APPEAL NO. 950060
FILED FEBRUARY 17, 1995

This appeal arises under the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held on November 3, 1994, to determine whether the claimant sustained a compensable injury on _____, and whether she has sustained disability. The hearing officer held that the claimant had failed to prove by a preponderance of the evidence that she had contracted human parvovirus within the course and scope of her employment, and that she did not have disability. The claimant appeals, contending that the medical evidence clearly shows a causal relationship between the claimant's illness and her work, and complains that the hearing officer relied principally on outdated laboratory studies and held her to an unjust burden of proof. In its response the carrier contends that the claimant's appeal is not timely. However, records of the Texas Workers' Compensation Commission (Commission) show the hearing officer's decision was distributed to the parties on December 22, 1994; assuming that it was received by the claimant five days later (*see* Tex. W. C. Comm'n, 28 TEX. ADMIN. CODE § 102.5(h) (Rule 102.5(h)), the appeal must have been filed with the Appeals Panel not later than the 15th day afterwards--in this case, on January 11, 1995. The record shows that the claimant's appeal was postmarked January 11, 1995, and date stamped as received by the Commission on January 13, 1995; it is thus timely pursuant to Rule 143.3(c) and Section 410.202(a). In the alternative, the carrier contends that the hearing officer's decision should be affirmed.

DECISION

We affirm.

The claimant, an LVN, was employed at (hospital). In May 1994 (all dates hereafter are in 1994) she cared for patients in the intensive care unit (ICU). The claimant testified that around the third or fourth week in May she began developing physical symptoms which included pain in her chest, shoulders, and arm, as well as generalized weakness and pain. On June 20th she went to the hospital's emergency room where she was admitted for observation and was seen by (Dr. K). Dr. K's initial diagnosis was of a viral infection such as bronchitis or pneumonia; he gave her medication which she said did not help. On July 7th she called Dr. K to tell him she was feeling worse; she was admitted to the hospital that evening and was ultimately diagnosed with human parvovirus. Dr. K told her she had contracted this disease from a patient at the hospital, who claimant later found out was a woman named (CA).

The claimant stated that she cared for CA on May 8th and 9th after that patient was admitted to the hospital on May 7th. She estimated that she was with her on an intermittent basis for approximately three to four hours on May 8th, providing such care as connecting her IV, helping her to the commode, and bathing and changing her; she also

cared for CA the following day for an approximate one to two hour period. Claimant's supervisor, (Ms. C), testified that she worked the same shift and observed claimant cleaning CA after the latter had had a bowel movement, although she said the nurses' notes from CA's hospital stay do not reflect any notations by claimant. She also recalled that CA had had abdominal pain, high fever, rash, liquid stools, and stupor. She acknowledged that one could contract parvovirus from blood and body fluids, but stated that hospital policy required employees to wear gloves and she had "never seen [claimant] break policy."

Ms. C said CA was transferred to another facility, the (medical facility), on May 9th, and that she accompanied CA in the ambulance to that facility. She said at the time of discharge, CA had not been diagnosed with human parvovirus, and the medical records from the hospital do not reflect that this disease was ever suspected or tested for, including by Dr. K who saw CA in consultation. Claimant said, however, that Dr. K reviewed CA's records from the medical facility and told her that CA had been diagnosed with parvovirus.

Contained in the record is a September 8th letter from Dr. K stating that "In all reasonable medical probability, [claimant's] exposure to another patient infected with Human Parvo, was a substantially [sic] contributing factor to her contracting Human Parvo." On November 1st Dr. K responded to questions propounded by the carrier, as follows:

1. By whom were you informed that [claimant] had been exposed to a patient diagnosed with Human Parvo Virus?

Cannot remember.

2. Have you, since making this statement, verified whether or not the patient mentioned to you by [claimant] in fact had the Human Parvo Virus? If so, please state (i) whether or not you now believe that this patient suffered from the Human Parvo Virus and (ii) if [claimant] could have been exposed to the virus by this patient.

Lab tests do not substantiate an acute infection in the patient in question.

3. In your letter, you state that exposure to an infected patient "was a substantially contributing factor to her contracting Human Parvo." Is it possible that [claimant] could contract this disease from another source or sources outside of the hospital?

Yes.

On November 2nd Dr. K wrote the Texas Workers' Compensation Commission (Commission) giving a history of claimant's illness and stating that after her symptoms did not abate parvovirus was suspected and that claimant was evaluated for this in July "approximately 4-6 weeks after her initial symptoms." He went on to state that the claimant:

> . . . was found to have an elevation of the IgM portion of her Parvo B19 antibody titer, however, a much greater and significant elevation of her Parvo B19 IgG antibody, which is a late phase elevation. In all reasonable medical probability, this indicates that [claimant's] illness in question was caused by Human Parvo B19 Virus infection. I also feel that in all reasonable medical probability, that this was acquired at her work place as the patient was exposed in May 1994 to a seriously ill patient that had similar symptoms, although much more seriously ill than [claimant]. This patient required a transfer to [medical facility]. Her Parvo Virus was checked at that time, she had a [sic] acute titer that demonstrated an early rise in the IgM antibody fraction to the Human Parvo B19 Virus of a 0061. The patient also had a mild elevation of the IgG to 0.46. This to me would give us reasonable medical probability that [CA's] illness was caused by Human Parvo Virus B19. That an absolute indication of this would have been a recheck of her titers in two weeks, and most likely a further elevation in the titers would have been found.
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> I would like to restate that it is my feeling that in all reasonable medical probability [claimant] acquired Human Parvo B19 Virus from contact with a patient she was caring for at [the hospital] in May of 1994. Previously I was in error when I looked at the titers and felt that on a quick glance that this did not indicate infection. However, re-evaluation of that leads me to believe that indeed there is a reasonable medical probability that [CA] had Parvo and it was transmitted from contact with this patient to [claimant].

Dr. K also wrote, and claimant testified to this effect, that claimant was unable to work due to her illness.

(Dr. P), a doctor who had also seen CA in consultation while she was at the hospital, wrote the carrier as follows on September 8th:

> In response to your letter pertaining to [CA's] hospitalization there is question regarding her infection with the virus from the Parvo strain. To my knowledge there is no documentation of this infection. The possibility of a Parvo infection was brought to my attention by Internal Medicine at [medical facility] the night of her transfer. This was based on her recent history of having several domestic animals at her home die from this virus just prior to

her becoming ill. Based on the discharge summary from [medical facility] the origin of infection remains unclear.

I wish I could be of more help to you in this manner but the cause of her illness remains unclear to me as well . . .

(Dr. B) of the medical facility wrote Dr. P on July 20 as follows:

It appears that you were not provided any follow-up on [CA] who was referred by you to [medical facility] on May 10, 1994. While I was not the attending, I apologize for this error on behalf of our [medical facility] physicians. In my review of her medical records, it appears that the patient's symptoms of abdominal pain and dyspnea improved on antibiotics but no definite etiology was established . . .

Dr. B enclosed a copy of CA's discharge summary from medical facility. While it mentioned the fact that three to four weeks earlier CA had lost several puppies secondary to parvovirus, the summary of the laboratory findings do not indicate that CA was tested for this condition. It stated, "The patient became afebrile on 5-55-94 [sic], and she continued to improve. Dermatology was consulted to evaluate her rash; this was biopsied and showed findings consistent with drug eruption. The patient was then transferred to 10B on 5-12-94. She continued to be afebrile and had no abdominal pain or diarrhea. On 5-14-94, the patient was discharged to home."

Also in evidence was claimant's lab report performed in July, which states that claimant's parvovirus B19 IgG antibody level was less than "10H" and that the IgM antibody level was 0.11. The report further states:

IgG and IgM Reference Range:

less than 0.8None Detected

0.8 - 1.2Equivocal

greater than 1.2Detected

For IgG Antibodies:Presence alone probably indicates past infection since antibodies are usually found by the seventh day of illness and persist for years. At least 50% of adults show evidence of past infection.

For IgM Antibodies:Presence is the most sensitive indication of recent infection since antibodies are usually found within 3-14

> days of illness and decline after 2-3 months. False positives are occasionally seen with other infections.

(Dr. S), an infectious disease specialist, wrote to the carrier on October 25th that claimant's serological studies indicated that claimant has had past parvovirus B19 and that "[t]he negative IgM antibody indicates that this is not recent. Therefore, there has been no recent infection due to parvovirus B19." On November 18th, Dr. S wrote the hearing officer that he had reviewed additional information which she had provided; he stated:

> As the records indicated, [CA] apparently had been hospitalized at the [medical facility]. She had an illness which included a rash. A biopsy was performed and was most consistent with a drug reaction. A variety of blood studies were done, including for parvovirus B19. Both IgM and IgG antibodies were negative on the patient. The parvovirus B19 serologies I saw on [claimant] indicated a past infection but not a recent infection. Parvovirus B19 is most commonly associated with a childhood disease called erythema infectiosum. This is transmitted primarily due to close person-to-person contact in crowded conditions, such as day care centers, schools, and in close household contacts.
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> Given the information on this particular situation, it does not appear that [CA] had parvovirus B19 and it does not appear that [claimant] had recent parvovirus infection either.

Claimant stated at the hearing that she owns no pets and has been around no one with parvovirus; that around the time she became ill in May she was working long hours and did not go many places besides work and home; that she occasionally went into a store for a brief errand; and that parvovirus can be transmitted through airborne droplets which could be encountered anywhere. (Ms. BC), the hospital's director of risk management, said she had done a computer search of the hospital's records and had found no record of a patient being diagnosed with parvovirus. She also said she had spoken with Dr. K, who told her he believed claimant had been infected through contact with CA; she said that she told Dr. K the records from medical facility did not confirm a parvovirus diagnosis for CA and asked whether he had received any records which did, to which he replied in the negative. She said Dr. K then approached Dr. P's partner to ask whether medical facility had confirmed a parvovirus diagnosis on CA, to which that doctor replied that CA did not have parvovirus.

Under the 1989 Act, Section 401.011(34), "occupational disease" is defined as "a disease arising out of and in the course and scope of employment that causes damage or harm to the physical structure of the body . . . The term does not include an ordinary disease of life to which the general public is exposed outside of employment . . ."

Texas courts have addressed the necessity of proving causation to establish the compensability of occupational diseases. As the court stated in Home Insurance Company v. Davis, 642 S.W.2d 268 (Tex. App.-Texarkana 1982, no writ):

> To establish an occupational disease, there must be probative evidence of a causal connection between the claimant's work and the disease; i.e., the disease must be indigenous to the work or must be present in an increased degree in that work as compared with employment generally.

Further, courts have held that causation must be proved by expert testimony which amounts to more than speculation or conjecture. *See* Schaefer v. Texas Employers Insurance Association, 612 S.W.2d 199 (Tex. 1980), in which the Supreme Court rejected the treating doctor's opinion as to causation because the doctor assumed the employee had a certain serotype of bacteria pathogenic to birds and further assumed that such particular bacteria was present in the soil where the employee worked.

In her discussion of the evidence the hearing officer wrote that the claimant's lab results indicate that the presence of parvovirus B19 IgG antibodies is indicative only of past infection, and that at least 50% of adults show such indication. She continued as follows:

> This exhibit further states that the most sensitive indicator of recent infection of human parvovirus is the level of IgM antibodies and that a level under .8 is considered a negative result. Laboratory tests performed on both claimant and [CA] indicate that neither of them tested at a level of .8 or greater for IgM antibodies; specifically, [CA's] test result was .61 and claimant's test result was .11. Since both Carrier's Exhibit 1 and the second article contained in Claimant's Exhibit 5 indicate that a test is not considered positive unless it has a value of 1.2 or greater, it does not appear that either claimant or [CA] did, in fact, test positive for parvovirus B19 IgM antibodies.

It is not clear whether the hearing officer determined that claimant's injury, which she alleged was directly caused by her work related contact with CA, was not compensable because CA did not have parvovirus, because claimant's own tests showed she herself did not have the disease, or because claimant's level of antibodies were indicative only of an old, rather than a new, exposure.

In her appeal the claimant says that the hearing officer primarily relied upon lab reports in reaching her decision, but that she incorrectly states that an elevated IgG antibody titer is indicative only of past infection, pointing out that the laboratory reports stated that an IgG antibody finding is "suggestive of past infection." However, she argues, the most sensitive indicator of recent parvovirus infection is the IgM antibody titer; claimant's was measured at .11 and claimant contends that "a finding of .8 or greater is

evidence of recent infection." Moreover, the claimant says, the lab report states that antibodies are usually found within three to 14 days of illness and decline after two to three months; she contends she was not tested until nearly two months after her exposure to CA. She also points to material from a medical journal which states that IgM antibodies which are present early tend to disappear by one to two months after onset of pain. Claimant thus contends that she is being held to a grossly unjust burden in establishing that her illness was causally related to her job, merely because her doctor did not order the appropriate tests until July.

We would agree that the hearing officer somewhat overstates the effect of IgG antibody presence, which the laboratory report indicates "probably" indicates past infection. However, both the hearing officer and the claimant appear to agree that the IgM is the crucial measurement of recent infection. The claimant bases much of her argument on the inequity of penalizing her because of the lapse of time which occurred before the lab test was performed, and the evidence does indicate that such measurements decline over time. By the same token, the lab report states that IgM antibodies decline after two to three months and the evidence indicates a lesser amount of time between the onset of claimant's symptoms (which she said began the third or fourth week of May) and the lab test itself which was administered on July 9th; Dr. K estimated the time elapsed was four to six weeks. Further noteworthy is the fact that claimant's antibody levels for IgM were measured at a level which was equal to a negative finding; i.e., less than 0.8. While there was no expert testimony as to whether IgM antibody levels could decline to this point during the time period of time involved in this case, Dr. S stated his opinion that the negative levels of both IgM and IgG indicated past but not recent infection. Dr. K, on the other hand, believed that claimant's lab results showed that claimant's current condition was caused by human parvovirus and that it arose from her contact with CA. However, the hearing officer did not err in failing to rely upon the opinion of claimant's treating doctor, as the evidence shows that his statements were conflicting and contradictory. The 1989 Act provides that the hearing officer is the sole judge of the evidence (Section 410.165(a)) and is also entitled to weigh, and resolve conflicts in, expert medical testimony. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). Nor can we conclude, as the claimant suggests, that the hearing officer disregarded Dr. K's opinion merely because she did not accept it; her summary of the evidence indicates that this evidence was considered, along with the other evidence in the record. In sum, we believe there was sufficient evidence to support a determination of noncompensability based upon claimant's low antibody levels, interpreted through the lab report and Dr. S's opinion as negative and demonstrating either no current parvovirus infection or only a past infection.

Despite claimant's argument that this presents a harsh result upon an employee who does not rush to have testing done immediately after an occupational exposure, the evidence in this case also presents a serious question as to whether CA ever had parvovirus. The only reference to parvovirus antibody levels is contained in the November

2nd letter from Dr. K, who states that CA was tested when she was transferred to the medical facility. The only medical records in evidence related to that period of hospitalization are the discharge report, which does not indicate that claimant was so tested, and the post-discharge letter from Dr. B stating that CA's problems had resolved with antibiotics. While Dr. K's November 2nd letter contains antibody levels, an affidavit in response to a Commission subpoena for all Dr. K's records with regard to CA states that Dr. K had no office records for CA, and had only seen her in the hospital. Dr. P, who saw CA while she was in the hospital, stated that parvovirus was discussed upon CA's transfer to the medical facility but that he did not know the cause of her illness. Ms. BC said she heard Dr. P's partner state that CA did not have parvovirus. There is no mention of parvovirus, suspected or confirmed, in the records from the hospital, nor was it a diagnosis in the discharge summary from the medical facility. Dr. B of the medical facility wrote that CA had recovered from an illness whose etiology was never established. Dr. S believed, on the basis of the medical evidence, that CA did not have parvovirus.

The facts of this case put it more squarely with those in which recovery was denied where evidence of causation was speculative. In Texas Workers' Compensation Commission Appeal No. 92093, decided April 24, 1994, a hospital employee who was diagnosed with hepatitis B believed she had gotten it from a patient who had died, because there was "no other way I could have got it." The medical evidence did not show, however, that the patient actually was infected with hepatitis B. In affirming the hearing officer's decision denying compensability, the Appeals Panel stated that there was no evidence that the patient or any other individual in the workplace had hepatitis B and it quoted Schaefer, *supra*, as stating that the "mere possibility" of disease constituted no evidence. In another hepatitis case, Texas Workers' Compensation Commission Appeal No. 92085, decided April 16, 1992, the claimant related the inception of her disease to one occasion on which she pushed down trash in a bag pursuant to her job at a hospital. There was no evidence that the claimant had come into contact with anyone in the workplace with hepatitis, and she had in fact denied such contact when consulting a doctor. In reversing and rendering a decision in favor of the carrier, the Appeals Panel wrote that "the quantum and quality of the evidence required to establish the causation element between respondent's disease and her employment is not merely insufficient to support the hearing officer's conclusion but is virtually non-existent . . ."

This case differs in that there was some evidence in claimant's favor, namely the opinion of Dr. K. However, from our review of the record, we cannot say that the hearing officer erred in rejecting that opinion in favor of the other evidence as detailed above, which could support a determination that a work-related source of parvovirus was not shown. (In addition, as the hearing officer noted, the evidence showed that parvovirus is not uncommon, as 50% of the adult population show past infection.) We would thus agree that the evidence supports a determination that a causal connection between the employment and the occupational disease had not been shown. Texas Workers' Compensation Commission Appeal No. 91113, decided January 27, 1992. The hearing

officer's decision and order are not against the great weight and preponderance of the evidence, Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986), and are thus affirmed.

Lynda H. Nesenholtz
Appeals Judge

CONCUR:

Robert W. Potts
Appeals Judge

Gary L. Kilgore
Appeals Judge