File Number:
HR20-D-H

RECEIVED MAR 19 2018

U.S. DEPARTMENT OF LABOR

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 Review of the Written Record, the case file was transferred to the Branch of Hearings and Review.

The review was completed on . As a result of such review, it has been determined that the decision issued by the District Office should be vacated and the case remanded to the district office for further action as explained in the enclosed copy of the Hearing Representative's decision.

Your case file has been returned to the Dallas 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 16 DAL
LONDON, KY 40742-8300

Sincerely,

Electronically Signed

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

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.

Washington DC, March 15, 2018

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

Examination of the written record was completed on Based on the review, the decision of the district office dated is set aside and the case remanded to the district office for further development.

The issue for determination is whether the district office properly adjudicated the claim for recurrent wage loss in their decision of

is employed as a with the was involved in a minor motor vehicle accident while performing her duties on She reported that while stopped at an intersection she was struck from behind. initially refused treatment, but several days later reported whiplash symptoms to occupational medicine specialist , MD. Claim was allowed for cervical and lumbar strains.

In an Attending Physician's Report dated Dr. noted a history of concurrent or pre-existing injury or disease of the cervical or lumbar spine, but did not elaborate. The patient resumed modified duties two weeks after injury, and received physical therapy for her soft tissue injuries. A lumbar MRI study dated revealed disc desiccation and bulges at L3-4 and L4-5, with degenerative changes at those levels. A note dated from Dr. indicated pain free and full neck and back range of motion, with no motor or sensory deficits in any limb and normal reflexes. was discharged and released to her full duties on that date.

On the claimant filed a second CA-1, Notice of Traumatic Injury claim, reporting that on she tripped and stumbled on uneven ground while carrying a parcel on her route, suffering pain in her neck, upper back, lower back, hips, and buttocks; no fall occurred. continued to work, but later stopped all work or returning to full time modified work on She was again followed by Dr. for her complaints. By decision dated the Office accepted that the claimant sustained cervical and lumbar strains.

A new lumbar MRI study dated found no changes in the degenerative pathology identified on the study. continued to work with limitations. Beginning

Washington DC, March 15, 2018

the employer was unwilling or unable to fully accommodate the work restrictions in place, and began working part time in a modified assignment. She continued in a part time role until , when the employer provided full time accommodation and she again resumed full time work. In the ensuing five years, the claimant continued to work in a full time, modified assignment. Medical records document ongoing evaluations roughly every two weeks by Dr.

The claimant suffered several minor injuries while performing her modified duties over the years. Among them was a rib sprain suffered on , when the claimant tripped over a dog chain, stumbling but again not falling. Claim was allowed for a rib sprain.

Dr. saw the patient on , noting pain free and full cervical motion, with no tenderness to palpation. Lumbar motion was limited, but gait and stance were normal, strength was full, and no neurologic signs were identified. Work restrictions were continued. The patient was seen again for a "personal illness" and back pain on . Work restrictions were continued. The patient was seen again on for back pain and Chronic Obstructive Pulmonary Disease (COPD). No change in symptoms since the last visit was admitted, and work activities were continued at the usual level.

On Dr. saw the patient, who reported improvement in back pain intensity. The exam was relatively unchanged from prior visits, but the physician retroactively disabled her beginning without explanation. His active diagnoses were thoracic and lumbar disc degeneration and COPD.

On Dr. wrote the district office, asking for approval for an inpatient drug rehabilitation program to wean the patient off the narcotics he had been prescribing for years. He noted that no disc herniation was identified after the 2008 injury, and no surgery was warranted. He indicated active diagnoses of lumbar and thoracic disc disease, offering no support for the allowed lumbar and cervical strains. The letter referenced no case file number, and was consequently filed under the 2014 rib injury case record. No response from the district office has been identified in any case record.

At a visit the patient reported that she had been seen in an Emergency Room (ER) two days earlier. She reported nausea and migraines, and attributed the symptoms to her back pain. Exam was unchanged, and Dr. continued her disability status.

On 1 Dr. T wrote the advising that the patient remained under his care for thoracic and lumbar strains with chronic severe back pain associated with significant degenerative thoracic and lumbar disc disease, which he attributed to the stumble on He added that on or around his patient had severe pneumonia and bronchitis that required the use of antibiotics and work cessation. Concurrent severe and increased back pain was noted, and disability was recommended due to the exacerbation of back pain and upper respiratory infection. He specifically offered, " indicated at that time that she was in fear of returning to work in any capacity as this might significantly impact and/or increase her level of back pain requiring even more use of pain medication from which she had been trying to wean off." He explained that she had been taking

potentially addictive narcotic pain medications for years, and she was apprehensive that a return to work might aggravate her back pain and consequently increase her use of these medications. He had attempted to admit his patient to a treatment facility for pain medication but insurance issues prevented this. He noted chronic severe degenerative thoracic and lumbar disc disease, with a dependence on narcotics.

A lumbar MRI study dated was submitted; no comparison to the prior studies was conducted. Mild degenerative changes were identified at L3-4, L4-5, and L5-S1 with disc desiccation and diffuse protrusion at L3-4, and a broad disc protrusion at L4-5.

On filed a claim for total disability for period to indicating "on the job injury" on the leave request form. The employer noted that the claimant returned to work on and had last worked or It was noted that it appeared that the claimant had been off since then for a non-work issue. also filed a claim for total wage loss beginning and continuing.

On the district office wrote asking for evidence relating the current need for wage loss benefits to the traumatic injury of It was noted that medical exams contemporaneous with the period of claimed disability identified numerous comorbid medical conditions not accepted by the Office as related to the stumbling injury of was to submit medical opinion identifying any relationship between the current medical status and the work injury of 2008, and to address the need for total work cessation in light of the continued accommodation of the work restrictions. Thirty days were afforded for a response.

The claimant responded to the development letter, explaining that Dr. only treats her back condition. She admitted that in she was diagnosed with pneumonia and bronchitis. Her back pain was aggravated by the coughing. She suggested that the narcotics Dr. had prescribed "could very well have caused [her] respiratory depression". She denied any relationship between her bronchitis or pneumonia and her work disability. She referenced a MRI, which she felt explained her back issues.

A Duty Status Report datec indicated full time work capacity with restrictions secondary to chronic degenerative disc disease. However, in a separate note, Dr. indicated on that the patient was not able to resume work until

Dr. wrote on reporting a motor vehicle accident on with injury to the neck, upper and lower back. A second injury on was caused by a stumble on uneven ground, again with injury to the back and neck. The patient had been treated conservatively over the years, and was diagnosed with chronic pain and degenerative thoracolumbar disc disease as a result of the motor vehicle accident and subsequent injury. The patient was addicted to pain killers, but no intervention had been initiated due to costs. She was being followed by a pain management physician (Dr.), who also had not been successful in reducing her usage.[1] The patient has been totally disabled for the past

[1] There are no reports in file documenting any exam or treatment by Dr.

year and continues to suffer from chronic low back pain as a result of severe degenerative lumbar and thoracic disc and spine disease.

Dr. wrote the Office on , indicating that I was totally disabled beginning He referenced his letter of , noting severe and chronic back pain associated with significant degenerative thoracic and lumbar disc disease as well as lumbar and cervical sprains that he had treated the patient for since Dr. argued that the Office had accepted the sprains as well as degenerative lumbar and thoracic disc disease due to the injury. He also clarified a reference to a pulmonary condition in his report, denying that he had ever treated the patient for COPD. He further argued that beginning the patient was totally disabled due to an exacerbation and aggravation of the chronic and severe back pain which occurred at work on that date. Dr. opined that the degenerative disc disease developed over several years after her injury, and those diagnoses have been confirmed by numerous specialists. The patient, in spite of use of medications, has episodes of severe pain which require temporary time off work. The patient usually was able to resume work after such episodes, but her attempt to perform light duty work on aggravated the underlying degenerative condition to such a degree that the patient was unable to resume any work, and remains totally disabled.

Chart notes documented ongoing office visits with Dr. through .

By decision dated the Office determined that the claimant did not provide sufficient medical evidence to establish a need for recurrent disability secondary to her traumatic injury of The Office acknowledged review of the statement as well as additional medical records, but noted that record indicated disability was secondary to pulmonary or respiratory conditions and chronic degenerative thoracolumbar disc disease rather than a spontaneous worsening of the traumatic injury.

The claimant's attorney, Paul Felser, disagreed with the denial and requested a hearing by letter dated . A hearing was scheduled for , Prior to hearing, the claimant's attorney requested that the hearing be converted to a request for review of the written record. No argument was submitted in support of the appeal. A new chart note from Dr. dated offers no new opinion or findings relative to the claimed recurrence of disability.

On the Branch of Hearings and Review sent a letter to the claimant's employing agency requesting comments or documents believed to be relevant and material to I claim. No response from the employer has been received. The Branch now conducts the review of the record. No new evidence has been submitted.

I have carefully reviewed all the evidence of record and find that the decision must be set aside for several reasons.

The first issue that must be addressed is the unanswered requests for drug rehabilitation. A review of the record shows very clearly that the claimant has been prescribed large

quantities of narcotics for many years. The prescribing physician has indicated an addiction issue, and the need for intervention.

Where recommended by the treating physician, the Office may approve a one-time inpatient substance abuse treatment program up to 28 days in length. Such a program may be approved even if the Office has not accepted substance abuse as related to employment in cases where the abuse is hindering the claimant from participating in a rehabilitation program or securing employment. The treatment facility should be located within 25 miles of the claimant's home wherever possible, and a cost comparison between comparable facilities should be made before care is authorized. Any request for a subsequent course of inpatient substance abuse treatment should be forwarded to the National Office for consideration. Outpatient treatment may be recommended by itself or as a follow-up measure to inpatient care. Such treatment may be authorized when recommended by the attending physician, as may medications prescribed to alleviate the effects of addiction (e.g., Antabuse). Likewise, counseling in a group setting may be undertaken at OWCP expense.[2]

Medical Rehabilitation refers to those medical and related services necessary to correct, minimize or modify the impairment caused by a disease or injury so that the injured worker can return to an adequate level of function and employment. Thus, it is distinguished from actual medical treatment to cure or relieve the effects of the injury. Various medical rehabilitation services can be provided during this phase. These include coordination of care in cases of catastrophic injury; Functional Capacity Evaluations (FCE), work hardening, or any other physical therapy program aimed at producing work tolerance limitations; clarification of a work release and/or imposed work tolerance limitations; speech therapy, orthotics, prosthetics, or other assistive devices that would make the claimant employable; and/or psychiatric pain management counseling. Substance abuse treatment may be considered if substance abuse prevents an injured worker from participating in a rehabilitation plan or returning to work.[3]

The above guidance establishes the Office obligation and authority to approve the requested treatment. This should be done upon return of the case record to the district office.

The remaining issues in file are complicated by the similarities in the allowed diagnoses between the accident and the stumble.

Cases should be doubled when correct adjudication of the issues depends on frequent cross-reference between files. Cases meeting one of the following tests must be doubled: A new injury case is reported for an employee who previously filed an injury claim for a similar condition or the same part of the body. For instance, a claimant with an existing case for a back strain submits a new claim for a herniated lumbar disc; two or more separate injuries (not recurrences) have occurred on the same date, or adjudication or other processing will require frequent reference to a case which does not involve a similar condition or the same part of the body. For instance, an employee with an existing claim for carpal tunnel syndrome files a new claim for a mental condition which has overlapping

[2] Federal Employees' Compensation Act Procedure Manual Section 3-0400.5 b.(4).
[3] Federal Employees' Compensation Act Procedure Manual Section 8-0100.8a.

periods of disability. Cases should be doubled as soon as the need to do so becomes apparent.[4]

It is clear that Dr. and the claimant have combined the effects of the motor vehicle accident and the stumbling incident of in addressing residuals and treatment of those incidents. The allowed diagnoses are also identical in those claims. While the medical record reflects that the strains of resolved, medical care was discontinued, and the claimant resumed regular work, Dr. has now opined that residuals of both incidents remain active and disabling; doubling of the claims is necessary to address this matter.

In reviewing the record, I find no medical opinion indicating that the strains of or remain active. There is prima fascia evidence of a link between the thoracic and lumbar disc disease and the injuries of and Dr. also suggested that suffered a respiratory infection in , which was in part the basis for her initial work stoppage, but also noted that the back injury was exacerbated by the coughing. It is not clear whether the work stoppages of and were related to the allowed conditions. It is not clear whether sufficient evidence exists to warrant claim expansion to include the thoracic and lumbar disc disease identified by Dr. . It is also not clear if the work stoppage was based on the inability to perform the modified assignment as written, or if the drug dependency issue impacted ability to continue in that position.

The medical evidence required to establish a causal relationship, generally, is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician 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 specific employment factors identified by the claimant.[5] When the medical report is *prima facie* sufficient but the opinion provided is unrationalized or speculative, the Office may find that causal relationship cannot be properly determined on the basis of the medical evidence of record. When this happens, the Office must obtain additional medical evidence.[6]

Recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[7]

To better understand the issues of claim expansion and work capacity, a second opinion exam with a board certified orthopedic surgeon is necessary. The Office must first prepare an accurate Statement of Accepted Facts, which clearly documents the prior injury under file and the instant file, as well as the limited work duties performed from

[4] FECA Procedure Manual Section 2-400-8.
[5] Victor J. Woodhams, 41 ECAB (Docket No. 89-1717 issued December 20, 1989).
[6] FECA Procedure Manual 2-805-5.
[7] Federal Employees' Compensation Act Procedure Manual Section 2-1500-7.

forward. The Office should then refer the claimant for an exam with the specialist, seeking an opinion on the current pathology, to include objective clinical findings in addition to any diagnostic studies used in making the diagnoses. The physician should then offer a reasoned opinion, acknowledging the factual exposure as explained in the Statement of Accepted Facts, regarding the continuation of the cervical and lumbar strains as accepted under the instant case. The physician should also offer a reasoned on opinion on whether the degenerative disc disease or any disc pathology of the thoracic and lumbar spine bears a relationship by direct causation or aggravation to the injuries of or This opinion should demonstrate awareness of all diagnostic studies available in the record, as well as the mechanisms of injury involved in both claims. The physician should also offer a reasoned opinion regarding the claimant's ability to continue to perform the modified assignment as last worked in . Work capacity going forward should be discussed. Treatment recommendations should also be solicited. Upon receipt of such a response, and the completion of any further warranted development, the Office should address the possible claim expansion, and then issue a de novo decision on the claims for wage loss benefits for period to and forward.

Accordingly, the decision of the Office dated is set aside, and the case file is remanded to the district office for additional development as indicated above.

Issued:

Washington, D.C.

Electronically Signed

Hearing Representative
for
Director, Office of Workers'
Compensation Programs

Washington DC, March 15, 2018