

## APPEAL NO. 991718

This appeal is brought pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on July 9, 1999. The appellant (carrier) and the respondent (claimant) stipulated that the claimant sustained a compensable injury on Injury 1, and that the Texas Workers' Compensation Commission (Commission)-selected designated doctor, Dr. Z, in a Report of Medical Evaluation (TWCC-69) dated April 1, 1998, certified that the claimant reached maximum medical improvement (MMI) on August 13, 1997, with a 20% impairment rating (IR). The hearing officer determined that that report of Dr. Z that the claimant's IR is 20% is entitled to presumptive weight, that the great weight of the other medical evidence is not contrary to that report of the designated doctor, and that the claimant's IR is 20%. The carrier appealed, urged that the decision of the hearing officer is so against the great weight and preponderance of the evidence as to be manifestly unjust, contended that the Commission erred in not appointing a second designated doctor, and requested that the Appeals Panel reverse the decision of the hearing officer and render a decision that the claimant's IR is "between 5-15%." In the alternative, the carrier requested that the Appeals Panel reverse the decision of the hearing officer and remand for a hearing following the appointment of a second designated doctor.<sup>1</sup> A response from the claimant has not been received.

### DECISION

We affirm.

The claimant was exposed to toxic chemicals. On April 28, 1997, Dr. K examined the claimant at the request of the carrier, reported that he needed to work in another job category, and assigned a three percent IR. In a TWCC-69 dated July 31, 1997, Dr. N, who treated the claimant, certified that the claimant reached MMI on July 25, 1997, with an eight percent IR. At the request of the carrier, Dr. C examined the claimant on August 13, 1997, and in a TWCC-69 dated August 20, 1997, certified that he reached MMI on August 13, 1997, with a 20% IR. In a narrative attached to the TWCC-69, Dr. C wrote:

It has come to my attention that neurologists rate this type of headache under episodic neurologic disorders. This table is predominantly restricted to rating epileptic seizures and severe headaches that are related directly to the workplace. This would be found on the first table on page 98. It is of such severity as to interfere moderately with the activities of daily living. If occupation is considered an activity of daily living and it interferes with his

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<sup>1</sup>In its overview of the appeal, the carrier also stated that the hearing officer abused his discretion, made erroneous evidentiary rulings, considered evidence not in the record, misapplied the law, and made reversible error as a matter of law. The appeal does not indicate how those alleged errors occurred. There were no objections to exhibits offered by the claimant. The claimant testified that he had memory problems, looked at a document while testifying, the carrier objected, and the hearing officer stated that he would permit the claimant to use the document to refresh his memory and overruled the objection. Review of the record does not reveal any of those generalized errors. In the absence of a specific request for review, we will not further address those statements of error.

only vocational area that he is skilled in, then it does interfere with that particular activity of daily living. He does have interference with his activities of daily living whenever he is exposed to excessive amounts of perfume, after shave, exhaust fumes, or other petroleum sources currently as well. This is episodic. I would rate him at 20% of the whole person accordingly.

On August 26, 1997, Dr. N noted that Dr. C is an internal medicine toxicologist and stated that he agreed with both the MMI date and the IR assigned by Dr. C.

Dr. Z examined the claimant on July 28, 1997, and reported that the claimant was not at MMI. In a TWCC-69 dated April 1, 1998, Dr. Z certified that the claimant reached MMI on August 13, 1997, with a 20% IR. In a narrative attached to the TWCC-69, Dr. Z said that the claimant had a syncopal episode at work; that he began having severe intermittent headaches that were of new onset; that initially the headaches occurred as often as three to four times weekly; that now he has only two to three headaches per month; that his headaches came under control after the use of the migraine prophylactic medication Inderal; that he is now off Inderal and takes Desyrel and Fioricet; that it is clear that subsequent exposure to hydrocarbons and other solvents is an ongoing trigger for his headaches; that trigger avoidance has been the main intervention in the control of his headaches; that he can no longer work as a printing press operator and must avoid pumping gasoline, working on his automobile, household cleaners, and stores where perfumes are sold; that a neurological workup was essentially negative; that he agreed with Dr. C that the claimant's impairment is most correctly assessed using Episodic Neurological Disorders on page 98 of the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association; that the severity of the claimant's headaches are clearly more than slight which describes the first level of impairment; that his inability to work as a printing press operator and his avoidance of other routine tasks at home are clearly impacting his way of life and that that places him in category 2, an episodic neurological disorder of such severity as to interfere moderately with the activities of daily living; that the claimant's level of impairment is in the range of 20% to 40%; and that he is placing him at the low end of the range at 20%.

At the request of the carrier, Dr. W reviewed the medical records of the claimant. In a letter dated May 21, 1998, Dr. W stated that in his opinion the claimant had one syncopal attack, not repeated syncopal attacks; that he does not have epilepsy or any convulsive disorder, only a problem that is not present as long as he is not in the presence of toxic fumes; that it appears that he is not having any problems at this point with his "Episodic Neurological disorder," except for occasional headaches; that it appears that he is able to do most of the activities of daily living; that his interpretation is that the claimant fits in category 1 with impairment from 5% to 15%; that he thinks that the IR "would be at least 15%"; and that his difference with the report of Dr. Z is a "matter of the doctor's interpretation of the facts." At the request of the carrier, Dr. G reviewed the records of the claimant and responded to the question of what should be a valid IR for the claimant's injury. In a report dated February 22, 1999, and received by the carrier the next day, Dr. G

said that the claimant had no impairment of his activities of daily living at the time; that a rating over 15% would not be appropriate; that the claimant's IR would fit into the 5% to 15% category based on the fact that he still continues to have occasional mild headaches when exposed to fumes; and that it is possible that the MMI date was assigned early and he was given an artificially high IR. At a benefit review conference held on March 16, 1999, the carrier requested that Dr. G's report be sent to the designated doctor for his review. The claimant opposed sending Dr. G's report to Dr. Z. In a letter to the benefit review officer (BRO) dated March 17, 1999, the attorney representing the claimant stated that the carrier obtained a report from Dr. W, apparently was not pleased with the report of Dr. W and continued to shop around, obtained a report from Dr. G 10 months after the report of Dr. Z, and that Dr. G's report does not assess a specific IR and could not be used to assign an IR. In a letter dated March 24, 1999, the BRO sent the report from Dr. G to Dr. Z and asked him whether it caused him to amend the IR he previously assigned to the claimant. Apparently a response from Dr. Z has not been received. At the hearing, the attorney representing the carrier stated that Dr. Z "is apparently no longer around." The record indicates that the BRO wrote that the office where Dr. Z worked did not have a forwarding address or telephone number and that the telephone company information had no business listing for Dr. Z and only an unlisted residential number. The record does not indicate any efforts by the carrier to locate Dr. Z or obtain information that could be used to contact Dr. Z.

We first address the contention that another designated doctor should be appointed. In Texas Workers' Compensation Commission Appeal No. 980641, decided May 14, 1998, the Appeals Panel said that it had often stated that the designated doctor occupies a unique position under the 1989 Act and that the need to select a second designated doctor should be limited to a situation such as when the designated doctor is no longer available or otherwise refuses to comply with appropriate requests for clarification or further opinion. In the case before us, the record does not indicate that more than limited efforts were made to locate Dr. Z. Neither medical association or licensing authorities were contacted. In addition, the report of Dr. G is dated approximately nine months after the date of the report of Dr. W. Under these circumstances, the hearing officer did not err in not ordering that a second designated doctor be appointed.

The 1989 Act sets forth a mechanism to help resolve conflicts concerning IR by according presumptive weight to the report of a doctor referred to as the designated doctor. Texas Workers' Compensation Commission Appeal No. 92495, decided October 28, 1992. If the Commission selects the designated doctor as was done in this case, the Commission shall base its determination of the claimant's IR on the report of the designated doctor unless the great weight of the other medical evidence is to the contrary. Section 408.125(e). We have held that it is not just equally balancing the evidence or a preponderance of the evidence that can overcome the presumptive weight given to the report of the designated doctor. Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. No other doctor's report is accorded the special presumptive status given to the report of the designated doctor. Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992. The hearing

officer resolves conflicts in expert evidence and assesses the weight to be given to expert evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). A difference of medical opinion is not a sufficient basis to discard a designated doctor's report. Texas Workers' Compensation Commission Appeal No. 950166, decided March 14, 1995. The hearing officer determined that the report of the designated doctor is entitled to presumptive weight, that the great weight of the other medical evidence is not contrary to the report of the designated doctor, and that the claimant's IR is 20%. Those determinations of the hearing officer are not so against the great weight and preponderance of the evidence as to be clearly wrong or unjust. In re King's Estate 408.122(c), 150 Tex. 662, 244 S.W.2d 660 (1951).

Finding the evidence to be sufficient to support the determinations of the hearing officer and no reversible error, we affirm the decision of the hearing officer.

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Tommy W. Lueders  
Appeals Judge

CONCUR:

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Gary L. Kilgore  
Appeals Judge

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Alan C. Ernst  
Appeals Judge