APPEAL NO. 941338

This appeal is considered in accordance with the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). On August 31, 1994, a contested case hearing was held. The issue was whether the carrier, who is the respondent, should be allowed to reduce impairment income benefits (IIBS) and supplemental income benefits (SIBS) to claimant based upon contribution from claimant's prior compensable injuries. The claimant, (WS), is the appellant and he injured his back on a date found by the hearing officer as (the (year) injury). He was employed by (employer) at the time of his injury. Claimant was assigned a 27% impairment rating by his treating doctor which had not been disputed.

The hearing officer determined that the carrier's argument that claimant was judicially estopped from denying contribution because of settlements in prior compensation cases was not well taken. The hearing officer, noting that the carrier had not provided evidence of any percentages that would be attributable to the prior injury, nevertheless allowed contribution, and computed that claimant's prior impairment resulted from a (year) injury (with no impairment resulting from a (year) injury) to the extent of nine percent. Based upon this calculation, she ordered that the amount of future IIBS and SIBS be reduced by one-third.

The claimant has appealed, arguing that the hearing officer erred by calculating a percentage of prior impairment herself, when no evidence was offered concerning the claimant's (year) injury and resultant 1967 back surgery, or the extent to which any permanent impairment resulted. The claimant argues that contribution must be based upon expert medical evidence, not presented in this case. The claimant further argues that the hearing officer failed to consider the "cumulative impact" of all injuries on his current impairment in determining that there was a prior impairment that amounted to one-third of his current impairment. The claimant argues that the current treating doctor based his entire 27% on claimant's (year) injury and its effects. Finally, the claimant argues that the date of injury was (claimant’s alleged date of injury), not (the (year) injury), as stated by the hearing officer. The carrier responds that the (the (year) injury) date is correct because claimant agreed that he was injured on his first day of employment, identified in a document as (the (year) injury); the carrier further asserts that claimant should be considered as estopped from denying a prior impairment because he settled earlier workers' compensation cases on a theory that he had sustained permanent disability. The carrier argues that records following claimant's (year) injury document a pre-existing impairment from his (year) injury, and further that the (year) injury exacerbated this. The carrier argues that the hearing officer correctly used the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides) to calculate the impairment attributable to the (year) injury.

DECISION

We reverse the decision and order of the hearing officer, and render a decision that the evidence fails to establish the contribution allowed by the hearing officer and the full amount of weekly benefits must therefore be paid.

Claimant did not specifically testify to the date he was injured, but on cross-examination agreed that he had been hurt on the first day of his employment by the employer. The nature of the injury was a back injury, apparently sustained as claimant lifted mattresses.

Claimant testified that he had sustained a work-related injury in (year), for which he had received surgery in 1967. There are no medical records in evidence for this injury or the related surgery. According to claimant's testimony, his 1967 lumbar back surgery was successful and he was able to work until November 25, (year), when he sustained a work-related back strain. He did not have surgery for this second injury. As a result of the (year) injury, claimant eventually received a settlement of around $6,000. After his second injury, he received a lump sum settlement of $18,000. Claimant was represented both times.

As to his current injury, claimant's treating doctor was Dr. BO, an orthopedic surgeon. Claimant went to a hospital emergency room on June 22, (year), and began consulting with Dr. BO on July 15, (year). A laminectomy was performed on claimant's lumbar spine on September 20, (year). Claimant said after about two weeks he began to experience pain which would not go away. The cause could not be determined by Dr. BO, and testing showed that there was no recurrent post-surgical disc lesion. Claimant said that the carrier eventually referred him to Dr. R, who performed a test using dye and determined claimant had arachnoiditis. Claimant said that he was told by Dr. R and Dr. BO that there could be several causes. The only specific cause he testified about, however, was that blood going into his spinal column could have caused the condition. Claimant said the condition was regarded by Dr. BO as a progressive disease which was incurable. As a result of some despondency over this, claimant had some psychological counselling.

Claimant apparently reached "statutory MMI" at 104 weeks after the date income benefits accrued, and pursuant to this, Dr. BO assessed impairment. Dr. BO certified on "11-24-93" that claimant had a 27% impairment (the bases of which are described below).

A summary of the more important medical records in evidence follows:

-12/12/86: Dr. L refers to a past history of disc excision from which claimant made "excellent recovery", with no pains in his back until the (year) injury. (year) injury recorded as acute low back strain.

-MRI for (year) injury, Dr. BH: Notes that "there appears to have been a left hemilaminectomy or laminotomy at the L5, S1 and L4, L5 levels." Desiccation of one disc was observed, no herniations, no evidence of significant narrowing or stenosis, and mild osteoarthritic changes at L4, 5. Small amount of epidural scar around L-5 nerve root. Some disc bulges in lumbar spine.

-9/22/87, Dr. A: repeats MRI notation that claimant had hemilaminectomy at L5, S1 and L4, 5 with small scar around L5 left nerve root. Impression is bulging lumbar disc.

-6/22/91- x-rays reveal degenerative changes at L3, 4 and L4, 5.

-7/19/91 Lumbar MRI. L4, 5 level bulging. Minimal scarring from prior surgery opined. No spinal column lesions noted, and rest of lumbar spine otherwise normal.

-8/29/91 MRI, lumbar spine. Possible moderate disc herniation detected at L5-S1.

- 9/11/91. Dr. BO suggests surgery after reviewing objective tests.

-9/16/91. Second opinion by Dr. H recommends surgery. Opinion based on diagnosis of ruptured L5, S1 disc.

-9/20/91: Back surgery (laminectomy) performed by Dr. BO and Dr. H.

-2/7/92. Functional capacity test evaluator concludes that claimant could not tolerate even a sedentary work environment. Recommends retraining.

-2/25/92 MRI, lumbar spine. Changes at L5, S1 indicate degenerative changes and/or residual changes of previous surgery. Moderate disc protrusion probably attributable to granulation tissue or scarring from previous surgery. (Date of previous surgery not specifically identified.)

-5/12/92. An independent medical examination by Dr. R, who notes that previous surgery was conducted at L4, 5 level, with current surgery at L5, S1 which involved removal of herniated disc. Dr. R recommends further testing, and on 5/18/92 notes that results are consistent with arachnoiditis. Says that he cannot say what caused arachnoiditis, that Dr. B did not do anything during operation that should cause the condition.

-6/15/92. Consulting Dr. K says that arachnoiditis is an unfortunate complication of lumbar surgery. Describes condition as inflammatory reaction of meningeal membrane, most commonly caused by surgery and injections of radiological contrast materials. Post operative infection may also play a role. Notes that condition is very painful and resistant to any known treatment.

-11/10/92. Benefit review conference (BRC) agreement states that parties agree that claimant's hypertension is related to his compensable injury.

-March and April 1993, Dr. BL, (College of Medicine), undertakes to get claimant in pain management program, which he cannot complete because it is too rigorous. Dr. BL notes that claimant is not feigning his signs.

-6/16/93. Claimant has intravenous pain control device implanted, has T12 surgery for this.

-8/9/93 letter from Dr. BO notes that range of motion of back almost nil and impossible to assess objectively.

-8/17/93. Abnormal EMG results for S1 level.

-11/24/93. Dr. BO, in a letter to adjuster, states that claimant has reached MMI and has 27% impairment rating, derived from the following: 15% range of motion impairment, 12% specific disorder apparently derived from multiple operative levels with residuals plus an increment for second operation. No impairment was apparently assigned for the abnormal EMG.

-6/12/94. Dr. BO wrote to Commission that the entire 27% derived from the (year) injury and arachnoiditis, and not at all from (year) injury. This letter specifically responded to carrier's contention that (year) injury contributed to present impairment. Letter does not mention (year) injury one way or the other.

TWCC-21s filed by carrier indicate that the occurrence of a (year) injury in the course and scope of employment was not disputed within 60 days. Medical records refer to delay in authorization for medical treatments for claimant, culminating in a medical review division order in claimant's favor in October 1992.

First, regarding the date of injury, we note that there were regrettably none of the common stipulations obtained on the record at the beginning of the hearing. The date of injury is referred to throughout the evidence in this case as both (the (year) injury) and (claimant's alleged date of injury). Claimant, whose claim for compensation uses the (the (year) injury), date, testified he was injured his first day of work for the employer, and this date is also used in the benefit review conference report. The employer's wage statement lists a date of (claimant's alleged date of injury) as do various medical records. There is sufficient evidence to support the date noted by the hearing officer.

Second, we agree with the hearing officer's reasoning that claimant was not estopped from disputing contribution because he had previously received workers' compensation benefits for earlier injuries.

Finally, on the balance of the appeal, we note that the hearing officer determined that claimant's (year) injury did not contribute to his current impairment; there has been no appeal of this finding. The hearing officer stated that carrier had an "entitlement" to contribution, and noted that "it would have been appropriate for carrier to have provided the opinion of a medical expert" to render a decision as to the proportion of claimant's 27% that derived from his 1967 surgery. Notwithstanding, the hearing officer undertook to calculate the amount of impairment from the first surgery, deducing that such operation would have resulted "in at least nine percent whole body impairment, if one assumes that claimant's surgery left him with no residual symptoms." Based upon her own computation, the hearing officer ordered a reduction of claimant's IIBS and SIBS by one-third.

The applicable statute by which the Commission may allow a reduction of IIBS and SIBS is Section 408.084; the pertinent subsections to this case are as follows:

(a)At the request of the insurance carrier, the commission may order that impairment income benefits, and supplemental income benefits be reduced in a proportion equal to the proportion of a documented impairment that resulted from earlier compensable injuries.

(b)The commission shall consider the cumulative impact of the compensable injuries on the employee's overall impairment in determining a reduction under this section.

"Impairment" for purposes of the 1989 Act is defined as "any anatomic or functional abnormality or loss existing after maximum medical improvement that results from a compensable injury and is reasonably presumed to be permanent." Section 401.011(23). The burden of proving that contribution should be allowed is on the carrier. Texas Workers' Compensation Commission Appeal No. 92610, decided December 30, 1992; Texas Workers' Compensation Commission Appeal No. 931084, decided January 12, 1994. In her discussion, the hearing officer refers to contribution as "an entitlement," but it is not so described in the statute, and is more accurately characterized as an adjustment allowed according to the discretion of the Commission. While we agree that it is not essential for the carrier to prove an exact percentage, there must be sufficient facts in the record for the trier of fact to find a percentage that is reasonably supportable. *See* Texas Workers' Compensation Commission Appeal No. 941074, decided September 23, 1994.

Although it is not required that the documented impairment be in the form of a TWCC-69, or based upon the AMA Guides, an impairment from the contributing injury must nevertheless be recorded in medical records. *See* Texas Workers' Compensation Commission Appeal No. 92549, decided November 24, 1992. That decision further cites

1 MONTFORD, BARBER & DUNCAN, A GUIDE TO TEXAS WORKERS' COMP. REFORM, § 4.30(a), page 4-132 ((year)):

> . . . Therefore, the Commission will be required to examine the medical evidence from the earlier injury and make a determination of the extent of the previous injury. It may be necessary to obtain a doctor's opinion to establish the extent of residual impairment resulting from the prior injury and the cumulative impact of the previous and present injuries on the employee's overall impairment.

We have previously stated that while contemporaneous medical records are not necessarily required, the requirement for documentation of an "impairment" from the prior injury is not obviated; the later records must contain evidence that an impairment resulted from the prior injury. *See* Texas Workers' Compensation Appeal No. 94451, decided May 23, 1994. We have previously affirmed a decision where contribution was denied where a carrier merely argued that Table 49 should be used to carve out contribution, but offered no evidence to support its contention. *See* Texas Workers' Compensation Commission 94366, decided May 11, 1994. In this case, the subsequent records carrier points to as establishing "impairment" from the 1967 surgery merely recite that it occurred without opining at all on the existence or extent of any impairment. We would note that the letter of Dr. L comments that claimant made an excellent recovery from the 1967 surgery with no problems. We appreciate what the hearing officer has attempted to do where the facts indicate that claimant has received two prior awards of compensation for back injuries. Nevertheless, we agree with claimant that the hearing officer has erred in this case in allowing contribution, because there is no evidence of a "documented impairment" in this record resulting from a prior compensable injury.

More significantly, we agree that the simple use of Table 49 by the hearing officer to derive a figure which was then carved out of the current rating was done with no analysis of the "cumulative impact" of the prior (year) injury on the (year) injury. We noted in Appeal No. 92610, cited above, that the prior law made the carrier for a current injury liable only for benefits for which it would be liable had not an earlier compensable injury taken place. *See* TEX. REV. CIV. STAT. Art. 8306, § 12c (repealed). This, it seems to us, summarizes the essence of the current statutory direction to consider the "cumulative impact" of the injuries on the current disability. Thus, we believe that consideration of the "cumulative impact" requires not only some assessment of extent of impairment for previous injuries but an analysis of how the injuries work together, i.e., the extent to which prior injuries "contribute" to the present impairment. Appeal No. 941074, *supra*. An earlier injury could well have a rating that does not parallel its impact on a subsequent injury. For example, if claimant's prior injury had been a wrist injury causing a 10% impairment, an analysis of the cumulative impact would appear to result in no contribution against his current impairment assessed for his back.

This would carry out what appears to be the intent of the statute: that the present carrier should not have the amount it pays increased by the effect of an earlier work-related injury that is part of the current impairment. By the same token, a current carrier should not receive a windfall by obtaining credit for an earlier impairment that does not effect the current impairment for which it is liable. The hearing officer's methodology ignores the fact that claimant would have been entitled to a substantial impairment rating from Table 49 because of subsequent surgery even if the earlier surgery had not occurred. In the absence of evidentiary support for the hearing officer's computation, it could be just as cogently argued that the "contribution" of the 1967 surgery is only one percent, representing the degree of enhancement for multiple operations.

The decision and order of the hearing officer are accordingly reversed, for the reasons stated above, because the record in this case does not prove either a documented impairment from the previous injury nor does the hearing officer's decision indicate an analysis of the cumulative impact of impairments. As ample opportunity was granted for the carrier to carry forth its burden of proof in this case, remand would serve no purpose other than granting a "second bite at the apple", which we are not disposed to do. We render a decision that the carrier is ordered to pay IIBS to the claimant, without contribution, in the full weekly amount due for the 27% impairment rating received by claimant.

Susan M. Kelley
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Thomas A. Knapp
Appeals Judge