File Number.
HR14-D-H

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U.S. DEPARTMENT OF LABOR

OWCP/DFEC, PO Box 8311
LONDON, KY 40742-8311
Phone: (202) 693-0045

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Date of Injury:
Employee:

Dea

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

Your case file has been returned to the Jacksonville District Office at:

US DEPARTMENT OF LABOR
OWCP/DFEC, PO Box 8311
LONDON, KY 40742-8311

If you disagree with the decision attached to this letter, you have the right to submit new evidence to the Office of Workers' Compensation Programs and request reconsideration of the case or, if you have no additional evidence to present to the Office of Workers' Compensation Programs, you may appeal the decision to the Employees' Compensation Appeals Board.

Sincerely,

Division of Federal Employees' Compensation

PAUL FELSER
7393 HODGSON MEMORIAL DR
SUITE 102
SAVANNAH, GA 31406

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, August 10, 2020

File Number:
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RECONSIDERATION: If you have additional evidence, not previously considered, which you believe is pertinent, you may request, in writing, the OWCP reconsider this decision. Such a request must be received within one year of the date of the attached decision, clearly state the grounds upon which reconsideration is being requested, and be accompanied by relevant evidence not previously submitted, such as medical reports or affidavits, or a legal argument not previously made. Your request for reconsideration and the new evidence you are submitting should be sent to the

US DEPARTMENT OF LABOR
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In order to ensure that you receive an independent evaluation of the evidence, your case will be reconsidered by persons other than those who made this determination.

APPEALS: If you believe that all available evidence has been submitted, you have the right to appeal to the Employees' Compensation Appeals Board (ECAB) (20 C.F.R. 10.625). The ECAB will review only the evidence received prior to the date of this decision (20 C.F.R. Part 501). Effective November 19, 2008, ECAB has changed its Rules of Procedure on the time limit to appeal and has eliminated its practice of allowing one year to file an appeal. **Request for review by the ECAB must be made within 180 calendar days from the date of this decision.** More information on the new Rules is available at www.dol.gov/ecab.

To expedite the processing of your ECAB appeal, you may include a completed copy of the AB 1 form used by ECAB to docket appeals available on the Department of Labor Web Site at www.dol.gov/ecab. **You must mail your request to:**

Employees' Compensation Appeals Board
200 Constitution Avenue NW, Room S-5220
Washington, DC 20210

Washington DC, August 10, 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 Wilton, Claimant; Employed by the
Case number A hearing was held on

The issue for determination are: 1.) whether by decision dated the Office properly rescinded the accepted diagnosis of spinal stenosis; 2.) whether by decision dated the Office properly terminated medical and compensation benefits for the injury.

is employed as a with the in He reported a low back injury while twisting and lifting luggage on The claim was recorded as a minor injury, and no formal adjudication of the case took place.

Mr. was seen on by family practitioner He was placed off work until when he was released to limited duty work. No record of Dr. exam is in file. Mr. returned to seated limited duty work. An MRI study was conducted on , revealed widespread degenerative changes and stenosis in the lower lumbar region.

Mr. reported worsening pain in late and sought care in new clinic on . This visit represents the first documented clinical exam of the patient following the injury. Mr. presented to the clinic because Dr. was not a registered medical provider for federal injury claims. Lumbar disc displacement was diagnosed. Additional restrictions were imposed, and he was provided with an office job answering phones. Physical therapy was initiated and he was referred to an orthopedic surgeon.

Pain worsened in late November and the claimant was seen at the clinic on . He stopped all work on and never returned. The patient was seen or by MD. Lumbar facet syndrome was diagnosed. No causation was established. Mr. reported an anxiety reaction on His family practitioner also changed his medications for hypertension on

Mr. underwent radiofrequency ablation on and These procedures were not authorized by the Office. Facet joint syndrome was diagnosed by MD. No causation was established.

Washington DC, August 10, 2020

While Mr last worked on no claims for wage loss were filed until when Mr. proscriptively reported wage loss beginning In an undated note Mr. reported that he received Continuation of Pay through , then used personal leave beginning pay period 2 through pay period 5, until filing his wage loss claims beginning pay period 6. No discussion of pay status was offered from to

Dr. saw the patient on diagnosing a lumbar disc herniation. Etiology was not addressed.

The Office reopened the previously administratively closed claim for formal adjudication based on the wage loss claim. A development letter was released on On the Office accepted that Mr. suffered a lumbar strain as a result of his lifting incident. The disc herniation and spondylosis diagnoses were not accepted, as these had not been attributed to the work incident. By separate cover, the Office again noted that the disc herniation was not an allowed diagnosis, and any disability due to that condition would not be covered.

Or Mr. the Office, summarizing the medical care provided to the patient since Mr. opined that a severe lumbar sprain was caused by the incident of [1]

On the Office amended the claim allowances to include mild spinal stenosis at L3 to L5. It is unclear which medical opinion was reviewed in making this determination.

Mr. remained off all work, receiving conservative care. The most recent medical record in file was a functional capacity evaluation ordered by NP. Prior to this evaluation, Mr. had performed an epidural injection on The most current exam by a recognized physician is the visit on with Dr.

On the Office determined that a second opinion exam was appropriate to consider residuals and work capacity. An exam with board certified orthopedic surgeon MD was arranged on

Dr. noted an accurate history of injury, but incorrectly identified the date of injury. Exam found tenderness to palpation in the lower lumbar paraspinals, with severely limited range of motion. Normal muscle tone, bulk and strength was present in the legs, but deep tendon reflexes were absent. Gait was slow and wide based; tandem walking could not be performed due to morbid obesity. Sensation was intact to light touch and pinprick. The medical record was briefly summarized. Dr. diagnosed low back pain, morbid obesity and lumbar spondylosis without myelopathy. He noted review of the Statement of Accepted Facts (SOAF), which included claim allowances of lumbar strain and mild spinal stenosis at L3-L5. He opined that the stenosis was not resolved, but added that this

[1] Prior treatment notes indicate authorship by a MD; beginning provides credentials as a nurse practitioner. It is not clear if the prior credentials were corrected, or if in fact two were employed at the practice at that time. A web search finds Mr. Linkedin page, where he indicates that he is in fact a nurse practitioner, employed at the clinic since

condition was a function of a chronic degenerative process rather than a work injury. The lumbar strain had resolved. No residuals of the work injury remained, but the pre-existing degenerative condition remained active and was the source of dysfunction. Modified work was possible.

On the district office released a proposal to rescind the stenosis diagnosis based on the report of Dr. Mr. wrote in opposition on arguing that the exam was perfunctory and the physician appeared biased. He noted 17 years of employment at TSA prior to injury. No medical evidence was introduced in opposition, and on the Office finalized the rescission. The Office based the rescission on Dr. comments and review of the letter from Mr.

On the district office released a proposal to terminate all medical and wage loss benefits. The Office noted that Mr. had diagnosed a severe sprain due to the work incident. The second opinion examiner had found that this condition resolved by his exam.

No medical opinion was received in opposition to the proposal. Attorney Paul Felser wrote in objection to the proposal on . He noted the claim allowances and payment of medical and wage loss benefits, as well as the referral to Dr. after an extended period of disability.

Mr. Felser argued that Dr. ; report was deficient, adding that there was no medical opinion that the stenosis had resolved. Mr. Felser argued that the Office should have asked if an underlying condition was aggravated, and as such, the baseline condition of his client was not properly considered. He also questioned how his client was capable of full duty work until the date of injury, but had experienced significant disability since the incident. He argued that Dr. failed to offer rationale for his opinion that the sprain had resolved or that the stenosis was unrelated to the lifting. As disc bulging was evident on imaging studies, the question of whether the discs were impacted by the lifting should have been addressed prior to termination. Mr. Felser argued that the office should have also considered the impact of the prior work experience, in essence adjudicating an occupational disease claim which was not filed. Mr. Felser argued that the second opinion was deficient because either it was based on an incomplete or inaccurate Statement of Accepted Facts (SOAF), or the physician did not use the SOAF in forming his opinion. No explanation or citation was offered to support the argument. He asked that at a minimum a referee examiner be sought to resolve a conflict, but failed to identify the conflicting opinions.

By decision dated the Office informed Mr. that his entitlement to wage loss and medical benefits was terminated based on the opinion of the second opinion examiner.

Mr. Felser disagreed with the and decisions and timely requested hearings before an OWCP representative. No new medical opinion was submitted in support of the appeals.

A hearing was held on 3oth the rescission and the termination appeals were combined into a single hearing for expediency and continuity. Mr. was represented by attorney Felser at the proceeding. He did not attend the hearing.

Mr. Felser argued that his client was having difficulty finding medical providers because this was a federal claim. In addition, the COVID-19 pandemic has made medical exams difficult to secure since He noted that on an exam recorded tenderness, spasm and limited lumbar range of motion. The MRI of found disc bulges and neuroforaminal stenosis which was attributed to the bulges and facet hypertrophy. As no prior back injury was documented and the claimant was working full duty, the Office should have considered whether the disc pathology was caused or aggravated by the lifting incident. Mr. Felser argued that the underlying condition has suspiciously progressed in a short period of time in order to be totally disabling after the incident, suggesting some involvement of the lifting duties described. He felt that Dr. should have discussed the medical evidence in file instead of just recording the findings and dates of treatment. It was noted that the medical record contained no current evidence of treatment since the summer of .

In order to afford the claimant an opportunity to submit any additional evidence to support his claim, the record was left open for 30 days. As required by Office procedures, a copy of the hearing transcript was forwarded to the employing agency to afford them an opportunity to comment on the claimant's testimony. Comments have not been received from the employing agency. The time allotted to all parties for the submission of additional evidence has now passed. No new factual or medical evidence has been received.

Mr. reported a low back injury after lifting luggage on . He sought timely care, but no documentation of his initial exams or treatment is in file until a chart note in 3 months after injury. Mr. had returned to seated work in the screening areas after injury, and continued in that capacity until late . He sought care and restrictions were tightened. The employer provided accommodating work in an office setting. Mr. stopped all work due to worsening pain an inability to walk significant distances on

I find only a single report on file which addresses causation – that of Mr. on . No report in file which is authored or countersigned by a physician establishes a causal connection between any diagnosis and the lifting duties While diagnoses of disc displacement, stenosis and sprain are in file, no opinion has linked these diagnoses to employment. The Office accepted a sprain as related to the lifting. Shortly thereafter, the Office expanded the claim to include mild stenosis.

When it has been determined that the original decision may have been issued in error, the CE is responsible for performing any necessary case development to fully resolve the issue. If, after proper development, it is established that the original decision was issued in error, the CE is responsible for issuing a proposed and final decision rescinding the original finding.[2] As rescission of a claim or a portion of a claim is often complex, the Notice Of Decision memorandum should be used. A rescission decision should contain a brief background of the claim, discuss the evidence on which the original decision was based, and

[2] FECA Procedure Manual Section 2-1400-19(b).

explain why the Office finds that the decision should be rescinded. The evidence used to rescind the claim should be thoroughly discussed so that it is clear to the reader how the case was incorrectly adjudicated, and why the original decision is now being invalidated.[3]

The Office addressed the defect in the medical decision making in the proposal. No evidence to the contrary was received, and on the Office rescinded the stenosis diagnosis. I find that the Office met its burden to demonstrate an error in the acceptance. While Mr. Felser argues that a conflict exists, there is no probative opinion linking the stenosis to the employment incident. I affirm the rescission decision. No opinion in file linked that finding to the work incident, and an opinion from Dr. attributes the condition to an unrelated degenerative process; the Office accepted a condition without positive medical opinion, and has properly rescinded that allowance.

Turning to the termination of benefits relative to the lumbar strain diagnosis, I again note that no report from a physician as recognized by the Office. Treatment by an advanced practice nurse or a physician's assistant is payable as a medical expense under 5 U.S.C. 8103 of the Act. However, a report from an advanced practice nurse or a physician's assistant is not competent medical evidence to support a diagnosis, disability or need for additional medical treatment unless the report is co-signed by a physician.[4]

In spite of this, the Office did accept a lumbar strain based on the report of Mr. The strain diagnosis was not included in the rescission decision, and stands as a claim allowance. Dr. opined that the strain had resolved, but he offered exam findings which are not apparently consistent with that opinion. Curiously, Mr. was able to continue to work in some capacity for over 4 months after injury, until stopping all work in November. It is not entirely clear whether the disability is related to the lifting incident of an unrelated condition, or some combination thereof.

I have carefully reviewed all the evidence of record and find that the decision should be reversed for the reasons set forth below.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits. 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. Adina D. Blanco, 39 ECAB ___ (1988); Pauline Brown, 39 ECAB ___ (1988); Maria Kunsman, 39 ECAB ___ (1988); Calvin S. Mays, 39 ECAB ___ (1988); Velta H. Mikelsons, 39 ECAB ___ (1988); Vito S. Caprio, 39 ECAB ___ (1988); Gurchuran Dehal, 39 ECAB ___ (1988).

If the second opinion specialist submits an opinion which is equivocal, lacks rationale, or fails to address the specified medical issues, the CE should seek clarification or further rationale from that physician. When the OWCP undertakes to develop the evidence by referring the case to an Office-selected physician, it has an obligation to seek clarification from its

[3] FECA Procedure Manual Section 2-1400-19(d).
[4] FECA Procedure Manual Section 2-810-4(a).

physician upon receiving a report that did not adequately address the issues that the OWCP sought to develop. As such, the CE should seek clarification from the referral physician and request a supplemental report to clarify specifically-noted discrepancies or inadequacies in the initial second opinion report.[5]

As the report of Dr. is flawed by his failure to offer a fully reasoned opinion that the strain had resolved, the report is insufficient to support the decision of the district office. As such, compensation benefits should be reinstated. The Office should update the allowed conditions based on the fruits of the medical development, and prepare a revised SOAF which reflects the sole claim allowance. An addendum should be solicited from Dr. which explains his opinion on why the strain is resolved, and how the clinical exam findings were unrelated to the lifting incident of While the Office has properly rescinded the claim allowance of the stenosis, this does not bar the Office from further considering the scope of injuries suffered in the accident. To that end, as part of the referral, the Office should solicit an opinion from Dr. on any other claim allowances which are directly or by aggravation related to the lifting as described in the SOAF. The timeline of work status and symptom onset should be addressed as part of that response. Any disc injury should specifically be addressed, as the radiologist attributed the stenosis at least in part to disc bulges. This development will ensure that the Office has fully considered the injury claim prior to any further adverse decision.

For the reasons set forth above, the decision of is affirmed, and the decision of the district office dated is hereby **reversed**.

Issued:

Washington, D.C.

Hearing Representative
for
Director, Office of Workers'
Compensation Programs

[5] FECA Procedure Manual Section 2-810-9(j).