

APPEAL NO. 990966

On April 1, 1999, a contested case hearing (CCH) was held. The CCH was held under the provisions of the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). The appellant (carrier) requests reversal of the hearing officer's decision that respondent (claimant) sustained a compensable lower back injury while in the course and scope of his employment with (employer) on \_\_\_\_\_, and that claimant had disability from October 31, 1998, and continuing through the date of the CCH. The claimant requests affirmance. The parties stipulated as to the average weekly wage.

DECISION

Affirmed.

Claimant had the burden to prove that he was injured in the course and scope of his employment. Johnson v. Employers Reinsurance Corporation, 351 S.W.2d 936 (Tex. Civ. App.-Texarkana 1961, no writ). "Course and scope of employment" is defined in Section 401.011(12). "Injury" means "damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm." Section 401.011(26). Claimant also had the burden to prove he has had disability. "Disability" means "the inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage." Section 401.011(16).

Claimant has worked as a welder for employer for 20 years. Claimant sustained two low back injuries in 1995 and another in (date of injury of 1997) and he treated with Dr. G for those injuries. Dr. G reported in August 1997 that claimant has a lumbosacral back derangement without radiculopathy, that that is a chronic condition, that claimant was cleared to resume normal duty, and that claimant reached maximum medical improvement on August 11, 1997, with a zero percent impairment rating for his injury of (date of injury of 1997).

Claimant went to Dr. G in August 1998 complaining of low back pain and Dr. G wrote that claimant had a work-related exacerbation of an underlying degenerative disc disease. Dr. U wrote that a CT scan of claimant's lumbar spine done on August 21, 1998, appeared relatively unremarkable aside from posterior facet joint degenerative changes that extend throughout the lumbar area, that no substantial disc bulging or impingement was seen at any level, and stated his impression as moderately-severe degenerative changes involving the posterior facet joints, but no other abnormalities of note were apparent. On August 21, 1998, Dr. G wrote that, for the next week, he would place claimant on modified work.

Claimant testified that on \_\_\_\_\_, he and a coworker were at work pulling and rolling heavy double axle wheels, which he referred to as trucks, out from underneath a railroad car that had been jacked up and as he was doing that he felt pain shoot up his back, felt a pop, felt something in his left leg, and could not straighten up. He said his pain was different than from before. Claimant went to Dr. G on \_\_\_\_\_, and Dr. G noted that

claimant told him that he had been doing reasonably well until that morning when he was on his knees underneath a car, bending backwards, working overhead, and pulling trucks out, when he began having sharp spasms in his lower back, which radiated into the left buttock and left thigh. Dr. G gave an assessment of degenerative arthritis of the spine exacerbated by work-related activities and that was another flare-up of a preexisting condition. Dr. G wrote that claimant could return to modified work, but was not to lift more than 20 pounds or work overhead.

The work-status report from Dr. G dated \_\_\_\_\_, reflects that claimant should work sedentary to light work. Claimant said he took the work release to his supervisor and was told that no light-duty work was available for him. On November 7, 1998, Dr. G gave an assessment of degenerative disc disease with aggravation from work-related activities, that this is a chronic condition that claimant has had all along, and that this is an aggravation of this injury. Dr. G noted on November 13, 1998, that claimant wanted to file this as a new injury and Dr. G noted that claimant has a chronic condition that is worsened by the physical demands of his job. Claimant said Dr. G told him he did not have a new injury.

The Texas Workers' Compensation Commission approved claimant's request to change treating doctors to Dr. B on November 16, 1998. Dr. B wrote on November 18, 1998, that he had seen claimant in May 1998 for a bladder problem and had at that time evaluated him from a neurological standpoint and found no weakness in the lower extremities and no indication of nerve injury or compromise in the lower extremities. Dr. B noted that on \_\_\_\_\_, claimant was pulling a truck out from under a railroad car when he felt a pop in his back. Dr. B wrote that claimant has some neurological findings now, while in the past he had not had any neurological findings in the lower extremities, so he may have had an L3-4 HNP (herniated nucleus pulposus) causing L4 nerve compression or possibly an L4-5 HNP, and recommended a lumbar CT scan.

Dr. M reported that a CT scan done on January 15, 1999, showed a disc herniation at L2-3, a disc herniation at L3-4, a disc herniation at L4-5, and a disc herniation at L5-S1 with probable effacement of the nerve roots and possible nerve root irritation at that level. On January 15, 1999, Dr. B wrote that claimant could return to full-time work with numerous restrictions, including minimal bending, no lifting or carrying over 30 pounds, frequent position changes, and no climbing. Claimant noted in his answers to written interrogatories, that he was told by his supervisor that they did not have light work for him and sent him home.

Dr. G wrote in March 1999 that he had reviewed the CT scan of August 1998 and the CT scan of January 1999 with his clinic's radiologists and that there is no significant difference between those two films. Dr. G added that on the morning of \_\_\_\_\_, claimant was able to describe a discreet event and activity that resulted in his back pain becoming markedly worse and that he, Dr. G, would consider this to be an acute exacerbation superimposed upon a chronic preexisting condition. At carrier's request Dr. H, a diagnostic radiologist, reviewed the CT scan of August 1998 and the CT scan of

January 1999 and he wrote that a comparison of those studies showed no interval change, that the degenerative disease is identical, and that no disc herniations occurred between the two studies. Dr. H diagnosed claimant as having degenerative disc disease at multiple levels, unchanged between the CT scans of August 1998 and January 1999. Dr. H also wrote that the herniations mentioned by Dr. M in his CT scan report of January 1999 would be better termed bulging annuli or spondylosis rather than herniations and that all of those findings were present in the CT scan of August 1998. Dr. H also wrote that there are no findings on the CT scan of January 1999 that would indicate a new injury was sustained. Dr. H repeated his opinions in a deposition on written questions and added that he would agree, based on his review of the two CT scans, that there is no new damage or harm to the physical structure of the lumbar spine.

The hearing officer found that claimant suffered damage or harm to the physical structure of his lower back while engaged in the furtherance of the affairs or business of employer on \_\_\_\_\_; that the evidence established a causal relationship between claimant's employment and the lower back injury suffered on \_\_\_\_\_; and that claimant was unable to obtain and retain employment at wages equivalent to the wage claimant was receiving prior to \_\_\_\_\_, from October 31, 1998, and continuing through the date of the CCH as a result of the lower back injury claimant suffered while working for employer on \_\_\_\_\_. The hearing officer concluded that claimant sustained a compensable lower back injury while in the course and scope of his employment with employer on \_\_\_\_\_, and that claimant had disability from October 31, 1998, and continuing through the date of the CCH as a result of the compensable lower back injury on \_\_\_\_\_. Carrier contends that the hearing officer's findings and conclusions on the injury issue are supported by no evidence, are supported by insufficient evidence, are against the great weight and preponderance of the evidence, and that the evidence conclusively established as a matter of law that claimant did not sustain an injury on \_\_\_\_\_. Carrier also contends that the hearing officer erred in finding disability.

The 1989 Act makes the hearing officer the sole judge of the relevance and materiality of the evidence offered and of the weight and credibility to be given to the evidence. Section 410.165(a). As the finder of fact, the hearing officer resolves conflicts in the evidence. The claimant claims a back injury from a specific activity at work on \_\_\_\_\_. We do not view this case as one requiring expert medical evidence to establish causation by a reasonable medical probability. Generally, in workers' compensation cases the issues of injury and disability may be established by the testimony of the claimant alone. Houston General Insurance Company v. Peques, 514 S.W.2d 492 (Tex. Civ. App.-Texarkana 1974, writ ref'd n.r.e.). We conclude that the hearing officer's decision on the issues of injury and disability are supported by sufficient evidence and are not so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. Cain v. Bain, 709 S.W.2d 175 (Tex. 1986).

The hearing officer found that carrier failed, without good cause, to timely exchange with claimant carrier's attorney's letters to Drs. G, B, and H, and a nurse's letter to Dr. H, and excluded those exhibits from evidence. We conclude that carrier has not shown

reversible error in the exclusion of those exhibits. Hernandez v. Hernandez, 611 S.W.2d 732 (Tex. Civ. App.-San Antonio 1981, no writ).

The hearing officer's decision and order are affirmed.

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Robert W. Potts  
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.  
Chief Appeals Judge

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Dorian E. Ramirez  
Appeals Judge