APPEAL NO. 93132

On January 21, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding. The hearing officer determined that the respondent/claimant, (Ms. W), did not sustain a new back injury in (date), but that required medical treatment beginning that date was a result of her compensable back injury of (date of injury). The compensability of the September injury had not been contested by the carrier, who is the appellant in this case. Because claimant had reached maximum medical improvement (MMI) from the September 1991 injury, only medical benefits were determined to be due by the hearing officer's decision.

The carrier asks for reconsideration by the Appeals Panel, arguing that the great weight of the evidence supports its contention that the claimant sustained either a new injury by aggravation to her preexisting back condition, or that the sole cause of her (date of injury) need for medical treatment was a back condition in existence before (date of injury). The carrier also asserts that the failure of the Texas Workers' Compensation Commission (Commission) to grant a required medical examination at the end of December 1992 compromised its investigation and preparation of the case. A late response was filed by the claimant.

DECISION

After reviewing the record, we affirm the determination of the hearing officer.

The claimant injured her back on (date of injury), while moving a file cabinet in the course and scope of her employment with (employer). Previously, claimant had undergone back surgery, a lumbar fusion, in 1982, and then had a work-related back injury in 1985. She stated in her testimony that she had recovered from the 1985 injury within two months, and, although she was not pain free between 1985 and the occurrence of her (date of injury) injury, she did not have continuous pain to her back. The evening of September 3rd she felt pain and noticed a knot on her back. The claimant said she was initially treated by a (Dr. SV), from whom she received muscle relaxants, and then was treated by a back specialist, (Dr. F). She eventually sought treatment from (Dr. T). She missed some time from work. In March 1992, the claimant was terminated by her employer and subsequently went to work in another office job.

A summary of the medical records in evidence following this injury reflect the following:

-A discharge summary from her physical therapist dated 10-16-91 notes that claimant decided to discontinue therapy as she was feeling better.

-An unsigned note from (Dr. C) dated 4/22/92 records an impression of mechanical low back pain secondary to stress aggravation of facet joint arthrosis, post-surgical myofibrositis, and possible chronic degenerative disc

disease at L5-S1.

-The carrier's doctor, (Dr. G), assessed MMI effective April 24, 1992, with a five percent impairment rating attributable solely to the (date of injury) injury. (Dr. G rated claimant with 20% rating overall, but then attributed 15% to her preexisting condition.) Dr. G noted that claimant had some pain when he examined her.

-On May 4, 1992, notes of Dr. T indicate that claimant was still experiencing low back pain. According to these notes, claimant was to remain working, take physical therapy at night, and continue pain medication. Dr. T stated that claimant might need further evaluation, and would need to return in six to eight weeks for reassessment.

-On July 6, 1992, claimant was examined by (Dr. S), a designated doctor appointed by the Commission to examine her relating to a dispute over Dr. G's MMI and impairment rating. Dr. S noted that she had present complaints of lower back pain radiating down her legs, and numbness in extremities when sitting too long, and difficulty sleeping at night. Dr. S noted that claimant had aggravated preexisting conditions she had, and she was advised to avoid stooping, bending, or heavy lifting. He stated that she had reached MMI in May 1992 and assigned a 13% impairment rating.

Around the 1st or 2nd day of August, 1992, the claimant stated that she was getting into a pickup truck and felt a "pop" in her back which was different from the pain she had felt before. Claimant, on rebuttal, clarified that the difference had to do with the side of her back affected, that both this incident and the (date of injury) injury involved her left side, while her surgery was on the right. (In an earlier deposition, claimant testified she didn't know which side "popped.") She was thereafter in pain and sought treatment again from Dr. T later in August. Very soon after this, further treatment was not obtained because the carrier denied liability for further medical treatment.

Medical records dated after the (date of injury) incident indicated the following:

-An unsigned file note from Dr. T dated 8/24/92 notes that claimant "twisted" her back and felt a pop and needs pain medication. Dr. T's note states that she was not helped in the past by ESI or physical therapy. Dr. T's note also indicates that claimant "is known" to suffer from spondylolisthesis at L5-S1.

-A letter from Dr. T dated November 2, 1992 confirms that claimant sustained a back

> injury on (date of injury). This letter then states "[t]he minor twisting episode which occurred in (date of injury) aggravated her low back pain but does not constitute a new injury. Her date of injury, therefore, remains that of her original injury on (date of injury)."

On January 5, 1993, the adjuster for the carrier, (Mr. B), wrote to Dr. S, who had been the previous designated doctor, and sought his opinion on whether the (date of injury) incident constituted a new injury. Mr. B testified that he did this after the carrier's request for a medical examination was denied by the Commission. A copy of Dr. T's November 2, 1992 letter does not appear to have been provided to Dr. S. While the letter stated a desire not to color Dr. S's opinion in any way, it fully articulated the carrier's position with regard to the (date of injury) incident. Mr. B testified that he had not sent anyone to be examined by Dr. S in four or five years, and that indicated that Dr. S would be paid for his opinion regardless of its contents. Copies of the letter are shown as mailed to the carrier's attorney and the carrier, but not to the claimant.

In response and without examining the claimant again, Dr. S wrote on January 8th that claimant has had continuous problems post-surgery, and that her (date of injury) "flare-up" stemmed from the surgery in 1982 and was not an aggravation of the (date of injury) injury. Dr. S opined that claimant had "gotten over" the flare-up on (date of injury) before the (date of injury) incident.

The carrier presented numerous records from claimant's treating doctor for her surgery to show that claimant experienced problems with her back between her surgery in 1982 and (date of injury). The carrier also developed testimony from claimant about her earlier history, although claimant did not recall much about her medications or earlier condition. However, there were no medical records presented to prove that claimant's (date of injury) back pain related only to her earlier condition, to the exclusion of her (date of injury) injury. Although the January 1993 letter from Dr. S opines that the (date of injury) flare-up was not related to the September 1991 injury, there were no records diagnosing a different, or enhanced, physical injury after (date of injury) that was different from before. Indeed, Dr. S characterizes the (date of injury) incident as a "flare-up." He similarly characterized the (date of injury) injury as a "flare-up." The hearing officer could have considered Dr. S's observation was made without the benefit of an examination following the (date of injury) incident, and was therefore not entitled to as much weight as his earlier assessment that the (date of injury) injury was substantial enough to cause 13% impairment. The burden is on the carrier to prove that a preexisting condition is the sole cause of an injured employee's incapacity. Texas Employees' Insurance Ass'n v. Page, 553 S.W.2d 98 (Tex. 1977). The carrier in this case did not prove to the hearing officer that the condition in existence prior to (date of injury) was the "sole cause" of the (date of injury) incident, or that the claimant sustained an independent (date of injury) "injury."

In contrast, the claimant has presented evidence that the (date of injury) manifestation of pain was not the result of a new "injury" but was a recurrence of the pain from her (date of injury) injury. This evidence, coupled with the assessment of both Dr. G and Dr. S that claimant would have lasting impairment from her compensable 1991 injury, and their observations of pain during their pre-(date of injury) examinations of claimant, support the hearing officer's findings and conclusions:

FINDINGS OF FACT

4.In (date of injury), [claimant] experienced a popping sensation in her back as a result of the injury she sustained on (date of injury), from pushing a file cabinet while working for [employer].

5.Medical treatment to [claimant]'s back commencing (date of injury), was required as a result of the injury she sustained on (date of injury), from pushing a file cabinet while working for [employer].

CONCLUSIONS OF LAW

3.[Claimant] is entitled to medical treatment to her back including, but not limited to, medical treatment commencing August, 1992.

Medical benefits are payable for life for health care that cures or relieves the effects naturally resulting from the compensable injury, that promotes recovery, or that enhances the ability of the employee to return to or "retain" employment. Texas Workers' Compensation Act, TEX. REV. CIV. STAT. art. 8308-4.61(a) (Vernon Supp. 1993) (1989 Act). The hearing officer is the sole judge of the relevance and materiality, the weight and credibility, of the evidence offered in a contested case hearing. 1989 Act, Art. 8308-6.34(e). Any inconsistencies in the claimant's testimony were the responsibility of the hearing officer to resolve. The decision of the hearing officer will be set aside only if the evidence supporting the hearing officer's determination is so weak or against the overwhelming weight of the evidence as to be clearly wrong or manifestly unjust. Atlantic Mutual Insurance Co. v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.). Whether or not an injury, including an injury through aggravation, has occurred is an issue for the trier of fact. Dealers National Insurance Co. v. Simmons, 421 S.W.2d 669, 675 (Tex. Civ. App.-Houston [14th Dist.] writ ref'd n.r.e.); Texas Workers' Compensation Commission Appeal No. 92463, decided October 14, 1992.

Concerning the contention that carrier's case was hurt by denial of a medical examination order in late December 1992, we would note that carrier has failed to demonstrate how this denial resulted in reversible error. The carrier did not object to this at the contested case hearing. The record contains support for a counter-argument that

carrier's own actions delayed its preparation and investigation of the case; although claimant's surgery and earlier work-related injury were disclosed to the carrier in September 1991, along with the name of her treating doctor for those ailments, the carrier did not take claimant's deposition nor seek her authorization for earlier medical records until about 10 days before the contested case hearing. The carrier cut off further medical care following the (date of injury) incident. The carrier waited until late December 1992 to request a medical examination order relating to treatment after the (date of injury) incident. The carrier obtained a continuance in early January 1993 to obtain medical records.

There being sufficient evidence to support the decision of the hearing officer, we affirm his decision.

Susan M. Kelley
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Thomas A. Knapp
Appeals Judge