APPEAL NO. 93092

On January 8, 1993, a contested case hearing was held in (city), Texas with (hearing officer) presiding as the hearing officer. The hearing was held under the provisions of the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq*. (Vernon Supp. 1993) (1989 Act). The issues at the hearing were whether the appellant's (claimant's) present back problems are related to his original injury of (date of injury); whether the claimant has reached maximum medical improvement (MMI); and if the claimant has reached MMI, what is the claimant's impairment rating. The hearing officer determined that the claimant sustained an injury to his face only and not to his neck and back while working for the employer, on (date of injury); that the designated doctor's finding that the claimant has not attained MMI is invalid because it is based on an incorrect assumption that the claimant sustained a neck and back injury in addition to the injury to his face; that the great weight of the other medical evidence is contrary to the report of the designated doctor; and that the claimant attained MMI on September 11, 1992, with a zero percent impairment rating. The hearing officer decided that the claimant is not entitled to additional temporary income benefits (TIBS) and is not entitled to any impairment income benefits (IIBS). The hearing officer also decided that the claimant is not entitled to medical benefits for his neck or back, but that the respondent (carrier) shall pay medical benefits for the claimant's face injury.

The claimant disagrees with the hearing officer's findings and conclusions that he sustained an injury only to his face and not to his neck and back on (date of injury), and disagrees with the findings and conclusions that he has reached MMI with a zero percent impairment rating. The claimant also contends that he did not request that the hearing be held at the Lubbock, Texas, field office which is located more than 75 miles from the claimant's residence at the time of the injury, and asserts that the carrier had him examined by a doctor who was located more than 75 miles from his residence. The carrier responds that the claimant agreed to hold the hearing in Lubbock, Texas, and that the challenged findings and conclusions are supported by sufficient evidence. The carrier requests that the decision of the hearing officer be affirmed.

DECISION

The decision of the hearing officer is reversed and remanded for further consideration and development of the evidence.

The carrier was represented by an attorney at the hearing. The claimant was not represented by an attorney, but was assisted by a Texas Workers' Compensation Commission (Commission) Ombusdsman.

Article 8308-6.03 provides that unless the Commission determines that good cause exists for the selection of a different location, a benefit review conference or a contested case hearing may not be conducted at a site more than 75 miles from the claimant's residence at the time of the injury. The claimant indicated at the hearing that at the time of

his injury he lived about 85 miles from the Lubbock, Texas, field office. The hearing officer advised the claimant of his right to have the hearing conducted within 75 miles of his residence at the time of injury and asked the claimant if it was "okay" with him to hold the hearing at the Lubbock, Texas, field office and the claimant replied "Yes, sir." Considering that the claimant agreed to have the hearing conducted at the Lubbock field office after being advised of his rights, and that he raised no issue concerning venue at the hearing, we find no merit in the claimant's complaint on appeal regarding venue. We also note that the hearing officer found good cause for holding the hearing at the Lubbock field office for the reason that the claimant had processed his entire claim through that office.

We also find no merit in the claimant's statement in his request for review that "I would like to state that this doctor [Dr. M] was 75 miles out of my jurisdiction." Rule 126.6(h) provides that "The Commission shall order examinations requiring travel up to 75 miles from the claimant's residence unless the treating doctor certifies that such travel may be harmful to the claimant's recovery." At the hearing the claimant indicated that the carrier requested that he see Dr. M and that Dr. M office was about the same distance from his residence as was the field office - 85 miles. The claimant did not indicate that the Commission ordered him to be examined by Dr. M nor did the claimant raise any issue or complaint about the distance from his residence to Dr. M office at the hearing. Since no issue concerning Rule 126.6(h) was raised at the hearing, we do not consider such issue on appeal.

The claimant contended that he injured his neck and back when he was hit in the face with dirt while working for the employer on (date of injury). The claimant, who was 39 years of age at the time of the hearing, testified that in 1986 he sustained a back injury while working for another employer, that he had a laminectomy performed for that injury at L3-L4, that the doctor who performed the surgery said he would continue to have low back pain, and that he has had intermittent low back pain over the years. The claimant said that he worked off and on for different employers since February 1987 and began working for his present employer as a gang pusher in December 1989. He said he has worked for the employer almost every day except for Sundays. The claimant said that on July 30, 1990 he was involved in an accident while driving his employer's truck, that the truck hit a light pole, and that his head hit the back window of the truck. The claimant further testified that on June 2, 1992, while wearing a hard hat working for his employer, he was hit on top of the head by an eight inch pipe and got knocked down by the blow. The claimant said that if he had not been wearing the hard hat he would have been killed by the blow from the pipe. He said he didn't report the June 2nd accident nor seek medical treatment after the accident because he didn't feel symptoms of being injured. The claimant testified that the June 2nd accident could have reinjured his lower back but he did not know if it did.

Concerning the accident of (date of injury), which the claimant made the basis of his claim, the claimant testified that on that day he and his helper, ES, were assigned to put in a new pipeline for a client of the employer's and that they discovered an old poly pipeline

during their work which another employee of the employer attempted to remove with a backhoe. One end of the pipe was sticking out of the ground and the other end was about a foot in the ground. The claimant said that the backhoe pulled the old pipe out of the ground and swung it to the right, but that the pipe then went back to its original position, and in so doing, dirt came out of the old pipe and hit him on the left side of the face, jerked his head to the right, and "my lower back." The claimant said that the dirt was all stuck together, that it did not knock him down or knock off his safety glasses or hardhat, but that it did cause his nose to bleed and hurt his neck and back. The claimant said he sat down and then two of the client's employees, JB and WE, who were at the work site took him to the hospital. The claimant said that on the way to the hospital the entire left side of his body felt numb and that he had no strength in his legs when he got to the hospital so he was taken to the emergency room in a wheelchair.

The claimant further testified that x-rays of his head and neck were taken at the hospital and that he was examined by Dr. B, and was told he had a real severe concussion and was given Tylenol and sent home to rest for three days. The claimant said that two days later he felt dizzy so he went back to the hospital where Dr. B referred him to Dr. S, who referred him to another hospital for three days of tests on his head and neck. The claimant stated that on July 3rd, while he was still having headaches, dizziness, and breathing problems, Dr. S released him to go home from the hospital and told him that there was nothing wrong with him. The claimant then chose to go to Dr. D, who took him off work. The claimant said that Dr. D is his current treating doctor. The claimant said that at the request of the carrier he was examined by Dr. M, Dr. F., and Dr. M, and that he was also examined by Dr. O, the designated doctor appointment by the Commission. The claimant said that he has been unable to work since his June 29th accident.

The claimant's helper, ES, said in a written statement that he and the claimant were hit with loose dirt from the pipe on (date of injury). The backhoe operator, RG, said in a recorded statement that he didn't see the claimant get hit in the face with what he described as a handful of loose sand, but he did see the claimant grab a hold of the claimant's nose and face and he saw blood on the claimant's nose. He said the claimant was standing 12 to 15 feet away from the backhoe.

JB, who works for the client company, testified that he saw the claimant get hit in the face with a handful of loose blow sand that came out of the pipe when the pipe slowly returned to its original position when it was released by the backhoe. He said that the claimant was about 12 to 15 feet away from the backhoe and that the claimant's helper was about three feet from the claimant. He also stated that the sand hit the claimant's helper first and that it did not knock the claimant or the helper down nor did it knock off their safety glasses or hardhats. He also said that after the claimant was hit with the sand the claimant went over and sat down on a pipe rack and that he had two or three drops of blood on his shirt and was breathing fast. When he asked the claimant if he wanted to go to the hospital

the claimant at first said no but then said he thought it would be a good idea. WE, who also works for the client company, testified that he also saw the claimant get hit in the face with blow sand that came from the end of the pipe. He said that when the pipe came loose from the backhoe it returned to its original position in "slow motion." Mr. B and Mr. E both said that the claimant did not say anything to them on the way to the hospital.

In an Initial Medical Report (TWCC-61) dated July 31, 1992, Dr. T, (apparently, Dr. T is the doctor the claimant saw at the hospital on June 29th and who he identified as Dr. B) reported that he saw the claimant on (date of injury), and that the claimant told him that on that day he got hit with a ball of dirt while working and that his head twisted to the right and his neck popped. Dr. T noted that x-rays of the cervical spine done at the hospital were normal as was a skull survey. He diagnosed head trauma with mild concussion and cervical sprain. He prescribed rest for one week and the use of a cervical collar for two to three weeks.

Dr. S, M.D., a neurosurgeon, examined the claimant on July 1, 1992, gave diagnoses of neck pain and headache in a TWCC-61, and anticipated that the claimant could return to full time work on July 2, 1992 and would achieve MMI on October 1, 1992. In a letter to the carrier dated July 20, 1992, Dr. S said he saw the claimant again on July 20th, that the claimant's major complaint was pain in the neck extending throughout the dorsal region of his body and into his back and legs and arms, and that neurological examination, including examination of the cranial nerves, revealed no abnormalities, although the claimant did have diminished range of motion of his neck. Dr. S stated that "essentially nothing about this case makes a great deal of sense to me starting with the mechanism of injury," and that "I believe that further follow-up here would be wasteful of everyone's time and money."

In a report dated July 29, 1992, Dr. D., stated the results of diagnostic studies and gave the following diagnoses: status post-laminectomy L3-L4, right side; degenerative disease lower back, no fracture; degenerative changes in the cervical spine with radiographic evidence of muscle spasms; and a normal thoracic spine. Dr. D also noted that the claimant had a "normal skull series." Dr. D conducted range of motion testing and reported on July 29th that the claimant's lumbosacral range of motion contribution to whole person impairment was 16%, and that the claimant's cervical range of motion contribution to whole person impairment was 19%.

On August 12, 1992, Dr. M, a neurologist, gave the claimant a neurologic examination. He noted that the claimant had decreased range of motion of the neck because of subjective posterior neck pain elicited with rotation and extension. No muscular spasm was noted in the lumbar or cervical area. Dr. M stated that "I can find no neurologic dysfunction on this patient's examination, and his cervical CT scan appears normal. Parts of his examination indicate either hysterical component or malingering." Dr. M also stated that "[a]t this point, from a neurological standpoint, I can find no justification for his [the claimant's] continued pain and sensory

complaints." In a TWCC-61 dated August 14, 1992, Dr. M stated that the anticipated date the claimant would achieve MMI was unknown.

In an undated Report of Medical Evaluation (TWCC-69), Dr. F certified that the claimant reached MMI on September 11, 1992 with a zero percent whole body impairment rating. In an attached report, Dr. F said he evaluated the claimant on September 11th, and recited the history of injury as having occurred on (date of injury) when the claimant was hit in the face with some dirt at work, causing him to twist his neck. It was noted that since the day of the accident, the claimant complained of cervical pain, low back pain, pain with radiation down the arm and down the leg, episodes of vertigo, and headaches. Dr. F stated that on physical examination the claimant appeared quite healthy and was in no acute distress, but noted that he detected a minor left hemi-sensory loss which he said was not significant. He further noted that review of x-rays demonstrated no problems with the skull, cervical spine, thoracic spine, or lumbar spine. He also noted that no abnormalities were found on cervial MRI or CT scan of the head. Dr. F stated that the claimant had only a slight lack of range of motion on cervical flexion and no abnormalities were noted in the lumbar range of motion.

On September 11, 1992, Dr. M., reported to the carrier that the claimant had been referred to him for evaluation and for a physical impairment rating for injuries he sustained in an on-the-job accident. Dr. M noted that the claimant related that in 1986 he had a L3-L4 hemilaminectomy for a work-related low back injury. He also noted that the claimant recited that at the time of his (date of injury) accident he had neck pain with stiffness which radiated into the entire spine. Dr. M stated that according to the American Medical Association Guides to the Evaluation of Permanent Impairment the claimant has zero percent impairment due to specific disorders of the spine, zero percent impairment due to range of motion loss (it was noted that all ranges of motion to the cervical spine were within normal limits); zero percent total impairment due to neurologic loss, and zero percent total spinal impairment (whole person).

In a Commission order signed November 3, 1992, it is recited that the claimant disputed MMI and impairment rating, that no agreement was reached between the claimant and the carrier, and that the Commission designated Dr. O., who is board certified in orthopaedics, as the designated doctor. In an undated TWCC-69, Dr. O reported that the claimant had not reached MMI. In a narrative report dated November 28, 1992, Dr. O recited as the history of the injury that the claimant was struck by some dirt from the pipe with consequential twisting injury to his neck and that the pipe apparently struck him on the left side of the face and as a result of this some of the dirt entered his mouth. The report notes that the claimant's main complaint is persistent pain in the neck which radiates down to the hands. The report also notes that the claimant had a laminectomy at L3-L4 in 1986 and that the claimant apparently recovered fully from this and resumed work in 1987. Dr. O stated that an MRI of the claimant's back demonstrated spondylolisis, disc degeneration,

and a disc herniation at L5-S1. Dr. O performed a neurological evaluation and gave the following impression: 1. Soft tissue injury to the face. 2. Closed head injury. 3. Lumbosacral strain with disc herniation at L5-S1. 4. Spondylolysis at L4-5 and L5-S1. 5. Ulnar nerve entrapment neuropathy. Dr. O stated that "[t]his patient obviously sustained a back injury related to the type of work he did on the day of the injury on 6-29-92. He also sustained a neck injury. Throughout the latter he complained of bilateral numbness involving the little and ring fingers. These latter symptoms have not showed any signs of improvement. A disc herniation was also noted on the MRI." Dr. O recommeded an EMG. Dr. O said that at this stage it is not possible to calculate the "percentage impairmant."

On December 2, 1992, Dr. C, M.D, performed nerve conduction studies of the claimant's upper extremities for neck and right shoulder pain, and nerve conduction studies of the claimant's lower extremities for low back pain. Dr. C stated that the nerve conduction study of both upper extremities was within normal limits and gave an impression of right C8-T1 radiculopathy. He further stated that the nerve conduction study of both lower extremities was within normal limits and gave an impression of right L4-L5 and S1-S2 radiculopathy.

In a narrative report dated January 5, 1993, Dr. D reported that the claimant's MRI of the lumbar spine showed spondylosis, and disc degeneration, as well as a disc herniation at "L5-S" according to Dr. Pevsner. He also noted the results of the December 2, 1992 EMG. Dr. D diagnosed: 1. Right C8-T1 radiculopathy. 2. Low back pain secondary to disc herniation at L5-S1. 3. Spondylosis at L4-L5. 4. Tension headaches. 5. Myofascial syndrome right trapezius.

As we read the claimant's request for review, the following findings of fact and conclusions of law are disputed by the claimant:

FINDINGS OF FACT

4.On (date of injury), claimant sustained an injury to his face only and not to his neck and back while working for [the employer].

5.The sole cause of any problems related to the claimant's neck and back are the result of a pre-existing condition which occurred prior to claimant's face injury on (date of injury).

6.The TWCC-69 "Report of Medical Evaluation" on claimant executed by Dr. O, the designated doctor appointed by the Commission finding that claimant has not attained MMI is invalid because it is based on the incorrect assumption that claimant sustained a neck and back injury in addition to the injury to his face.

7.The TWCC-69 "Report of Medical Evaluation" on claimant executed by Dr. F, is a valid certification that claimant attained MMI on September 11, 1992, with a whole body impairment rating of zero percent (0%).

8.The great weight of the other medical evidence is contrary to the TWCC-69 "Report of Medical Evaluation" on claimant executed by Dr. O., the designated doctor.

CONCLUSIONS OF LAW

4.Claimant sustained a compensable injury to only his face on (date of injury).

5.Claimant did not sustain a compensable injury to his neck and back on (date of injury).

6.Claimant attained MMI on September 11, 1992, with a zero percent (0%) impairment rating.

The first issue to be resolved at the hearing was whether the claimant's present back problems are related to his original injury of (date of injury). This was an unresolved issue from the benefit review conference (BRC) and both parties agreed to the issue as stated. Rule 142.7(a) provides that a dispute not expressly included in the statement of disputes will not be considered by the hearing officer. There was no issue before the hearing officer regarding whether the claimant's neck problems are related to his injury of (date of injury), and neither party requested that such an issue be included in the statement of disputes. In its opening statement the carrier stated that its position was that the claimant's low back problems are not related to his injury of (date of injury). The carrier did not contend that the claimant's neck problems were not related to his injury of June 29th. In fact, the carrier said "whether the low back problems are causally related to the incident of 6-29-92, it is the carrier's position that they are not; that the witness--the claimant has given a description of other incidents that could have caused the low back problems; that the only thing that this incident of getting the dirt thrown in the face may have caused may have been neck

problems, or headaches." The carrier added that "[t]he carrier's arguments on MMI and impairment rest on the first argument that the low back problems aren't related to the injury; that the only thing that ought to be considered are neck problems and--and perhaps the headaches . . .." Considering that the first issue was limited to the claimant's back problems, that there was no issue before the hearing officer concerning the claimant's neck problems, and that the carrier acknowledged at the hearing that the claimat's neck problems should be considered for purposes of MMI and impairment rating, we are of the opinion that the hearing officer erred in determining that the claimant did not sustain an injury to his neck on (date of injury). An issue concerning the claimant's neck injury was simply not before the hearing officer for determination.

In addition to finding that the claimant did not sustain back and neck injuries on (date of injury), the hearing officer also found that the sole cause of any problems related to the claimant's neck and back are the result of a preexisting condition. To defeat a claim for compensation because of a preexisting injury the insurance carrier must show that the prior injury was the sole cause of the worker's present incapacity. Texas Employers Insurance Association v. Page, 553 S.W.2d 98, 100 (Tex. 1977). In its opening statement the carrier urged that "the low back problems stem from either 1986, 1990, or, most likely, June 2nd, 1992. That's the carrier's positon." In closing argument the carrier argued that the claimant's low back pain was not caused by the accident of (date of injury), and stated that "[i]t may have been a continuation of the 1986 lumbar injury and surgery. It may have been caused by the car accident in 1990. I admit we have no medical on that. I think it is most likely that the incident that caused compression of [the claimant's] spine was on June the 2nd, 1992, when this eight inch pipe hit him on the head hard enough to knock him down." The carrier acknowledged that no doctor had opined on whether the June 2, 1992, incident caused the claimant's low back condition. It is clear from the carrier's stated position at the hearing that it was urging the hearing officer to find that the claimant's low back problems were caused by a preexisting condition or injury, which is what the hearing officer found.

It has been stated that the trier of fact is entitled to decide causation with or without medical testimony in areas of common experience. Director, State Employees Workers' Compensation Division v. Wade, 788 S.W.2d 131 (Tex. App.-Beaumont 1990, writ denied). However, causal connection must be proved upon the strength of reasonable probability; otherwise the relationship between preexisting condition and injury can be no more than conjecture. Webb v. Western Casualty and Surety Company, 517 S.W.2d 529 (Tex. 1974). In Webb, the Supreme Court of Texas held that a doctor's testimony that the employee's heart attack "could have" been caused by a preexisting heart condition was insufficient to raise an issue that the preexisting condition was the sole cause of the heart attack. The court said that since there was no evidence tending to prove that the employee's preexisting heart condition was the sole cause of his heart attack, the trial court was correct in refusing to submit such special issue. In the instant case, Drs. Ogunro and Driscoll diagnosed the claimant as having a herniated disc at the L5-S1 level, and Dr. Driscoll was of the opinion

that the claimant's low back pain was secondary to that disc herniation. There was no evidence that the claimant had a preexisting disc herniation at L5-S1. There is evidence that the claimant had a back injury in 1986 for which he had surgery at the L3-L4 level, that he had intermittent back pain after that surgery, that he had a truck accident in 1990, and that he had an accident on June 2nd 1992. However, there is no evidence tending to show that the claimant's disc herniation at L5-S1 was caused by any of those events. The carrier's argument that the claimant's back problem was most likely caused by the June 2, 1992 accident is not supported by any medical evidence nor by lay testimony. The claimant said that after that accident he felt no symptoms of injury and that he did not seek medical treatment or even report the accident. There isn't even any evidence that the accident of June 2, 1992 resulted in the claimant having any back pain or having to take off any time from work. We also observe that the carrier did not assert that the claimant's neck problem was the result of a preexisting injury or condition. In our opinion, the hearing officer's finding that the sole cause of the claimant's back problem is the result of a preexisting conditon is not supported by sufficient evidence. It was also error for the hearing officer to find that the sole cause of the claimant's neck problem is the result of a preexisting condition because there was no issue before the hearing officer concerning the cause of the claimant's neck problems and the carrier acknowleged at the hearing that the claimant's neck problem should be considered for purposes of MMI and impairment rating.

Having determined that the hearing officer erred in finding that the claimant did not sustain a neck injury because that issue was not before the hearing officer for resolution, and having determined that the hearing officer erred in finding that the sole cause of the claimant's back problem was a preexisting condition because there is no evidence that the claimant had a preexisting disc herniation at L5-S1, we conclude that there is a substantial likelihood that the hearing officer also erred in finding that the designated doctor's report is invalid on the stated basis that the designated doctor incorrectly assumed that the claimant sustained a neck and back injury. However, we remand the case to the hearing officer for futher consideration and development of evidence, as appropriate, instead of reversing and rendering a decision because we recognize that the claimant has the burden of proving that an injury was received in the course and scope of his employment. Spillers v. City of Houston, 777 S.W.2d 181 (Tex. App.-Houston [1st Dist] 1989, writ denied). In the instant case, the hearing officer's finding that the sole cause of the claimant's back and neck problems are the result of a preexisting condition could be seen as the basis for his finding that the claimant did not sustain a back or neck injury on (date of injury), because, if the preexisting condition was the sole cause, there could be no other cause such as the accident of June 29th as asserted by the claimant. We also observe that the hearing officer's finding that the designated doctor's report was invalid certainly would have affected his finding on the great weight of the medical evidence being contrary to the designated doctor's report.

The decision of the hearing officer is reversed and remanded for further consideration and development of the evidence, as appropriate. A final decision has not been made in

this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Texas Workers' Compensation Commission's division of hearings, pursuant to Article 8308-6.41. *See*
Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

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Robert W. Potts
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.
Chief Appeals Judge

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Joe Sebesta
Appeals Judge