U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Federal Employees' Compensation
Washington, D.C. 20210

File Number:

December 20,2001

(202) 693-0045

CA9999

File Number: 06-2007502
Date of Injury: 05/02/2000
Employee: JOHN W. POOLE

JOHN W. POOLE
1606 BOY SCOUT RD
DEFUNIAK SPRINGS, FL. 32433

Dear Mr. POOLE:

This is in reference to your worker's compensation claim and request for a hearing. A hearing has been scheduled to take place in Atlanta, Georgia, on January 8, 2002. However, a further review of the case record revealed that the case is not in posture for a hearing at this time. Accordingly, the January 8, 2002 hearing is cancelled and a Remand Order has been issued instructing the District Office to take further action on your case.

Enclosed please find a copy of the Remand Order. Your case record has been returned to the District Office for it to take action in accordance with the Remand Order. Further correspondence should be addressed to: OWCP, 214 N. Hogan St., Suite 1006, Jacksonville, FL 32202.

Sincerely,

THOMAS A. TERRILL
Hearing Representative ext 30994

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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 John W. Poole, claimant; employed by Department of the Air Force, Elgin Air Force Base, Florida. Case No. A6-2007502.

Merit consideration of the case record was given in Washington, D.C., and based on such consideration the July 26, 2001 decision of the District Office is reversed for the reason stated below.

The issue is whether the claimant has recovered from his employment-related cervical sprain, lumbar sprain and left wrist contusion.

On May 2, 2000, the claimant, then a 52-year old Liquid Fuels Mechanic, filed a Form CA-1, Federal Employees' Notice of Traumatic Injury and Claim for Continuation of Pay and Compensation, asserting that same day he was injured when he lost his balance and fell approximately three to five feet onto some piping valves. He claimed injuries to his left index finger, left knee, right leg and back from his neck to his lower back.

On the Form CA-1, the claimant's supervisor, Wayne Driskell, indicated that his knowledge of the facts of the injury agreed with the statements that the claimant was injured in the performance of duty. He further indicated that the claimant stopped work on May 2, 2000, received medical attention on May 2, 2000 and returned to work on May 5, 2000.

Evidence was submitted indicating that the claimant has some medical problems that pre-existed the May 2, 2000 injury. In an April 22, 2000 report Dr. Terrence L. Riley indicated that he was evaluating the claimant at the request of Dr. James Howell, D.O. Dr. Riley indicated that the claimant had back pain since 1996 and he had an injury in 1999 when he was working temporarily on a naval base in Guantanamo Bay, Cuba and lifted some heavy objects above his head. He had a recurrence of severe low back pain in the last several months. He had a

tingling and numbing sensation in the lower middle part of his face and was seeing Dr. Riley because of the tingling and numbness of his face. He had a right knee operation in May 1994 and a fracture of his right leg in December 1996 which he underwent an operation. Hardware was removed from his lower right leg in March 1997 and a third operation. He did not have diabetes. He was overweight at approximately 250 pounds. Dr. Riley indicated his physical examination of the claimant concluded that he did not have an explanation for the claimant's sensory deficit.

In an undated Form CA-16 report a physician with an illegible signature indicated the claimant had a contusion and spasms causally related to the May 2, 2000 incident and was disabled until May 5, 2000 when he could return to light duty.

In a May 18, 2000 report Dr. Donald Schak, Sr., D.C., M.D., indicated that that on May 2, 2000, the claimant lost his balance and fell backwards onto a concrete platform from which some type of pipes and valves were extending and he struck his back on a valve and fell with his arms outstretched and also twisting his back in the process and scraped the inside of his right ankle and chin. His history was significant for prior low back injuries, some type of procedure on his right knee in June 1994, a broken right leg in December 1995 and coronary artery disease. He underwent an MRI of the lumbar spine in December 1999. Dr. Schak diagnosed cervicothoracic and thoracolumbar strain/sprains, pain in the left hand, resolving right ankle contusion and left knee sprain with clinical findings suggestive of a torn medial meniscus.

In a June 6, 2000 note Dr. Schak indicated the claimant should be excused from his regular work duties until July 6, 2000.

In a June 7, 2000 report Dr. Schak indicated that the claimant continued with his cervicothoracolumbar strain/sprain injuries, a sprain of the left wrist and second PIP (proximal interphalangeal) joined at the left hand and left knee sprain with persistent signs of possible meniscus tear.

By letter dated June 15, 2000, the Office of Workers' Compensation Programs informed the claimant that his claim had been accepted for conditions of sprain of neck, sprain of lumbar region, sprain of left knee, and contusion of left wrist/hand.

In a June 16, 2000 report Dr. Schak indicated that x-rays of the lumbar spine showed generalized hypomobility of the lumbar spine

with advanced degenerative changes at L3-4. X-rays of the left wrist and hand were normal.

In a June 20, 2000 report Dr. Schak indicated that the claimant's lumbosacral strain/sprain was recently exacerbated but was now improving and an MRI (magnetic resonance imaging) was scheduled for the left knee.

In a June 27, 2000 report Dr. David Gaillard indicated that an MRI of the claimant's left knee showed a tear of the anterior horn of the lateral meniscus and a small tear of the posterior horn of the medial meniscus.

In a July 9, 2000 report Dr. Theodore Macey, apparently an orthopedist, indicated the claimant had degenerative joint disease (DJD) of the left knee and could return to work, not as a Liquid Fuels Mechanic, but in a more sedentary type job.

In a July 20, 2000 report Dr. Macey said that an MRI showed a tear of the anterior turn of the lateral meniscus and a possible tear of the posterior horn of the medial meniscus and the claimant needed to undergo left knee arthroscopy.

In a July 20, 2000 report Dr. Schak indicated that the claimant had continued problems with his back and left knee and had been referred to Emerald Coast Pain physicians for further management of his low back pain which had been unresponsive to conservative care.

In an August 7, 2000 report Dr. Stephanie Noak indicated that she was evaluating the claimant for pain management at the request of Dr. Schak. She noted that on May 2, 2000, the claimant fell at work landing flat on his face. He complained of pain from his neck to his lower back along with his left wrist and finger and left knee. He also noted numbness in several areas of his lower face which he stated occurred prior to the injury and constant tingling in both hands along with intermittent numbness of the legs and feet. His past medical history included hypertension coronary artery disease with stable angina. His past surgical history included right knee surgery in 1994, right leg repair, a fracture in 1995, removal of plate in 1996 and heart catheterization done in 1998 and 1999. Dr. Noak indicated that she had physically examined the claimant and reviewed x-rays. She diagnosed spondylosis without myelopathy, associated myofascial pain, possible peripheral neuropathy, and cervical strain with associated myofascial pain.

The claimant stopped work on August 22, 2000, for surgery.

In an August 22, 2000 report Dr. Macey indicated that day he performed surgery on the claimant consisting of arthroscopic partial medial and lateral meniscectomy left knee and arthroscopic chondroplasty of the left knee. The post operative diagnoses were tear of the posterior horn of the medial meniscus left knee; tear of the anterior horn at the lateral meniscus left knee; and chondromalacia grade II of the medial femoral condyle, lateral femoral condyle and patella.

In an August 28, 2000 report Dr. Macey indicated that the claimant complained of pain of the left wrist which he hurt at the time of his initial injury. He indicated that x-rays of the left wrist showed what appeared to be a healed fracture through the scaphoid, but no finger fractures. He stated that on June 2, 2000 the claimant slipped and fell twisting his left knee and he had no prior problems with the left knee but he did have prior right knee problems. X-rays showed a healed fracture of the left wrist but there were no fractures of the left index finger. His diagnoses were post op arthroscopy left knee and healed fracture left scaphoid. He should not work for two weeks.

By letter dated September 11, 2000, the Office authorized Dr. Noak to perform two medial branch blocks, an EMG of the upper and lower extremities, nerve conduction studies of the upper lower extremities and a one-time referral to Dr. Talman, a pain psychologist.

In a September 11, 2000 report Dr. Macey indicated that the claimant was status post operative arthroscopy of the left knee and could return to work on September 12, 2000, full duty.

The claimant returned to light duty work on September 12, 2000.

In a September 20, 2000 report Dr. Noak indicated that day she performed a lumbar medial branch block on the claimant for his condition of lumbar spondylosis.

In a September 28, 2000 report Dr. Noak indicated that the branch block provided no significant relief for the claimant.

In an October 11, 2000 report Dr. Noak indicated she did another medial branch block on the claimant.

In an October 12, 2000 report Dr. Michael Shawbitz, a neurologist, indicated that he was seeing the claimant at the

request of Dr. Noak. He said that the claimant had seven injuries in the past primarily of the lower back. His last injury occurred on May 2, 2000 when he fell backwards from a platform and hit part of his body on an 8" pipe and flipped over face first onto the floor and landed about 7' from where he started. He was not knocked out. He sustained a low back injury and a neck injury in the accident. He also had a left knee injury. He also had numbness and tingling of his hands all the time. In a previous accident in November 1999 he had a chipped fracture of his left wrist. He also complained of tingling of both feet. He had CT scans of his head and neck in November. In November he apparently lifted a lid off a fuel tank and pulled his neck. Dr. Shawbitz further indicated that he performed a physical examination of the claimant. He diagnosed cervical pain syndrome, low back pain syndrome and possibly obstructive sleep apnea syndrome along with CTS and cervical and lumbosacral radiculopathy/radiculitis. He said the claimant needed an MRI of the cervical and lumbosacral spine and electrodiagnostic studies. He further said the claimant could perform light duty.

In an October 19, 2000 report Dr. Noak indicated that the claimant had 10% relief at best from the branch block.

In an October 25, 2000 report Dr. Shawbitz indicated that the claimant underwent electrodiagnostic studies which showed bilateral carpal tunnel syndrome (CTS) moderately severe but no ulnar neuropathy and no significant involvement of the lower extremities.

In a November 2, 2000 report Dr. Shawbitz indicated that the claimant had undergone an MRI of his lumbosacral spine and this was fairly unremarkable.

In a November 6, 2000 report Dr. Noak indicated the claimant said his neck pain was worsening and more significant than his low back pain. She diagnosed cervical intervertebral disc disease, bilateral CTS, lumbar intervertebral disc disease with radicular pain, lumbar spondylosis and associated myofascial pain.

In a November 6, 2000 report Dr. Noak indicated the claimant said his neck pain was worsening and more significant than his low back pain. She diagnosed cervical intervertebral disc disease, bilateral CTS, lumbar intervertebral disc disease with radicular pain, lumbar spondylosis and associated myofascial pain.

In a November 7, 2000 report Dr. Gregory Staviski, an associate of Dr. Noak, indicated that the family should undergo a trial of cervical epidural steroids and a trial of lumbar epidural steroids.

In a November 21, 2000 report Dr. Macey indicated the claimant was doing well status post arthroscopy of the left knee and was back to normal activities as far as his knee was concerned, but was on light duty because of a back problem.

In a December 28, 2000 report Dr. Staviski indicated that day he performed a cervical epidural steroid injection on the claimant for a condition of cervical intervertebral disc disease.

In a December 21, 2000 report Dr. Staviski indicated that day he performed a cervical epidural steroid injection on the claimant for a condition of cervical intervertebral disc disease.

In a December 28, 2000 report Dr. Staviski indicated that day he performed a cervical epidural steroid injection on the claimant for a condition of cervical intervertebral disc disease with radiculopathy.

In a January 2, 2001 report Dr. Staviski indicated that the claimant had no response to two cervical epidural steroid injections and was interested in surgery. He was referred to his neurologist, Dr. Shawbitz, and to Dr. Dale Johns for neurosurgical options.

By letter dated February 7, 2001, the Office asked Dr. Staviski whether the claimant had recovered from the cervical and lumbar sprains causally related to the May 2, 2000 work injury. The Office noted that Dr. Staviski had diagnosed cervical lumbar disc disease and asked him whether this condition was causally related to the employment injury.

In a March 12, 2001 report Dr. Dale Johns, presumably a neurosurgeon, indicated that on May 2, 2000 the claimant fell off a platform, landing between two valves, which caused him to twist and fall face forward over a pipe. Dr. Johns noted the claimant's medical treatment after that date. He said the claimant's present complaints were constant neck pain as well as constant numbness in his hands and feet, constant low back pain with numbness of both feet in the left leg. He noted the claimant said that he had neck and low back pain since 1986 and that he had a total of seven workers' compensation injuries since 1986. He said the claimant's primary source of discomfort, however, was severe bilateral CTS. Dr. Johns indicated his physical examination of the claimant. He diagnosed bilateral CTS, left greater than right, significant cervical and lumbar degenerative joint and disc disease without radiculopathy, and cervical and lumbar myofascial syndrome. Dr.

Johns opined that the claimant was not a surgical candidate for his neck or low back problems but was a surgical candidate for his CTS.

An Office claims examiner prepared a Statement of Accepted Facts (SOAF) dated April 3, 2001, which indicated that on May 2, 2000 the claimant lost his balance and fell approximately 3-5 feet onto some piping and valves onto concrete, landing on his side and back. He filed a claim for worker's compensation which was accepted for cervical sprain, lumbar sprain, left knee sprain and contusion of the left wrist. He returned to light duty work on June 26, 2000. He stopped work again on August 22, 2000 for a left knee surgery performed that date. He returned to light duty work on September 12, 2000. The SOAF further noted that the claimant had prior accepted work related injuries, one for a 1987 lumbar sprain, another for a 1997 lumbar sprain, another for a 1995 low back strain, and another for a November 29, 1999 lumbosacral sprain. However, one case for August 10, 1986 lumbar strain was not accepted.

By letters dated April 12, 2001, the Office referred the claimant, SOAF and copies of medical records for a second opinion medical evaluation by Dr. Raymond Fletcher. Dr. Fletcher was asked to give a reasoned medical opinion concerning whether the claimant had recovered from his cervical sprain, lumbar sprain, left knee sprain, and left wrist contusion causally related to the May 2, 2000 injury.

In an April 25, 2001 statement the claimant wrote that he had no symptoms of CTS until the May 2, 2000 incident and felt that the May 2, 2000 incident might have aggravated the condition.

By letter dated April 26, 2001, the Office advised the claimant that he should have his physician provide a rationalized medical opinion explaining the causal relationship between the May 2, 2000 work injury and the bilateral CTS. The Office further advised him that if he felt that conditions of his employment since returning to work aggravated his CTS he should file a Form CA-2.

In a May 4, 2001 report Dr. Fletcher, a board-certified orthopedic surgeon, indicated the history of the May 2, 2000 injury and medical treatment after that date. He noted his physical examination of the claimant. He did not indicate that he had reviewed any x-rays. He concluded as follows:

Summary: This is a 50-year old man with a work injury on 5-2-2000. He fell resulted in injury to cervical spine and lumbar spine with an aggravation of pre-existing degenerative spondylosis which has resolved. He also injured the left wrist with subsequent carpal tunnel syndrome requiring surgery. He also injured the left knee with aggravation of degenerative arthritis. Knee MRI revealed meniscus tears requiring arthroscopic surgery. Currently, the claimant is working at his regular job with restrictions at 40 hours/week. This evaluation reveals that these subjective complaints correlate with the objective findings (left knee and left carpal tunnel). The pain pattern is well established and spontaneous recovery is unlikely. The claimant's described impairment correlates with the true impairment prediction based on this evaluation. There is no secondary gain demonstrated. The claimant has much work experience which coincides with current physical limitations.

Work Status Determination: The claimant is able to work at his present job as Liquid Fuel Mechanic on a full-time basis with restrictions. Physical demand characteristics of work: light-medium. Permanent restrictions: Lifting limit: 35 lbs. Infrequent. 10 lbs. Frequent. Standing limit: 2 hours sustained. No climbing unprotected heights. No repetitive squatting, kneeling or crawling. No repetitive use of left upper extremity.

Questions to the second opinion examiner:

1. The cervical and lumbar sprains have resolved.
2. The left knee sprain with meniscus tear exhibits ongoing residual impairment. This impairment will limit repetitive squatting, kneeling and crawling to a certain degree. This is based on permanent aggravation of pre-existing degenerative arthrosis and meniscus tears.
3. The wrist sprain and carpal tunnel syndrome exhibit ongoing residual impairment. This impairment will limit repetitive use of the left upper extremity.
4. There is permanent aggravation of pre-existing degenerative changes of the left knee. There is no permanent aggravation of cervical or lumbar spondylosis.

5. It is more medically probable that the cervical and lumbar work injuries have resolved. Current cervical and lumbar symptoms are related to the natural progression of disease.
6. The subjective complaints correlate with the objective findings with the left knee and the left carpal tunnel.
7. The claimant is not able to perform all his duties as Liquid Fuel Mechanic due to ongoing residuals of left knee and left wrist related to work injury of 5-2-00.
8. OWCP 5-C completed.
9. The claimant has reached maximum medical improvement for the work injury of 5-2-00. Current restrictions outlined [are] permanent.
10. No specific recommendations for change of treatment.

In a May 4, 2001, Form OWCP 5-C Dr. Fletcher indicated that the claimant had work restrictions with regard to walking, standing, repetitive motion of the wrists, pushing, pulling, lifting, squatting, kneeling and bending.

On May 4, 2001, the claimant filed a Form CA-7 for a schedule award. On the form he did not indicate what member of the body he was claiming.

In a May 7, 2001 report Dr. Johns indicated that the claimant's symptoms had largely disappeared following his carpal tunnel release. He noted that the claimant told him that the symptoms in his left wrist had been coming on for several years time and that he used heavy wrenches, lifted heavy valves and carried a heavy tool box at work. He noted that the claimant further said that in the year 2000 he fell backwards onto two valves and then rolled over falling down and attempted to catch himself with his hands and symptoms became much worse thereafter. Dr. Johns commented "From this history it would appear to me that the symptoms he is describing, that is the carpal tunnel syndrome and subsequent surgical procedure, would be related to the work he does, that is that it would be a repetitive stress injury."

By letter dated May 23, 2001, the claimant indicated that he was provided a report from Dr. Johns establishing that his bilateral CTS was causally related to his May 2, 2000 injury. He requested the Office to authorize him to see Dr. Macey again for his left knee and to see an arthritis doctor for his upper and lower back and wrist pain.

claimant 30 days to submit evidence contrary to this proposal, if he disagreed with it.

By letter dated June 21, 2001, the Office advised the claimant that it evaluated schedule awards in accordance with the American Medical Association's (AMA) Guides to the Evaluation of Permanent Impairment Fifth Edition (Guides).

On July 13, 2001 the claimant appointed Paul Felser, Attorney-at-Law, as his representative.

In a July 16, 2001 letter the claimant indicated that he did not agree with Dr. Fletcher and felt that Dr. Fletcher's evaluation was incomplete as he never asked the claimant one question about his cervical or lumbar sprains and his examination lasted only eight to ten minutes. He also said that he brought x-rays and MRI's for Dr. Fletcher to review but Dr. Fletcher did not do so. He said that he also felt that Dr. Fletcher should have taken new x-rays since the ones he didn't look at were over a year old.

In an undated Form CA-20 report Dr. Johns indicated that he examined the claimant on July 20, 2001 and he felt the claimant had a 9% impairment rating.

On July 26, 2001 the Office issued a decision terminating medical benefits for the claimant's cervical, lumbar and left wrist conditions causally related to the May 2, 2000 injury, finding that the claimant had recovered from them. The Office found that Dr. Fletcher had presented the only current rationalized medical opinion based upon review of accepted facts, medical history and objective findings and therefore his reports constituted the weight of medical evidence of record with regard to these conditions.

In a July 30, 2001 report Dr. Harry L. Collins, Jr., a District Medical Director Advisor (DMA) opined that based on Dr. Macey's July 9, 2001 examination there was no basis for permanent partial impairment rating of the left knee.

By letter dated August 8, 2001, Counsel for claimant requested a hearing.

By letter dated August 9, 2001, the Office provided Dr. Macey with a copy of the DMA's report and asked for his comments.

On August 17, 2001, the Office issued a decision finding that the claimant's light duty employment effective September 12, 2000 as a Modified Fuel Distribution Systems Mechanic fairly and reasonably represented his wage earning capacity (WEC) and based on this job, in which actual wages met or exceeded the wages of the job held when injured, he had no loss of wage earning capacity (LWEC).

(I note that the claimant apparently did not appeal this decision.)

In a September 12, 2001 report Dr. Johns indicated that the claimant was doing well with regard to his left hand and arrangements would be made for him to have right carpal tunnel surgery.

In an October 5, 2001 memorandum the claimant's supervisor indicated that based on Dr. Fletcher's restrictions, no light duty was available to him.

By letter dated October 9, 2001 Counsel for claimant stated that the employing agency was processing the claimant's separation due to no light duty being available to him with regard to his left knee condition and the claimant wanted compensation and vocational rehabilitation.

On October 16, 2001, the claimant underwent right carpal tunnel surgery.

The Office paid TTD compensation for the period beginning November 14, 2001,

I find that the case is not in posture for a hearing at the present time. The Office has not met its burden to justify termination of medical benefits on account of the claimant's neck, low back and left wrist conditions.

Once the Office has accepted a claim and paid compensation it may not terminate compensation without justification. Generally, the Office may not terminate compensation without medical evidence showing that the disability due to the accepted employment injury has ceased. Medical evidence is probative to the extent that it is from a well-qualified physician, is based on a correct and complete factual and medical background, is based on objective findings, and is well-reasoned.[1]

[1]Hubert W. Pickens, 35 ECAB 298 (1983).

In the present case, the Office terminated compensation based on the reports of Dr. Fletcher. However, it is not clear that Dr. Fletcher had a complete factual and medical background as he gave no explicit indication that he had reviewed the SOAF, and he clearly did not review any x-rays or MRI's. Moreover, he gave no specific rationale to support his opinion that the cervical and lumbar sprains had resolved. He said that the work injury aggravated cervical and lumbar spondylosis but this was not permanent. However, he gave no particular rationale for this opinion either. He said the claimant's left wrist problems were more likely related to CTS than the injury-caused wrist contusion, but gave no particular rationale for this opinion either.

Based on the foregoing, the July 26, 2001 decision of the District Office is reversed and the case is returned to the District Office for it to refer the SOAF, copies of all medical records and all plain and MRI films of the claimant's neck, back and left wrist to Dr. Fletcher for him to review and to submit a supplemental report concerning whether the claimant's current back, neck and left wrist conditions are causally related to his work injury, giving medical reasons for such opinion. After this, the District Office should perform any other development it deems necessary and should issue a new decision concerning whether compensation should be continued or terminated for the neck, back and left wrist conditions.

DATED: December 20, 2001
WASHINGTON, D.C.

Thomas A. Terrill
Hearing Representative
For
Director, Office of Workers'
Compensation Programs