APPEAL NO. 93695

On June 17, 1993, a contested case hearing was held in (city), Texas, with (hearing officer) presiding, to determine the issue of the correct impairment rating to be assigned to the claimant, (claimant), who is the appellant. The claimant had sustained an injury to his back on (date of injury), when he slipped and fell on his buttocks while in the course and scope of his employment with (employer).

The hearing officer adopted the report of the designated doctor on impairment and found that claimant's impairment rating was five percent. Maximum medical improvement was not disputed and the date found by both the treating doctor and the designated doctor was November 13, 1992.

The claimant has appealed this decision as to adoption of the designated doctor's impairment rating, arguing that the designated doctor's report "puts too much emphasis on a previous, and healed, injury and is therefore too low." The claimant also argues that the evidence established his disability from the date of injury to the present. The carrier responds that the appeal fails to invoke the Appeals Panel's jurisdiction, that the claimant has the burden of proof on disability, and that the hearing officer was correct in according presumptive weight to the designated doctor's report.

DECISION

We reverse and remand the decision of the hearing officer for further evidence and proceedings in accordance with this decision, finding that the designated doctor's report fails to rate the injury sustained by the claimant in full.

We believe that claimant has filed an appeal that sufficiently raises the issue of whether the designated doctor properly omitted from his impairment rating a condition that the designated doctor stated related to a prior injury, specifically, spondylolysis. We will consider the appeal on that basis.

The claimant testified that he injured his back on (date of injury), when he slipped and fell on his buttocks on a floor while working for employer.

Claimant's medical records will be briefly summarized. Records from a previous compensable back injury in 1988, a strain from carrying a piano, indicate that claimant had spondylolysis at that time. Many of the records submitted from that claim are frankly illegible. His doctor at the time refers to "spondylolisthesis" at L5-S1. One indicator of what those records state is in the designated doctor's report, which stated that his review of such records showed spondylolysis at "L-5."

After the injury that is the subject of this proceeding, claimant was treated by (Dr. U), who initially diagnosed lumbar and thoracic strain and sprain. Within a few days after his injury, an x-ray revealed (and a later CT scan also showed) spondylolysis at L-4 and L-5,

but no spondylolisthesis, and this was added to the overall diagnosis by Dr. U and by a doctor to whom he was referred, (Dr. M). The record does not contain any indication that the carrier disputed the extent of the injury or in any way argued a "sole cause" defense. Treatment records from Dr. M span a period of time from August 1991 through August 1992.

Pursuant to a medical examination order sought by the carrier, claimant was examined on September 17, 1991, by (Dr. B). His report was long and detailed; as pertinent to the issue under appeal, the doctor noted that claimant had spondylolysis at L4- and L-5 as indicated by an April 15, 1991 x-ray and June 18, 1991, CT scan. Dr. B stated, in a specific portion of his report dedicated to spondylolysis:

> This condition is congenital or developmental in nature and was present before [claimant's] injury of (date of injury). Obviously, it was also present prior to his back injury of 1988. It is not possible to determine if [claimant's] symptoms from either injury were in part or not associated with that condition. The presence of magnification and inconsistency in [claimant's] symptoms makes this task even more difficult, if not impossible.

The same difficulty was apparently not experienced by claimant's treating physician. Dr. M, in his August 24, 1992 report, noted claimant's continued pain and stated "we attribute his symptomology to his spondylolysis." He opined then that he suspected claimant had reached maximum medical improvement (MMI). In December 1992, Dr. M completed a TWCC-69 Report of Medical Evaluation stating that claimant had reached MMI effective November 13, 1992 with an 18% whole body impairment. He derived this rating from assessing 11% for loss of range of motion, and eight percent from Table 49 of the *AMA Guides to the Evaluation of Permanent Impairment* (Guides) for Grade 1 spondylolysis of the lumbar region. The TWCC-69 completed by Dr. M called upon him to base his rating on the "compensable injury."

The carrier disputed this rating, and a designated doctor, (Dr. P), was appointed by the Commission. (Although carrier argued that the Commission is bound by the impairment rating of an agreed designated doctor, there is no evidence that Dr. P was appointed by agreement.) Dr. P examined the claimant on March 25, 1993. He concurred in the MMI date found by Dr. M. He found normal range of motion and did not assess any impairment related to that. Dr. P found a five percent impairment, based upon Table 49, section 2b. His impression is 1) muscle ligamentous strain, 2) low back pain, and 3) spondylolysis at L5 (old injury; 1988). In a clarifying letter to the carrier's attorney dated May 28, 1993, Dr. P stated that the spondylolysis "related" to an old injury, observing that "[t]he claim for 1988 was settled and the patient has already been compensated for this type of injury."

A letter from Dr. U dated July 19, 1993, stated that Dr. P's report was incorrect because he did not account for claimant's thoracic strain and bilateral radiculopathy. Dr. U also related the spondylolysis to the 1991, and not the 1988, accident.

On the face of his report and clarifying letter, the designated doctor has essentially deducted from the rating the contributing effects of a prior compensable injury. We believe that the only manner in which this can be properly done is by Commission action through the 1989 Act, Article 8308-4.30 (recodified as TEX. LAB. CODE ANN. § 408.084), and not through a designated doctor "downloading" the impairment rating for the current injury. This section states (in pertinent part):

(a)At the request of the insurance carrier, the commission may order that impairment income benefits and supplemental income benefits be reduced in a proportion equal to the proportion of a documented impairment that resulted from earlier compensable injuries.

(b)The commission shall consider the cumulative impact of the compensable injuries on the employee's overall impairment in determining a reduction under this section.

This statute makes clear that it is the Commission, not a doctor assessing impairment, who will determine the extent to which any contributing compensable injury is one for which a claimant "has already been compensated." *See also* Texas Workers' Compensation Commission Appeal No. 93272, decided May 24, 1993; Appeal No. 92610, decided December 30, 1992. By failing to assess any rating at all for the reasons he stated, the designated doctor has not provided any information from which the proportion of the effects of the prior compensable injury could be ascertained.

As we have stated many times, 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 the inception of a condition is congenital or that it "related" to a prior injury do not standing alone rule out "aggravation" by way of the current, and undisputed, fall. To the extent that the hearing officer observed in his statement of the evidence that the spondylolysis dated from claimant's earlier compensable injury, and may have premised his adoption of the designated doctor's report on this, we believe he committed error.

There was no evidence that the carrier in this case contested the extent of spondylolysis as part of the claimant's current injury. There is no evidence that prior to (date of injury), claimant's spondylolysis caused pain or limited range of motion. Dr. M's report indicates that there has been an aggravation in that current symptomology stems from the spondylolysis. Dr. B, the carrier's doctor, arguably acknowledges the possibility of aggravation, although he was unable to assess it one way or the other. Further, Dr. P attributes spondylolysis at the L-5 level to the prior injury, with no mention of that detected at the L-4 level. There is no indication that Dr. P considered or was aware that aggravation

of a pre-existing condition can itself be considered part of the "compensable injury."

The determination of the hearing officer that the great weight of medical evidence is not against the report of the designated doctor is not sufficiently supported by the record. We are unable to render a decision adopting the report of Dr. M, however, because claimant has not appealed the designated doctor's conclusion assigning no impairment for loss of range of motion, and Dr. M's report attributes some impairment to loss of range of motion. We believe that the appropriate course of action is to remand the case so that the designated doctor may re-assess claimant's impairment without factoring in, at this stage, contribution from the prior compensable injury. Any contribution must be resolved as set forth in the 1989 Act. Whether carrier can at this point dispute the apparent extent of the injury as to the spondylolysis may have to be determined in another forum, if not in issue in this proceeding. The hearing officer may develop other evidence as he deems necessary.

Regarding point of error relating to disability, we would note that disability (defined in Section 401.001(16)) was not an issue in this hearing, and there are no findings on the issue. We therefore assign no error on the basis of this point of appeal.

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 Section 410.202. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Susan M. Kelley
Appeals Judge

CONCUR:

Robert Potts
Appeals Judge

Gary L. Kilgore
Appeals Judge