

## APPEAL NO. 000740

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 March 9, 2000. The hearing officer determined that the respondent (claimant) suffered a compensable lumbar injury, in addition to the accepted compensable head, facial, and cervical injuries, on \_\_\_\_\_, and that claimant had disability from November 12, 1999, through the date of the CCH. The appellant (carrier) appealed the determination concerning the lumbar injury, essentially arguing that the "lack of complaints" until three weeks after the injury occurred equates to a lack of injury. The carrier also argues that there can be no disability after the date that a doctor found that claimant reached maximum medical improvement (MMI). The carrier argues that the decision is against the great weight and preponderance of the evidence. The claimant responds by reciting evidence favorable to the decision, including objective evidence of a lumbar injury.

### DECISION

The decision is affirmed.

The carrier accepted the cervical injury as part of the \_\_\_\_\_, injury, and the lumbar injury was litigated. The claimant had been employed for two months by (employer) as a cutter of pipes. He said that on \_\_\_\_\_, he was cutting a pipe that was nine feet from the ground; he could barely reach it with his three-foot cutting equipment. The claimant said he was standing back underneath another pipe to shield him when the pipe above fell, but when it did, it hit something and bounced back and upward, striking him in the forehead. The claimant said he was wearing a hard hat. The claimant said he fell back onto his rearend, like a pile driver. In the course of falling, he also hit his back right rib cage. The claimant estimated that the pipe section would weigh 500 pounds.

The claimant was taken to a company doctor that day, who put 22 stitches into his forehead. There is apparently a large scar as a result, referred to at the CCH and which the hearing officer could also see as the claimant testified. The claimant said that his neck and head hurt; his low back began to hurt about an hour later.

The company doctor was Dr. W, who said that claimant could return to work the next day. However, claimant said he was unable to work because the swelling was such that he could not wear his hard hat. He said Dr. W described the injury as an "explosion" outward, rather than a cut, caused by the force of the blow.

Dr. W's medical report of the day in question noted that the claimant was knocked down by the blow. Dr. W's report says that claimant may resume limited duties at work and is to return for suture removal on November 16, 1999. The report mentions only the facial wound. If Dr. W completed an Initial Medical Report (TWCC-61), it is not in the record.

The claimant decided to consult his own doctor one week and one-half later. He said that he did not go sooner because he thought the pain in his neck and lower back would go away, but it did not. He also said he could not afford a doctor. However, he sought treatment from Dr. M "on credit," and Dr. M informed him that this would be covered by workers' compensation. Dr. M's TWCC-61 diagnoses, in addition to the head wound, included cervical and "rib strain/sprain." The claimant was taken off work by Dr. M. A January 17, 2000, letter by Dr. M stated that his chart note of December 3, 1999, indicated that claimant began to complain of lumbar pain.

Dr. M referred claimant for further treatment and testing. A brain MRI was negative. Dr. S, an orthopedic surgeon, recommended lumbar and cervical MRIs. He noted that claimant had received treatment for pain and numbness in his legs. The claimant's MRIs were done on February 21, 2000, and reported an annular tear with herniation at the far right L5-S1 level. The claimant said he had a back injury in 1976 and 1977, with surgery thereafter. The claimant said he had been fine since that surgery and not bothered with back pain.

A doctor for the carrier, Dr. N, examined the claimant on February 22, 2000, and opined that claimant had reached MMI with a 12% impairment rating. He noted that there was no tenderness or swelling in claimant's lumbar spine. However, claimant had difficulty walking on his heels and toes, with an unsteady gait. There was a mild paraspinal spasm bilaterally. Claimant's lumbar range of motion varied from the normal primarily in the flexion area. He did not rate the lumbar spine because he believed that it was not likely that claimant injured his lumbar spine at the time of his accident. Dr. N's history of the accident does not indicate that he understood that the claimant was knocked down.

A statement from Mr. MG, who was a superintendent for the employer, verified the incident. However, as to a fall, Mr. MG was only asked if claimant fell "first," before being struck by the pipe, and he answered "no." The claimant had not been returned to work by Dr. M. Records in the file show that a termination notice dated December 1st or 9th, 1999, shows that the claimant was terminated effective November 15, 1999. This was characterized as a "voluntary" termination. This was signed by Mr. MG, and stated that claimant did not call or show up for work and was "to [sic] intoxicated to return to work." In his statement, Mr. MG said that he went to claimant's house a few days after the injury and smelled alcohol on claimant's breath when he answered the door. Mr. MG also made the assertion on the day of the injury that he smelled alcohol on claimant, but then stated that blood tests done on the day of injury did not reveal the presence of alcohol in claimant's system.

We would note at the outset that while chronology alone does not establish a causal connection between an accident and a later diagnosed injury (Texas Workers' Compensation Commission Appeal No. 94231, decided April 8, 1994), neither does a delayed manifestation nor the failure to immediately mention injury to a health care provider necessarily rule out a connection. See Texas Employers Insurance Company v. Stephenson, 496 S.W.2d 184 (Tex. Civ. App.-Amarillo 1973, no writ). A claimant's testimony alone may establish that an injury

has occurred, and disability has resulted from it. Houston Independent School District v. Harrison, 744 S.W.2d 298, 299 (Tex. App.- Houston [1st Dist.] 1987, no writ). Generally, lay testimony establishing a sequence of events which provides a strong, logically traceable connection between the event and the condition is sufficient proof of causation. Morgan v. Compugraphic Corp., 675 S.W.2d 729, 733 (Tex. 1984). In this case, there is a clear objective lumbar injury. While the carrier notes that the occurrence of a fall backward is not clear, that the claimant was knocked down was noted by the first doctor who treated the claimant. As the hearing officer noted, the mechanism of injury of forcefully falling onto one's buttocks was consistent with this injury.

The hearing officer was not required to accept the carrier's doctor's certification of MMI as an end to claimant's inability to obtain and retain employment equivalent to his preinjury average weekly wage. MMI and disability are distinct, not equivalent, concepts. Texas Workers' Compensation Commission Appeal No. 931026, decided December 22, 1993.

The decision of the hearing officer will be set aside only if the evidence supporting the hearing officer's determination is so weak or against the overwhelming weight of the evidence as to be clearly wrong or manifestly unjust. Atlantic Mutual Insurance Company v. Middleman, 661 S.W.2d 182 (Tex. App.-San Antonio 1983, writ ref'd n.r.e.). We cannot agree that this is true here, and affirm the decision and order.

Susan M. Kelley  
Appeals Judge

CONCUR:

Tommy W. Lueders  
Appeals Judge

Elaine M. Chaney  
Appeals Judge