APPEAL NO. 121300
FILED SEPTEMBER 7, 2012

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on June 4, 2012, in [City], Texas, with [hearing officer] presiding as hearing officer. The hearing officer resolved the disputed issues by deciding that the compensable injury sustained on [date of injury], does extend to chronic obstructive pulmonary disease (COPD) but does not extend to right-sided heart failure. The appellant (carrier) appeals the hearing officer's determination that the compensable injury extends to COPD. The appeal file does not contain a response from the respondent (claimant).

The hearing officer's determination that the compensable injury sustained on [date of injury], does not extend to right-sided heart failure was not appealed and has become final pursuant to Section 410.169.

DECISION

Reversed and rendered.

The claimant testified that he was exposed to fumes leaking from a metal bottle while at work and that he does not know what substance was contained in the rusted bottle or what specific kind of gas fumes leaked from the bottle. The claimant testified that he was sure it was not anhydrous ammonia. The claimant further testified that he was taken to a hospital emergency room (ER) after exposure. The evidence reflects that another co-worker, exposed to the gas fumes for longer than the 2-5 minutes that the claimant breathed the fumes, was also taken to the hospital and is currently on a ventilator.

In evidence is a Notice of Disputed Issue(s) and Refusal to Pay Benefits (PLN-11) dated November 15, 2010, which states that the carrier accepted the compensable injury extends to acute toxic effect of gas/fume inhalation but disputed the compensability of COPD. A second PLN-11 dated April 25, 2012, states that the carrier accepted the compensable injury is inhalation of anhydrous ammonia but disputed compensability of heart disease/disorders which includes but is not limited to right-sided heart failure as well as COPD and gastric diseases/disorders because they are ordinary diseases of life and not the direct result of the work injury on [date of injury].

In the Background Information section of his decision, the hearing officer stated:

All the medical evidence is consistent in finding that [the] [c]laimant suffered an inhalation type injury as a result of breathing an unknown fume or vapor. The cloud of unknown chemical fumes was visible and had immediate respiratory effects on the two

workers that were exposed to it. [The] [c]laimant may have had some level of COPD prior to the chemical fume inhalation incident on [date of injury]. He has a history of [20] plus years of smoking. However, he had no history of medical treatment for respiratory problems. [The claimant] has a history of working full time at construction type jobs. After the [date of injury], inhalation injury, he is no longer able to perform construction type work. Clearly, [the] [c]laimant had a worsening of his respiratory condition after the chemical exposure incident on [date of injury].

The carrier contends in its appeal that the claimed extent-of-injury condition, COPD, required expert evidence causally linking the diagnosis to the work injury. Additionally, the carrier contends that the hearing officer erred in determining that COPD was part of the compensable injury without sufficient expert evidence. Rather, the hearing officer relied upon "a temporal causation standard" which "does not sufficiently provide proper analysis of whether a particular gas caused an injury or aggravation."

MEDICAL RECORDS REVIEW

[Texas Hospital]

In evidence are the medical records from [Texas Hospital] where the claimant received emergency care following his exposure on [date of injury]. A record dated that same day states the diagnosis of inhalation injury. It further states:

> Respiratory [d]ifficulty – [o]nset 30 min ago. No cough, fever, (-) pain-with inspiration, (+) relief with self interventions prior to arrival. [The claimant was] involved in [a]nhydrous [a]mmonia spill. Decontaminated [prior to arrival (PTA)]. [The claimant] receiving [a]lbuterol [b]reathing [treatment (tx)] upon arrival.

Under the general appearance of the physical exam, the report stated that the claimant was alert, oriented "X3" and in no acute distress, no obvious discomfort. Upon release after observation following a breathing treatment, the claimant was prescribed an albuterol inhaler. A chest x-ray report's impression was "[q]uestionable reticular opacities involving the right costophrenic angle area which may be due to an acute process such as early developing interstitial pulmonary edema and/or pneumonia versus chronic fibrotic changes. If an inhalation injury is of clinical concern a follow-up exam may be helpful."

There is a [Texas Hospital] record dated August 17, 2010, that states the claimant returned to the ER complaining of shortness of breath for a week. The claimant is diagnosed with "[b]ronchospasm, [a]cute ([b]ronchospasm NOS)." Under

the physical exam, lungs, the record states “mild inspiratory and expiratory wheezing left and right upper, no rales, no rhonchi, (-) accessory muscle use, fair air exchange bilateral.” The claimant received a breathing treatment but was advised not to smoke and to be cleared medically before returning to work. A chest x-ray report dated August 17, 2010, had findings that the lungs “are grossly clear. There are no infiltrates, effusions or pneumothoraces.” The impression listed is: “1. [n]o active cardiopulmonary disease identified. 2. [m]ild scoliosis of the dorsal spine is incidentally noted.”

[Medical Center]

The claimant was initially seen at [Medical Center] on August 20, 2010, by [Dr. K]. The [Medical Center] report dated that date states the diagnosis of toxic effect of unspecified gas, fume, vapor and takes the claimant off work, with medication prescribed.

There is a follow-up visit at [Medical Center] on August 27, 2010, and the same diagnosis and off work status is documented.

A [Medical Center] report dated September 3, 2010, states that the claimant returned for a re-check. The claimant reported that “the pattern of symptoms is worsening;” however, it also states that the claimant has been taking the prescribed medications and has noted improvement. The claimant reported pain on his anterior chest. Under physical exam findings for the chest is “[d]iffuse expiratory wheezes.” The assessment lists ammonia exposure. The claimant is continued in off work status with no smoking. The record documents that a pulmonologist should be seen at the earliest convenient time.

A [Medical Center] report dated September 17, 2010, states that the claimant in his follow-up visit, “feels the pattern of symptoms is improving . . . . [The claimant] does not have any pain.” For the chest, it states “[s]cattered expiratory wheezes.” The assessment is ammonia exposure. The claimant is released to modified duty to operate a crane. There is another referral for a pulmonologist.

A [Medical Center] report dated October 1, 2010, states that “[the claimant] feels the pattern of symptoms is essentially unchanged. [The claimant] has been working within the duty restrictions, but states that he tired out yesterday working his crane and ‘had to be sent home.’” It also states that the claimant has been taking his medications and noted improvement in his symptoms, “though he ran out of his albuterol inhaler. He is still smoking.” The report states that the doctor, [Dr. S] is still awaiting a pulmonary consult. The assessment is “inhalation of gas, fumes or vapor.”

A [Medical Center] report dated October 7, 2010, by Dr. S states that the findings of the physical exam of the chest are "[b]reath sounds clear bilaterally. Shallow respirations. No retractions. No rhonchi. No stridor. No wheezes. Some pursed-lip breathing noted." Dr. S ordered a pulmonary function test (PFT) but noted "[the claimant] seemed agreeable at first, but [the claimant] refused after his initial attempt at testing." Dr. S further stated "[t]he role that smoking plays in his respiratory health was again discussed, as it was at his last visit, and he was advised that the pulmonologist will likely want at least PFTs and likely other testing as well." The assessment is inhalation of gas, fumes or vapor. The plan is to keep the pulmonology consult as scheduled. Medication was prescribed but the claimant left [Medical Center] before the prescriptions were given to him. He was continued on modified duty.

The claimant received a diagnosis of "[p]robable COPD" for the first time in a [Medical Center] report dated October 21, 2010. He also received a diagnosis of inhalation of gas, fumes, or vapor and lumbar strain. In that report, it states "[the claimant] states that he has less shortness of breath and difficulty breathing, but that he was clearing out a lot of mucus and at one point had a coughing fit that strained his lower back a few days ago." The chest findings are "[b]reath sounds clear bilaterally. Good air movement . . . . No wheezes."

In a [Medical Center] record dated November 11, 2010, Dr. S states that the claimant is reporting his patterns of symptoms are no better. "[The claimant] has been unable to get his pulmonary consult because a PFT is required." However, the claimant submitted to a PFT that date and the report states the test revealed "[m]oderately severe obstruction." Dr. S's assessment was inhalation of gas, fumes or vapor and COPD not work-related.

There is a [Medical Center] record dated February 21, 2011. Dr. S states that "[the claimant] has not been using his inhalers because he ran out. [The claimant] has not had his pulmonary consult because he has 'been in Georgia for the past [3] months.' This problem of noncompliance was discussed with the patient." The chest findings noted good air movement and clear breath sounds. The assessments lists inhalation of gas, fumes or vapor and COPD not work-related. The claimant was referred for a certifying examination to determine maximum medical improvement (MMI)/impairment rating (IR).

[Dr. H] Referral Doctor Selected by Treating Doctor Acting in Place of Treating Doctor

Although there are no issues of MMI/IR before the hearing officer, Dr. H's medical narrative contains his opinions concerning the inhalation injury. We note that Dr. H stated in his narrative dated February 25, 2011, that he only had [Medical Center] records and none from [Texas Hospital]. Dr. H also documents the claimant's father's

death related to COPD and smoking and the claimant's reported history of no prior shortness of breath prior to the [date of injury], work injury. The claimant is still smoking although down to 4-5 cigarettes per day. The claimant reported doing crane work while in Georgia. Dr. H's physical findings for the chest include bilateral breath sounds in the lungs but wheezing particularly expiratory wheezing, "somewhat diminished breath sounds particularly more superiorly" and noted shortness of breath just conversing about his history. Dr. H's diagnoses are: (1) [i]nhalation injury secondary to toxic fumes possible anhydrous ammonia (a substance the claimant testified he was not exposed to); and (2) [COPD] secondary to long term smoking.

In discussing the assignment of the IR, Dr. H states:

> Some of his expiratory impairment is related to his smoking but certainly a portion of it is related to his inhalation injuries. He has had such a significant change in his overall level of function since the day of his injury . . . my estimation the portion of his injury that is felt to be related the inhalation injury would place him in a Class 2 injury . . . . This is based particularly on the fact that the other employee suffered a significant respiratory injury as well and is still on a ventilator . . . other employee did not smoke.

[Dr. O] Designated Doctor for MMI/IR

Dr. O was appointed by the Texas Department of Insurance, Division of Workers' Compensation (Division) to examine the claimant in Georgia for the purposes of MMI/IR. In his narrative report dated June 8, 2011, Dr. O lists the compensable injury as an inhalation injury secondary to toxic fumes-possible anhydrous ammonia. The claimant is noted to still be smoking "[4] cigarettes daily" and a past "history of bronchitis on and off." Dr. O notes the claimant's history of shortness of breath and difficulty in breathing since [date of injury], decrease in amount of physical activity able to perform, a cough producing whitish sputum and low back pain, and family history of COPD with his father. The findings on exam are wheezing inspiratory and expiratory. Dr. O performs a PFT which revealed evidence of severe restriction.

Dr. O concluded:

> In summary I conclude that [the claimant] has severe pulmonary disease which restricts his ability to function and may indeed have some secondary right-sided heart failure from his lung disease.

[Dr. T] Designated Doctor for Extent of Injury and Return to Work

Dr. T examined the claimant on January 13, 2012. In an undated narrative report, Dr. T listed the compensable injury as "[r]espiratory [s]ystem, [inhalation] injury secondary to toxic fumes anhydrous ammonia." Dr. T listed the mechanism of injury as accidental inhalation of fumes from anhydrous ammonia that caused the claimant to have severe pains in his lungs and chest and shortness of breath. Dr. T reviewed the August 17, 2010, chest x-ray and noted "[m]oderate COPD."

Under the "Extent-Of-Injury Determination" section of his report, Dr. T states:

> Extent of [i]njury is described as damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. This can include an aggravation of a pre-existing condition which is an enhancement, acceleration, or worsening of an underlying or pre-existing condition and can extend to a condition that arises out of or naturally results from the compensable injury.
>
> Based on the information provided and the examination findings presented today, I render the following opinion with regards to the examinee's [d]etermination of [e]xtent of [i]njury.
>
> It is my opinion from the medical records reviewed that the extent of injury is to include an inhalation injury and an aggravation of his [COPD] which did contribute to his right-sided heart failure.

Under the "Disability" determination section of his report, Dr. T states:

> Disability is directly related to [t]oxic fumes, making COPD worse, and may have caused right heart failure.

[Clinic] and [Dr. N]

In evidence is the initial [Clinic] medical record dated September 19, 2011. The claimant complaint is chest problems, cough, and difficulty breathing. The claimant reports smoking 10 cigarettes per day. Findings of the chest and respiratory system include normal expansion of the chest, no intercostals retractions with shall diaphragmatic movement, and decreased breath sounds in the lungs. The listed diagnoses are: (1) [t]oxic effect of unspecified gas, fume or vapor; (2) [d]ependent tobacco use disorder; (3) [c]hronic airway obstruction, not elsewhere classified; and (4) [h]eart failure, unspecified. The report notes that there was a discussion of the claimant's x-ray report, "expanded chest, nothing acute" and the risks of continued

tobacco use. The report states the claimant needs to be under the care of a pulmonologist.

In evidence is a medical report from Dr. N dated February 1, 2012. Dr. N notes the claimant's complaint of shortness of breath and history of being in excellent health until the date of the work injury, [date of injury], at which time he was "exposed to anhydrous ammonia for approximately 2 minutes. He immediately developed respiratory symptoms, which includes cough and shortness of breath. He was seen in the [ER] and discharged. He has had significant respiratory symptoms since then." The claimant denied any history of any other chronic respiratory disease. The claimant reported that he did not smoke now. His family history is positive for COPD in his father. Dr. N lists as problems: (1) [r]espiratory condition due to chemical fumes and vapors; (2) [r]estrictive lung disease; (3) dyspnea; and (4) GE reflux. Dr. N documents 2 PFT results which vary in range.

In that same report, under assessment, Dr. N states:

> This patient clearly has developed respiratory symptoms following this inhalation. He has significant impairment. His pulmonary function tests are quite abnormal. He most likely has a diffuse brochiolitis causing significant small airway narrowing and dysfunction. He also has GE reflux, which could contribute to his respiratory symptoms particularly his cough.

[Dr. J] Witness at CCH

At the request of the carrier, Dr. J testified by phone. He stated he did a peer review of the claimant's medical records submitted by the carrier. He further stated that the PFTs performed by Dr. N did not meet the standards accepted by the profession for valid testing. Dr. N also testified that there was no way to say if the claimant's exposure of an unidentified gas caused COPD or aggravated pre-existing COPD. All Dr. N could generally opine that the findings and assessments contained in the NTH record dated [date of injury], revealed nothing that would explain the permanent effects now alleged as a result of the inhalation work injury.

COPD OR AGGRAVATION OF PRE-EXISTING COPD

The Appeals Panel has previously held that proof of causation must be established to a reasonable medical probability by expert evidence where the subject is so complex that a fact finder lacks the ability from common knowledge to find a causal connection. Appeals Panel Decision (APD) 022301, decided October 23, 2002. *See also* Guevara v. Ferrer, 247 S.W.3d 662 (Tex. 2007). To be probative, expert testimony

must be based on reasonable medical probability. City of Laredo v. Garza, 293 S.W.3d 625 (Tex. App.--San Antonio 2009, no pet.) citing Insurance Company of North America v. Meyers, 411 S.W.2d 710, 713 (Tex. 1966). In APD 110054, decided March 21, 2011, the Appeals Panel stated that "[a]lthough the claimed conditions are listed in the record, there is not any explanation of causation for the claimed conditions in the record. We hold that in this case the mere recitation of the claimed conditions in the medical records without attendant explanation how those conditions may be related to the compensable injury does not establish those conditions are related to the compensable injury within a reasonable degree of medical probability."

Section 408.0041(a)(3) provides that at the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about the extent of the employee's compensable injury. Section 408.0041(e) provides, in part, that the report of the designated doctor has presumptive weight unless the preponderance of the evidence is to the contrary. 28 TEX. ADMIN. CODE § 127.1(a)(3) (Rule 127.1(a)(3)) provides that [a]t the request of the insurance carrier, an injured employee, the injured employee's representative, or on its own motion, the Division may order a medical examination by a designated doctor to resolve questions about the extent of the employee's compensable injury.

Dr. T, the designated doctor appointed on extent of injury, does not provide an attendant explanation how any gas, fume or vapor caused the claimant to develop COPD or how any gas, fume or vapor aggravated a pre-existing condition of COPD. Dr. T's report is conclusory and a mere recitation of a diagnosis. Dr. T's report is not sufficient expert evidence to causally link the claimed diagnosis of COPD or aggravation of COPD to the accepted inhalation work injury of [date of injury].

A review of the other medical records in evidence (as discussed above) do not establish an attendant explanation of how COPD (or aggravation of pre-existing COPD) is causally related to the work injury of [date of injury].

Accordingly, the hearing officer's finding that the claimant's COPD arose out of and naturally flowed from the compensable injury of [date of injury], is so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust.

We reverse the hearing officer's determination that the compensable injury sustained on [date of injury], does extend to COPD and render a new decision that the compensable injury sustained on [date of injury], does not extend to COPD.

The true corporate name of the insurance carrier is **TEXAS MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

RON O. WRIGHT, PRESIDENT
6210 EAST HIGHWAY 290
AUSTIN, TEXAS 78723.

Cynthia A. Brown
Appeals Judge

CONCUR:

Thomas A. Knapp
Appeals Judge

Margaret L. Turner
Appeals Judge