File Number:
HR10-D-H

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

JUL 13 2010

Date of Injury:
Employee:

RECEIVED JUL 15 2010

Dear Mr. :

This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A hearing was held on 04/19/2010. As a result of such hearing, it has been determined that the decision issued by the District Office should be vacated and the case remanded to the district office for further action as explained in the enclosed copy of the Hearing Representative's Decision.

Your case file has been returned to the Jacksonville District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300

Sincerely,

Carol E. Adams
Hearing Representative

PAUL H FELSER, ESQ.
FELSER LAW FIRM, P.C.
PO BOX 10267
SAVANNAH, GA 31412

U.S. DEPARTMENT OF LABOR

Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U.S. Code 8101 et. seq. of Claimant; Employed by the ; Case number . A hearing was held on April 19, 2010.

The issue for determination is whether the claimant has established he was unable to work for more than four hours a day beginning on October 5, 2009, as the result of his work injury of

is employed as a maintenance supervisor for the . He filed a traumatic claim of injury, alleging he injured his head, shoulder and lower back when a conveyor fell off a pallet jack and hit his head, knocking him into another conveyor, pinning him. His claim was accepted for contusions of face, scalp and neck; cervicocranial syndrome and sprain of the thoracic region. On April 13, 2006, cervical and thoracic subluxations were later added to the accepted conditions.

The claimant lost time from work after the injury. The claimant was offered a modified duty job effective March 18, 2006, working fours hours a day from 7:00 a.m. to 11:00 a.m. The claimant accepted the position on March 13, 2006.

Later, the claimant filed claims for total disability beginning in October 2007. The Office on May 23, 2008, called the employing agency to ascertain whether the claimant ever returned to work more than four hours a day since the injury. The employer stated that since the claimant was a supervisor he was on automatic pay where he received pay for eight hours even though he was only working four hours. The employer stated that this was why the claimant had not filed previous claims for compensation. She noted that she expected that the claimant would file for compensation once his automatic pay dropped to half. The employer noted that they were going to recommend that the claimant file a new occupational claim for aggravation of his condition in conjunction with his total wage loss claims beginning in October of 2007.

The Office, after development of the case for wage loss beginning on October 1, 2007, by decision dated February 26, 2008, denied compensation. The claimant never filed an appeal of that decision.

Also, the claimant filed a new occupational claim under case number , which was denied by decision dated November 24, 2008.

In the instant case, on November 10, 2009, the Office received claims for compensation for four hours of wage loss a day, which covered the period from October 5, 2009, and ended on October 30, 2009.

The Office determined there was insufficient evidence to support the payment of compensation for the period. Therefore, by development letter dated November 16, 2009, the claimant was requested to submit additional evidence to support that he was unable to work more than four hours a day as the result of his work injury.

The Office determined that insufficient evidence was received to support the claims. Therefore, by decision dated December 18, 2009, the Office denied the claims for compensation. The claimant disagreed with the decision and, through his attorney, requested a hearing with an OWCP hearing representative.

A hearing was held on April 19, 2010. The claimant was represented at hearing by attorney Paul Felser. Mr. Felser requested that thirty days be granted for additional evidence to be provided. The request was granted.

The employing agency was sent a copy of the transcript and afforded twenty days to submit comment or evidence. No additional information was received, and all time allotted for this purposed has now past.

A review of the evidence of record indicates the claimant has never been paid compensation for wage loss in the instant case.

I have completed a thorough review of the claimant's records. The following is an abbreviated history of the medical treatment the claimant has received. The history is as follows:

- , the claimant received medical treatment at the emergency department at . The claimant gave a history of the injury of one in which he was struck on the head by a conveyor belt and pinned against another conveyor belt. He denied that he lost consciousness. He did indicate he fell and hit his head.

  The claimant was initially diagnosed with closed head injury, scalp laceration, blunt abdominal trauma and back hematoma.

  A CT scan with contrast was done of the head, thoracic spine, lumbar spine, abdomen and pelvis. The spine CT showed degenerative changes of the lumbar and thoracic spine and bilateral pars defect at the L5-S1. Also Grade I spondylolisthesis was present. The head was normal except for soft tissue swelling over the left frontoparietal region. No organ or bowel injury was noted of the abdomen.

  Also PA lateral chest x-rays were performed and no fractures were noted.

Also, a pelvis x-ray was performed and an irregularity along the right margin of the pubic symphysis was found but no discrete cortical break was demonstrated and the symphyseal interval was normal. No additional fractures or evidence of dislocation was seen. The pelvis finding was not felt to represent a fracture but correlation with clinic examination was requested.

The claimant was referred to Dr. and was advised not to return to work until cleared by him.

- Dr. saw the claimant on November 14, 2005, and referred the claimant to a chiropractor for treatment of the cervical sprain.

On November 28, 2005, Dr. diagnosed healing rib fractures, dizziness and disassociation feelings.

Because of anxiety and depression Dr. on December 12, 2005, referred the claimant to Dr. , a licensed psychologist.

Dr. referred the claimant to Dr. an ENT doctor for the dizziness.

Dr. referred the claimant to a , neurologist for evaluation of the dizziness as well.

By letter dated February 15, 2006, Dr. responded to a letter from the claimant's employer, advising the employer that he had treated the claimant's rib fractures and had coordinated the claimant's care. He advised that the rib fractures were completely healed. He deferred to the neurologist and psychologist who were seeing the claimant for opinions, regarding the closed head injury, postconcussive syndrome, cervical cranial syndrome and dizziness. He advised that the claimant did not have any limitations from the rib fractures.

The claimant continued in Dr. care

- The claimant was treated for cervical, thoracic and lumbar strains by D.C. beginning on November 16, 2005. Spinal x-rays were taken on that date.

March 6, 2006, Dr. has the November 16, 2005, x-rays read by chiropractor Dr. and makes diagnoses of subluxations of the thoracic and cervical spine.

- The claimant was first treated by Dr. on December 20, 2005. The doctor's initial impression was that of post concussive and post traumatic symptomology.

On March 9, 2006, Dr. released the claimant to work four hours a day with no supervisory work, increasing to regular work in eight weeks.

May 12, 2006, Dr. indicates claimant was having memory problems at work unless his work was routine and repetitious.

- Dr. saw the claimant on January 5, 2006, and diagnosed benign paroxysmal positional vertigo, right.

- Dr. first saw the claimant on January 23, 2006, and ordered an EEG. The doctor diagnosed post concussive syndrome and probable benign positional vertigo

  The EEG was performed on February 17, 2006, and it was found to be normal.

  On March 1, 2006, reviewed the EEG and diagnosed post-concussive syndrome and vertigo. He released the claimant to work, pending Dr. psychological evaluation.

- May 8, 2006, CT scan was done and spondylosis and osteoarthritis of the cervical spine was found.

- On May 22, 2006, Dr. took over the claimant's care. He ordered home traction, facet blocks and physical therapy.

  On June 1, 2006, Dr. released the claimant to four hours light work.

  On July 10, 2006, the doctor increased the claimant's work to five hours a day. The doctor recommended that cervical spondylosis and cervical degenerative discs should be added to the workers' compensation's accepted conditions.

  September 8, 2006, the doctor recommended the claimant continue with the chiropractor treatment.

  January 18, 2007, the claimant indicated to the doctor he could not work because of pain in the occipital region radiating to the right side of his head.

  January 31, 2007, the doctor diagnosed bilateral occipital nerve blocks and reduced the claimant's work hours to four hours a day.

  February 14, 2007, the doctor, in response to a letter, stated the work-related conditions were occipital neuralgia, cervical spondylosis, cervical degenerative disc disease (DDD). The doctor recommended an implant percutaneous stimulator for pain, pending psychological evaluation.

  June 26, 2007, the doctor ordered Cymbalta for depression and ordered an MRI of the spine. MRI was completed on July 10, 2007, and cervical spondylosis and stenosis and thoracic spondylosis were found.

  August 7, 2007, the claimant had a severe flare of pain.

October 1, 2007, Dr. referred the claimant to Dr. for consideration of surgery. The claimant was held off work.

January 22, 2008, Dr. released the claimant to sedentary work four hours a day.

Dr. orders a new MRI, which was performed on March 3, 2009, and it was found to be the same as the July 10, 2007, MRI.

On March 12, 2009, the doctor indicated the claimant had neuropathy in his arms. The doctor recommended acupuncture.

In response to Attorney Felser's letter, by letter dated December 31, 2009, Dr. states as follows: "I am in receipt of your letter dated December 17, 2009, regarding Mr. . Per my statement, Mr. symptoms did improve when he was taken out of work substantiating the fact that his work activities at that time were aggravating his preexisting work comp injury. In correspondence dated July 7, 2009, I indicated that Mr. previously attempted increasing his hours of work unsuccessfully. Mr. is capable of working four hours per day. His current disability is due to his injury on November 2, 2005. If I can be of any further assistance, please do not hesitate to contact this office....."

Dr. continues, to the present, to treat the claimant and to restrict the claimant to working sedentary work for fours a day.

- December 10, 2007, the claimant was seen by and he indicated that the claimant could possibly need a fusion at C4-C7.

- December 14, 2007, the case was referred to the District Medical Advisor (DMA) for concurrence with the recommended surgery. The DMA noted there was insufficient evidence to support the surgery. The DMA did not approve the surgery.

The record shows that new medical evidence was received from Dr. after the hearing. In response to Attorney Felser's letter, Dr. by letter, dated May 7, 2010, states as follows:

I am in receipt of your letter dated May 3, 2010 concerning on [sic] our mutual patient Mr. . There seems to been some misinterpretation by the Department of Labor and Mr. ability to work and his diagnosis. I have been providing care for Mr. since 5/22/2006 for a work related injury which occurred on or about 11/7/2005. He has been treated for chronic intractable neck pain. His initial diagnoses from his initial evaluation included cervical degenerative disc disease, cervical spondylosis, cervicobrachial syndrome. I have had him on restricted duties of 4 hours per day, 20 hours per week.

> When Dr. initially saw this patient on 4/21/2006 patient had complaints of neck pain radiating to the base of his skull and tingling into his right arm. Cervicocranial syndrome means neck pain and headache. Cervicobrachial syndrome means neck pain with arm pain. Dr. and I are talking about the same thing. The fact that [there is a] slightly different diagnoses is irrelevant.
>
> His MRI of C-spine from 5/8/2006 gave a history of cervical radiculopathy and had finding including cervical spondylosis, retrothesis of C3 with respect to C4 and C5. I did order a contemporary MRI of Mr. cervical spine in March 2010, which was compared to the original study of July 10, 2007.
>
> There has been no substantial change in his condition since I first saw him. He continues to be treated for chronic intractable neck pain which was resultant from his work injury. His work restrictions continue to be based on his complaints of chronic neck pain as a result of his work injury. There are no new injuries.

The test of disability under the FECA is whether an employment-related impairment prevents the employee from earning the wages he or she earned when injured.[1] The Board has held that the claimant, for each period of disability claimed, has the burden of proving by the preponderance of the reliable, probative and substantial evidence that he or she is disabled for work as a result of his or her employment injury. Whether a particular injury causes an employee to be disabled for employment and the duration of that disability are medical issues which must be proved by a preponderance of the reliable, probative and substantial medical evidence.[2] The Board has also long held that proceedings under the Federal Employees' Compensation Act are not adversary in nature, nor is the Office a disinterested arbiter.[3] While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[4]

The claimant has had on going treatment since his work injury, and I find that although Dr. does not provide sufficient reasoning to accept the additional conditions he has diagnosed as causing disability, he has provided a statement on causality sufficient to support *prima facie*. He stated that the claimant's spondylosis, cervical DDD and resulting neck pain are due to the work injury sufficient to warrant further development. Also, it appears that it is these conditions that are preventing the claimant from working no more than four hours a day.

After review of the evidence, I find, although the decision of the office was correct, that the claimant has submitted sufficient new *prima facie* evidence in combination with the evidence on record to warrant further development. Once an employee has made a *prima facie* case, *i.e.*,

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[1] *Gewin C. Hawkins*, 52 ECAB 242 (2001).

[2] *Fereidoon Kharabi*, 52 ECAB 291 (2001).

[3] *Vanessa Young*, 55 ECAB 575 (2004).

[4] *Richard E. Simpson*, 55 ECAB 490 (2004).

when he or she has submitted evidence supporting the essential elements of the claim, including evidence of causal relationship, the Office has the responsibility to take the next step.[5]

On remand the Office should prepare a Statement of Accepted Facts and along with a complete copy of the medical records refer the claimant for a second opinion evaluation. The doctor should be asked as to whether the claimant's cervical and thoracic spondylosis, cervical degenerative disease and resulting neck pain are medically connected to the work injury by way of aggravation, acceleration or direct cause. The doctor should provide detailed reasoning for his opinion. If the doctor finds that a pre-existing condition was aggravated he or she should be asked to provide his opinion as to whether the aggravation was permanent or temporary. Again, he or she should be asked to provide reasoning for his or her opinion.

After completion of the above development and after any other development the Office deems necessary, a new decision should be issued.

In accordance with the above findings, the decision of the Office dated December 18, 2009, is set aside and the case **remanded** for further development.

JUL 13 2010

Dated:

Washington, D.C.

Carol Adams
Hearing Representative
for
Director, Office of Workers'
Compensation Programs

[5] *Linda L. Newbrough,* 52 ECAB 323 (2001).