APPEAL NO. 990884

A consolidated contested case hearing of the disputed issues in two cases identified by Docket No. _____and Docket No. _____ was held on March 8, 1999, with the record closing on March 25, 1999, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). In separate decisions, the hearing officer, resolved the disputed issue in Docket No. _____ by finding that appellant (claimant) did not injure his low back on (DOI for Docket No. 2), while pushing a large dumpster, and that his current back condition, a bulge of the annulus, bilateral sciatica, and bilateral sacroiliitis, is a continuation and result of an (DOI for Docket No.1), compensable injury. He resolved the two disputed issues in Docket No. _____ by finding that claimant did not injure his low back on (DOI for Docket No. 2), while pushing a large dumpster and that any inability of claimant to obtain and retain employment at wages equivalent to his preinjury wages is due to something other than an alleged compensable injury sustained on (DOI for Docket No. 2). Based on these findings, the hearing officer concluded, respectively, that claimant's current bulge of the annulus, bilateral sciatica, and bilateral sacroiliitis are a result of the (DOI for Docket No.1), compensable injury; that claimant did not sustain a compensable injury on (DOI for Docket No. 2); and that claimant did not have disability from an alleged (DOI for Docket No. 2), compensable injury.

Appellant (carrier 1), who on (DOI for Docket No. 1), was the workers' compensation insurance carrier for (employer), has appealed, on the grounds of insufficient evidence, the determination that claimant's current back condition is a result of the ((DOI for Docket No. 1), compensable injury. Claimant has appealed, also on the grounds of insufficient evidence, the determinations that he did not sustain a new injury on (DOI for Docket No 2), and that he did not have disability from such an injury. Respondent (carrier 2), who was the employer's workers' compensation insurance carrier on (DOI for Docket No.2) has responded to both appeals urging the sufficiency of the evidence to support them. The file does not contain a response from claimant to carrier 1's appeal.

DECISION

Affirmed.

We note, at the outset, that, although the matter of separate decisions was raised at the hearing where these two cases were consolidated with the consent of the parties and the hearing officer indicated that he was not inclined to issue a single or unified decision, no party has asserted error in the hearing officer's having issued separate decisions. *Compare* Texas Workers' Compensation Commission Appeal No. 990133, decided March 8, 1999, where error in this regard was assigned and the Appeals Panel, agreeing there was legal error in the issuance of two decisions in that case, reversed and remanded for the issuance of a single decision, as required by Section 410.196.

Claimant testified that he has been employed by the employer for 27 years; that on or about (prior doi), he sustained a low back injury at work; that on or about (subsequent

doi no. 1), he sustained a neck injury at work; that on or about (DOI for Docket No. 1), he sustained another low back injury at work; that on or about (subsequent doi no. 2), he sustained still another low back injury at work; that he underwent lumbar spine surgery (micro discectomy at L5-S1) by Dr. J on October 18, 1996; that in March 1997 he returned to work, performing his regular duties as a packaging machine operator without restrictions; and that his duties included lifting heavy rolls and pushing heavy dumpsters in addition to the machine operation. He stated that, after returning to work, he continued to have back pain and continued to receive treatment including prescription medication from Dr. F; that he had numerous discussions with his supervisor, (Ms. W), about his back pain; that on July 21, 1998, he saw Dr. Z, who had apparently become his treating doctor, and that Dr. Z gave him a shot and a Medrol pack; and that on (DOI for Docket No.2), he reinjured his back at work pushing a dumpster. Claimant said that, while pushing the dumpster at about 9:00 a.m. on (day after DOI), his legs "locked up" and he had "very harsh pain," was "paralyzed," and "could not move for a minute or two" until the pain diminished. He said he finished the shift in pain, did not work on (day after DOI) because of the pain, and on July 28, 1998, saw Dr. Z who took x-rays, gave him another shot, and prescribed therapy. Claimant said he informed Dr. Z he had sustained a new injury and that he had no explanation as to why Dr. Z's records of the July 28, 1998, visit do not mention a new injury. He further stated that in September 1998 he changed treating doctors to Dr. R because when he said to Dr. Z that, if he had a new injury Dr. Z needed to call carrier 2, Dr. Z responded, "Well, I just don't know, you know," and claimant said he stated, "I need to get me another doctor." Dr. R's records indicate that claimant was taken off work. Claimant further indicated that, although he had continued to be treated for low back pain after returning to work in March 1997, his symptoms after his new injury on (DOI for Docket No.2) were different in that, previously, he had back pain with pain radiating down his right leg, whereas, after the (DOI for Docket No. 2) injury, his low back pain was more intense and radiated down both legs and he had some numbness in both legs and groin and bilateral hip pain. Claimant said he could not account for Dr. R's records not mentioning these symptoms if, indeed, they do not.

Ms. W testified that, after claimant returned to work in early 1997, he and she talked "numerous times" about his back pain and did so on (DOI for Docket No.2). She said that, at the beginning of claimant's (day after DOI) shift, she went to his area and asked him how he was feeling and he responded that his back had been bothering him and that he had been to the doctor for a shot and pills. Ms. W further stated that claimant gave no indication of having sustained a new injury on (DOI for Docket No. 2), nor did he report such an injury to her or mention hurting himself pushing a dumpster. She also testified that claimant's time card reflected that he worked full days on both (day's after DOI).

Ms. S testified that she is a carrier nurse case manager assigned full time to coordinate the workers' compensation claims at the employer's site where claimant works and that claimant called her on July 29, 1998, and related a history of back problems and of returning to work in March 1997 and working in pain. She said he stated that, over the past several weeks, he experienced gradually increasing back symptoms and that on July 27, 1998, he could not come to work. She said he never mentioned pushing a dumpster but

did want to know how to get disability payments re-established and inquired about changing doctors. Ms. S said that claimant called her on August 4, 1998, and told her that Dr. Z had told him the pain was from the old injury and that claimant did not mention a new injury. She said claimant called her again on August 6, 1998, and said that the doctor had looked at x-rays and told him he had a new injury.

The May 9, 1997, report of Dr. G, the designated doctor, who certified that claimant reached maximum medical improvement on March 5, 1997, for (DOI for Docket No. 1), injury and assigned an eight percent impairment rating (IR) states that claimant's neurological examination was normal, that his range of motion was determined to be invalid, and that his diagnosis is low back pain and status post surgery for herniated disc. Dr. G further reported that, under current subjective findings, claimant has constantly present low back pain "of a magnitude of 4/10 of worse possible pain."

Dr. Z wrote on July 21, 1998, that claimant injured his back in August 1996 and, later that year, had a discectomy and went to work hardening; that claimant has a recurrence of low back pain with radiation to both lower extremities; that an exam showed a good deal of paravertebral muscle spasm in the lumbosacral spine and only 50% of normal motion; and that he gave claimant a Toradol injection, put him on a Medrol dose pack, and scheduled a follow-up visit in a week. Dr. Z's record of July 28, 1998, states that claimant still has persistent low back pain, a good deal of paravertebral muscle spasm, and only 50% of normal motion, and that he was given another injection and medications. No mention was made of a history of pushing a dumpster on (DOI for Docket No. 2), and sustaining a new low back injury. The record of claimant's August 4, 1998, visit to Dr. Z reflects that claimant still had the muscle spasm and loss of motion and that he was taken off work and prescribed daily physiotherapy. Dr. Z's record of August 6, 1998, states that claimant became very upset, feeling that Dr. Z was calling him a liar by asking him which injury is causing his symptoms, the recent injury or the original injury, and that he tried to explain to claimant that it was very difficult for a doctor to tell. Dr. Z also reported claimant as saying that he had reported this injury at work, that it was never written down, and that he is going to go back and make sure his paper trail is covered. Dr. Z wrote on January 26, 1999, that claimant came in to "clear up some paper work in his chart"; that he, Dr. Z, assumed claimant's care when Dr. F, who treated claimant's (DOI for Docket No.1), injury, retired; that, according to claimant, he hurt himself again on (DOI for Docket No. 2), at work; that he, Dr. Z, has no record of this in the chart; and that he cannot tell what claimant's present state is due to, the first or second injury, and that should be clarified with his present treating doctor.

In evidence is an October 27, 1998, letter to the Texas Workers' Compensation Commission from Ms. G, a therapy technician at the back clinic where Dr. R practices, stating that she spoke to Dr. R on the phone and that he does not feel that claimant's recent injury is a continuation of his "previous September 1996 injury" nor an aggravation of a preexisting condition and that claimant would not have been able to carry a strenuous work load had the previous injury not resolved. Ms. G further wrote that Dr. R felt that, since claimant "had returned to full duty at work and had been doing the same duties with

no indications or problems for 15 months, he felt that the previous injury had in fact been resolved." Dr. R wrote on December 8, 1998, that claimant had only received an eight percent IR following his back surgery, that he "was doing fine with no indications of pain and no limitations," that claimant "had been completely rehabilitated from the other injury," and that, in his opinion, the (DOI for Docket No. 2), injury is a new injury. In his deposition, apparently taken on March 15,1999, Dr. R stated that he understood from claimant that claimant reported an injury on (DOI for Docket No. 2) not necessarily that it occurred on that date.

Dr. C wrote on February 4, 1999, that he had reviewed claimant's medical records including the records of Dr. F, Dr. Z, and Dr. R; that claimant's diagnosis is lumbar pina status post discectomy; that a September 9, 1998, MRI revealed disc degeneration of L5-S1 without recurrent disc bulge or herniation; and that the radiology reports he reviewed did not indicate new pathology, injury to the spine, or indications for operative intervention. Dr. C concluded that he saw no specific, objective evidence of pathology or conditions which would indicate that there has been a specific, new injury; that it appears that claimant's current complaints of low back pain are a continuation of a previous injury; and that claimant's symptoms do not support a new injury but, rather, a continuation of a previous injury.

Claimant had the burden to prove by a preponderance of the evidence that he sustained a new low back injury at work on (DOI for Docket No. 2), as he claimed and that he had disability, as defined in Section 401.011(16), resulting from that injury. These issues presented the hearing officer with questions of fact to resolve. The Appeals Panel has held that whether a claimant sustained a new injury or merely suffered a continuation of an original injury is normally a question of fact for the hearing officer. Texas Workers' Compensation Commission Appeal No. 93515, decided July 26, 1993. We have also held that an aggravation of a previous condition can be an injury in its own right. Texas Workers' Compensation Commission Appeal No. 91038, decided November 14, 1991. However, the new injury must produce more than a mere recurrence of symptoms inherent in the etiology of the preexisting condition that has not been completely resolved and there must be some enhancement, acceleration, or worsening of the underlying condition from the second injury. Texas Workers' Compensation Commission Appeal No. 94428, decided May 26, 1994.

The hearing officer is the sole judge of the weight and credibility of the evidence (Section 410.165(a)) and, as the trier of fact, resolves the conflicts and inconsistencies in the evidence including the medical evidence (Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ)). The Appeals Panel, an appellate tribunal, will not disturb the appealed findings of a hearing officer unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust and we do not find them so this case. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951).

The decision and order of the hearing officer are affirmed.

_____
Philip F. O'Neill
Appeals Judge

CONCUR:

_____
Robert W. Potts
Appeals Judge

_____
Elaine M. Chaney
Appeals Judge