File Number:
HR10-D-H

U.S. DEPARTMENT OF LABOR

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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 hearing was held on

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.

It has also 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
OWCP/DFEC, PO Box 8311
LONDON, KY 40742-8311

Sincerely,

Division of Federal Employees' Compensation

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

Washington DC, July 29, 2020

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 An oral hearing was held on

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The issues for determination are whether: 1.) the claimant has an emotional condition causally related or consequential to the accepted work-related claim, and/or 2.) the Office met its burden of proof to justify termination of wage loss compensation, based on the weight of medical evidence.

The claimant was employed as a social worker with the when she filed a CA2 Notice of claiming after the clinic moved to a new location she used a desk chair that was not comfortable, and the cushion was higher in the back which caused her spine to sit in an awkward position. The nature of illness claimed was sore spine. The claimant indicated she first became aware of her condition and realized it was related to her employment on In a separate statement, she identified that , was the first date she worked at the new primary care clinic, and was the first date she sought chiropractic treatment with , D.C., in relation to the claim. The claimant noted she was given a new chair on , and a stand up desk or . The record reflected she stopped work on and returned to part-time work at the end of l

On the occupational disease claim was initially denied based on the third basic element of Fact of Injury-Medical. The claimant disagreed with this decision and requested an oral hearing. The record reflected the claimant continued chiropractic treatment and was later seen by M.D., on and and was diagnosed low back pain secondary to lumbar degenerative joint disease and foraminal stenosis, and malaise/depression. A letter from Dr. requested accommodations to improve her ergonomics. In progress reports, Dr. continued to diagnose lumbar degenerative joint disease with radiculopathy and malaise/depression. On the claimant was evaluated by M.D., who gave the history of pain in her lower back for two to three years. His impression was degenerative disc changes with mild disc herniation and degenerative facet changes at L3, L4, and L5, weak core muscle, and tight hamstrings. On the claimant was evaluated by interventional orthopedist, , D.O., who gave the history of progressive axial back pain that started in when she sat for three consecutive days in a poorly constructed chair. Dr. assessed degenerative disc disease, worse at L4-L5, L5-S1, with annular tearing at L4-5; bilateral foraminal stenosis at L4-L5, L5-S1 creating bilateral radiculopathy; bilateral facet effusions and facet arthropalhy at L4-L5, L5-S1; and bilateral lumbar instability with Kader grade IV muitifidus atrophy, based on a IRI. The record reflected the claimant underwent various types of therapy

Washington DC, July 29, 2020

On , a hearing was held. By decision dated the hearing representative affirmed the denial, with the modification that the fifth basic element of Causal Relationship had not been established.

On , the claimant came under the care of neurologist, M.D., who noted a history of degenerative disc disease and exacerbation of pain by poor ergonomics. She reported to him that when her office moved she had to sit in a broken chair for three days. Diagnostic testing (MRIs) were performed on and In a report, Dr. advised the claimant was under his neurological care for chronic lower back pain worsened since the incident with herniated nucleus pulposes (HNP) at L3-4, L4-5, and L5-S1 and radiculopathies; neck pain with herniated discs at C4-5, C5-6, and C6-7, with radicular symptoms; HNPs in the thoracic spine times three; and anterior falx tumor – suspecting meningioma causing face and nose pain for years, worsening. He noted she should not work more than five hours per day.

The record reflected the claimant stopped work completely by and underwent brain surgery on , for meningioma resection. She reported she was cleared to return to work on after the craniotomy, but that Dr maintained her off work due to her spine.

By reconsideration decision dated the Office denied modification of the decision.

The claimant remained under the care of Dr. and in a narrative report, Dr. gave a description of the claimant's history, noting she had been receiving chiropractic care for lumbar and cervical conditions since He discussed the ergonomic issues involving her chair i , and her subsequent medical treatment. Dr. gave his opinion to a reasonable degree of medical certainty that the broken chair, along with the delay in receiving the ergonomic chair/desk, caused a permanent aggravation of her degenerative disc disease in the lumbar and cervical spine. In addition, he opined due to the additional stress placed on her spine in a sitting position because of the faulty chair, it caused the development of the disc herniations at the levels noted. A repeat lumbar MRI was performed on and it was noted the previously mentioned retrolisthesis of L4 could not be appreciated on the present study, and there was no significant interval change in the degree of lumbar spondylosis predominantly from L3-S1.

By reconsideration decision dated the Office accepted the occupational disease claim for intervertebral disc degeneration, lumbar region; dislocation of L4/L5 lumbar vertebral degenerative disc disease at L4-L5, L5-S1 with annular tearing at L4-5; bilateral foraminal stenosis at L4-L5, L5-S1; bilateral radiculopathy; bilateral facet effusions and facet arthropathy at L4-L5, L5-S1; bilateral lumbar instability with Kader Grade IV multifidus atrophy; and lumbosacral spondylosis and facet arthrosis. The Office paid wage loss compensation for intermittent wage loss beginning and began paying temporary total disability as of She was placed on the periodic roll as of

In a progress report, Dr noted an EMG/NCS revealed right S1 radiculopathy and a repeat lumbar MRI was performed which was interpreted as showing HNPs and degenerative disc disease at L3-4, L4-5, and L5-S1. He continued to treat the claimant with lumbar traction, physical therapy, and aqua and massage therapies, and medications. In a report, Dr. listed her current diagnoses as intervertebral disc degeneration, lumbar region; radiculopathy, lumbar region; and right drop foot. He opined she was disabled from all work.

The Office determined that a second opinion examination was warranted and referred the claimant to Board-certified orthopedist, M.D., on He was provided with a Statement of Accepted Facts (SOAF) and the pertinent medical records for reference. Dr. gave a detailed description of the claimant's history, physical examination findings, and his review of the diagnostic lumbar MRI results. He assessed advanced lumbar spondylosis, from L3 down to the S1 level, most prominent at L5-S1 level, and right gluteal pain. Dr. noted the claimant had preexisting severe low back pain with gluteal pain, evident by her history of chiropractic treatment for ten years. He stated it appeared she had some exacerbation of the back and leg pain when she sat awkwardly in an ergonomic chair, and that this may have exacerbated her preexisting condition throughout the back. Dr. advised the claimant continued to be symptomatic with low back pain, localized to the midline/axial area, with no type of reproducible pain in the SI joints. Dr. reported he did not see any evidence of continuing or residual radiculopathy, noting her leg pain did not follow any specific dermatomal pattern, and she had good/intact strength and sensation with negative straight leg test and Lasegue test. He opined the claimant had reached a fixed and stable state in regards to her back pain. Dr. indicated he did not feel any additional treatment was warranted as she had already undergone an extensive amount of conservative treatment with injections and therapy. He also opined the claimant was capable of performing the requirements of her job without limitations.

The Office later received a letter from the claimant's attorney requesting expansion of the claim to include (but not limited to) depression, anxiety, and posttraumatic stress disorder (PTSD). In support of this request, a medical report from Board-certified psychiatrist/neurologist, D.O., was submitted. Dr. noted the claimant was seen for a complete neuropsychiatric evaluation or and listed the diagnoses of abnormal brain scan; frontal lobe and executive function deficit; diffuse traumatic brain injury without loss of consciousness, sequela; posttraumatic stress disorder, chronic; chronic fatigue, unspecified; insomnia, unspecified; autoimmune thyroiditis; and adjustment disorder with mixed anxiety and depressed mood. Dr. indicated the claimant had a significant past history of emotional trauma that was treated to a great extent prior to her work-related injury and current struggles with chronic physical pain. Dr. opined the work-related injuries that the claimant sustained retriggered and exacerbated her preexisting posttraumatic stress disorder, setting her back emotionally, with symptoms including feeling overwhelmed and tearful with even small amounts of stress, poor sleep with recurrence of nightmares, and feeling at baseline "on edge" and irritable. Dr. noted the claimant was not fit to return to her previous line of work, and she required ongoing treatment, including a psychiatrist for medication and weekly trauma therapy. A report from psychologist, Ph.D., stated the claimant had been treated since , for serious psychological stress related to her lumbar spine injuries. Dr. stated she was suffering from severe major depression disorder secondary to her medical condition, with intense sense of hopelessness and inability to cope with the pain and physical limitations. He also opined her posttraumatic stress disorder had been reactivated due to anxiety related to her compromised ability to take care of herself due to her pain from the spinal injuries. Dr. indicated the claimant's depression and PTSD were disabling and her prognosis was guarded.

On ne Office sent Dr a copy of Dr. second opinion report for review. In a response, Dr. advised the current diagnoses were back pain and right > left radicular symptoms and HNPs at L3-4, L4-5, and L5-SI, mainly right L5 nerve, as well as retriggering of PTSD from this injury. He described the findings on his physical examination, and opined the claimant was medically unable to perform the duties outlined in the SOAF and was TTD.

In a separate report, in direct response to the questions posed to Dr. Dr. indicated that he agreed with Dr. regarding the summarization of the claimant's history of injury/onset of illness. Dr also agreed with his description of the objective and subjective findings and correlation of both, noting, however, that straight leg raising test was positive on his exam. Dr. advised that the MRIs showed HNPs, with right L5 radiculopathy on EMG. Dr. gave his medical opinion that the claimant's work-related conditions had not resolved, which he stated was supported by the continuation of symptoms related to her work injury, and the testing including MRI and EMG. He indicated the claimant's prognosis was guarded. Dr. further opined the claimant was not capable of returning to work as a social worker and remained disabled. He advised the claimant still needed treatment, including physical therapy, massage therapy, and Vax-D or surgery.

The Office also issued the claimant a development letter on addressing the claim for a consequential psychiatric condition. In a statement received on the claimant explained that her PTSD symptoms re-emerged within the first month after her spinal injury when she became restricted by the pain and her inability to take care of herself. She noted these symptoms included flashbacks, nightmares, and severe depression, insomnia, and anxiety. The claimant explained that from through , she was in psychological and psychiatric treatment for PTSD, depression, and anxiety, in relation to extensive long-term childhood abuse and neglect, and a rape in adulthood. The claimant stated this treatment ended in and she was able to be gainfully employed with the VA for years until the chronic pain and limited physical ability from her spinal injury.

A new medical report from Dr. gave a more detailed description of the claimant's history and her physical limitations resulting from the spinal injury. He noted they were compounded by severe chronic pain, which interfered with her activities and sleep. Dr. explained that being housebound, unable to go to work full time or rely on others for assistance without a reliable source of income, and being unable to take care of herself, she felt hopeless and alone, which triggered intrusive traumatic memories/flashbacks of frequent assaults that she endured throughout her childhood without anyone to protect her. He noted the claimant's medical and financial issues also led to severe depression and exacerbated her insomnia. Dr. discussed the subsequent treatment she had received, and gave his professional opinion that the retriggering of the claimant's PTSD, after it had been in remission for a decade, was attributable to the fact that her spinal injury resulted from the lack of responsiveness to her requests for a suitable standing desk and a replacement for her broken ergonomic chair at work, and the physical limitations and severe pain caused by the spinal injury. Dr. also opined the physical limitations and chronic pain related to the spinal injury were the reason for her depression and insomnia. A medical report from , Ph.D., LCSW, listed the dates she saw the noting that because of the pain and suffering the claimant was experiencing she began to feel helpless and out of control, which triggered old PTSD symptoms as her physical symptoms worsened.

By letter dated , the claimant's attorney submitted additional development was warranted. The record reflected the claimant was removed from employment effective for medical inability to maintain a work schedule.

The Office determined that a second opinion examination was warranted to address expansion of the claim for a consequential emotional condition and referred the claimant to Board-certified psychiatrist, M.D., on . Dr. was provided with a SOAF and the pertinent medical records for reference.

In his narrative report, Dr. gave a description of the claimant's history involving her work-related condition and subsequent medical treatment. He also outlined her psychiatric history and personal history. Dr. discussed the claimant's mental status examination and confirmed she met the criteria for posttraumatic stress disorder. He opined the claimant was unable to return to her date of injury job, due to the diagnosis and the worsening of her PTSD symptoms. Dr. stated the claimant had been in difficult situations before and was able to pull herself out, so he felt this was a temporary aggravation of her condition and not necessarily a permanent disability. Dr. opined it was a long stretch to consider that not being able to find a comfortable position in her work chair for a period of time was sufficient to cause the aggravation of her posttraumatic stress disorder to the level that the claimant had, so he did not think the aggravation of her long-term orthopedic problems had any significant relationship to the aggravation of her PTSD symptoms. Dr. emphasized that the claimant's perception and anger reaction toward her employer regarding her request for accommodations in the workplace were symptoms of the PTSD and not the cause of her disorder or decompensation. Dr. advised he saw no relationship between the accepted condition (aggravated PTSD) and the occurrence of tolerating an uncomfortable non-ergonomic working seating arrangement. He reiterated it would be a far-fetched conclusion attributing the aggravation of PTSD to a seating arrangement and conflicts with her employer about it. Dr. reiterated the claimant's reported symptoms and behavior were not compatible with any type of employment.

By notice dated , the Office proposed to terminate wage loss compensation only based on the weight of medical evidence of the second opinion physician, Dr. , who found the claimant physically capable of performing her date of injury position as a social worker.

The claimant's attorney submitted arguments in a correspondence, with copies of progress reports from Dr. . A medical report was also received from Dr. in which he discussed the claimant's distress after having met with Dr. and his refusal to let her discuss her employment matters, rather focusing on her childhood trauma, which was triggering. He indicated Dr report appeared to be riddled with inaccuracies as he did not fully consider her work factors. The curriculum vitae for Dr. was provided.

By decision dated the Office formally denied expansion of the claim to include a consequential aggravation of preexisting posttraumatic stress disorder based on the weight of medical evidence of the second opinion of Dr. The claimant disagreed with this decision and by letter postmarked , through her attorney, requested an oral hearing.

By formal decision date the Office finalized the proposed termination of wage loss compensation effective , he Office noted the claim remained open for entitlement to medical benefits. The claimant disagreed with this decision and by letter postmarked through her attorney, requested an oral hearing. By letter dated , , , the claimant's attorney requested that both issues under appeal be considered at one hearing, which was granted.

The hearing was held via teleconference on with the claimant's attorney, Paul Felser, Esquire. Mr. Felser pointed out the claimant's date of injury job was not merely secretarial or sitting behind a desk. He submitted Dr. did not take into account the claimant's entire medication regime or her treating physicians reporting pain caused her to have difficulty coping with the effects of her work-related physical conditions. Mr. Felser referenced the . eport of Dr. , and also the report from Dr. , and contended this evidence contradicted Dr. ultimate conclusion and caused a conflict [in medical opinions] at the very least.

Mr. Felser submitted Dr. also put aside the claimant's accepted physical injuries and the fact that she was dealing with chronic pain, minimalizing and trivializing her complaints/conditions. He argued Dr. did not give any discussion of a baseline assessment when analyzing preexisting conditions, and pointed out that any aggravation was compensable and the case should have been accepted for at least a temporary aggravation as noted by Dr for the Office to then have to determine whether it resolved. In relation to Dr. Mr. Felser discussed that the SOAF provided to this physician was different from the one provided to Dr. He stated Dr. did not address whether or not the claimant's medications affected her demeanor or ability to handle combative patients. Mr. Felser referenced Dr. report and his review of the SOAF and his responses to the same questions, and submitted Dr. eviewed testing Dr. did not address. Dr. Felser also questioned the age of Dr. report in a case where the accepted conditions were progressive and degenerative. It was advised the record would remain open for thirty days. On the hearing transcript was issued and the employing agency was given twenty days to provide information related to the claim and testimony. No comments were received.

Post hearing, progress reports from Dr. were received, along with therapy reports. A new narrative report from Dr. i was also submitted in which he addressed the report of Dr. and listed the discrepancies found. Dr. indicated it was important to highlight that prior to the claimant's ten year period of stability (from , she had to engage in years and years of intense trauma therapy to achieve that prolonged level of stability, and that Dr did not address why after ten years of stability, the claimant needed to seek regular treatment/medications for her PTSD symptoms. Dr. confirmed it was his opinion the claimant experienced a re-triggering of her PTSD as a result of the injury and the resultant need for ongoing medical treatment. Dr. Ali contended Dr. minimized the severity of the claimant's accepted physical injury and that the lack of proper accommodation contributed to the worsening of her condition and issues with chronic pain. Dr. eiterated Dr. did not adequately explain why the claimant would have so severely decompensated since the injury, despite her prior ten year ability to function well. A transcript of a deposition of Dr. in relation to a case involving the claimant as the plaintiff versus the as the defendant, was also received.

Based on my complete review of the testimony/written evidence of record, the denial for expansion of the claim is set aside and the termination of wage loss compensation is reversed for the reasons set forth below.

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence that includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the established incident or factor of employment. The opinion must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[1] In any case where a pre-existing condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation or precipitation, the attending physician must provide rationalized medical opinion which differentiates between the effects of the employment-related injury or disease and the pre-existing condition.[2]

[1] *John W. Montoya*, 54 ECAB 306 (2003).
[2] FECA Procedure Manual, 2-805-3(d)(5).

The general rule respecting consequential injuries is that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause, which is attributable to the employee's own intentional conduct.[3] The subsequent injury is compensable if it is the direct and natural result of a compensable primary injury.[4]

Once the Office accepts a claim, it has the burden of justifying a termination or modification of compensation benefits.[5] The Office may not terminate or modify compensation without establishing that the disabling condition ceased or that it was no longer related to the employment.[6]

In assessing medical evidence, the weight of such evidence is determined by its reliability, its probative value and its convincing quality. The opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion are facts, which determine the weight to be given to each individual report.[7]

In the instant case, the Office accepted the occupational disease claim for the conditions of intervertebral disc degeneration, lumbar region; dislocation of L4/L5 lumbar vertebral degenerative disc disease at L4-L5, L5-S1 with annual tearing at L4-5; bilateral foraminal stenosis at L4-L5, L5-S1; bilateral radiculopathy; bilateral facet effusions and facet arthropathy at L4-L5, L5-S1; bilateral lumbar instability with Kader Grade IV multifidus atrophy; and lumbosacral spondylosis and facet arthrosis. The factors of employment cited by the claimant involved sitting in an awkward position for at least three days in an office chair that could not be properly adjusted. The Office paid intermittent compensation for wage loss beginning and compensation for temporary total disability as of The claimant has remained off all work.

In relation to the denial of expansion of the claim for a consequential emotional condition, I find the weight of medical evidence was not established by the second opinion report of Dr. Dr. ; medical opinions were incomplete and lacking in sufficient medical rationale. The claimant's treating psychiatrist, Dr. and psychologist, Dr. , attributed the claimant's retriggering of her preexisting PTSD condition to her physical spine injuries and the resulting chronic pain, difficulties with daily activities, and her inability to take care of herself. While Dr. opined he did not think the aggravation of her long-term orthopedic problems had any significant relationship to the aggravation of her PTSD, as not being able to find a comfortable position in her work chair for a period of time was not sufficient to cause the aggravation of her posttraumatic stress disorder to the level that it was, he did not definitely opine that there was no contribution at all. No significant relationship would not be synonymous with no relationship at all, and it is not necessary to prove a significant contribution of factors of employment to a condition for the purpose of establishing causal relationship. If the medical evidence reveals that an employment factor contributes in any way to the employee's condition, such condition would be considered employment related for purposes of compensation under the Act.[8]

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[3] *Albert F. Ranieri*, 55 ECAB 598 (2004).
[4] *Carlos A. Marrero*, 50 ECAB 117 (1998); A. Larson, *The Law of Workers' Compensation* § 10.01 (2005).
[5] *LaDonna M. Andrews*, 55 ECAB___(Docket No. 03-1573, issued January 30, 2004)
[6] *Jaja K. Asaramo*, 55 ECAB___(Docket No. 03-1327, issued January 5, 2004)
[7] *Michael S. Mina*, 57 ECAB 379 (2006).
[8] *Arnold Gustafson*, 41 ECAB 131 (1989); *see Glenn C. Chasteen*, 42 ECAB 493 (1991).

The question posed to Dr regarding whether the claimant continued to suffer from residuals of the accepted conditions in the SOAF was also inappropriate, as Dr. was not an appropriate specialty to address residuals of the physical lumbar conditions. He attempted to answer the question, stating there was no relationship between the accepted condition (aggravated PTSD) and the occurrence of tolerating an uncomfortable non-ergonomic seat or to her conflicts with the employer regarding such. However, since an aggravation of PTSD was not an accepted condition listed in the SOAF and Dr. did not specifically opine that the aggravation of PTSD the claimant was experiencing was work-related, his medical opinion was unclear and needed clarification. The Office failed to ask Dr. to address the pertinent questions of whether there was a diagnosed emotional condition causally related to the identified work factors by causation, aggravation, acceleration, or precipitation, or whether a preexisting condition became active/reemerged or an emotional condition developed consequentially to the effects of the accepted physical conditions. Dr. did not fully consider the effects of the accepted physical conditions or the medical opinions presented by the claimant's treating physicians regarding chronic pain.

Once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[9] Where the Office secures an opinion from a specialist for the purpose of clarifying the medical evidence and the opinion requires further clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original report.[10] Due to the deficiencies noted, the second opinion report required further elaboration and clarification.

In relation to the termination of wage loss compensation, I find the Office did not meet its burden of proof as the weight of medical evidence was not established by the second opinion report of Dr. Although Dr. gave his medical opinion that he saw no reason why the claimant could not perform her date of injury job as a social worker, his opinion was not more well-rationalized than the medical opinion of the claimant's treating neurologist, Dr. who responded to the same questions in a report and gave his medical opinion that the claimant was disabled from her date of injury job due to the accepted conditions. In contrast to Dr. , Dr also reported he found a positive straight leg raising test. The two physicians would be of equal specialty, and Section 8123(a) of the Act provides that when there are opposing medical reports of virtually equal weight and rationale, the case must be referred to an impartial medical specialist to resolve the conflict of medical opinion.[11]

The attorney questioned the Statement of Accepted Facts used by the second opinion physicians. Both SOAFs contained a general description of the physical demands of the job, but were not accurate regarding the claimant's work history as of . Based on my review, the record reflected the claimant missed intermittent time from work until stopping completely on or around on She returned to part-time work at the end of and continued to work up to five hours per day until she stopped completely by prior to undergoing brain surgery on

Further, given that it was well documented the claimant had preexisting degenerative lumbar conditions prior to the acceptances in this claim require clarification for the record; specifically, the diagnoses being accepted as directly caused by the identified work factors and the conditions which are preexisting and being accepted as aggravated by the accepted work factors.

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[9] *Linda L. Newbrough*, 52 ECAB 323 (2001).
[10] *William N. Saathoff*, 8 ECAB 769 (1956).
[11] *William C. Bush*, 40 ECAB___(Docket No. 89-0449, issued July 10, 1989)

On remand, the Office should ensure that the Statement of Accepted Facts is accurate regarding the accepted conditions and the claimant's work history, and provides a complete description of the date of injury job duties and physical requirements. The Office should request a supplemental report from Dr. to specifically address whether a diagnosed emotional condition(s) was caused, aggravated, accelerated, or precipitated as a result of the accepted work factors and/or the accepted work-related physical lumbar conditions, or developed/became active as a consequence of the accepted physical injuries, by any degree. The accepted definitions of Causal Relationship and a consequential condition should be provided for reference. Dr. also should address whether the effects of any treatment related to the accepted physical conditions, including medications, etc. contributed to an established emotional condition. If Dr. negates causal relationship, he should explain to what he attributes the claimant's PTSD symptoms following the work conditions and ten year period of stability. Dr. should specifically discuss the medical reports and opinions of Drs. and including their new and reports, regarding the claimant's work-related physical injuries and chronic pain, and the impact on her preexisting PTSD. Supportive medical rationale should be provided for all opinions rendered. Upon receipt of his supplemental report, the Office should carefully review all the medical evidence pertaining to expansion of the claim to determine if a true medical conflict now exists. After any further development deemed necessary, the Office should issue a *de novo* decision regarding expansion of the claim for a consequential emotional condition.

In relation to the accepted physical conditions, the Office should consider referring the claimant for an independent medical evaluation with an appropriate Board-certified specialist to resolve the conflict in medical opinions between Dr and Dr. regarding the claimant's work capacity. The Office should reinstate entitlement to wage loss compensation as of as the weight of medical evidence had not been established at the time these benefits were terminated.

Accordingly, the decision dated is hereby set aside for further development and a *de novo* decision as explained above. The termination is hereby reversed and entitlement to wage loss compensation should be reinstated retroactive to the date of termination.

ISSUED:

WASHINGTON, D.C.

Hearing Representative
Branch of Hearings and Review
For
Director, Office of Workers'
Compensation Programs

Washington DC, July 29, 2020