APPEAL NO. 94232

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was convened in (city), Texas, on December 1, 1993, and was continued and re-convened on January 27, 1994. Three issues were before the hearing officer, (hearing officer): does the compensable injury sustained by the claimant extend to an injury to the head; has the claimant reached maximum medical improvement (MMI) and, if so, on what date; and if the claimant has reached MMI, what is his impairment rating (IR). The hearing officer held that the claimant did not injure his head, including any ear injury, on (date of injury); that the great weight of credible medical evidence is contrary to the findings of the designated doctor appointed by the Texas Workers' Compensation Commission (Commission) because that doctor's findings are based upon incorrect assumptions and improper criteria for evaluation, including subjective complaints of the claimant; and that the great weight of credible medical evidence is that the claimant reached MMI on February 3, 1992, with a zero percent IR, in accordance with the findings of another doctor. In his appeal, the claimant cites evidence from the record which he contends disproves the hearing officer's determinations, and he asks that this panel reverse the hearing officer's decision, order medical treatment by a specialist, and hold that the claimant has not reached MMI. The carrier responds that the hearing officer's decision is sufficiently supported by the evidence.

DECISION

We reverse the hearing officer's decision insofar as it holds that claimant's head injury was not related to his compensable injury of (date of injury). We also reverse the hearing officer's determination of MMI and IR, and remand for further development of the evidence.

The claimant, who worked as an air conditioning installer for (employer), was injured on (date of injury), when he was replacing duct work on a ceiling and the ladder on which he was standing fell. At the hearing, the claimant said he was thrown against the wall, hitting the wall with the left side of his head, and that he heard his neck snap. He did not fall to the ground, but was left hanging upside down from the ladder. After the accident, he was assisted to his truck by his wife and his stepson (who was also his assistant); he denied having blacked out, but said he "felt goofy" for several hours. His wife, who was present when the incident occurred, testified to essentially the same events, except that she maintained that he lost consciousness. He went home to bed and awoke with pain in his back, which was swollen to a lump between his shoulders, and in his hips.

On September 3, 1991, carrier's adjustor spoke with claimant. In the transcription of that conversation, claimant described the accident as, "the ladder went over against the wall and throwed [sic] me face first against the wall." He also said his initial pain occurred in his neck, between his shoulders, and the right lower part of his hip; he described his current pain as affecting those areas. Later, in response to the adjustor's question as to whether he was having any other pain, the claimant said, "Except my head feel like it full of water [sic], that's about it."

Claimant's workers' compensation claim (Form TWCC-41), filed on August 31, 1991, states that his injury was to his back, neck, and hips. A later claim form filed (date), after claimant secured counsel, states that the body parts affected by the injury were claimant's neck and back/shoulders and that the nature of the injury was "lower/upper back pain." When claimant on December 13, 1991, filed a request to change treating doctors (from Dr. C to Dr. P, see below) he characterized the nature of his injury as "injured - upper & lower back," but also stated he was requesting permission "to see a second doctor concerning my lower back and ear condition."

Claimant said the first doctor he saw was (Dr. W), to whom his employer referred him on August 27th. Dr. W's initial medical report gives a diagnosis of musculoskeletal strain, cervical, and notes muscle spasms in the cervical, thoracic and lumbar spine. Claimant also treated with a chiropractor, (Dr. C), beginning in September. A narrative history from that doctor stated, "Patient stated that he was climbing a ladder while lifting some air conditioning duct and the duct fell on him, knocking him sideways and pinning him against the wall, the duct laying across his low back." Because he was not getting relief from treatments with Dr. C, claimant changed treating doctors, to (Dr. P). Dr. P's narrative report of November 19th indicates complaints of bilateral cervical area pain, numbness in the upper extremities, and pain in the right lumbar area that occasionally radiates into the buttocks and left leg. On December 23rd Dr. P reported claimant's complaints of dizziness and falling to the right.

At the carrier's request, claimant saw (Dr. G), who wrote on (date), that claimant was complaining of pain in his lower neck, mid thoracic area, low back, and into the right hip; he also stated, "The patient has also complained of vertigo and tinnitus involving his left ear. He says this has been present since he fell. He has had no review of that." (Dr. G's impression was tinnitus and vertigo, as well as low back pain secondary to work injury.) The claimant testified that Dr. G told him that nothing was wrong with him and that he just needed therapy; Dr. G indicated on a Report of Medical Evaluation (Form TWCC-69), on which he certified MMI on February 3, 1992, with a five percent IR, that claimant started therapy but refused to complete the program, contending that it increased his pain. Dr. G's records also indicate he referred claimant to an ear, nose, and throat specialist, (Dr. M).

A February 12, 1992, letter from Dr. M, whose letterhead indicates he is a professor of otology and neurology, stated:

> . . . claimant suffered a head injury about six months ago and subsequently developed a rather confusing and convoluted history of balance disturbance. His balance disturbance manifest (sic) as a gait disturbance as well as a spacey sensation and lightheadedness. The gait disturbance is present almost constantly, but the spacey sensation seems to come in spells. He is troubled by one or both of these problems almost all of the time . . . He also feels, on occasion, like he is having fluid moving around in his ears. In addition, he has bilateral tinnitus which varies in its severity as well as bilateral high frequency hearing loss. In addition to his balance disturbance he

apparently suffered a back injury in his fall causing some loss of strength in his right leg and some migraine like headaches. The headaches have improved substantially over the last six months.

Dr. M concluded by stating that an audiogram of claimant showed a sensorineural hearing loss in both ears which is compatible with either head injury, noise exposure, or both. (In response to a question on cross examination, the claimant said that he operated power tools and did not wear ear plugs, but that the tools were a sawsall, which is like a jigsaw and does not make much noise, and a power drill which was cordless and noiseless.) Dr. M said he was not certain as to the cause of the balance disturbance, but said the claimant could have developed a perilymph fistula with his head injury. Dr. M ordered vestibular and auditory studies to confirm this diagnosis, but claimant said carrier refused to approve any further visits to Dr. M.

On May 28th carrier's adjustor wrote Dr. M and contended that the claimant did not indicate initially that he had struck his head and that the facts of claimant's accident "have changed greatly from one doctor to another--intensifying as time went by." She asked for Dr. M's opinion as to whether claimant's current complaints are related to his original injury. In a June 10th reply, Dr. M said his February 12th report "state[s] quite accurately the history that was related to me," and that the carrier would have to determine the credibility of the history.

In July of 1992, due to continued complaints of pain, Dr. P referred claimant to an orthopedic surgeon, (Dr. H). On September 24, 1992, Dr. H wrote that claimant "fell off a ladder approximately 10 feet a year ago [and] hit the left side of his head and he was unconscious for 30 minutes and he continues to have hearing difficulties and balance difficulties." He noted that claimant had not been able to pursue further testing as recommended by Dr. M; on September 25th he wrote the Commission stating that he believed it was "truly disturbing" that claimant "had a severe fall and was knocked unconscious . . . [and] has seen an ENT specialist who says that he has inner ear damage and yet the insurance company will not pay for further evaluation . . . . " On October 12th carrier's adjuster replied to this letter, stating that claimant never contended he was knocked unconscious, that he never claimed a head injury, and that the mention of ringing in the ears was made on January 24, 1992, five months post injury.

On January 19, 1993, the claimant was seen by (Dr. MC). (Although Dr. MC's report is entitled "Independent Medical Examination," the carrier contended at the hearing that Dr. MC was an agreed-upon designated doctor, and a carrier's exhibit which purported to be a communication between carrier and claimant's then-attorney refers to Dr. MC as "the agreed upon doctor chosen to determine MMI." However, this argument was not preserved upon appeal.) Dr. MC found the claimant at MMI as of February 3, 1992, and assigned a zero percent IR. In his discussion, Dr. MC stated:

This patient has normal examination with no objectively measurable musculoskeletal pathology to suggest any permanent residual impairment as the result of his

> work-related injury. It is conceivable that this patient could have a perilymph fistula as discussed by [Dr. M] which could result in a permanent impairment. Such perilymph fistula could be consistent with his mechanism of injury. I am in agreement with [Dr. G's] assessment of this patient's problem although I personally would not rate the patient's permanent impairment as high as 5%. At this point, the patient would have a 0% impairment based upon lack of objective musculoskeletal findings at the time of this examination.

On June 30, 1993, a Commission benefit review officer apparently appointed (Dr. MR) designated doctor for an assessment of MMI, IR, and causation (this presumption is drawn from Dr. MR's report and the testimony at the hearing; the order appointing Dr. MR was not in evidence). Dr. MR characterized claimant's case as "complicated," and stated that "causation of the injury, based on the patient's report, appears reasonable from the fall, indicating appropriateness of [Dr. M's] year (sic) evaluation . . . " However, Dr. MR found that claimant had had "a reasonable soft tissue healing period" and was not a surgical candidate. Dr. MR also stated his impression that claimant was depressed due to numerous stressors. He recommended that claimant enter a tertiary rehabilitation program during which time "a maximum of 10 weeks of TIBS should be provided." He gave claimant two weeks to agree or disagree with this option and stated that if he did not agree, "I believe he has exhausted all medical options designed to 'improve or cure' the condition and he will have reached MMI and I will then provide an appropriate PPI (sic) rating." Despite this last statement, attached to Dr. MR's report were charts indicating claimant had been assessed a 10% IR due to spine impairment, zero percent impairment for cervical range of motion, and one percent impairment for lumbar range of motion. Apparently, no rating was given due to claimant's alleged head or ear injury.

The hearing officer stated in his decision that "the witness statement given by claimant to carrier is subject to various interpretations, but the greater weight of credible evidence supports carrier's position that claimant did not assert a head injury initially and that claimant did not sustain a head injury." In addition, as noted above, the hearing officer found that Dr. MR was the Commission-appointed designated doctor, and this finding is not challenged on appeal. However, he also determined that the great weight of the credible medical evidence is contrary to Dr. MR's findings because such findings were based "upon incorrect assumptions and improper criteria for evaluation including subjective complaints of claimant." (His discussion of the evidence states that Dr. MR's findings "are generally based upon incorrect assumptions, sympathy to the subjective complaints of claimant, claimant's psychological overlay and claimant's family and financial problems . . . . ") He thereafter found that the great weight of credible medical evidence is that claimant reached MMI on February 3, 1992, with a zero percent IR as found by Dr. MC.

With regard to the head injury, the evidence shows that less than two weeks after his accident the claimant, in responding to carrier's adjustor's questions, stated that he was thrown against a wall "face first" and that his current symptoms included his head feeling like it was "full of water." While these statements might be subject to various interpretations, they also support the claimant's rendition of events stating that he struck the wall with his

head, as he later maintained. More important, the unusual head symptoms he described to the adjuster are consistent with other symptoms (fluid, ringing in the ears, dizziness) that later manifested. While the early medical reports and claimant's written notice of his claim describe back and neck problems, the claimant readily testified at the hearing that his immediate problems and pain were with his back and hips. In December, claimant requested another treating doctor for problems with his back "and ear condition." Also in December, ear and head complaints (including dizziness) began to emerge and claimant thereafter saw several doctors who identified a head or inner ear problem to some degree. We note that the medical reports of Drs. G, M, H, MR, and MC do not question that claimant's symptoms were not consistent with the type of accident claimant had described from the beginning; no medical reports state that claimant's symptoms could not have arisen from the accident. Further, any confirmation or refutation regarding causation was thwarted by carrier's refusal to allow the testing recommended by the specialist, Dr. M.

Clearly, the claimant had the burden of proof to establish that his head injury occurred in the course and scope of his employment. Reed v. Aetna Casualty & Surety Company, 535 S.W.2d 377 (Tex. Civ. App.-Beaumont 1976, writ ref'd n.r.e.). It has been held that under Texas workers' compensation law the immediate effects of the original injury are not solely determinative of the nature and extent of the compensable injury and that "[t]he full consequences of the original injury . . . upon the general health and body of the workman are to be considered." Texas Employers' Insurance Association v. Thorn, 611 S.W.2d 140 (Tex.Civ. App.-Waco 1980, no writ). In this case, there was some delay in the manifestation of effects of a head injury, although the claimant reported one symptom early on. Such delay would not, however, as a matter of law, prevent the later condition from being part of the compensable injury where a claimant provides evidence establishing a causal connection between the original injury and a head injury. Such causal connection can be established from all of the evidence. Texas Workers' Compensation Commission Appeal No. 92160, decided June 8, 1992. Further, an injury may be shown by symptoms and circumstances which support a reasonable inference that the injury occurred. Travelers Insurance Company v. Stretch, 416 S.W.2d 591 (Tex. Civ. App.-Eastland 1967, writ ref'd n.r.e.). Generally, lay testimony is sufficient to establish an injury, except where the subject is so scientific or technical in nature that a fact finder cannot form an opinion based upon the evidence as a whole and his own experience and knowledge; the latter exception applies when an injury to a specific part of the body is alleged to have caused damage or infirmity to other unrelated portions of the body. Houston Independent School District v. Harrison, 744 S.W.2d 298 (Tex. App.-Houston [1st. Dist.] 1987, no writ). In this case, claimant's testimony, including his early statement to the adjuster, is corroborated by later pronouncements of doctors who examined him. In sum, the evidence establishes a sequence of events providing a strong, logically traceable connection between cause and result. Griffin v. Texas Employers Insurance Association, 450 S.W.2d 59 (Tex. 1969).

Based on the foregoing, we find that the great weight and preponderance of the evidence supports a determination that the claimant's head and ear problems were related to his original injury. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). We therefore reverse the hearing officer's determination on this point.

An issue remains as to claimant's proper MMI date and IR. The hearing officer invalidated the report of the designated doctor, presumably based in part upon that doctor's reference to claimant's head problems. However, it is clear that Dr. MR's report did not rise to the level of an opinion on MMI and IR, and thus, it was premature to consider it as a designated doctor's report. Clearly, Dr. MR did not certify MMI, and based any possibility of an MMI certification upon claimant's agreement, or not, to further therapy. (While Dr. MR somewhat arbitrarily purported to give claimant two weeks to reach a decision, no further reports or correspondence from this doctor were in evidence.) While documents attached to Dr. MR's letter rated claimant's lumbar and cervical spine, Dr. MR did not refer to them in his report and in fact indicated he would give claimant an IR at a future date. In any event, an IR would have been invalid in absence of a certification of MMI. Section 408.123.

We also observe that, even if Dr. MR had prepared a proper report certifying MMI and assessing IR, some of the reasons given by the hearing officer for rejecting this report are questionable, specifically the reference to "subjective complaints of the claimant." (The hearing officer also stated the report was "based upon incorrect assumptions and improper criteria for evaluation." This could have been a sound basis for rejection, insofar as it appears to refer to the doctor's consideration of an injury other than the compensable injury; however, as noted above, we have determined that the head injury should be considered compensable and thus rated by a designated doctor.) This panel has many times held that the designated doctor's report occupies a "unique status" under the 1989 Act and is not to be rejected absent a substantial basis for doing so. Texas Workers' Compensation Commission Appeal No. 93483, decided July 26, 1993.

Based upon the foregoing, we reverse the hearing officer's decision and render a decision that claimant's head injury was related to his compensable injury of (date of injury). We also reverse the hearing officer's determination on the issues of MMI and IR, and we remand the case to the hearing officer for the development of further evidence, as necessary, given the fact that further medical treatment may be necessary before the designated doctor makes a determination of MMI and IR. Pending resolution of the remand, 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.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Alan C. Ernst
Appeals Judge