JUAN MENDEZ-MERINO, Employee/Appellant, v. FARMSTEAD FOODS and ITT SPECIALTY RISK SERVS., INC., Employer-Insurer, and MN DEP'T OF HUM. SERVS., OWATONNA PHYSICAL THERAPY, ABBOTT NW. HOSP., OWATONNA HOSP., MN DEP'T OF LABOR & INDUS./VRU, TWIN CITIES SPINE CTR., AND CONSULTING RADIOLOGISTS, Intervenors.

WORKERS' COMPENSATION COURT OF APPEALS
AUGUST 7, 2001

No. [REDACTED SSN]

HEADNOTES

CAUSATION. The compensation judge's Findings and Order must be remanded for redetermination where the compensation judge may have applied a more stringent test of legal causation than is required; the judge made no specific factual findings to support his legal conclusion of no causation; and the judge's memorandum contains confusing and inconsistent explanations for his determination.

Vacated and remanded.

Determined by: Johnson, J., Wilson, J. and Pederson, J.
Compensation Judge: Harold W. Schultz II

OPINION

THOMAS L. JOHNSON, Judge

The employee appeals from the compensation judge's decision that the employee's October 15, 1992 personal injury was not a substantial contributing factor to the employee's need for medical treatment on various dates between 1994 and the date of hearing, and wage loss beginning on March 14, 1999. We vacate and remand for redetermination in accordance with this decision.

BACKGROUND

Juan Mendez-Merino, the employee, worked as a laborer for Farmstead Foods, the employer, insured by ITT Specialty Risk Services, Inc. The employee worked in the hog cut department weighing and cutting meat. Hog carcasses were moved to the assembly line on a hook and dropped onto a conveyer belt. The employee aligned the carcass on the belt for cutting. On October 15, 1992, a hog carcass fell off a hook onto the floor. As the employee lifted the carcass to put it on the conveyor belt, he felt something crack in his lower back. He testified he was in a lot of pain and he couldn't turn. The employee completed his shift that day.

The following day, an English-speaking friend of the employee called the employer and reported the injury.[1] The employee continued to work, but was assigned a light-duty job that did not require lifting. Approximately a week after the injury, the employee went to Mexico because his father was ill. When he returned to Minnesota, after a week or so, the employee was informed he no longer had a job with the employer.

On November 9, 1992, the employee sought treatment from Gary Mumaugh, D.C., complaining of constant low back pain since lifting a hog at Farmstead Foods approximately 25 days before. The employee also reported some right sacroiliac (SI) and sciatic pain.[2] Dr. Mumaugh noted restricted lumbar range of motion and tenderness in the lumbar spine area. X-rays showed a marked decrease of the L5-S1 disc space. The employee received eight chiropractic treatments to the low back and sacroiliac joints, through December 16, 1992, with some improvement. (Pet. Ex. L.)

The employee was seen by Dr. Joanne B. Rogin, on December 21, 1992 for a neurological consultation on referral from Dr. Mumaugh. The employee reported a worsening of his pain, but denied any lower extremity symptoms. Mild lumbar spasm with decreased range of motion was noted on examination. An EMG conducted by Dr. Rogin on December 28, 1992 was normal. (Pet. Ex. K.) The employee was seen in follow-up at the Owatonna Clinic on December 30, 1992. The doctor noted persistent back pain for two months with no significant radicular symptoms. The doctor's impression was mechanical low back pain, and the employee was advised to use heat or ice and given an anti-inflammatory medication. (Pet. Ex. J.)

The employee began treating with Frederick R. Smith, D.O., at the Albert Lea Regional Medical Group on January 4, 1993. The employee reported a lot of low back pain without radiation into the hips or lower extremities. Dr. Smith recorded tenderness and pain on palpation in the sacroiliac area and diagnosed a lumbar strain/sprain. The doctor prescribed Flexeril and an anti-inflammatory and referred the employee for physical therapy. The employee completed six therapy sessions during which he continued to experience exacerbations of low back and sacroiliac pain. The employee returned to see Dr. Smith on January 18, 1993. An x-ray taken on that date revealed bilateral spondylolysis at L5.[3] Dr. Smith diagnosed a lumbar strain/sprain occurring on October 15, 1992 and pre-existing spondylolysis which he felt had little to do with the employee's current back pain. (Pet. Ex. I, Resp. Ex. 4.)

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[1] The employee was born in Mexico and immigrated to the United States in 1985. He is a United States citizen, but speaks very little English. The hearing was conducted with the assistance of an interpreter.

[2] "Sciatica" refers generally to any pain radiating from the back into the buttock and lower extremity. The term may, but does not necessarily, refer to sciatic nerve (radicular) pain. See Dorland's Illustrated Medical Dictionary (29th ed. 2000) at 1609.

[3] Spondylolysis is the disintegration of a bony vertebra marked by a separation of the pars interarticularis. See Dorland's, supra, at 1684.

The employee returned to see Dr. Smith on April 1, 1993. The employee had been in Mexico due to the death of his father, but was back in Owatonna and working at the turkey processing plant in Faribault. He reported continuing pain over the lower lumbar and upper sacral area, especially with bending or prolonged standing. Dr. Smith prescribed medications and a back brace and referred the employee for additional physical therapy. He advised the employee he would likely have back pain off and on for the rest of his life. By report dated April 26, 1993, Dr. Smith diagnosed a lumbar strain/sprain occurring on October 15, 1992, with bilateral spondylolysis at L5 which was likely pre-existing but could have been aggravated by the work injury. The doctor provided a permanent partial disability rating of 3.5 percent, prescribed Amitriptyline and Darvocet, and imposed moderate-duty work restrictions. The employee continued to receive physical therapy through May 17, 1993. On July 1, 1993, following a recheck examination, Dr. Smith stated the employee had reached maximum medical improvement (MMI), and reaffirmed the 3.5 percent permanency rating for a healed sprain/strain with rigidity and loss of motion.

The employee was examined on September 1, 1993 by Dr. Paul Cederberg at the request of the employer and insurer. The doctor noted the employee was taking Darvocet or Motrin and had a lumbar support. On examination, the employee reported localized tenderness over L5-S1 and was able to bring his fingertips to within one foot of the floor. The doctor diagnosed a musculoligamentous sprain of the lumbar spine, resolved. Dr. Cederberg opined the employee had reached MMI, had a 0 percent permanency, and was capable of working without formal work restrictions. (Resp. Ex. 7.)

The employee was next seen at the Owatonna Hospital emergency room on February 20, 1994 complaining of back pain and swelling of his feet and ankles at the end of the day. He followed-up with Dr. Smith on February 22, 1994 reporting a major increase in his low back symptoms and swelling in his lower extremities. The employee stated he was working at a hotel in the Twin Cities which required pushing a cart with cleaning and maintenance supplies. On examination, the doctor noted restricted lumbar motion and pain over the sacroiliac area. Dr. Smith diagnosed an exacerbation of the employee's lumbar sprain/strain. The doctor felt the swelling in the employee's ankles was probably due to being on his feet for long periods of time and the leg symptoms likely did not have anything to do with his back injury. The doctor saw the employee twice more, prescribing anti-inflammatories and physical therapy. (Pet. Ex. K.)

On April 11, 1994, Dr. Smith requested an MRI scan due to the employee's continuing low back pain. The April 13, 1994 scan revealed dehydration, degeneration and rupture of the disc annulus at L5-S1 with a small, confined central/posterior herniation. Bilateral spondylolysis at L5 with minimal subluxation was also reported.[4] Dr. Smith discussed the MRI scan and treatment options with the employee on May 3, 1994, including referral to the Institute for Low Back Care or to an orthopedic surgeon at the Orthopaedic and Fracture Clinic. Physical therapy was discontinued as the employee did not seem to be getting long term relief. By report dated May 5, 1994, Dr. Smith revised his permanency rating based on the MRI scan findings, assessing seven percent for a healed strain/sprain with pain and rigidity associated with

[4] Subluxation refers to an incomplete or partial dislocation. See Dorland's, supra, at 1719.

demonstrable degenerative changes, single vertebral level, plus nine percent for a single vertebral level herniated disc, not surgically treated, for a total of 16 percent.

The employee began treating with Dr. Sunny S. Kim at the Institute for Low Back Care on May 23, 1994. His chief complaint was chronic low back pain with a history of a work-related injury on October 15, 1992. Based on the MRI scan, Dr. Kim diagnosed isthmic spondylolisthesis,[5] spondylolysis. The doctor found restricted lumbar range of motion and localized tenderness at L5-S1. Dr. Kim noted the employee had received conservative care for about two years and raised the option of a spinal fusion. On June 24, 1994, the employee advised Dr. Kim he did not want to have a fusion. (Pet. Ex. F.) The employee returned to Dr. Smith on July 6, 1994, who concurred with this decision stating he believed surgery should not be considered until all else failed and the employee's pain was significantly interfering with his life.

The employee had filed a claim petition on May 24, 1993, alleging a low back injury on October 15, 1992, and seeking wage loss benefits, permanent partial disability and rehabilitation assistance. The parties entered into a Stipulation for Settlement in early July 1994, in which the employer admitted liability for a personal injury to the low back on October 15, 1992.[6] The employee accepted a lump sum payment of $22,000.00 which included a closeout of wage loss benefits through January 1, 1999 and permanent partial disability to 15.37 percent, along with payment of various medical expenses. Reasonable and necessary non-chiropractic medical expenses remained open. An Award on Stipulation was served and filed on July 18, 1994.

On July 20, 1994, the employee was seen by Dr. Gordon Welke at the Orthopaedic and Fracture Clinic in Owatonna. Dr. Welke examined the employee "briefly," but deferred giving an opinion, stating he was generally biased against fusions. The employee then saw Dr. Gene Swanson at the Orthopaedic and Fracture Clinic in Mankato on August 31, 1994. The employee reported low back discomfort and occasional discomfort in his feet. On examination, the doctor noted limited forward flexion and localized discomfort over the L5 spinous process. His impression was a pre-existing spondylolysis at L5 aggravated, but not initiated, by a work incident. Dr. Swanson concluded the employee's symptoms were "certainly real," but did not favor surgery given the relatively minimal nature of the symptoms, and opined it would be more reasonable to control the employee's symptoms by a change in occupational activities, avoiding heavy labor. (Resp. Ex. 3.)

The employee was not seen by a doctor for eleven months, then saw Patrick Corrigan, RPA-C, at Dr. Kim's office on July 31, 1995. The employee stated he continued to work as a laborer and reported an increase in his low back pain over the last several weeks for which he

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[5] Isthmic spondylolisthesis is the forward displacement of one bony vertebra over another due to a defect or lesion in the pars interarticularis. See Dorland's, supra at 925, 1684.

[6] Although the employer and insurer claim, and the compensation judge found, that the employer and insurer maintained a denial of primary liability, we can find nothing in the Stipulation for Settlement to support this assertion. Rather, the employer and insurer unequivocally admitted liability for a personal injury to the low back, on October 15, 1992, arising out of and in the course of the employment. (1994 Stipulation for Settlement, art. III.)

was taking Flexeril. Mr. Corrigan diagnosed an exacerbation of the employee's low back strain and referred the employee for physical therapy. The employee received nine physical therapy treatments reporting a 50 percent improvement. On August 23, 1995 he returned to Mr. Corrigan who continued the physical therapy. The employee completed six additional physical therapy treatments and was discharged from the program with a 70 percent improvement and instructions to continue his home exercise program. The employee reported continuing low back pain when seen in follow-up by Dr. Kim on December 11, 1995. Dr. Kim prescribed anti-inflammatory medication and again discussed the option of fusion surgery.

The employee did not see a doctor again until November 11, 1997 when he returned to Dr. Kim reporting lumbosacral pain with intermittent pain into both calves over the past year. On examination, the doctor found restricted range of motion and tenderness in the lumbosacral area. His neurological examination remained normal. The employee was fitted with a new lumbar corset and given a prescription for pain medication. Dr. Kim opined the employee's pain was most likely due to the spondylolisthesis. The employee was seen by Jay Ferguson, PA-C, in Dr. Kim's office on January 5, 1998, again noting bilateral leg pain that had gradually worsened. The employee was given anti-inflammatory medication, advised to wear his corset when working, and provided with home exercises. On October 20, 1998, the employee was seen by Patrick Corrigan complaining of severe back pain. On examination, range of motion was quite restricted with tenderness at the L5 facet joint radiating into the right flank. The employee was neurologically intact. Anti-inflammatories and Flexeril were prescribed and the employee was referred for physical therapy.

The employee returned to see Dr. Kim on February 22 and March 25, 1999, with increasing low back and bilateral leg pain. He told Dr. Kim he wanted to have surgery as he was tired of putting up with his pain and symptoms. Dr. Kim requested a repeat MRI scan. The March 25, 1999 scan showed degenerative disc desiccation and an annular tear with a small, central posterior protrusion at L5-S1 and spondylolysis at L5 with associated minimal anterolisthesis of L5 on S1. (Resp. Ex. 1; Pet Ex. F, Resp. Ex. 2: 3/25/99.) On May 13, 1999, Dr. Kim recommended a posterolateral fusion with pedicle fixation based on a persistent painful spondylolisthesis complicated by an annular tear at L5-S1.

The insurer refused approval for the surgery and requested a second opinion. The parties agreed upon Dr. Manuel Pinto. The employee was examined by Dr. Pinto on July 14, 1999. The doctor's neurological examination was essentially normal and he found no evidence of stenosis on the MRI scan. Dr. Pinto concluded the employee's symptoms were likely discogenic with referred pain to the legs and recommended a three level discogram. The doctor indicated that if the discogram reproduced the employee's symptoms, an anterior posterior fusion would be appropriate. The discogram, performed on September 2, 1999 showed abnormal morphology with a posterior annular tear at L5-S1 and 10/10 concordant low back pain. (Pet. Ex. C.)

The employee was re-examined by Dr. Cederberg on September 30, 1999, at the request of the employer and insurer. The doctor noted limited flexion and extension and a normal neurological examination. Dr. Cederberg diagnosed a resolved lumbar sprain/strain secondary to the employee's October 15, 1992 work injury, pre-existing spondylolysis at L5-S1, and degenerative disc disease at L5-S1. Dr. Cederberg concluded the employee's current condition

was due to congenital spondylolysis and noted age-related degenerative changes at L5-S1 as well as pre-existing spondylolisthesis. He opined there was no evidence the work injury of October 15, 1992 caused any permanent aggravation of the employee's condition and stated the work injury was not a substantial contributing factor to the spondylolysis/spondylolisthesis condition for which surgery was being proposed.

Although the insurer denied approval for the surgery, the employee decided to proceed because he couldn't stand the pain in his low back and legs any more. The surgery, consisting of a discectomy at L5-S1, an anterior and posterolateral fusion at L5-S1 with instrumentation, and a laminectomy at L5, was performed by Dr. Pinto on June 28, 2000. The employee testified his condition improved following the surgery. (T. 35, 37-38.)

Dr. Cederberg re-examined the employee following the surgery, on November 16, 2000. The doctor reiterated his opinion that the employee's complaints prior to the surgery were due to a pre-existing congenital spondylolysis at L5-S1. In Dr. Cederberg's opinion, the October 15, 1992 work-related lumbar strain was a temporary aggravation of the spondylolysis, and did not contribute to the need for the June 28, 2000 surgery.

By report dated December 14, 2000, Dr. Pinto agreed the employee had spondylolisthesis/spondylolysis likely present for many years preceding the work injury, but noted the condition is most often asymptomatic. Dr. Pinto stated the lumbar discography showed an extremely painful L5-S1 disc, indicating the majority of the employee's symptoms resulted from a symptomatic lumbar disc and not the spondylolisthesis/spondylolysis. Thus, the surgery was performed primarily to relieve the painful disc derangement at L5-S1, and treatment of the spondylolisthesis/spondylolysis was incidental. In Dr. Pinto's opinion, the work injury of October 15, 1992 was a substantial contributing factor to the employee's disability and need for surgical treatment. He noted, first, that the employee was doing well prior to the injury. He hypothesized that if the employee's symptoms had resolved within a few weeks or months of the injury and only recurred many years later, he would feel the surgery was not causally related. But, based on the employee's treatment records, Dr. Pinto felt it was apparent the employee continued to have symptoms all along, requiring periodic medical care for persistent low back and leg symptoms. He, therefore, opined the employee's diagnosis was, from the date of the injury, a symptomatic lumbar disc derangement and the source of his lumbar strain/sprain symptoms was the underlying disc derangement.

The employee filed a claim petition on June 1, 2000, seeking temporary partial disability benefits from March 8, 1999 to February 27, 2000, temporary total disability benefits from February 28, 2000 and continuing, payment of medical expenses, and rehabilitation assistance. The employer and insurer admitted the employee sustained a personal injury to the low back on October 15, 1992, but denied any additional benefits were due. The case was heard by a compensation judge at the Office of Administrative Hearings on January 4, 2001. In a Findings and Order, served and filed on March 5, 2001, the judge found the October 15, 1992 personal injury was not a substantial contributing factor to the employee's wage loss beginning in March 1999, and the need for medical treatment. The employee appeals.

DECISION

The employee argues the compensation judge erred, as a matter of law, by applying an erroneous standard of proof in finding the employee's October 15, 1992 work injury was not a substantial contributing cause of his disability and need for medical treatment. The compensation judge, the employee asserts, appears to have improperly required the employee to show his need for medical care arose solely from a condition caused by the October 15, 1992 work injury. The employee also contends that substantial evidence does not support the compensation judge's finding of no causal relationship. Although acknowledging it is the compensation judge's responsibility to choose between conflicting medical expert opinions, the employee asserts the compensation judge did not do so in this case, but simply found the employee failed to prove the need for surgery was related to the work injury. The employee argues the judge misinterpreted the opinions of Dr. Pinto and failed to properly apply the law to the evidence.

The employer and insurer respond the compensation judge properly concluded the employee failed to establish his work injury "brought about," "created" or "initiated" the employee's spondylolysis/spondylolisthesis condition. They further contend that substantial evidence supports the compensation judge's determination that the employee's surgery was intended to correct his pre-existing spondylolysis/spondylolisthesis condition and was not causally related to the 1992 injury.

The compensation judge's ultimate findings on this issue are conclusory, stating merely "The preponderance of the evidence is that the October 15, 1992 injury is not a substantial contributing factor to the employee's wage loss" or "the need for the treatment rendered to the employee." (Findings 44, 45.) The remaining findings merely recite the evidence and provide no guidance to this court with respect to the judge's choices between conflicting evidence and opinions.[7] Neither is the judge's memorandum helpful in that it provides different explanations for the decision which are difficult to reconcile, and reaches conclusions which are not based on any factual findings. As a consequence, this court is unable to discern the basis or underlying facts upon which the compensation judge's decision was based.

Initially, the judge stated the case involved "a very close legal issue centering around the burden of proof." (Mem. at 8.) What the judge intended by this statement is unclear. The burden of proof is undisputed in this case. The employee has the burden of proving a causal relationship between the October 15, 1992 injury and his subsequent disability and need for medical treatment. Rather, the question is whether the judge applied a correct legal standard in determining the work injury was not an appreciable or substantial contributing cause. There is

[7] A recitation of the evidence is not a finding of fact. A compensation judge should state with clarity and completeness the facts essential to the ultimate decision so that a reviewing court can determine from the record whether the facts support the judge's decision. The compensation judge should not leave to the reviewing court the obligation to seek or spell out the facts supporting the judge's decision or to choose between conflicting testimony and inferences. See Bryan v. Community State Bank of Bloomington, 285 Minn. 266, 172 N.W.2d 771 (1969).

some merit to the employee's argument that the judge may have imposed a more stringent test of legal causation than is required.

In his memorandum the compensation judge commented,

> There might not be the occurrence of another injury that brought about verifiable leg pain, but the defense does not have to prove subsequent trauma. The employee must present convincing evidence that the injury in issue brought about a medical condition that is a substantial contributing factor in the need for surgery. That was not done here.

(Mem. at 9.) One interpretation of this statement is that the compensation judge believed it was necessary for the employee to prove that his work injury directly caused ("brought about") the employee's underlying medical condition(s), that is, the spondylolysis/spondylolisthesis or the disc derangement at L5-S1, resulting in the surgery. This is the position taken by the employer and insurer.

The fact that the employee had underlying or pre-existing vertebral and/or disc degeneration does not necessarily preclude a finding of substantial contributing cause. Rather, the question is whether the October 15, 1992 work injury "aggravated, accelerated or combined with the [existing] infirmity to produce the disability for which compensation is sought." Felton v. Anton Chevrolet, 513 N.W.2d 457, 50 W.C.D. 181 (Minn. 1994); Bender v. Dongo Tool Co., 509 N.W.2d 366, 49 W.C.D. 181 (Minn. 1994). The employee asserted he had been asymptomatic prior to the personal injury and suffered ongoing chronic pain and symptoms following the injury. It was his position that the 1992 injury substantially contributed to his disability either by causing his degenerative disc disease, or by aggravating, accelerating or combining with the disc derangement and/or his pre-existing spondylolysis/spondylolisthesis, to produce disability and, ultimately, the surgery performed on June 28, 2000.

The employee's treating surgeon, Dr. Pinto, believed the employee had discogenic pain[8] due to internal derangement of the L5-S1 disc, which, in his opinion, had been the source of the employee's pain and lumbar sprain/strain symptoms since the date of injury, ultimately requiring surgery. The compensation judge appears to have discounted Dr. Pinto's opinion, in part, because the judge concluded there was no diagnosis of disc derangement in the four or five years following the employee's 1992 work injury. (Mem. at 9.) This conclusion is not consistent with the evidence. An x-ray taken by Dr. Mumaugh on November 9, 1992 showed a marked decrease of the L5-S1 disc space. An MRI scan on April 13, 1994 showed dehydration, degeneration and a tear in the disc annulus at L5-S1. (See finding 18.) On May 3, 1994, Dr. Smith diagnosed degenerative disc disease at L5-S1 along with a lumbar strain/sprain and bilateral L5 spondylolysis. By report dated May 5, 1994, Dr. Smith revised his permanency opinion incorporating the degenerative changes found on the MRI scan. This report provided the basis for

[8] Discogenic pain refers to pain from the abnormal disc itself; pain from a "herniated" disc normally results from impingement of the protruding disc on a nerve.

the employee's permanent partial disability claim which was closed out to 15.37 percent in the July 1994 Stipulation for Settlement. A repeat MRI scan was taken on March 25, 1999. The findings on the scan were virtually unchanged, again showing degenerative disc dessication and a posterior annular tear in the L5-S1 disc. The September 2, 1999 discogram also showed abnormal morphology at L5-S1 with a posterior annular tear.

The judge also concluded that the records of employee's earlier treating physicians did not support the employee's claim of a causal relationship between his disability and need for medical treatment. The judge specifically included in his findings Dr. Swanson's impression in August 1994 that the employee had "spondylolysis L5 aggravated by work incident, but not initiated." (Finding 22; Mem. at 9.) Dr. Smith had previously indicated, in his report of April 26, 1993, that the employee's spondylolysis was likely pre-existing but "could have been aggravated by the work injury." Even Dr. Cederberg concluded the October 15, 1992 work-related lumbar strain was an aggravation of the employee's pre-existing spondylolysis, but concluded it was temporary and had resolved as of September 1993. As discussed above, it is not necessary that the work injury "initiate" or cause the underlying condition, it is sufficient if the work injury aggravated, accelerated or combined with the pre-existing condition resulting in the employee's symptoms and disability. While this is a question of fact for the compensation judge, it was not clearly resolved in this case.

Although conceding the compensation judge did not specifically state he was accepting Dr. Cederberg's opinion, the employer and insurer urge this court to affirm the compensation judge's decision based on the judge's choice of experts. In his memorandum, the compensation judge notes the employer and insurer admit the employee sustained a lumbar sprain/strain relying on the opinion of Dr. Cederberg, but states it is not clear what the employer and insurer admit regarding the extent of the wage loss and medical bills resulting from the lumbar sprain/strain. The judge concludes by stating "the temporary aggravation probably lasted into 1993." (Mem. at 8.) It is unclear whether that is the judge's conclusion or his understanding of the employer and insurer's argument.[9] In the final two paragraphs of his memorandum, the compensation judge states, first, "[t]he sum and substance of this is that the employee, through his evidence, failed to make a consistent case of causal relationship between the personal injury and the need for surgery." The judge follows this statement with the comment that "Dr. Cederberg . . . does not find that there is a causal relationship between the employee's lumbar strain/sprain and the surgery that was performed." (Mem. at 10.) We cannot conclude from these statements that the compensation judge adopted the causation views of Dr. Cederberg.

Moreover, nowhere in his decision does the judge make any findings specifically determining the nature of the employee's October 15, 1992 injury. Although the employer and insurer assert the judge found the surgery was performed to address the employee's pre-existing spondylolysis/spondylolisthesis, there is no such finding.[10] We further note the employee's claims include medical expenses incurred as early as 1994 and a claim for wage loss benefits beginning

[9] If it is the compensation judge's conclusion, we again point out there are no findings of fact which support such conclusion.

[10] There is no finding the employee had any pre-existing condition.

in March 1999. We are, therefore, troubled by the judge's comments which seem to focus the issue almost entirely on the June 28, 2000 surgery. We are unable to determine the basis for the compensation judge's determination, and must, therefore, vacate the decision and remand for redetermination based on the existing record.