counsel that she has moved and advised her treating doctor but did not advise the carrier. Rule 102.4(a) provides, in part, that all written communications to a claimant shall be sent to the most recent address or fax number supplied by the claimant.

172565 (also 175265) – SIBs, listing job searches within Claimant’s ability - The ALJ indicated that she actually based her decision that the claimant is not entitled to SIBs for the quarter at issue on her belief that the claimant conducted work search efforts for positions that were not within his work restrictions and that he was not capable of performing. Her basis for this finding is the July 25, 2017, report of (Dr. W), appointed by the Division as designated doctor for the purpose of determining the claimant’s ability to return to work during the qualifying period for the third quarter of SIBs. In his report, Dr. W stated that the claimant could return to work and wrote further that “[t]he only [restriction] I would put is that the [claimant] cannot drive a commercial vehicle in his current state as he states he is a danger to other people.” However, Dr. W provided no explanation regarding what he meant by the term “commercial vehicle.” The claimant testified that he drives his personal pick-up truck around town and also drove himself 50 miles in order to attend the CCH but that he no longer possesses a commercial driver’s license. A review of the claimant’s DWC-52 for the third quarter reveals that during the fifth week of the qualifying period, he made six job search contacts, four of which contacts were for positions described as a warehouse delivery driver, a beverage company driver, a local pickup and delivery driver, and a commercial driver’s license (CDL) driver. No evidence was offered regarding whether any of the vehicles which the claimant would have driven in performing the duties of the positions listed above would be considered a “commercial vehicle” or whether a CDL would be required to operate any of such vehicles.

172582 – Extent of injury, chemical exposure - The ALJ found the claimant’s evidence persuasive to establish that the compensable injury extends to reactive airway disease. In evidence are records showing that the claimant sought treatment with Care Now on October 29, 2015, for complaints of shortness of breath and dizziness. The claimant returned to Care Now in November 2015, and December 2015, with increased complaints. The claimant was referred to (Dr. B), who examined the claimant on January 21, 2016. Dr. B diagnosed the claimant with reactive airway disease post exposure to smoke and chemicals when his truck caught on fire on (date of injury). Also in evidence is a medical report from (Dr. D), dated December 20, 2016, in which Dr. D noted that the claimant had inhaled smoke while extinguishing the fire on (date of injury). Although the medical records in evidence contain a diagnosis of reactive airway disease and show the claimant inhaled smoke and chemicals, there was no evidence establishing the chemicals to which the claimant inhaled, nor was there an explanation as to how the inhalation of the chemicals and smoke from the truck fire caused reactive airway disease. Without an explanation of causation these records are merely conclusory in nature and insufficient to establish that reactive airway disease was caused by the (date of injury), compensable injury.

172600 – TIBs - The carrier argues that the value for post-injury earnings for each week as calculated by the claimant is incorrect because it does not consider that the claimant’s hours were reduced, in part, based on her own request to lower her hours so that her income would not impact her receipt of Social Security disability benefits for a condition unrelated to the compensable injury. The claimant testified at the CCH that she did in fact request the employer to reduce the number of hours she worked each week so that her Social Security disability benefits would not be affected. As previously noted, the claimant’s Social Security disability benefits were for a condition unrelated to the compensable injury. The claimant also testified she missed time during the period at issue because of issues with her car, among other things. There was evidence presented that the claimant’s time missed was for causes not related to the compensable injury. See Appeals Panel Decision (APD) 091807, decided January 29, 2010. The ALJ made no findings of fact on the evidence presented regarding the claimant’s earnings based on reduced hours for reasons unrelated to the compensable injury, which impacts the amount of partial TIBs to which the claimant is entitled.

172600 – Bona fide offer of employment- The ALJ noted that in evidence is a letter dated May 18, 2017, in which the employer offered the claimant a light duty position. Regarding that offer the ALJ stated the following: Although the offer outlined the job activities and time requirements that the position would entail, the offer did not persuasively describe how she could perform those activities within her work restrictions. Neither the Act nor Rule 129.6 require that the offer describe how an injured employee can perform the job activities within his or her work restrictions. The ALJ has used an incorrect standard of law in making her determination.

172615 – Impairment rating - Designated Doctor cannot reduce impairment for contribution - Dr. H assessed two percent whole person impairment for the right upper extremity based upon loss of ROM. Dr. H then subtracted one percent whole person impairment from that assessment based upon ROM measurements obtained by a (Dr. N) on September 25, 2014, to take into account the decrease in ROM existing prior to the work-related injury of (date of injury), which reduction resulted in the assigned one percent IR adopted by the ALJ.

172652 – Disability and MMI are different - The carrier’s choice of physician, (Dr. M), examined the claimant on April 19, 2017, and also determined that the claimant reached MMI on February 9, 2017, with a zero percent IR. As noted by the ALJ, Dr. M issued a DWC-73 dated April 19, 2017, indicating the claimant could return to work without restrictions as of October 15, 2016. The ALJ found that the claimant’s disability ended on February 9, 2017; however, there is no evidence in the record to support February 9, 2017, as the ending date of the claimant’s disability. The fact that further material recovery from or lasting improvement to the compensable injury could no longer reasonably be anticipated does not necessarily mean the claimant did not have disability, as defined by Section 401.011(16), after the date of MMI.

172699 – Carrier waiver of compensability - The ALJ found that the carrier had notice of the (date of injury), claimed injury on June 23, 2017. The evidence supports the ALJ’s finding. We note that the 60th day after June 23, 2017, is August 22, 2017. The ALJ noted in her discussion that although a copy of an amended Notice of Denial of Compensability/Liability and Refusal to Pay Benefits (PLN-1) dated August 8, 2017, was in evidence, there was no copy that had been date stamped as received by the Texas Department of Insurance, Division of Workers’ Compensation (Division). It is clear that the claimant and the Division were informed of the carrier’s position at the BRC held on July 31, 2017, and the carrier’s dispute of compensability of the (date of injury), claimed injury and its reasons for that dispute were reduced to writing by the benefit review officer (BRO) in the BRC report dated August 4, 2017. The Appeals Panel has previously held in similar cases that a carrier’s dispute at a BRC was sufficient to satisfy the requirements for filing a written notice of denial when the BRC was held within the time period for disputing a claim, the carrier stated its reasons for contesting compensability at the BRC, the contest of compensability and reasons therefor were reduced to writing by the BRO within the time period for filing a dispute, and the parties proceeded to a CCH based on the carrier’s contest of compensability. In the case on appeal the carrier notified the claimant and the Division at the BRC held on July 31, 2017, that it was disputing the (date of injury), claimed injury in its entirety, and the BRC report dated August 4, 2017, clearly reflects the carrier’s position. As noted previously the deadline by which the carrier had to file a denial of the claimed injury was August 22, 2017.

172725 – Impairment rating, certifying doctor cannot randomly reduce range of motion impairment for non-valid results - Dr. B noted in his narrative report that over half of the claimant’s impairment can be attributed to his non-compliant behavior. Thereafter, on June 12, 2017, Dr. B submitted an addendum together with an amended DWC-69 in which he “factors the non-compliance of the claimant into the final impairment. . . .” Dr. B assigned an IR of 9%, reduced from the 18% originally derived from the claimant’s ROM testing. The methodology used by Dr. B in adjusting the numerical impairment assigned based upon a failure of the claimant to comply with prescribed treatment for the compensable injury is not provided for in the law or the AMA Guides. Dr. B’s assignment of a 9% IR is not based upon the claimant’s condition as of the MMI date as required by Rule 130.1(c)(3) but rather is based upon what Dr. B believes the claimant’s condition would have been had he completed his prescribed treatment.

172734 – MMI/impairment rating certification has to rate the entire compensable injury - Dr. K considered and rated a right leg puncture wound with metallic foreign body, intravascular right tibial peroneal vein, right leg pseudo aneurysm and AV fistula of posterior tibial artery; right hip strain, right knee sprain, right ankle sprain, and lumbar spine strain. As previously noted the parties stipulated that the carrier has accepted as compensable right leg cellulitis, right leg abscess, right leg pseudo aneurysm and AV fistula of posterior tibial artery. Dr. K considered and rated conditions that have not been determined to be part of the compensable injury and failed to rate conditions that are part of the compensable injury.

172757 – ALJ failed to put letter of clarification into evidence - In discussing Dr. F’s MMI/IR certification the ALJ stated the following: After the hearing, the [ALJ] determined that further clarification was needed for [Dr. F’s] IR analysis and a letter of clarification (LOC) was issued to [Dr. F]. However, neither the ALJ’s LOC nor Dr. F’s September 29, 2017, response are in the appeal file. We note the decision states ALJ Exhibits 1 through 6 were admitted, and those exhibits are in the appeal file. However, the record reflects that at the CCH ALJ Exhibits 1 through 5 were admitted with no mention of ALJ Exhibit 6. There is no other reference to ALJ Exhibit 6 in the appeal file, including any discussion with the parties after the CCH of its admittance. As noted above neither the ALJ’s LOC nor Dr. F’s September 29, 2017, response are in the appeal file. The ALJ has based her MMI and IR determinations on facts that are not in evidence.