File Number:
HR13-D-H

RECEIVED OCT 1 3 2014

U.S. DEPARTMENT OF LABOR

OCT - 8 2014

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

Date of Injury:
Employee:

Dear

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 preliminary review was completed on the case. Based upon that review, it has been determined that the decision of the District Office should be reversed as outlined in the attached 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,

David Cattani
Hearing Representative

DEPARTMENT OF THE AIR FORCE
WARNER ROBINS, GA-WRAMA
HQ AFPC/DPIEPC
500 C STREET WEST, SUITE 57 M/S 667
RANDOLPH AFB, TX 78150

PAUL H FELSER
FELSER LAW FIRM
POST OFFICE BOX 10267
SAVANNAH, GA 31412

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

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 Air Force, Warner Robins, Georgia, case file number

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Merit consideration of the case file was completed on October 3, 2014. Based on the review, the decision of the district office dated March 5, 2014 is reversed for the reasons set forth below.

The issue is whether or not the office appropriately terminated compensation and medical benefits by decision dated March 5, 2014.

born is employed as a the suffered a traumatic injury in the performance of his duties on when he fell from the bed of a truck while moving a large printer. Mr. stopped work on the date of injury and has not returned.

Mr has treated with physical medicine and rehabilitation specialist MD since primarily for neck symptoms. Mr. has treated with orthopedic surgeon MD primarily for low back symptoms since February 29, 2012.[1] X-rays taken on February 10, 2012 indicated mild compression fractures at thoracic spine levels T10, T11, and T12 (ICD-9 code 805.2), but ruled out any acute fractures. Cervical and thoracolumbar neuritis were diagnosed by exam. By letter dated March 7, 2012 the claim was allowed for closed, non-displaced fracture at C2 (ICD-9 code 805 02), cervical neuritis and thoracolumbar neuritis. I note that there was no evidence in file supporting a cervical fracture, nor any evidence linking the thoracic compression fractures to the work incident. Mr. continued with severe pain complaints over the next year.

On Since June 19, 2012 Dr. has consistently found no cervical tenderness, atrophy, instability or malalignment. Range of motion has also been normal. He has consistently diagnosed only lumbar disc disease and thoracolumbar neuritis.

On December 3, 2012 Dr. wrote the office, recalling the history of injury, and requesting expansion of the claim to include the lumbar disc pathology. On

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[1] These physicians practice together

January 10, 2013 the Office expanded the claim to include lumbar degenerative disc disease secondary to the fall. Dr. requested approval for a lumbar fusion procedure. The Office forwarded the medical record to the District Medical Advisor (DMA) for review on January 28, 2013.

On January 30, 2013 the Office also referred the claimant for a second opinion exam with a board certified orthopedic surgeon, to address the question of the surgery authorization. On the date of the referral, the scheduling contractor arranged for an exam with MD on

In his reply of February 4, 2013 the DMA noted that the claimant was experiencing pain in both legs, with diminished motor strength The lumbar MRI interpretation revealed a disc at L5-S1, with foraminal protrusion. Based on these findings, the pathology was related to the work accident, and the procedure should be authorized. The Office issued approval for the lumbar fusion on February 11, 2013, without waiting for the report from Dr. The procedure was scheduled for March 25, 2013.

Dr. report was received by the Office on February 28, 2013. He noted review of the Statement of Accepted Facts (SOAF) and the medical record. He noted an accurate history of injury, with no return to work since the fall. Continued neck pain and low back pain were reported. Dr was aware of the planned surgery. He reviewed the MRI interpretations from February 2012, noting degenerative changes on both studies Dr. noted that the cervical study did not support a diagnosis of fracture at C2. The lumbar study did not reveal any clinically significant pathology, just age related changes.

His exam found exaggerated and non-anatomical responses to gait performance, axial loading of the shoulders, light touch of the lumbar region, and prone knee flexion. Evidence of carpal tunnel syndrome (CTS) of the right wrist was found Reflexes in all extremities were intact, as was strength. Dr found that the CTS was unrelated to the fall He opined that there was no evidence of a cervical fracture, nor any evidence of brachial or thoracolumbar neuritis. He further opined that the MRI findings were consistent with age related mild degenerative disc disease, and that this condition was not aggravated by the work injury. He very strongly opined that the proposed surgery was contraindicated based on the malingering demonstrated on exam. He found no evidence to suggest that the subjective symptoms would be improved with the proposed surgery. He closed by stating that the symptom magnification was intentional, and opined that the patient was capable of performing the regular duties of a logistics manager [2]

[2] I note that the January 30, 2013 Statement of Accepted Facts described the physical requirements of the position in minimal detail, as taken directly from the employer's position description

In spite of the opinion of Dr. , the Office did not revisit the authorization of the pending lumbar surgery. Mr. underwent the lumbar fusion on March 25, 2013, as performed by Dr. The operative report offered, "The patient is aware of his underlying condition with the thoracolumbar junction not being connected to his work, after failing conservative care as it pertains to the L5-S1 levels."

On May 1, 2013 MD reported severe neck pain. On May 8, 2013 Dr updated his diagnosis to reflect Post Laminectomy Syndrome in the lumbar spine.

On August 7, 2013 the Office declared a conflict in medical opinion between Drs. and regarding the continuation of the accepted conditions and the resultant need for work restrictions. An exam was arranged with board certified orthopedic surgeon MD on September 23, 2013. The Office continued to solicit opinion on whether a cervical fracture remained active. No opinion was solicited on whether the lumbar degenerative condition was related directly or by aggravation to the work fall. No opinion was solicited on whether the thoracic compression fractures were related to the fall

Dr. related the history of the fall at work on February 8, 2012, with onset of neck and back pain. Prior neck or back pain was denied. Dr. noted that x-rays administered on February 10, 2012 revealed no acute anomaly. The subsequent MRI studies revealed a small disc protrusion at L5-S1, effacing the foramin on the left. No sign of anv acute compression fracture at T10, T11,, or T12 was in evidence. Dr noted multilevel lumbar disc disease, and multilevel cervical spondylosis with stenosis. Dr noted the opinion against surgery offered by Dr and the subsequent procedure in spite of that opinion. Despite operative intervention, Mr. had not returned to any form of work, and continued to complain of neck and arm pain, with bilateral weakness, periscapular pain, and lumbar pain radiating to both legs. A repeat MRI of the cervical region was performed on September 12, 2013, which showed moderate cervical spine degeneration. Dr. recorded a detailed exam of the limbs and spine. He diagnosed cervicalgia, cervical spondylosis, lumbago, lumbar pain syndrome, and lumbar spondylosis with myelopathy, as well as CTS.

Dr. opined that the cervical fracture had resolved. He opined that the cervical neuritis had resolved, as there was no evidence of the condition on exam. He found the CTS to be unrelated to the fall. He further offered that the cervical spondylosis was unrelated. He found no evidence of ongoing thoracolumbar neuritis. He found that the current low back symptoms were related to the authorized surgery in combination with the age related lumbar disc disease. He opined that the cervical and lumbar disc disease was unrelated to the work accident, noting that the recent cervical MRI showed progression since February 2012. He acknowledged that no specific physical requirements of the

date of injury position were provided, and opined that given the recent surgery work should not exceed medium demand He recommended work hardening, and discouraged any further surgical interventions.

On January 24, 2014 the Office proposed to terminate all compensation and medical benefits, based on the reports of Dr. The Office noted that a conflict had been declared between Drs. and . No mention of the surgery or any residuals of the surgery was made. The Office assigned the weight of evidence to Dr. again noting that the cervical fracture had resolved The Office noted that Dr found that the lumbar disc disease was unrelated to the work injury, and that the patient could return to their customary duties.

On February 23, 2014 attorney Paul Felser noted that the Office had authorized the lumbar fusion. He argued tat Dr exceeded the scope of his authority in opining that the lumbar pathology was unrelated to the work accident, as the Office had previously accepted such a relationship. Mr. Felser also noted that no rationale supported Dr opinion that the condition was comorbid. He further pointed out that referee examiner found that ongoing symptoms were related to the approved surgery, in part, and in part to the degenerative condition itself. Despite a recommendation for occupational rehabilitation services, he released the patient to regular work duties. He argued that such a statement was contradictory. He further argued that Dr. did not demonstrate how the underlying conditions were found to be unrelated to the work accident, either by causation or aggravation

The Office denied entitlement to ongoing compensation for medical expenses and wage loss by decision dated March 5, 2014. While the Office acknowledged receipt of the letter from Mr. Felser, no real consideration was given to any of the arguments raised therein The claimant appealed the decision of March 5, 2014, and requested a hearing.

Based upon my review of the evidence and testimony of record, I find that the decision of March 5, 2014 must be reversed.

I note that the Office was advised that thoracic compression fractures were evident on x-ray films There remains no medical opinion on file that these fractures were acute, or that they were related to the fall, or symptom productive. In spite of this, the Office accepted the fractures as work related. However, in inputting the diagnostic code into the system, the Office miskeyed the code and the resultant acceptance addressed a closed fracture of the C2 vertebrae, which is not supported on any diagnostic test nor attributed to the work accident by any physician. Dr pointed out this discrepancy, but the Office failed to realize the import of the error, continuing to develop the medical record for ongoing residuals of a cervical fracture.

Dr. also offered his unrationalized opinion that the lumbar disc disease was unrelated to the fall. As the response was unrationalized, the Office was bound to address the issue further with Dr. before affording such an opinion any probity. A medical opinion not fortified by medical rationale is of little probative value.[3] Upon receipt of the report, the CE should review the report to ensure that the physician has adequately addressed the questions posed. If clarification or additional information is necessary, the CE should write to the specialist to obtain it, either directly or via the medical referral group, as appropriate. Upon receipt of any clarifying information, the CE should again review the report to ensure that it is complete and responsive to the questions asked.[4]

The Office declared a conflict in opinion regarding these residuals, and arranged for an exam by Dr. As no true conflict existed, this referral was premature. Further, Dr. opined that the cervical fracture had resolved, when again the question of whether such a condition existed had not been satisfactorily addressed. Dr. also opined that the cervical and lumbar conditions were unrelated an unaffected by the work fall. While he offered the progressive MRI findings as support for this opinion, he did not address the sudden and total disability contrasted with the reported denial of any symptoms or work disability prior to the fall.

The office is tasked with evaluating and weighing medical evidence when conflicting opinions are offered. When weighing medical evidence, there are five criteria that are considered: qualifications of physicians, thorough examination, accurate history of injury and care, well reasoned medical opinion, and the equivocality of the opinions.[5] The Federal Employees' Compensation Act provides in part: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[6]

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.[7] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[8] Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which

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[3] Ronald C. Hand, 49 ECAB ___ (Docket No. 95-1909, issued October 1, 1997)
[4] FECA Procedure Manual Section 3-500-3f(2)
[5] James T. Johnson, 39 ECAB ___ (1988)
[6] 5 USC 8123(a)
[7] Lawrence D. Price, 47 ECAB 120 (1995).
[8] Id; Patricia A. Keller, 45 ECAB 278 (1993)

require further medical treatment.[9] Authorization by OWCP for medical examination and/or treatment constitutes a contractual agreement to pay for the services regardless of whether a compensable injury or condition exists. Moreover, any medical condition resulting from authorized examination or treatment (such as residuals from surgery) may form the basis of a compensation claim for impairment or disability, regardless of the compensability of the original injury. For both of these reasons great care must be exercised in authorizing medical examination and/or treatment.[10]

Finally, the Board has held that it is a denial of administrative due process for the Office to terminate compensation benefits on the grounds that a claimant no longer has residuals of an accepted condition, where the record supports that the reason for the Office's action was that the condition was not causally related to the claimant's employment and should1 not have been accepted as such. The Office must inform claimants correctly and accurately of the grounds on which a decision rests, so as to afford them an opportunity to meet, if they can, any defect appearing therein.[11]

In the instant case, I find that the Office did not meet its burden of proof when it terminated Mr compensation and medical benefits on the basis that he no longer had residuals as a result of his work-related cervical fracture, cervical or lumbar neuritis, or lumbar disc disease.

Accordingly, upon return of the file, the Office should reinstate compensation and medical benefits. The Office should then further develop whether the correct claim allowances have been accepted. It appears clear that the acceptance of the cervical fracture was in error. The Office must therefore first address this issue, and concurrently develop whether the thoracic compression fractures were related to the work fall. If no such condition exists, then rescission of the acceptance is required. If the Office accepts such a diagnosis, then continuation of such fractures must be considered. The Office must also address the issue of whether the lumbar disc pathology is related in some way to the work fall. If no such relationship is found, then rescission of the acceptance is required. Such rescissions must include a proposal to rescind, to afford the claimant due process. The Office must advise the medical examiner that the surgery was authorized by the office, and develop the issue any residuals and work limitations secondary to that procedure. Finally, the Office should address the work capacity in greater detail. The employer has provided little information upon which a medial practitioner can determine whether work restrictions are required, as noted by Dr

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[9] Furman G. Peake, 41 ECAB 361, 364 (1990)

[10] FECA Procedure Manual Section 3-300-2b.

[11] *Sylena Wilkes*, Docket No. 05-1402 (issued June 2, 2006)

Following any additional development which is needed, a de novo decision should be released.

DATED: OCT - 8 2014

WASHINGTON, D.C.

David Cattani
Hearing Representative
For
Director, Office of Workers'
Compensation Programs