

## APPEAL NO. 990453

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on February 3, 1999. The issues at the CCH were whether the respondent's (claimant) compensable injury of \_\_\_\_\_, includes a C5-6 herniated disc, whether the appellant (carrier) contested compensability on or before the 60th day after being notified of the injury, and whether the claimant had disability. On the only issues on appeal from the decision, the hearing officer determined that the \_\_\_\_\_, injury included a C5-6 herniated disc and that the claimant had disability beginning September 22, 1998, and continuing through the date of this hearing. Carrier's appeal urges that the hearing officer erred in determining the injury included a C5-6 herniated disc arguing that the expert medical evidence does not establish the necessary causation between the work and the herniated disc. The carrier also challenges the resulting disability determination. Carrier asks that the decision be reversed and a new decision rendered or, in the alternative, that the case be remanded for further proceedings. Claimant responds that the claimant provided sufficient testimony to establish a causal link as it was not beyond common experience and that the medical evidence is sufficient to show that the compensable injury was a cause of the cervical herniation and thus compensable. Claimant urges the decision be affirmed.

### DECISION

Reversed and remanded.

The key issue in this case was whether the claimant's injury of \_\_\_\_\_, extended to a C5-6 herniated disc. There was no dispute, and the parties so stipulated, that the claimant sustained a compensable cervical strain/sprain injury on \_\_\_\_\_, a Saturday. On that date, the claimant testified that while on a break he sat down on a wire spool and scooted to the back edge, the spool tilted over and broke resulting in his falling back and hitting the back of his neck on an outrig of a backhoe. He said some coworkers told him to get up so they could laugh, at which time he said he was going to sit there a few minutes because he was hurt. Someone helped him up and he went back to work the rest of the shift. He did not work Sunday and on Monday, he states, he got up with a headache and called his doctor, Dr. D, and got a prescription. He did not mention his fall to Dr. D. Medical records showed that the claimant previously (back to October 1997) had complaints of headaches and neck problems for which he was treated by Dr. D (a knot on the back of the neck was treated in March 1998) on several occasions. Claimant did not go to work on Monday, (2 days after the date of injury), and on Tuesday he called the employer, went into the office, and was sent to a Dr. ST. X-rays were taken and Dr. ST diagnosed a cervical/lumbar strain, and prescribed some therapy and medication. The claimant continued working and received treatment over the next three weeks. Dr. ST released the claimant to regular duty on July 27th and from further care on August 3, 1998. A number of statements from coworkers indicated that they were unaware of any injury sustained by the claimant, that the claimant worked without any indication of pain or an injury, and that he did not complain about hurting or having an injury. The claimant did not

see any doctor from August 3, 1998, until September 21, 1998, when he states he woke up with his hands and arms numb, the first time he had ever had that problem. He stated that between \_\_\_\_\_, and September 21, 1998, although he worked his regular job, he never had numbness in his hands and arms. He indicated that he went to another job site sometime later and that he experienced subdued pain on one side of his head. He stopped working on September 22, 1998. Dr. D subsequently referred the claimant to a Dr. G, and later an MRI was performed which indicated a herniation at C5-6. Claimant stated that Dr. G has recommended surgery.

In a medical note dated October 12, 1998, Dr. D indicates that an MRI of the neck shows a herniated disc but that the injury of \_\_\_\_\_, had fully resolved and in his opinion, "I don't think that his injury of \_\_\_\_\_ is the cause of his pain now." Later, Dr. D states he would defer to Dr. G regarding causation. Subsequently, on November 9, 1998, the claimant requested a change in treating doctors to Dr. G which was approved by the Texas Workers' Compensation Commission. At about this same time, Dr. M was appointed as a designated doctor and states in a report dated November 20, 1998, that it is to be determined whether the claimant has reached maximum medical improvement (MMI) and, if so, the impairment rating. Dr. M was of the opinion that the claimant had not reached MMI.

In letters dated October 28, 1998, and November 13, 1998, Dr. G states, respectively, that "based on the patient's injury that he had no cervical problems prior to his work injury, it is my opinion that his cervical herniated disc is related to his work injury" and "in reviewing the patient's history, his work related neck injury originally in July with subsequent development of referred arm pain is entirely consistent with the natural history of disc herniation." Dr. G again states that he feels that this is a work-related disc herniation. The claimant acknowledged that he never told Dr. G about his pre-\_\_\_\_\_ headaches and neck problems and stated that when asked if he had neck problems, he did not tell Dr. G about treating with Dr. D for those problems prior to \_\_\_\_\_ and stated, "we only discussed what he was looking for from the injury."

The claimant was seen for an independent medical evaluation on October 14, 1998, with additional medical records submitted to the doctor, Dr. P, who rendered two reports, the latter of which is dated December 16, 1998. In his report, Dr. P does not take issue with recommendations for surgery at this time but notes that the previous medical records do not note or document any pre-\_\_\_\_\_ neck or headache problems, that he does not feel the claimant's history is consistent with an acute disc herniation from a \_\_\_\_\_, event, and that the "particular history of this delayed onset of symptoms is not consistent with known physiologic soft tissue patterns, nor is it related specifically to known pathophysiology for disc herniation." He states that there is no evidence that claimant's disc herniation is related to the \_\_\_\_\_, event.

The claimant saw a chiropractor, Dr. GT, on November 11, 1998, who diagnosed disc degeneration, cervical sprain/strain and myofascitis, moderate. The claimant gave a history of the fall off the spool and Dr. GT states that his "symptoms appear to have come

on as a result of an injury consistent with the one described in this report." He recommended an orthopedic surgical consult.

Although the hearing officer erroneously couched some of his decision in terms of "newly discovered evidence," in pertinent part he found that the claimant fell in the course and scope of his employment and struck the back of his neck just below the skull causing a C5-6 herniated disc, and concluded that the \_\_\_\_\_, injury includes a C5-6 herniated disc. In doing so, he discusses Dr. G's opinion that the herniated disc was caused by the \_\_\_\_\_, incident as contrasted with Dr. P who finds no causal connection. The hearing officer, after noting that the designated doctor, Dr. M, concluded that the claimant had not reached MMI (citing the herniated disc), goes on to state that Dr. M in reaching his conclusion "had to determine the \_\_\_\_\_ injury was a cause of the herniation and this is the more persuasive conclusion based on the evidence." We do not agree with that observation and do not find support in the evidence of record. To the contrary, Dr. M's report does not appear to address causation.

Although claimant urges that expert medical evidence was not necessary to show causation and that this was a situation where the causal link is not beyond common experience, we do not agree under the particular factual situation involved here. Texas Workers' Compensation Commission Appeal No. 982649, decided December 23, 1998. *Compare* Texas Workers' Compensation Commission Appeal No. 961850, decided November 1, 1996. Although the case under review is not a claim of a repetitive trauma injury to the neck, we conclude that it is analogous to Appeal No. 982649, *supra*, in pertinent part. In both cases, the particular neck symptoms did not manifest themselves for a couple of months after the asserted cause of an injury. Here, the claimant had been released to full duty, did not seek further treatment, continued working his regular duties, and some two an one-half months after the incident first experienced the numbing symptoms. Of significance, the claimant's medical records show prior headache and neck problems for which he was under treatment. Under these conditions, as the Appeal Panel stated in Appeal No. 982649, *supra*, we conclude that this is a case where expert medical evidence was necessary to show causation. Houston General Insurance Company v. Pegues, 514 S.W.2d 492 (Tex. Civ. App.-Texarkana 1974, writ ref'd n.r.e.).

While there was medical evidence offered on both sides of the issue of causation, that is, whether the disc herniation was causally connected to the work-related incident of \_\_\_\_\_, what causes us concern and leads to our reversal and remand is the misreliance on the report of Dr. M that it "had" to determine causation related to the \_\_\_\_\_, incident, and the strong indication that Dr. G was not told of the claimant's prior history of headache and neck problems. To the contrary, the claimant testified he did not so inform Dr. G, and Dr. G's reports give no such indication of his knowledge of this history. Where an expert's opinion is based on assumed facts (or lack of pertinent facts) that differ materially from the actual, undisputed facts, the opinion lacks probative value. Appeal No. 982649, *supra*, citing Burroughs Wellcome Company v. Crye, 908 S.W.2d 497 (Tex. 1995). That appears to be the situation in this case.

Because the hearing officer's decision relied on the apparently factually flawed medical report of Dr. G as to causation, together with the unsupported reliance on the report of Dr. M that it "had" to determine the \_\_\_\_\_, injury was a cause of the herniation, we necessarily reverse the decision and remand the case for further consideration and development of the medical evidence. It might be appropriate to consider the appointment of a designated doctor for the sole purpose of examining the claimant and all his medical records and rendering an expert medical opinion whether the \_\_\_\_\_, injury included or extended to the herniation at C5-6. The underlying disability is set aside pending resolution of the extent-of-injury issue. The hearing officer's decision is reversed and the case remanded for further appropriate action.

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.

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Stark O. Sanders, Jr.  
Chief Appeals Judge

CONCUR:

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Alan C. Ernst  
Appeals Judge

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Tommy W. Lueders  
Appeals Judge