

File Number:
HR12-D-H

RECEIVED MAY 03 2011

U.S. DEPARTMENT OF LABOR

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

APR 28 2011

Date of Injury: 09/12/1992
Employee:

Dear Ms. :

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 02/07/2011. Based upon that hearing, it has been determined that the decision of the District Office should be reversed as outlined in the attached decision.

Your case file has been returned to the Chicago 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 10 CHI
LONDON, KY 40742-8300

Sincerely,



Carol E. Adams
Hearing Representative

UNITED STATES POSTAL SERVICE
LAKELAND PERFORMANCE CLUSTER
INJURY COMPENSATION OFFICE
P O BOX 5024
MILWAUKEE, WI 53201

PAUL H FELSER
ATTORNEY AT LAW
7 EAST CONGRESS ST
SUITE 400
SAVANNAH, GA 31401

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 United States Postal Service; Case number _____ hearing was held on February 7, 2011.

F.A.

The issue for determination is whether the Office has met its burden of proof to terminate the claimant's compensation and medical benefits.

The claimant was employed by the United States Postal Service as a letter carrier. She filed an occupational claim for date of injury of September 12, 1992. She first stopped working on that date. She claimed she injured her back as the result of lifting trays of mail at the set up stage of her route and transferring the trays of mail to her jeep.

In a letter dated September 17, 1992, the claimant stated that her pain occurred throughout the previous week. She noticed muscle tension and strain in her lower back. She tried to get an appointment with her physician but was told she could not get an appointment until the following week. Dr. Apte, her doctor, advised her to take Advil and use heat on her back. Her back pain worsened and she again called her physician who advised her to go to the hospital. She stated she went to the hospital on September 13, 1992 and was diagnosed with disc disease and was sent home with medication. She saw her doctor the next day and he ordered bed rest because he believed she had ruptured a disc.

On October 14, 1992 the claim was initially accepted for displacement of lumbar intervertebral disc at the L4-5 with sciatica. Later, the following conditions were added as accepted conditions: closed dislocation of lumbar vertebra, lumbago, insomnia with sleep apnea, convulsion (due to medication taken for the work injury) and backache.

There was a question as to whether the claimant suffered a traumatic injury or an occupational injury. Therefore, on November 18, 1992 a telephone call was made to the claimant to obtain additional information as to how her injury occurred. The claimant indicated her injury happened over a period of time (more than a week) from the work she was performing before September 12, 1992. The claimant stated, about a week before the injury, she was working a heavy workload lifting trays and bags of mail.

According to the Office Statement of Accepted Facts (SOAF), the claimant filed another claim for injury for date of injury of March 20, 1995. She was hit with a hamper, thrown off balance and claimed she injured her lower back.

In a letter dated March 23, 1995 to Dr O'Neil, the claimant reported a hamper was pushed her way which caused her to fall backward and twist her back. She advised the doctor she treated herself with heat and medication. She indicated that her treatment did not help, which she believed was due to her daily standing at work. She asked the doctor for permission to obtain chiropractic treatment.

By District Office letter dated May 11, 1995, the claimant was advised that she would need to file a CA-1 for a new traumatic claim of injury. She was also advised that treatment and compensation claims would not be paid.

The claimant never filed an injury claim for the hamper incident of May 20, 1995.

The claimant later filed a traumatic claim for date of injury of March 19, 1998. The case was created under case number [redacted]. She felt pains in her lower back and hip after standing up to pull her chair closer. The claim was accepted for herniated disc at the L4-L5. The claim was combined with the present case and was made a subsidiary to it.

As the result of her injuries, the claimant stopped working and was paid compensation for total disability every twenty-eight days automatically.

The Office referred the claimant for a second opinion evaluation. The claimant was seen by Dr. Kimball Fuiks on December 21, 2009. The Office posed five questions to the doctor. The doctor's responses to the questions are listed below.

1. What was his assessment of her back condition?

- Ms. Lori Adams carries the diagnosis of lumbar degenerative disc disease. Her lumbar disc disease would be considered chronic and unrelated to any work-related injury. Her objective finding on today's examination show that she can forward flex to 90 degrees with ease and that she can walk evenly and pivot with ease. She has no neurologic weakness and therefore no clinically significant disc herniation.

I do not believe that this examinee has a significant disc herniation at the L4-5 level. There are many MRI reports that can be generated whereby the radiologist or neuro-radiologist will interpret a lesion as being consistent with a disc herniation and may label the disc herniation as very small. On the basis of her clinical examination, I would contend that the L4-5 disc structure is degenerative in nature and that there might be impurities in the contour of the disc structure that would mimic a disc herniation. Clinically speaking, there is no disc herniation that is causing significant symptoms and signs that would warrant active intervention, either conservative or more aggressive.

As for narcolepsy and sleep apnea, this examinee should have undergone a multiple sleep latency examination which could document whether or not she has a verifiable organic cause for excessive daytime sleepiness. It is my contention that these diagnoses are muddled by the fact that she was on drugs and medications that might have induced sleep very easily.

Once again her objective findings on clinical examination i.e. the negative Faber's, straight leg raising tests, and normal motor examination as well as sensory examination, do not support the diagnosis of a clinically significant lumbar disc herniation. If narcolepsy and sleep apnea remain relevant at this point, I would authorize that the patient visit with a sleep specialist i.e. a neurologic or pulmonary specialist and have the appropriate tests conducted.

2. Were the claimant's subjective complaints consistent with objective findings? The doctor provided the following response:

- No. The patient does complain of back, bilateral buttock pain and leg pain but she does not have physical examination findings on her neurospinal testing that back up her clinical symptoms. Put another way, there are no objective findings on her neuro-orthopedic examination that are consistent with her subjective complaints. On certain occasions, individuals with lumbar degenerative disc disease can have chemical irritation created by the disc to the neighboring structures that result in irritation to the nerve root and this examinee might be feeling some of those complaints but her clinical examination does not show a lot of nerve root irritation and therefore I would not recommend any active therapy at this point other than a home exercise program and occasional follow up with her family physician and physical therapist.

3. Was there any current connection between any current condition and the employment injuries or activities as noted in the SOAF?

- No. I do not agree with either Dr. Morton or some of the other examiners who would contend that she suffered a work-related complaint or injury. Although Dr. Mark Benson had awarded her a 1% permanent partial disability rating, and although I would find it difficult to retract that, I would not consider that this examinee has sustained any permanent work-related injury that would result in permanent restrictions. If this patient cannot perform certain tasks and it is my concern that she may not be up to the task of medium work (Department of Labor standards), those restrictions are due to her degenerative condition and due to the consequence of natural disease and aging and not to any work-related injury.
- Although she has had a series of aggravations to her lower back due to the impact of certain work activities, most of those aggravations would have healed within 90 to 120 days following the injury. If one goes back to Dr. Stephen Robbins' report, he does not believe that she suffered any radiculopathy and he felt she was capable of returning to full time work within one month after his examination. I recall that his examination was performed in January 1993 and that he felt that she could resume full activities in February of 1993. Much time has elapsed since that report was written and **I would contend that this examinee would benefit from a functional capacity evaluation to better determine her restrictions for future work. In conclusion, I do not feel that she should be totally disabled as the result of a series of incidents that occurred in her spinal history over the last sixteen years.**

4 Was a pre-existing condition aggravated by any employment injury or activity as described in the SOAF? The doctor provided the following response:

- This patient suffered a temporary aggravation of her back condition as the result of her work-related injury. I would consider that temporary aggravation a musculoskeletal lumbar strain and not a herniated disc or a protruding disc or a focal disc herniation as described in the reports. This aggravation in 1992 would be considered temporary and would have lapsed after 90 to 120 days. As for the other injuries that took place in 1995 and 1998, I would adhere to the same thesis that I have provided for the 1992 injury

5. Had the claimant reached maximum medical improvement from conditions that resulted from the work injury or activities? The doctor provided the following response:

- Ms. [redacted] has reached maximum medical improvement from conditions attributable to her work injury and activities. I would contend that she reached maximal medical improvement 90 days following each of her work-related events so that her maximal medical improvement would have been reached by late 1998.
- As for whether the claimant could work, I would strongly recommend that she undergo a functional capacity evaluation to determine her capacity for physical and for locomotive types of work. She might only be capable of performing sedentary work with minimal lifting and with frequent change in position but I would be willing to put her through the task of a functional capacity evaluation to better determine her capabilities. In the absence of any functional capacity evaluation, I would certainly recommend that she try a sedentary job for limited hours during the course of the day to be slowly and progressively increased and lengthened to the eight hour day

The Office determined there was a conflict in medical opinion between the claimants's attending physicians and the second opinion physician. The Office scheduled a referee examination to resolve the conflict.

On June 3, 2010 the claimant was seen by Dr. Thomas Marra, neurologist, for referee evaluation. In a report dated June 24, 2010, the doctor provided the answers to questions posed to him. The doctor was asked to respond to eight questions. The first five questions were similar to the five questions asked of the second opinion physician.

The Office questions and the doctor's responses are summarized below as follows:

1. Assessment of the claimant's back condition, narcolepsy and sleep apnea

- The doctor noted that the MRIs between 1992 and 2006 revealed mild chronic lumbar spondylosis predominately at the L5-S1 level and to a lesser extent at the L4-L5 level. He stated that the conditions were chronic, likely pre-existing, and unrelated to any work-related injury. He also noted that the claimant did not have significant herniation at the L4-L5 level and that there were no objective clinical findings to support the diagnosis of

discogenic lumbar radiculopathy related to either the L4-5 or L5-S1 discs. The doctor referenced a September 1992 EMG and stated, "...she did have some EMG support for the diagnosis of acute L5 radiculopathy in her right leg, but only 12 days after the workplace injury of September 12, 1992, suggesting that the radiculopathy was pre-existing. Since spinal imaging revealed only minor findings at the L5-S1, I suspect her radiculopathy was more likely due to release of inflammatory mediators than nerve root compression from a right lateral disc herniation."

- Regarding the sleep disorder, the doctor found that the claimant did not have true narcolepsy. The doctor based his opinion on the results of a "MSLT" test. He believed her excessive daytime sleepiness was attributed to the sedative effects of her various medications. He noted that at the time she was diagnosed with sleep apnea in 2000 the claimant was morbidly obese but that it seemed to improve following bariatric surgery. The doctor supported his opinion by noting that a 2006 sleep study failed to show any evidence of significant sleep apnea.

2. Were the claimant's subjective complaints consistent with objective findings?

- The doctor referred to the "Comment and Summary" portion of his report in which he discussed chronic pain syndrome. The doctor stated that the claimant's duration, severity, and level of disability claimed was far out of proportion to any of the objective clinical and diagnostic imaging findings. He also noted that the pain had persisted long after expected healing and stated "for what sounds like simple lumbar strain injuries of 1992, 1995 and 1998. The doctor determined that those injuries had healed and there was no longer any active tissue nociception to account for her pain syndrome. The doctor stated, "The latter can be best analyzed employing a bio-psychosocial model that address the claimant's emotional state and underlying behavioral operants, including primary, secondary and tertiary gain factors

3. Was there any current connection between any current condition and the employment injuries or activities as noted in the SOAF?

- The doctor answered "No" and stated that he agreed with Dr. Fuiks that the claimant did not sustain a permanent workplace injury, but rather a series of temporary aggravations of her lower back underlying degenerative spondylosis due to the impact of certain work activities and that most of the aggravations would have healed within 6 weeks or up to 90 to 120 days at very most following the injury

4. Was a pre-existing condition aggravated by any employment injury or activity as described in the SOAF?

- The doctor stated that the claimant had sustained a temporary aggravation of pre-existing lumbar spondylosis following the work place injuries of 1992, 1995 and 1998. He supported his opinion that the aggravations were temporary, stating "We know from the literature that the usual time course of healing for lumbar strain or non-specific low back pain is typically 6 weeks in 90 percent of cases, and it would be generous to extend this

healing time out to 6 months. More likely than not, she would have reached a satisfactory plateau of healing without residuals from each of the lumbar strain injuries of 1992, 1995, and 1998 within 6 months from the date of each injury.”

5. Had the claimant reached maximum medical improvement from conditions that resulted from the work injury or activities?

- The doctor stated that he agreed with the assessment offered by Dr. Kimball Fuiks that more likely than not the claimant would have reached maximum medical improvement from conditions attributed to her work injury and activities within 90 days to six months of each of the work-related events or by late 1998

6. Discuss the claimant’s ability to work and whether she had any work-related restrictions. Also, the doctor was asked to discuss the claimant’s ability to drive in minutes and miles

- The doctor reviewed the functional capacity test of April 2010 and determined that the claimant was capable of sedentary work. He also stated that that it was an inescapable fact that the claimant being on disability since 1998 now 12 years and the literature suggests that it is very unlikely for an individual been disabled for that period of time to ever return to gainful employment in any capacity. The doctor in response to the claimant’s ability to drive stated, “with concern to the driving issues and frequent motor vehicle accidents attributable to inattentiveness or excessive daytime sleepiness, I am not optimistic that she can safely drive to/from work.”

7. If the claimant was not able to work, the doctor was to estimate when and under what circumstances the claimant would recover sufficiently to perform some type of work

- The doctor again stated the claimant could do sedentary work with restrictions. He recommended the claimant start with limited hours and slowly progress to an eight hour day. He noted that the claimant had improvement with her level of sedation since she started taking Provigil that she should probably undergo a behind the wheel drivers readiness examination to assess her current ability to drive safely.

8. The doctor was asked to provide his prognosis and recommendations for continued medical treatment, physical therapy or work hardening. He provided the following response:

- “Ms. [redacted]’s prognosis to return to work is poor for the reasons noted above. Her workplace lumbar strain injuries of 1992, 1995, and 1998 have long since healed and no longer require any specific formal physical therapy, chiropractic therapy, or anesthetic pain relief injections that are administered at presumed peripheral pain generator sites. None of these interventions will provide any lasting relief and may only serve to reinforce the concept of chronic pain and disability in this emotionally vulnerable individual who is probably at risk to develop a dependent relationship on health care providers. In my experience, the best treatment approach for a chronic pain syndrome is referral to a multi-disciplinary pain management program that takes a broad bio-psychosocial view of chronic pain, rather than a narrowly focused and mechanistic

approach that emphasizes injections. The best results probably occur in patients who have no unresolved primary or secondary gain issues. Since Ms [redacted] continues to have such primary and secondary gain issues and has also failed three previous pain clinics, I am not optimistic that another pain clinic referral will resolve her problems. Certainly, a home-based physical therapy program that emphasizes stretching and range of motion and aerobics can be readily recommended to maintain fitness. She will likely need to continue on scheduled narcotics and anti-depressant therapy. Due to the complexity of her emotional problems, this should be under the direction of a psychiatrist.”

The Office determined additional information was needed from Dr. Marra. By letter dated August 12, 2010 five additional questions were asked of Dr. Marra.

The Office questions and the doctor's answers are as follows:

1) Do you ascribe that there are continuing residuals of the claimant's work injuries, to include chronic pain syndrome; a pain disorder associated with both psychological features any general medical condition; narcotic dependency; and generalized anxiety disorder; muscular spasms; lumbar disc displacement; radiculopathy; spondylolisthesis; daytime somnolence; restless leg syndrome; myofascial pain syndrome; seizure disorder; facet joint hypertrophy at L4/5 and L5/S1; lumbar spondylosis at L4/5 and L5/S1? Please explain your reasoning, supported by objective medical findings. Do you feel that her chronic pain syndrome is a direct result of the lumbar injuries?

Doctor's Response: The above noted list of diagnostic impressions represents a summary of her current medical problems and does not imply that there is causation to any of the three workplace lumbar strain injuries of 1992, 1995, and 1998. In fact, all three of those lumbar strain injuries would have predictably resolved without residuals within 90 days from the date of the injury. Although the etiology of chronic pain syndrome is a controversial and somewhat thorny issue, individuals with this disorder likely have a pre-existing bio-psychosocial framework that is not work-related but does make them more vulnerable to develop various chronic pain disorders. Such individuals frequently have a history of pre-existing anxiety and depression but lack psychological insight, and the tendency to somatize may be due to the examinee's inability to appropriately address psychological conflicts. Such conflicts then emerge in the form of a physical complaint or chronic pain syndrome. The duration and intensity of such chronic pain syndromes are probably further augmented by patient's expectations and the reinforcement of the legal community and healthcare system that further promotes the concept of chronic pain, disability, and the sick role. In essence, the somatoform disorders are not caused by any particular workplace injury, but they adversely affect the recovery and rehabilitation from such injuries.

2) Please provide your rationale for indicating that there was only a temporary aggravation of the degenerative disc disease. Please provide your rationale and a specific date as when you feel the aggravations ceased for each injury. Please explain as to whether or not there is an exacerbation or acceleration of the degenerative disc disease.

Please provide your rationale as well as objective medical findings to support your reasoning

Doctor's Response: "The mechanical factors associated with each of the workplace injuries reported from September 12, 1992, March 20, 1995, and March 19, 1998, all indicate that these were relatively minor injuries, in essence acute lumbar strain injury only occurred. We know from the literature that the natural history of a lumbar strain injury is favorable, and approximately 90 percent of individuals will have a satisfactory resolution of acute low back pain within six weeks. You may be interested to read the review article on persistent low back pain published in the New England Journal of Medicine (May 5, 2005); 352: 1891-98. The authors have stated that low back pain without sciatica, stenosis, or severe spinal deformity is common with a reported point prevalence as high as 33 percent and a one year prevalence as high as 73 percent. In physically active adults not seeking medical attention, the annual incidence of clinically significant low back pain (pain level 4 or more on a 10 point scale) with functional impairment is approximately 10 to 15 percent. Acute low back pain (lasting three to six weeks) usually resolves in several weeks, although recurrences are common, and low grade symptoms are often present years after an initial episode. Serious or persistent disability is uncommon even among those with low back pain lasting more than three months. Risk factors for the development of disabling chronic or persistent low back pain (various defined as lasting more than three months or more than six months) include pre-existing psychological distress, disputed compensation issues, other types of chronic pain, and job dissatisfaction. The authors go on to mention that even when one or more of these adverse factors are present, only six percent of individuals were out of work for more than a five year period. I have stated in the report that Ms. [redacted] likely had some evidence of mild to moderate pre-existing degenerative disease of the lumbar spine and lumbar discs, and, in my opinion, the relatively minor lumbar strain injuries of 1992, 1995, and 1998 would not have accelerated the progression of the known natural history of her degenerative spine disease beyond its known rate of progression."

3) Please explain as to whether or not the claimant can return to her date of injury job as a letter carrier. If not, what are her limitations? Are the conditions of chronic pain syndrome; subluxation; muscular spasms; radiculopathy; seizure disorder; pain disorder associated with both psychological features and general medical condition; restless leg syndrome; narcotic dependency; generalized anxiety disorder; lumbar disc displacement; daytime somnolence; myofascial pain syndrome causally related to the claimed work incidents? Do any of the conditions limit her ability to work in a sedentary position? It is noted that, you indicated that she cannot drive safely. However, this office does not feel that this is a limitation, only it is much as a claimant can find other transportation to and from work.

Doctor's Response: the problem list noted above is not causally related to the three lumbar strain injuries of 1992, 1995, and 1998. As noted above, these were all relatively minor lumbar strain injuries that would have predictably resolved within 6 weeks (90 percent probability) or up to 90 days at the outside. Whether or not she can return to a sedentary work situation is difficult to say and primarily depends on her motivation. From

the physical point of view, she should be able to meet the demands of a sedentary position. Nonetheless, one is also confronted by the inescapable fact that she has been on disability for 12 years, and individuals who have been away from the workplace for that duration of time, are seldom able to successfully re-enter the work force in any capacity. I am, therefore, not terribly optimistic regarding her chance. Because of medication-related excessive daytime sleepiness, she is unable to safely operate a motor vehicle, and she will need to use alternate transportation to reach her place of employment. It is my understanding that your office does not consider this to be a limitation.

4) Do you feel that her emotional conditions, daytime somnolence, and narcotic dependency a[re] causally related to the work incidents or have any bearing on her ability to perform sedentary work? Please explain your rationale.

Doctor's Response: As I have indicated above, this individual had pre-existing emotional or psychosocial vulnerabilities that likely make her more prone to develop a chronic pain syndrome. Her medication-related excessive daytime sleepiness and narcotic dependency have developed as a result of efforts to treat her chronic pain syndrome and not the three relatively minor work-related lumbar strain injuries of 1992, 1995, and 1998. Those injuries have all long since healed, and there is no longer any peripheral pain generator emanating from the lumbar spine that requires her use of narcotics or other sedative medications.

Based on the referee opinion, the Office issued a proposed termination of benefits on July 6, 2010.

By decision dated September 17, 2010, the proposed action was made final and all compensation and medical benefits were terminated.

The claimant disagreed with the decision and requested a hearing before an OWCP representative.

A hearing was held on February 7, 2011. The claimant was represented by attorney Paul Felser. Mr. Felser requested and was granted an additional thirty days to submit argument and evidence.

A copy of the hearing transcript was sent to the employer for comment. No comments were submitted.

After review of the evidenced, I find the Office has not met its burden to terminate compensation and medical benefits. Therefore, the decision of the Office must be reversed for the following reasons:

- Dr. Marra did not base his opinions on the SOAF. The Board has held that in situations where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper

factual background, must be given special weight.¹ Also, the Board has defined that a proper factual background is obtained by the doctor's review of a detailed SOAF and review of the claimant's entire file.² In this case the doctor's opinions were not based on the SOAF. He continuously indicated that the claimant only suffered lumbar strains as the result of the work injuries and ignored all the conditions that the Office advised him that were accepted in the SOAF. Therefore, Dr. Marra's report cannot be given special weight afforded to a referee examiner.³ The Office provided Dr. Marra with the SOAF to use as a frame of reference in forming his opinions. The SOAF made it clear that the Office had accepted the claim for lumbar disc displacement with sciatica, herniated disc at the L4-5, convulsions (seizures due to medication interactions), lumbago, insomnia with sleep apnea and backache. Dr. Marra was entitled to reject the Office acceptance of the conditions, but in doing so, without convincing rationale, his opinion has little probative or evidentiary value.⁴ If the impartial physician does not use the SOAF as a basis in forming his or her opinion the probative value of the opinion is seriously diminished or negated altogether.⁵

The Office found that Dr. Marra's opinion held the weight of medical evidence and terminated the claimant's compensation benefits for the reasons Dr. Marra provided. However, Dr. Marra's opinion was based on the premise that the claimant did not have the work-related conditions as outlined in the SOAF and indicated that many of the accepted conditions were due to other causes. The Office did not use the doctor's opinion to rescind the acceptance of the work-related conditions. Instead, the Office terminated medical and compensation benefits on the basis that the accepted work injury had ceased. The Board has held that it is a denial of due process requiring reversal for the Office to terminate compensation benefits on ostensibly grounds that a claimant no longer suffers residual of an accepted condition, where the record supports the real reason for the Office's action was that it had determined that the condition was not causally related to the claimant's employment and should not have been accepted as such.⁶ The Board has held the Office must correctly and accurately inform the claimant of the grounds on which a decision rests, so as to afford the claimant an opportunity to meet any defect appearing in the case.⁷

- Also, Dr. Marra, when referencing the injuries, does not seem to realize that the injury claim of September 12, 1998 was not a one-time incident but was caused by the work the claimant had performed on a day to day basis over a period of time. Therefore, many of his opinions were construed by the idea that it was a simple incident that caused the 1992 occupational claim and not one that came about over the course of time. For this reason the doctor's opinion that the claimant suffered only strains is not convincing.

¹ *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980)

² See *Roberts*, note 1

³ 5 USC § 8123(a); *Manuel Gill*, 52 ECAB 282 (2001)

⁴ *Willa M. Frazier*, ECAB _____ (Docket No. 04-120, March 11, 2004)

⁵ *id.*

⁶ See note 4

⁷ See note 4

I also find that the claimant has long been prescribed medication for her work injury conditions, which the evidence indicates she has become dependent upon. Also, the medical evidence indicates that it is the medications she has been prescribed that are causing her problems with her sleep and daytime drowsiness. I find the Office has not met its burden to support that all of her work injuries have resolved and are not disabling. The doctor also indicates the claimant developed a pain disorder and somatoform disorder. His statements, regarding the conditions relationship to the work injury, are vague and somewhat contradicting.

On return of the case file, the Office should schedule a psychiatric evaluation to determine if the claimant has developed a pain disorder or somatoform disorder as the result of her work injury. Psychological testing should be approved if the psychiatrist determines it is needed. The doctor should also be asked if the claimant has become dependent on prescribed pain medication as the result of work-related treatment. If so, he should be asked to provide recommendation for treatment of the drug dependency.

Before the Office refers the claimant for additional evaluations, the SOAF should be updated to include a clear description of 1992 injury. The SOAF should clearly reflect that the 1992 injury developed from work activities that occurred over more than one workday. The work duties should be clearly described. Also, there is evidence on record, in the paper portion of the record, that the Office accepted that the claimant aggravated her DDD as the result of her injuries.⁸ The aggravation should also be added to the accepted conditions in the SOAF. In addition, a search of the computer database and the paper file showed that the claimant never filed a claim for work injury for March 20, 1995. The SOAF should be updated to reflect this fact.

In accordance with the above findings, the decision of the Office dated September 17, 2010 is **reversed. Compensation and medical benefits are reinstated to the date of termination.**

Date: APR 28 2011
Washington, D.C.



Carol Adams
Hearing Representative
for
Director, Office of Workers'
Compensation Programs

⁸ In a SOAF dated June 23, 1998, for case number _____ it was noted that the claimant had an approved occupational disease claim for permanent aggravation of degenerative disc disease (DDD) at the L4-L5. There is also a referee decision in which the physician determined that the claimant suffered and aggravation of her DDD.