APPEAL NO. 931084
FILED JANUARY 12, 1994

On October 11, 1993, a contested case hearing (CCH) was held in [City 1], Texas, with [hearing officer] presiding, to determine the issues of the correct impairment rating to be assigned to the claimant, [JT], who is the respondent, and to further determine whether the carrier was entitled to recoup from claimant's impairment income benefits (IIBS) amounts paid in addition to weekly income benefits, whether claimant was entitled to reimbursement for mileage expense for travel to and from his treating doctor, and whether carrier was entitled to reduce impairment income or supplemental income benefits due to the contributing effect of a prior compensable injury. The claimant injured his neck and back on [date of injury], while fighting a fire in the course and scope of his employment as a fire fighter for the [employer]. The City is self-insured for workers' compensation insurance under the authority of the TEXAS LABOR CODE § 504.001 *et seq*. (formerly TEX. REV. CIV. STAT. ANN. Article 8309(h)), and shall be referred to hereinafter as "employer" or "carrier," depending upon the capacity in which it acted.

The hearing officer incorporated the report of the designated doctor on impairment and found that claimant's impairment rating was 26% percent. Maximum medical improvement (MMI) was not an issue in the case and the date found by the designated doctor and the hearing officer was February 26, 1993. The hearing officer further determined that the carrier had not proven a basis for reducing claimant's IIBS for any amounts by which it had supplemented his temporary income benefits (TIBS) up to the amount of his pre-injury wages. As part of the facts underlying this decision, the hearing officer determined that claimant had not requested a salary supplement nor entered into an agreement to authorize a reduction to his IIBS. The hearing officer further determined that carrier had not shown a documented impairment relating to claimant's prior compensable injury. Finally, the hearing officer determined that the claimant was entitled to reimbursement for mileage to and from his residence [(City 2)] to the office of his treating doctor [(City 3)].

The carrier appeals all of these decisions, for various reasons. First, it argues that because the employer was compelled to pay the full amount of the claimant's wage, a written request or agreement was not required for it to act, and that it is entitled to recoup the excess amount in accordance with the Texas Workers' Compensation Act. Section 408.127. Carrier further argues that the hearing officer erred by basing his decision on the 26% impairment rating of the designated doctor. Carrier contends that the hearing officer erred in finding that there was not a documented impairment from claimant's previous injury, or in denying contribution. Finally, the carrier argues that the hearing officer erred by determining the mileage issue at all, because a previous

Appeals Panel decision opined that jurisdiction for such determination was in the medical review division of the Texas Workers' Compensation Commission (Commission). In the alternative, the carrier appeals the mileage decision because claimant could have received medical treatment for his injury in [City 2]. The claimant responds that the decision should be upheld in its entirety.

DECISION

We affirm the determination of the hearing officer, finding claimant's points of error to be wholly without merit.

The claimant fell over some furniture while putting out an apartment fire on [date of injury]. He injured his neck and back. The employer is obligated according to TEX. LOCAL GOV'T CODE ANN. § 143.073 (Vernon 1988) to ensure that fire fighters and police officers injured in the line of duty have up to one year fully paid leave of absence. This law allows extension beyond a year, discretionary with the municipality. The claimant agreed that he had been at full pre-injury salary for the period from March 30, 1992, through April 18, 1993. The city, as carrier, paid him his TIBS. The city, as employer, paid the additional amount up to his pre-injury average weekly wage of $958.24 a week.[1]

Claimant testified that he had a previous compensable injury to his back in 1990. However, although he had herniated discs, he fully resolved this problem through therapy. He emphasized (and earlier tests from that injury indicate) that these herniations were in the lumbar spine.

For his [month and year of] injury, an MRI conducted March 24, 1992, showed herniation at the C5-6 level, and what was believed to be a protrusion at C6-7. The lumbar spine MRI showed a central posterior protrusion at the L5-S1 level, with disc degeneration at L4-5. These tests were performed at the request of Dr. JM, who was claimant's first treating doctor. Claimant stated that he avoided surgery at all costs due to complications he had had several years ago from surgery on his ankle. It appears that conservative care, as opposed to surgery, was also recommended on March 27, 1992, by Dr. BM, referred by Dr. JM.

Claimant changed treating doctors to Dr. B, who was specially certified in the use of a piece of equipment called an "activator," which claimant stated gave him great pain relief. He said his understanding was that the activator actually manipulated and moved bone. Claimant said that he travelled to another town, 64.1 miles each way, to see Dr.

[1] It is unclear why claimant would receive his average weekly wage, as TEX. LOCAL GOV'T CODE ANN. § 143.073 (Vernon 1988) would seem to require full pay at the time of injury, which was $959.31 per week.

B, and that such travel actually was hard for him due to pain and the need to stop frequently. However, he found that the only chiropractor in his town, Dr. S, was not certified to use the activator, and told him that he used the activator only on persons that could not be manipulated, such as young infants or senior citizens, and would not use it on him. Dr. S's very limited use of, and lack of certification in, the activator, is confirmed in an August 24, 1993, letter to the carrier's attorney. Claimant said that Dr. B has treated him although the carrier has stopped paying his bills.[2]

A September 3, 1992, CT scan of the cervical spine indicated evidence of an old herniation at C5-6 and suspicion of a current focal herniation at C6-7. An EMG performed September 8, 1992, showed moderately severe cervical radiculopathy.

The carrier sought a medical examination order in January 1993, and, pursuant to that order, claimant was examined by Dr. M, a neurosurgeon, who determined that claimant reached MMI on March 22, 1993, with a 24% whole body impairment rating. Dr. M determined that claimant had compression of the spinal cord at C5-6, abnormal upper body sensory examination, and disc degeneration at L5-S1 with some evidence of this at L4-5. No evidence of cervical radiculopathy or cervical myopathy was found[3], and Dr. M commented that he thought claimant magnified his symptoms (although, no impairment rating was based on magnified symptoms). Dr. M assessed the following discrete ratings:

> cervical, 6% disc condition, 14% [range of motion] ROM; lumbar, 6% disc condition, 0% ROM.

Claimant had obtained a letter on April 5, 1993, from Dr. B agreeing with Dr. M's evaluation but adding another one percent, citing the AMA Guides to the Evaluation of Permanent Impairment (Guides) as the basis for "rounding up." Dr. B's letter stated that he accompanied claimant to Dr. M's examination. According to the claimant, the carrier disputed Dr. M's rating (although it filed a TWCC-21 stating that it disputed Dr. B's 25% rating). The commission appointed a designated doctor, Dr. H, for the purpose of determining impairment rating only. Dr. H examined claimant personally for an hour. He determined that claimant had a whole body impairment of 26%, and had achieved

---

[2] The carrier offered no evidence at all in support of the assertion that claimant could find reasonable and necessary medical treatment of his condition in [City 2]. Although it disputed claimant's requested transportation on the basis that claimant could obtain chiropractic care in [City 2], it appears from the record that it did not contact another chiropractic provider (Dr. S) to inquire about services offered by him until after the benefit review conference. As noted above, Dr. S's letter favored claimant's position.

[3] We note that Dr. M mentioned all objective tests performed on claimant except the September 1992 EMG and CT scan. It is therefore unclear if he considered the EMG test results in concluding that there was no evidence of radiculopathy.

MMI effective February 26, 1993. Dr. H notes review of all of claimant's objective tests. The elements of his impairment rating are:

> cervical, 6% disc condition, 14% ROM; lumbar, 5% disc condition, 4% ROM. The total was derived through use of the Combined Values Chart as required by the Guides.

The document that carrier tendered as a 10% "impairment" for claimant's 1990 injury is a one page form filled out by Dr. JM, entitled "Disability Rating Report." It described various lumbar conditions, including chronic strain. It stated that claimant had a permanent partial disability of 10% "percentage of loss." Aside from this form, no evidence was offered by the carrier as to the basis or methodology for this assessment, or how it would equate to impairment under the 1989 Act. In answer to a deposition on written questions from the carrier, Dr. H indicated that the impairment that he evaluated was attributable to claimant's [month and year of] injury.

A benefit review conference was held July 23, 1993. Thereafter, carrier's attorney wrote to Dr. M, representing that claimant had been given a 10% "disability" for his previous injury. Dr. M responded that he would deduct this 10%, yielding a new rating of 14%. The City, as employer, filed a "Report for Reimbursement of Voluntary Payment" (TWCC-2) dated March 25, 1992, stating that it was initiating compensation. The form did not indicate supplement to income.

TRAVEL REIMBURSEMENT ISSUE

The assertion that previous Appeals Panel decisions deprive the hearing officer of jurisdiction over medical mileage reimbursement is without merit, as those decisions were effectively overruled by adoption of TEX. W.C. COMM'N RULES, 28 TEX. ADMIN. CODE § 134.6(e) (Rule 134.6), effective December 1, 1992, which provides that disputes over travel shall be resolved through the BRC and CCH process.

The hearing officer's decision is supported by sufficient evidence. Indeed, carrier essentially offered no evidence to bolster its contention that claimant's travel to Dr. B was unnecessary, or that medical treatment was available in [City 2]. By contrast, claimant made a persuasive case for the ameliorative value of Dr. B's treatments, and the unavailability of similar services in the area. His statement about the distance travelled was uncontroverted. Although carrier has apparently withheld payment from Dr. B, and argued that the necessity of medical services related to travel had not been finally determined, there was no indication that carrier has sought to bring such matters to resolution. One may infer that it has not, because carrier's attorney questioned

claimant as to whether he had sought a decision through the medical review dispute resolution process[4]. We affirm the hearing officer.

IMPAIRMENT RATING

Carrier does not argue that the great weight of medical evidence is contrary to the designated doctor's report. Its argument is largely premised on Dr. H's purported failure to consider claimant's prior injury.

We observe that we have noted many times that an aggravation of a pre-existing condition is an injury in its own right. INA of Texas v. Howeth, 755 S.W.2d 534, 537 (Tex. App.-Houston [1st Dist.] 1988, no writ). A carrier that wishes to assert that a pre-existing condition is the sole cause of an incapacity has the burden of proving this. Texas Employers' Insurance Association v. Page, 553 S.W.2d 98, 100 (Tex. 1977); Texas Workers' Compensation Commission Appeal No. 92068, decided April 6, 1992. Observations that an impairment is caused in part by a prior injury does not rule out "aggravation" by way of the current, and undisputed, fall. Both could be appropriately considered part of the current "compensable injury." Further, we have stated that the way to adjust for the contributing effects of a previous compensable injury is through a finding of contribution, and not through deflation of the impairment rating. Texas Workers' Compensation Commission Appeal No. 93695, decided September 22, 1993.

Certain aspects of carrier's dispute over impairment bear comment. At the close of the contested case hearing, and in its appeal, carrier argued that 24% was the appropriate impairment rating, as opposed to 26% of the designated doctor. That 24% is from carrier's own doctor rendered in March 1993. Carrier's dispute over impairment rating, filed in April 1993, asserts that 14% is the correct rating. (While it disputes Dr. B's 25% rating, it is clear that Dr. B's rating is essentially agreement with carrier's own doctor's 24% rating). It appears from the record not to have had any documentation in support of a 14% figure until after the BRC, held July 14, 1993, and even then the documentation went to the issue of contribution, not the accuracy of the disputed impairment ratings of 24% or 25%. The designated doctor thereafter found 26% impairment.

The hearing officer properly gave presumptive weight to the designated doctor's report. Carrier's contention to the contrary is without merit.

[4] It does not appear to us that Rule 133.305 vests the burden solely in the claimant to request dispute resolution. Indeed, given the administrative sanctions that can be brought to bear against a carrier for unreasonably disputing the reasonableness and necessity of medical care, Section 415.002(21), or for failure to process claims in a reasonable and prudent manner, Section 415.002(13), a carrier would seem to have some incentive for seeking adjudication of the necessity of treatment rather than let months of rendered, but unpaid, services elapse.

RECOUPMENT ISSUE

The carrier argues that the hearing officer has erroneously recast this issue on his own motion. We disagree. While the hearing officer's discussion about how the issue should have been phrased, given that the city wore both the hat of carrier and of employer in this case, is somewhat confusing, we do not believe it to be tantamount to recasting the issue. It is clear that the hearing officer decided the dispute over whether the relief sought by the carrier, reduction of claimant's IIBS to "reimburse" what had been paid by the employer over and above the TIBS income benefits, was authorized by applicable laws. He correctly decided this issue against reduction of IIBS.

Section 408.127(a) makes clear that the carrier may reduce IIBS only for employer payments made under Section 408.003. Although the City did not supplement claimant's TIBS under the express conditions set out in Section 408.003(a), the carrier argues that this section should be applied, asserting that the mandates of TEX. LOCAL GOV'T CODE ANN. § 143.073 (Vernon 1988) are intended by the legislature to equate to an agreement between an employer and an employee under Section 408.003(a). The carrier does not mention at all, however, the statute that is directly applicable which is Section 504.001 *et seq.*, relating to self-insured political subdivisions.

Section 504.002 incorporates certain provisions of the 1989 Act "except to the extent that they are inconsistent with this chapter." Two of the provisions so incorporated are Sections 408.003 and 408.127. However, payment of benefits to injured workers who may also be entitled to incapacity payments under other laws is expressly dealt with in Section 504.051. Subsection (a)(1)(A) states:

> OFFSET AGAINST PAYMENTS FOR INCAPACITY. (a) Benefits provided under this chapter shall be offset: (1) to the extent applicable, by any amount for incapacity received as provided by: (A) Chapter 143, Local Government Code. . . . "

In short, the legislature expressly noted its awareness of special provisions relating to police officers and fire fighters, and expressly directed how offsets and credits, if any, would be handled in such a situation. We believe these specific provisions prevail over any general and inconsistent provisions in 408.003. There is certainly no reason to imply a purpose contrary to express language in Sections 408.003 and 408.127 that allows for IIBs reduction only if there is a written agreement or request from the employee to supplement.

Section 504.051(a)(1)(A) makes clear, in our opinion, that the two classes of employees injured in the line of duty who are entitled to paid leave under Section

143.073 of the Local Government Code may not "double dip" and receive full pay plus full workers' compensation income benefits for the period of leave. Whatever is paid out of the municipality's accounts for both civil service leave and workers' compensation income benefits may not exceed the pre-injury weekly wage, and it is the amount paid under Chapter 143 of the Local Governmental Code which is reduced, not the workers' compensation benefits. *See* Angelina County v. Modisette, 667 S.W.2d 881 (Tex. App.-Beaumont 1984, no writ). The offset provision in the workers' compensation law applicable to political subdivisions was added in 1975, as Section 5(a) to TEX. REV. CIV. STAT. ANN. Article 8309(h), and changed what had been previously the law, that payment could be received under both the workers' compensation laws and civil service laws with no offset against either. *Note* City of Corpus Christi v. Herschbach, 536 S.W.2d 653, 657 (Tex. Civ. App.-Corpus Christi 1976, writ ref'd n.r.e.) [giving prospective effect only to offset provision of Article 8309(h).] We find no authorization in the statutes cited above, as a whole, for the carrier to obtain a double offset by reducing the amount of IIBS paid after the leave period ends. To allow this would go beyond the offset expressly authorized by Section 504.051, and could effectively read the full leave pay accorded to police officers and fire fighters in Section 143.073 of the Local Governmental Code out of existence.

CONTRIBUTION ISSUE

Although the hearing officer announced as part of his introduction that the claimant had the burden of proof on all issues, we believe that it is the carrier who seeks a proportionate adjustment to the benefit for contribution under Section 408.084 who has the burden to prove that an injured employee has a documented impairment from any prior compensable injury. Texas Workers' Compensation Commission Appeal No. 92610, decided December 30, 1992, citing Transport Insurance Company v. Mabra, 487 S.W.2d 704 (Tex. 1972).

Carrier offered only the one-page report of Dr. JM, which its own attorney described as a "disability" rating. The hearing officer apparently believed that the document in question, standing alone and unexplained, fell short in that carrier failed to demonstrate that a 10% loss or disability under "old law" would necessarily equate to impairment under the 1989 Act. Dr. H, the designated doctor, opined that it did not. While the Appeals Panel has held that contribution from an "old law" injury is not precluded by the statute[5] we nevertheless agree that the carrier should show that the basis for assessing any previous percentage was similar to that used to assess impairment under the 1989 Act.

[5] Texas Workers' Compensation Commission Appeal No. 92549, decided November 24, 1992.

Even though Dr. M, after being contacted by the carrier, simply deducted Dr. JM's 10% from his own impairment rating, any overlap between the physical conditions at the heart of the 10% assessment and the impairment rating for the current injury is not readily apparent, and claimant's argument that most of his current impairment comes from cervical injuries that were not sustained in 1990 has support in the evidence.

At best, the evidence might persuade a finder of fact that there could have been an impairment from the prior injury. With no evidence to equate the premise underlying the previous rating to the basis for the current rating, there is no support for a proportionate reduction in benefits.

Finally, claimant points out a typographical error in the decision. Claimant's evidence and testimony was that his total mileage was 17,802 miles. The hearing officer found that claimant's mileage was 17,082. We agree that this appears to be a typographical transposition and correct references to 17, 082 miles to read "17,802" miles.

The claimant, who was indisputably injured in what could be seen as heroic service to the employer, made clear in closing argument that he felt ill-treated by delays and denials of the carrier. We therefore emphasize that the hearing officer's decision, which we affirm in its entirety as our decision, subject to the typographical correction, is binding from henceforth on the carrier, pending any judicial appeal of this decision, Section 410.205(b), and payment of benefits must be made in accordance with that decision.

Susan M. Kelley
Appeals Judge

CONCUR:

Lynda H. Nesenholtz
Appeals Judge

Gary L. Kilgore
Appeals Judge