APPEAL NO. 951336

This appeal is considered in accordance with the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq.* (1989 Act). A contested case hearing was held on May 24 and July 14, 1995, before (hearing officer). The two issues involving the respondent who is the claimant, were his correct impairment rating (IR), and whether he was eligible for lifetime income benefits (LIBS). The basis for the claim for LIBS was that claimant had sustained an injury to the skull resulting in incurable insanity or imbecility. Claimant had been sitting in his cement truck on _____, while employed by (employer), when it was struck by lightning. There was no indication in this record that the compensability of the injury had ever been disputed. Claimant had reached maximum medical improvement (MMI), according to the definition set forth in Section 401.011(30)(B), on July 20, 1993.

The hearing officer found that claimant had a brain injury for which he had an IR of 90% in accordance with the report of the second designated doctor, Dr. S, and that the great weight of other medical evidence was not to the contrary. He found that claimant did not have entitlement to LIBS, and had not sustained an injury to his skull. The hearing officer further found that an individual depicted on various surveillance videotapes who was engaged in activities inconsistent with the claimed injury was not the claimant.

Both parties have appealed certain portions of the hearing officer's decision. The claimant appeals the determination that claimant is not entitled to LIBS, arguing that the workers' compensation statute should be liberally construed in favor of compensability. Claimant argues that Section 408.161(a)(6) should be construed as allowing coverage for brain injuries resulting in imbecility, and that if the section is read literally there would never be lifetime benefits resulting from injuries to the skull. The carrier responds by arguing testimony from the claimant's doctor that the skull and brain are two different parts of the body, and that an injury to the brain will not always constitute an injury to the skull, or result from same. The carrier argues that the 1989 Act substantively revised the prior law on this issue.

The carrier appeals the determination of impairment, arguing that the great weight of contrary medical evidence is against a 90% IR. The carrier argues that the claimant's current condition is not related to the effects of the lightning strike, arguing that "all" of the medical evidence supports this. The carrier argues that the designated doctor was not given all of claimant's medical records to review. The carrier argues that claimant's doctor testified that he called up the designated doctor and "urged her to accept a higher impairment rating" and that this was impermissible unilateral contact. The carrier also asks that fact findings relating to the identity of persons on the videotape be reviewed. The claimant responds that the hearing officer's decision on impairment is sufficiently supported by the evidence and the treating doctor's live testimony. The claimant also asks that the carrier be sanctioned for its surveillance which it argues has served to "harass" and "disrupt" the lives of claimant's family, and that surveillance and providing tapes to doctors in the case allows a "disproportionate advantage" over claimants, and that the Appeals

Panel should protect other claimants from such activity. The claimant points out that the designated doctor had ample records to make a decision as to IR, and that any contact between the designated doctor and the treating doctor occurred after the IR report was rendered.

DECISION

We affirm.

The claimant did not testify at the hearing although he was physically present. It was established that claimant's wife, Mrs. C, was legally appointed guardian of his person and estate through the court in (county), Texas, in which proceeding claimant was adjudicated incompetent. The designated doctor in the case was Dr. S, who was appointed to serve as such after the benefit review officer (BRO) determined that the first designated doctor, Dr. L, had been subject to unilateral contact by the claimant's attorney and that such had the appearance of influence on the outcome. The claimant's treating physician was Dr. D, a neuropsychiatrist.

The hearing was lengthy, but the essential facts may be summarized briefly. Dr. D testified personally, stating that he was not being paid for his presence but that he was testifying out of his strong convictions about the case. He had been in practice for 30 years, and prior to entry into private practice had been in positions of authority in military hospitals throughout the world. Dr. D stated that since his entry into private practice in the late '70s, he had seen approximately 100,000 patients. He stated that his forensic experience in approximately 50 cases had been both for plaintiffs and defendants. Dr. D began treating claimant on December 14, 1992. He agreed that he would have no personal knowledge of what had occurred prior to that other than what Mrs. C told him, and what was indicated in claimant's medical records. He indicated his belief that claimant's truck had been struck by lightning while claimant, who was driving, had his left arm resting on the door of the truck with the window open[1], and that he considered that claimant had sustained an electrocution injury which caused portions of his brain to die. He agreed that while such things as drug abuse, a blow to the head, or stroke could cause some of the same symptoms, there had been no evidence in his 2 years of treating claimant of any of these alternatives.

Dr. D testified that claimant had incurable imbecility. He stated that, while he would have expected that such symptoms as claimant demonstrated would have begun shortly after the injury, his consultation with Dr. L, a neurologist, indicated that a progressive deterioration was not inconsistent with the literature on lightning strike survivors. Dr. D indicated that the knowledge of the aftereffects of lightning strikes was somewhat limited due to a limited number of survivors.

[1]While there are some references in the record to the fact that some witnesses thought that claimant's elbow may have been struck, Dr. D testified that his examination revealed no entry or exit burns on claimant's body and it was his belief that the truck in which claimant had been seated was the point of contact.

Dr. D stated that claimant's SPECT scan was reported as abnormal. He indicated that an MRI may, or may not, indicate an injury to the "skull." Dr. D stated that he had been contacted by the adjustor for the carrier, and that she expressed her conviction that claimant was malingering. Dr. D stated that she would have his fullest cooperation if it turned out that claimant was malingering. Dr. D said he reviewed videotapes that were purportedly made by the carrier of claimant's activities; with the exception of a brief sequence on one of the tapes, Dr. D stated that the person on the videotapes was not his patient. He stated that he believed the person to be claimant's brother Mr. R, based upon photographs produced by Mrs. C. Dr. D agreed he had never met Mr. R. Dr. D stated that he had had experience with malingering in the course of his practice and it was his opinion, forcefully expressed, that claimant was not faking. Dr. D stated that he had observed claimant and his wife at times when they would not have been aware that he was around (such as in the parking garage) and did not observe any behavior inconsistent with claimant's condition. He stated that claimant had not been referred by his attorney and that he had never worked with claimant's attorney before, and had only talked to him four times prior to the CCH.

Dr. D agreed that he had sent records to Dr. L, the first designated doctor, and was unsure about what records he sent to Dr. S, although he recalled that he had sent some. A letter directing the treating doctor to forward records to Dr. S had been misdirected to his wife, who was not a doctor, but had come to his office. Dr. D stated that he had talked with Dr. S after he had received a copy of a report from the carrier's doctor, Dr. JD, which assessed a zero percent IR for claimant. He stated that this was after Dr. S had rendered her report, and that the content of the conversation was his disagreement with Dr. JD's assessment.

Dr. D was unequivocal in his testimony that the skull and brain were two different body parts. He stated that the skull was part of the skeletal system. He agreed that he had found no evidence of an injury to the skull, although he speculated that a PET scan that claimant was scheduled to have in the future would likely show some damage to the inner lining of the skull. Dr. D stated that it was possible to injure the skull without injuring the brain, and it was also possible to injure the brain without injuring the skull. His opinion was that claimant had organically caused psychosis, not solely emotional in origin. He derived his opinion that claimant had an organic brain injury from the lightning strike, which he stated was based upon reasonable medical probability, from the abnormal SPECT test, his examinations and treatment of claimant in 100-125 sessions, and the lack of any evidence of a cause other than the lightning strike. Dr. D stated that claimant had a 100% IR, and that he based this upon the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides).

There was general evidence that Dr. D had prescribed some medications that could

have adverse side effects. There was evidence that claimant had to have blood tests to monitor the effects of a drug called Clozapine, which he was no longer taking by the time of the CCH. There was no evidence developed that claimant had suffered adverse side effects of drugs prescribed.

Mrs. C testified. She stated that, the day of the lightning strike, claimant was leaning to the left and his mouth was drooping to the left side. She stated that, while he could talk, she could not fully follow his conversation. Mrs. C stated that claimant had been normal in every respect prior to this. He had been a truck driver who had worked continuously and was often on the road 18 hours a day, but did not work after the day he was injured. She said that he became progressively worse and had stopped talking to her entirely. She stated that he required 24-hour care, that while he could walk around, and would occasionally turn on the water, he needed assistance with eating, dressing, and personal hygiene. Mrs. C said she had not worked prior to claimant's accident but had had to do so since, and that her sister, Ms. R, who was the wife of claimant's brother, Mr. R, had cared for claimant. Mrs. C agreed that claimant had on occasion walked around the neighborhood, either with family members or alone, but that she had installed locks on the doors to prevent him from wandering off. She stated that her husband did not recognize her or their two minor children who were still living at home.

Ms. R testified that she and her husband had lived off and on with claimant and his wife since the accident. Ms. R contended that Mr. R had left in early 1995 and she did not know his whereabouts. She also identified the videotapes as showing her husband, as opposed to claimant, engaged in various activities that could be characterized as normal.

Considerable testimony and argument was devoted to the identity of persons depicted in still photographs and a series of surveillance videotapes. The still photographs show that claimant and Mr. R resemble each other. The testimony and written statements from claimant's first wife and oldest son are either inconclusive (with the statement of claimant's first wife stating for several tapes that she was not sure), or conflicting, about the identity of the men who were videotaped. The owner of the investigative service testified that he had personally observed claimant acting normally while walking to a bakery with a younger woman, and then seeking assistance from his wife while going to the doctor. The record indicated that Mr. R had not shown up for two scheduled depositions[2] at a time when he was living in the area. Although carrier attempted to subpoena Mr. R through the private investigator, service was not accomplished prior to Mr. R's departure.

Below is a brief summary of medical documents in the case; several of the records recite at length the history of claimant's accident and functional decline, which will not be repeated unless pertinent. Likewise, Dr. D's records and letters are consistent with his testimony and will not be summarized here.

[2]Carrier's attorney argued that claimant's attorney had agreed to produce Mr. R for deposition. Claimant's attorney stated that he had agreed only to the depositions but not to produce Mr. R. A prehearing order signed by another hearing officer indicated that the parties had agreed to cooperate in the taking of depositions.

- During July and August 1991, claimant was treated six times by either a hospital or clinic associated with H Hospital, for electric shock, and on August 14, 1991, he was put on light duty. Thereafter, claimant received pain management therapy.

- February 2, 1992, Ms. M, documented that claimant has been treating with her clinic since November 1991, and manifested significant cognitive impairment.

- June 22, 1992, Dr. HO, a neuropsychologist, stated that, while the possibility of malingering could not be ruled out, claimant's symptoms appeared to go beyond malingering. He concluded that claimant had a psychotic, as opposed to neurological, problem.

- July 30, 1992, at the request of the carrier, Dr. J reviewed claimant's records, but did not personally examine claimant. He concluded that claimant had major depression with psychotic features. While he noted there was the possibility that the condition existed prior to claimant's lightning strike, he said that the accident brought the condition to claimant's attention.

- August 3, 1992, Dr. M, a neuropsychologist, examined claimant, documented confusion, suspicion, lack of verbal response, and disorientation. Dr. M opined that claimant had sustained severe organic impairment due to the lightning strike.

- November and December 1992, Dr. P, clinical psychologist, to whom claimant was referred by Dr. H, opined that claimant's medical, mental, and emotional problems were directly attributable to the lightning strike. Dr. P referred claimant to Dr. D.

- December 30, 1993, Dr. L, a neurologist, opined that claimant had a progressive neurological disorder ancillary to the lightning strike.

- December 30, 1993, a Brain SPECT scan conducted at D Hospital was reported by Dr. G as showing areas of "decreased uptake" more prominent on left than right, reflecting decrease in metabolic activity. Dr. G indicated that this and other conditions were likely related to the electric shock.

- October 31, 1994, Dr. JD, whose specialty is occupational medicine, wrote the adjuster a letter reciting studies on the accuracy and utility

of SPECT scans. She questioned the probative value of the claimant's abnormal SPECT results. She noted that certain types of drug abuse could cause abnormalities in a SPECT scan.

- November 7, 1994, Dr. JD examined claimant pursuant to an independent medical examination on behalf of the carrier. Dr. JD assessed that claimant had a psychotic or organic brain syndrome versus a personality disorder.

- November 17, 1994, Dr. S examined claimant and certified that claimant had a 90% IR. Her impression was lightning injury with probable electric shock, psychotic depression, and severe functional compromise secondary to this. Her recitation of claimant's history indicated that he was seen in hospital emergency rooms twice in the week following the accident complaining of weakness, nausea, pain on the left side, and shaking. She commented that claimant had a normal MRI on May 13, 1992. She commented that he had a normal SPECT scan.[3] The report is extensive and fully recounts limitations both reported to her by Mrs. C and observed by Dr. S. Dr. S stated that she would tend to believe that claimant's condition was not purely psychiatric, and that she would tend to consider his findings as more indicative of a neurological disorder.

- January 10, 1995, Dr. JD certified that claimant had a zero percent IR from his organic brain syndrome. Her basis for doing so is "based on the history of his presentation, I find no evidence that his current problems are due to the incident where the patient's truck was struck by lightning." Dr. JD indicated she had reviewed videotapes and that "if indeed" the person in the video was claimant, than there would appear to be a fictitious component to his complaints. A drug screen run at her request tested negative for various types of drugs commonly associated with drug abuse, such as marijuana, barbiturates, cocaine, methadone, and alcohol.

- March 10, 1995, Dr. S reviewed additional evidence, including additional laboratory findings and the opinion of Dr. JD. She stated that she had treated many patients with brain injury and negative diagnostic imaging studies were not unusual. She did not believe the SPECT scan to be significant. She stated that she had reviewed videotapes which did not change her assessment because she was

[3] Dr. D testified that he believed that this could be a typographical error in Dr. S's report, because the report of the SPECT scan clearly indicated it was abnormal. He said that general practice would be to review the report, and not the scan itself.

> not able to identify the individual depicted thereon as the claimant. She indicated that her IR was based upon a functional assessment and that whether the source of claimant's functions was psychiatric or neurological was essentially a moot point.

WHETHER CLAIMANT IS ENTITLED TO LIFETIME INCOME BENEFITS

As there was no evidence that claimant sustained a blow to his skull, or any injury to the skull that had been identified by the time of the CCH, whether claimant is eligible for LIBS is based solely upon the legal interpretation of Section 408.161. Claimant argues that the doctrine of liberal interpretation of the workers' compensation law confers eligibility; however, it is well settled that the doctrine of liberal interpretation cannot be applied where the law is expressed in plain and unambiguous statutory language. Second Injury Fund v. Keaton, 345 S.W.2d 711 (Tex. 1961); Employers Casualty Co. v. Texas Attorney General, 878 S.W.2d 1994 (Tex. App.-Corpus Christi 1994, no writ); Texas Employers' Insurance Ass'n v. Leake, 196 S.W.2d 842, 844 (Tex. Civ. App.-Fort Worth 1946, no writ).

As applicable to this claim, Section 408.161(a)(6) provides that LIBS are payable for "an injury to the skull resulting in incurable insanity or imbecility." We further note that this section also provides for coverage of permanent and complete paralysis affecting members described in the statute if the condition results from "an injury to the spine". Section 408.161(a)(5).

The same language was included (since 1927) in the prior workers' compensation statute, at Art. 8306, § 11a (Vernon's 1967), repealed, which listed conditions that would be conclusively held to be total and permanent incapacity for paying benefits as then existed. However, that statute also contained the provision:

> The above enumeration is not to be taken as exclusive but in all other cases the burden of proof shall be on the claimant to prove that his injuries have resulted in permanent, total incapacity.

When the 1989 Act was enacted, and the system of benefits replaced by temporary income benefits (TIBS), impairment income benefits (IIBS), and supplemental income benefits (SIBS), the "not exclusive" clause above was omitted. The statute providing for payment of the benefit called "lifetime" income benefits, Article 8308-4.31(d), included the conditions which had been previously enumerated in Art. 8306, § 11a, but further provided:

> In no other case may the period of income benefits be greater than 401 weeks from the date of injury.

While this clause was not expressly included in the recodification of the 1989 Act into the Labor Code, the recodification cannot be interpreted as a substantive change in the 1989 Act.

Neither party has cited cases, and we could find none in Texas, where the term "skull" has been construed to mean the head in general or to include the brain. TEXAS GOV'T CODE ANN. § 311.011 provides:

> (a) words and phrases shall be read in context and construed according to the rules of grammar and common usage.
>
> (b) words and phrases that have acquired a technical or particular meaning, whether by legislative definition or otherwise, shall be construed accordingly.

While there may be good policy reasons why the Legislature should extend LIBS coverage to all incurable brain injuries, (or, for that matter, all forms of complete paralysis), which have their genesis in the work place, we believe that a plain, or even a technical, and medical, interpretation of the statutory language indicates that only insanity or imbecility resulting from an injury which also involves the skull is currently eligible for LIBS. We note in this regard not only the testimony of Dr. D, but the definition of "skull" contained in DORLAND'S ILLUSTRATED MEDICAL DICTIONARY (28th ed. 1994):

> The bony framework of the head, composed of the cranial bones and bones of the face.

Section 408.161 does not include all organic or psychological brain injuries, nor is imbecility or insanity resulting from causes other than injury involving the skull within its terms. While the Legislature could have extended LIBS to brain injuries in general, or imbecility and insanity caused by environmental toxins, or by work-induced stroke, when the previous workers' compensation act was overhauled, it did not do so. Given the express omission of language previously providing that the list was not exclusive, and the incorporation of language indicating that the list will be exclusive, we are constrained from reading into the statute ambiguity where it does not exist.

We therefore affirm the hearing officer's holding that claimant is not entitled to LIBS.

WHETHER THE HEARING OFFICER ERRED IN GIVING PRESUMPTIVE WEIGHT TO THE DESIGNATED DOCTOR'S REPORT

At various times during the CCH, it appeared that the theory of defense was not based solely upon a dispute over the extent of IR for claimant's brain injury, but an assertion that a compensable brain injury had either not occurred or that the sole cause of such was something other than the lightning strike. We have before noted that belated disputes as to compensability or extent of an injury should be raised well before the parties seek to resolve IR or MMI. Texas Workers' Compensation Commission Appeal No. 950330, decided April 17, 1995. Carrier's alternative theory of defense, that claimant had embarked upon a four-year ruse, apparently carried even into the county court of Hays County, was not credited by the hearing officer, whose determination as trier of fact on this matter is sufficiently supported by the record.

The report of a Commission-appointed designated doctor is given presumptive weight. Sections 408.122(b) and 408.125(e). The amount of evidence needed to overcome the presumption, a "great weight," is more than a preponderance, which would be only greater than 50%. *See* Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992. Medical evidence, not lay testimony, is the evidence required to overcome the designated doctor's report. Texas Workers' Compensation Commission Appeal No. 92164, decided June 5, 1992. We cannot agree with the carrier that the great weight of the medical evidence is against Dr. S's report, or that the report is not based upon objective indicia of impairment. Given essentially unanimous medical opinion that claimant had an organic or neurological brain syndrome (evidenced in the reports of Dr. JD and Dr. S as well as Dr. D), and the documented progression of claimant's symptomatology in the medical records, beginning the week after the lightning strike, the hearing officer's agreement that claimant had a ratable impairment is sufficiently supported. We further note that the evidence establishes the causal link of claimant's condition to the lightning strike. We would note that, evidence for the carrier from Dr. J, arguing that the matter was emotional rather than organic, identified the electric shock as the likely triggering event.

We would further note that although considerable time during the CCH was devoted to arguments over the videotapes, these do not constitute medical evidence, standing alone, even if they had been believed to depict the claimant.

However, we decline to issue the advisory against surveillance requested by the claimant in its response. We note that a previous hearing officer had declined to issue a protective order, which was not appealed by the claimant. We cannot agree that surveillance activities are per se outside the realm of legitimate defense of a claim. To the extent that either party to a specific claim engages in abuse of discovery, those are matters that must either be specifically appealed where error results or addressed through the

Division of Compliance and Practices when an administrative violation may have occurred. The rejection by the hearing officer of the videotapes as persuasive in this case, within his discretion as the sole judge of the weight and credibility of the evidence, appears to be sanction enough in the hearings process.

Finally, concerning the technical arguments raised against Dr. S's report, there is no evidence that she lacked records necessary to her decision on IR. We cannot agree that Dr. D's input, as a treating doctor, to the designated doctor would fall within the ambit of a "unilateral contact" about which we have expressed concern in past decisions. The carrier's characterization in its appeal of Dr. D's testimony as indicating that he sought to influence Dr. S to render a higher IR is not supported by the record.

We affirm the hearing officer's decision and order.

Susan M. Kelley
Appeals Judge

CONCUR:

Philip F. O'Neill
Appeals Judge

Tommy W. Lueders
Appeals Judge