APPEAL NO. 002536

Following a contested case hearing held on October 4, 2000, pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act), the hearing officer, resolved the disputed issue by concluding that, based on the report of the designated doctor, Dr. T, which she found not to be contrary to the great weight of the other medical evidence, the respondent's (claimant) impairment rating (IR) for his occupational disease (inhalation injury) is 25%. The appellant (carrier) has appealed, disputing sufficiency of the evidence to support this conclusion and finding and pointing to the reports of three other doctors, each of whom assigned an IR of 0%. The file does not contain a response from the claimant.

DECISION

Affirmed.

The carrier does not dispute findings that on _____, the claimant sustained an injury while engaged in the exercise of his job duties with (employer); that Dr. T was appointed by the Texas Workers' Compensation Commission (Commission) as the designated doctor; and that Dr. T certified that the claimant has a 25% whole body IR. The hearing officer notes that the parties did not dispute that the claimant reached maximum medical improvement (MMI) by operation of law on August 10, 1998.

The claimant testified that he has been employed by the employer as a laborer working on environmental cleanups of hazardous materials at various sites, that he was provided only with a paper dust mask which was ineffective in protecting him from inhaling hazardous fumes and substances, and that on _____, he began "coughing up black stuff." He stated that he agrees with the 25% IR assigned by the designated doctor for his occupational disease injury and that he disagrees with the reports of Dr. EC, Dr. GF, and Dr. GC, notwithstanding that Dr. GF and Dr. GC are pulmonary medicine specialists.

The Report of Medical Evaluation (TWCC-69) from Dr. S, the treating doctor, dated January 25, 1999, assigns to the claimant a 75% IR. In his narrative report of January 22, 1999, Dr. S states that on _____, the claimant was exposed to occupational fumes containing metallic dust, lyme dust, inorganic acids, mixed hydrocarbons, and ash; that the claimant has been tested and treated for over two years; that he has been unable to enjoy the majority of activities of daily living without experiencing dyspnea; and that in February 1998 he demonstrated a more significant Cor Pulmonale component (heart disease due to pulmonary hypertension secondary to disease of the lung). Dr. S stated the diagnosis as reactive airway disease secondary to occupational exposure to caustic agents and assigned the claimant an IR of 40% from Table 8 (Classes of Respiratory Impairment) of Chapter 5 in the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), and 35% for the cardiovascular system for a total IR of 75%.

Dr. EC, who reviewed the claimant's medical records, reported on February 6, 1999, that in his opinion, the definitive procedure for determining the presence of reactive airway dysfunction has not been performed and the available information fails to support an obstructive pulmonary dysfunction; that on those occasions when the pulmonary functions appear to be restrictive, a more reasonable explanation is inadequate patient effort; and that the June 18, 1998, pulmonary function test (PFT) shows that the pulmonary functions are normal "when properly interpreted." Dr. EC's extensive report discusses in detail why Dr. EC feels the claimant has not sustained an occupational disease injury and he also states in detail why he views Dr. S's calculation of the claimant's IR as erroneous. In an addendum dated June 28, 1999, Dr. EC states that the June 18, 1998, PFT results (forced vital capacity of 83% FEV-1 of 87% and FEV-1/FVC of 92%) place the claimant at 0% IR pursuant to Table 8 and that these pulmonary functions demonstrate that there is no residual impairment.

Dr. T's TWCC-69 dated March 18, 1999, assigns the claimant an IR of 25%. Dr. T's narrative report of his February 27, 1999, examination states that he felt he should use a PFT close in time to the MMI date and so he used the June 18, 1998, test run at (hospital 1); that the test report states that the claimant showed good understanding, cooperation, and effort; and that in this PFT only one value, the FVC, met the criteria for a Class 2 impairment, from Table 8 of the AMA Guides. Table 8 provides for four classes of respiratory impairment with Class 2 reflecting a range of 10 to 25% for mild impairment. The June 18, 1998, PFT report from hospital 1 states that there is no definite evidence of obstructive disease, but there does appear to be a mild restrictive ventilatory defect; that the diffuse capacity is normal; and that there is some improvement following bronchodilator, the significance of which is unclear. Dr. T also stated that in considering the claimant's IR, he felt that the "advocacy" of the treating doctor, Dr. S, should be given weight.

Dr. GC, who reviewed the claimant's medical records, reported on February 23, 1999, that the PFTs of August 4, 1996; May 5, 1997; and December 22, 1998, are of poor quality and do not meet the minimum criteria for reproducibility but that the PFT of June 18, 1998, is an adequate test. Dr. GC further stated that the latter test reveals a minimal restrictive ventilatory defect with normal diffusion capacity; that such defect could be secondary to being overweight; and that he does not find any residual effect from the July 29, 1998, exposure and ensuing episode of acute chemical bronchitis.

At the request of the Commission, Dr. T reviewed the report of Dr. EC and Dr. GC and wrote on March 29, 1999, that, having reviewed that information, he would nonetheless "stick with" the 25% IR he assigned.

Dr. GF's TWCC-69 dated April 18, 2000, assigns the claimant an IR of 0%. In his narrative report, Dr. GF, who did examine the claimant, notes that an initial medical report of Dr. L diagnosed acute bronchitis secondary to chemical exposure and pneumonitis secondary to chemical and environmental exposure; that the February 23, 1999, letter of Dr. GC opined that the claimant does not have obstructive lung disease but does have

“minimal restrictive ventilatory defect that could be secondary to overweight”; and that the claimant may have had mild chemical bronchitis after exposure but did not have "any significant pulmonary disease." Dr. GF further notes the February 6, 1999, report of Dr. EC to the effect that the conclusions reached by Dr. S are grossly erroneous and that the June 18, 1999, studies would have resulted in a 0% IR. Dr. GF also states that given the fact that the studies from hospital 1 were nearly normal, it is "unclear" why Dr. T would have opined for a 25% IR; that, based on a (hospital 2) PFT on December 22, 1998, there is evidence neither of airway obstruction nor of a reversible component and that Dr. S’s diagnosis of reactive airway disease has not been substantiated by that study; and that in his opinion, the claimant has a 0% IR from any occupational disease or illness.

Dr. S wrote on July 19, 2000, that he reviewed Dr. GF’s report and found Dr. GF’s statement of the history and diagnostic work-up, as well as his assessment and assigned IR, to be “totally erroneous.” At the request of the Commission, Dr. T reviewed the report of Dr. GF. Dr. T wrote on July 20, 2000, that he again reviewed his own report, that he cannot find mistakes, that his logic seems sound, and that he is satisfied that the IR he assigned is “reasonable and fair.”

With regard to the determination of an injured employee's IR, Section 408.125(e) provides that the report of the designated doctor selected by the Commission shall have presumptive weight and the Commission shall base the IR on that report unless the great weight of the other medical evidence is to the contrary. The Appeals Panel has frequently noted the important and unique position occupied by the designated doctor under the 1989 Act. *See, e.g.,* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. We have just as frequently stated that a "great weight" determination amounts to more than a mere balancing or preponderance of the evidence (Appeal No. 92412) and that a designated doctor's report should not be rejected "absent a substantial basis to do so." Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993.

The hearing officer is the sole judge of the weight and credibility of the evidence (Section 410.165(a)) and resolves the conflicts and inconsistences in the evidence including the medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ)). The Appeals Panel, an appellate reviewing tribunal, will not disturb the challenged factual findings of a hearing officer unless they are so against the great weight and preponderance of the evidence as to be clearly wrong or manifestly unjust and we do not find them so in this case. Cain v. Bain, 709 S.W.2d 175, 176 (Tex. 1986); In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). We cannot say that Dr. T’s report is contrary to the great weight of the other medical evidence given that his opinion is supported by Dr. S and that he reviewed the reports of Dr. EC, Dr. GC, and Dr. GF and declined to change his opinion.

The decision and order of the hearing officer are affirmed.

Philip F. O'Neill
Appeals Judge

CONCUR IN THE RESULT:

Elaine M. Chaney
Appeals Judge

CONCURRING OPINION:

I agree that the decision of the hearing officer should be affirmed. I write separately merely to observe that the hearing officer provided a well-reasoned rationale for finding that the great weight of the medical evidence was not contrary to the opinion of the designated doctor. She specifically noted that the three carrier-selected doctors who expressed views contrary to the designated doctor appeared to be laboring under the mistaken impression that the claimant's injury was the result of a single occurrence, rather than the result of multiple chemical exposures. She also pointed out that one of these three doctors conceded that he had no information regarding what personal protective equipment, if any, the claimant had been using during the exposures, and that another of the three doctors conceded that the objective test results would support an impairment in the range of 10 25%. Finally, I do not believe the hearing officer was required to give any weight to the impairment opinion of any doctor whose opinion was based on only a paper review as opposed to a physical examination.

Gary L. Kilgore
Appeals Judge