

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 10 June 2014

CASE NO.: 2013-LDA-333

OWCP NO.: 02-221034

IN THE MATTER OF:

DEBORAH H. BLAIR

Claimant

v.

DYNCORP INTERNATIONAL

Employer

and

CONTINENTAL CASUALTY COMPANY
c/o CNA International

Carrier

APPEARANCES:

GARY B. PITTS, ESQ.
For The Claimant

GREGORY P. SUJACK, ESQ.
For The Employer/Carrier

Before: LEE J. ROMERO, JR.
Administrative Law Judge

DECISION AND ORDER

This is a claim for benefits under the Defense Base Act, 42 U.S.C. § 1651, et seq., an extension of the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, et seq., (herein the Act), brought by Claimant against Dyncorp International (Employer) and Continental Casualty Company, c/o CNA International (Carrier).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. Pursuant thereto, Notice of Hearing was issued scheduling a formal hearing on September 25, 2013, in Covington, Louisiana. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. Claimant offered 14 exhibits, Employer/Carrier proffered 10 exhibits which were admitted into evidence along with one Joint Exhibit. This decision is based upon a full consideration of the entire record.¹

A post-hearing brief was received from the Claimant on the due date of February 14, 2014. Employer/Carrier belatedly filed a post-hearing brief without objection from Claimant on April 7, 2014. Based upon the stipulations of Counsel, the evidence introduced, my observations of the demeanor of the witnesses, and having considered the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

I. STIPULATIONS

At the commencement of the hearing, the parties stipulated (JX-1), and I find:

1. That the Claimant was injured on September 8, 2011.
2. That Claimant's injury occurred during the course and scope of her employment with Employer.
3. That there existed an employee-employer relationship at the time of the accident/injury.
4. That the Employer was timely notified of the accident/injury.
5. That Employer/Carrier filed a timely Notice of Controversion.
6. That an informal conference before the District Director was held on February 22, 2013.
7. That Claimant received temporary total disability benefits from October 5, 2011 through present at a weekly compensation rate of \$1,256.84.

¹ References to the transcript and exhibits are as follows: Transcript: Tr.____; Claimant's Exhibits: CX-____; Employer/Carrier's Exhibits: EX-____; and Joint Exhibit: JX-____.

8. That Claimant's average weekly wage at the time of injury was \$2,831.82.
9. That medical benefits for Claimant have been paid in the amount of \$41,990.00 pursuant to Section 7 of the Act.

II. ISSUES

The unresolved issues presented by the parties are:

1. Causation; fact of injury for all injuries except Claimant's lumbar condition.
2. The nature and extent of Claimant's disability.
3. Entitlement to and authorization for medical care and services.
4. Attorney's fees, penalties and interest.

III. STATEMENT OF THE CASE

The Testimonial Evidence

Claimant

Claimant was born in 1953 in El Paso, Texas. Her father was a Marine involved in the nuclear program. (Tr. 12). Claimant graduated from high school in 1971. She attended Texas Tech University for three years. She attended South Plains Junior College, where she took real estate classes. She earned an Associate Degree in Business from Merriman Business College. (Tr. 13).

Vocationally, Claimant worked in insurance and real estate before 1992. She also worked as an executive assistant and office manager. She worked in Human Resources from 1992 to 1998 for General Aluminum Corporation, from 1998 to 2001 for Simmons Mattresses and from 2004 to 2009 for Anderson Windows. (Tr. 14). Her duties in Human Resources included employee relations, recruiting, hiring, disciplinary action, termination, payroll, benefits, workers' compensation and safety. (Tr. 14-15). She was terminated by Anderson Windows before working for Employer, but the severance was the subject of a confidential agreement. (Tr. 16).

Claimant was a Human Resources generalist for Employer. She worked in Afghanistan and Kurdistan for a period of six months. Her job was to hire locals to work in fulfilling contracts. (Tr. 15). She did not recall undergoing a pre-employment physical for Employer. (Tr. 16).

Before her accident, Claimant stated she was in good health and active. (Tr. 16). When she was 30 years old, she was involved in a motor vehicle accident in which she injured her left knee. She had four to five surgeries on her left knee; the last surgery was eight to ten years ago. (Tr. 17).

Claimant's left knee was problematic before going to work for Employer, but it was functional. (Tr. 17). She had pain for which she took hydrocodone and walked 45 minutes daily four to five days a week before her accident. (Tr. 17-18). She could climb stairs and did not use a cane in the month before going overseas to work for Employer. She uses a cane now if walking for 15 minutes or more. She avoids stairs now as well. It is painful for her to walk after ten minutes of walking. (Tr. 19). She now has chronic knee pain, which is worse than before she went overseas. Before she began working for Employer, her pain was two or three out of ten and now it is six or seven out of ten on a scale of ten being the worst. (Tr. 20).

On September 8, 2011, she was descending stairs at about 11:30 a.m. Her right foot slipped, and she fell on the stairs. She hit her back on the stairs and her left heel was caught under her buttock. (Tr. 21). The next day, she reported the accident to her supervisor. She went to the medics on September 10, 2011. She reported lower back pain radiating into her left leg. (Tr. 22; CX-1, p. 1). She remained in Iraq for a couple of weeks before returning to the U.S. (Tr. 22).

Claimant treated with Dr. Cable on October 5, 2011. She reported numbness in her left foot, left leg pain and left knee pain. She was using a cane. She reported that her knee and leg are still problematic. She depicted her left leg pain in a drawing at CX-1, p. 5, where she reported pain in her entire left leg. (Tr. 23). An orthopedist informed her that she needed a total knee replacement. She has undergone physical therapy which has helped some, but her knee pain is still chronic and constant. (Tr. 24).

Claimant began treating with Dr. Cohen, a psychologist, in the spring of 2012 because she was suicidal, very depressed, had anxiety, could not sleep and felt isolated. (Tr. 24-25). She was prescribed Wellbutrin and Abilify for depression and Xanax for anxiety. (Tr. 26). The medications have helped. Her depression comes from her pain, little sleep and the loss of a great job with Employer. Psychotherapy was suggested. As an alternative, she attends AA meetings which she has attended since 1987. (Tr. 26). Her private health insurance covers Dr. Cohen's bills and medications, but she has paid out co-pays of several hundred dollars. (Tr. 27). Prior to her employment with Employer, Claimant attended AA meetings two times per week. Following her employment with Employer, she attends AA meetings four to five times a week. (Tr. 28).

Claimant testified she had medications for depression two to three years before she went overseas to work for Employer. She took the medications for six to nine months and stopped the medications two years before beginning work for Employer. (Tr. 28). That treatment was received from Dr. Mary Welp, a primary care physician. (Tr. 29). Claimant saw a psychiatrist for a six month period because of a divorce six or seven years before going to work for Employer. (Tr. 29-30).

Claimant described her prior health issues to include a tonsillectomy, a partial thyroidectomy, a hemorrhoidectomy, left knee surgeries, a right knee surgery, femoral bone tumor removal, repair of a synovial cyst of her spinal sheath, an amniocentesis, an appendectomy, and removal of a benign tumor from her spinal canal. (Tr. 30-31).

Claimant testified that she spends her life in her house. She experiences stress when she has to leave her house. Before going overseas, she was active in her church, but she does not attend church now. (Tr. 32). She would go out for coffee or dinner a couple of times a week before her accident, but not now. She lives alone. She makes herself leave her home to visit her granddaughter, go to the grocery store and attend AA meetings. She has to change positions every 15 to 30 minutes. Claimant has sleep problems. She cannot sleep every third night. (Tr. 33).

On cross-examination, Claimant affirmed that she was involved in a head-on motor vehicle collision in 1983 and sustained substantial injuries which required surgery. (Tr. 34-36). She hurt both knees in the motor vehicle accident and lost her teeth. She had ACL tears and a femur tumor which required

surgery as well. (Tr. 35). She tore her ACL while playing soccer. (Tr. 36). Prior to the motor vehicle accident, Claimant was a runner, but she did not resume that activity after her accident. (Tr. 36-37). She confirmed that she has dependency issues and has been going to AA since January 21, 1987. She has disclosed her dependency issues to all of her medical care providers since 1987. (Tr. 37).

Claimant has been treating with Dr. Westergaard for pain management since 2008. (Tr. 37-38). Before going to work for Employer, she had been prescribed medications and given injections in her thigh for her knee. (Tr. 38). She was also prescribed Lunesta for sleep well before going overseas. (Tr. 38-39).

Claimant takes Robaxin, a muscle relaxer, and hydrocodone, for pain. (Tr. 39). She could not recall whether she was taking Robaxin when she first began treatment with Dr. Westergaard. (Tr. 39-40). She did not disagree with Dr. Westergaard's records showing that Claimant was taking Robaxin. Claimant testified she has had lower back pain for 30 years before seeking treatment with Dr. Westergaard. Her pain level was at a six to eight out of ten for her lower back and left knee before going overseas. (Tr. 40). Claimant also received prescribed medication for depression and anxiety before going overseas. (Tr. 42).

Claimant reported stabbing pain, pins and needles sensations and shooting pain in her left leg following the work accident. (Tr. 44-45).

Claimant had a synovial cyst in the spinal sheath of her lumbar spine. This issue was 100 percent resolved by surgery. (Tr. 45). The cyst caused shooting pain that ran from her hip down to her feet on her left side. (Tr. 46).

On re-direct examination, Claimant confirmed that she had no physical limitations before her work accident. (Tr. 47-48). She went to the medic once in Afghanistan for treatment of a dysentery type illness. She did not have trouble sleeping while overseas. (Tr. 48). She stopped taking Lunesta for sleep about six months to one year before going overseas. (Tr. 48-49).

When overseas, she was required to walk two to three miles a day, climb stairs ten to 15 times a day and wear a back pack weighing 30 pounds. (Tr. 49). She also had to wear personal protective equipment weighing 60 pounds when she went off site. (Tr. 50).

On re-cross examination, Claimant stated her pain management doctor prescribed Norco, a form of hydrocodone, during her last visit in March or April 2011. The prescription ran out after six months. (Tr. 51).

On further re-direct examination, Claimant testified she took Cymbalta for depression and was later prescribed Paxil to wean her off the Cymbalta. (Tr. 52). She took Norco while in Afghanistan, for approximately three or four months until the prescription ran out. (Tr. 52-53). During the last few months before her work accident she was taking Ibuprofen and "Centurion," a thyroid replacement. She did not recall taking any other medications at that time. (Tr. 53).

On further re-cross examination, Claimant confirmed her last appointment with Dr. Westergaard was April 18, 2011. She was deployed on April 22, 2011. She was overseas for five months. (Tr. 54).

On further examination by the undersigned, Claimant testified she has problems with her neck during physical therapy. She did not seek any medical treatment for her neck after her work accident. (Tr. 55).

The Medical Evidence

Medical Clinic of North Texas Medical Records

On November 29, 2005, Claimant presented to Dr. Mary Welp with anxiety complaints. (EX-7, pp. 100-102).

On December 22, 2005, an MRI of Claimant's liver was reviewed, which revealed a tumor. (EX-7, pp. 98-99).

On April 5, 2006, Claimant presented with depression complaints. (EX-7, pp. 94-96). Her family history of bipolar disorder was discussed. Dr. Welp noted that a mood stabilizer would be needed if antidepressants were utilized. Claimant agreed to increase her Neurontin usage before trying an antidepressant. (EX-7, p. 97).

On December 13, 2006, an MRI of Claimant's thoracic spine was reviewed, which revealed a tumor at T11 and near total effacement of the spinal cord at that level. (EX-7, p. 86). She presented for a follow-up on March 6, 2007, after the tumor was removed. She was healing well. (EX-7, p. 82).

On February 16, 2009, Claimant presented with depression complaints. (EX-7, p. 69). On July 27, 2009, Claimant presented for medication monitoring. She was taking Cymbalta and Xanax for anxiety. (EX-7, p. 59). She indicated that the source of her stress was work and her daughter. (EX-7, p. 60). On March 9, 2010, Claimant presented with depression complaints, which she related to stress from losing her job. (EX-7, pp. 51-53).

Claimant presented on June 3, 2010, with thyroid complaints. (EX-7, p. 42). Claimant underwent a thyroidectomy on July 22, 2010. (EX-7, pp. 114-117).

Claimant presented for a follow-up on October 22, 2010. She was taking Cymbalta. (EX-7, p. 35). Claimant presented for a follow-up on November 2, 2010. She reported mood swings. She was trying to stop using Cymbalta. (EX-7, p. 32).

On March 10, 2011, Claimant presented for a follow-up. She was "weaning down" her usage of Cymbalta. Her mood was worsened but stable. (EX-7, p. 21).

On April 29, 2011, Claimant presented for a follow-up. She had "weaned off" of Cymbalta but was taking Paxil. She reported that she was going to Afghanistan. She was given a three month prescription of Paxil. (EX-7, p. 17).

Claimant presented for an examination by a physician's assistant on September 23, 2011. She had returned from Iraq earlier that day. She reported slipping while going down the stairs. She reported paresthesias in the left foot and two to three numb toes on the left foot. She had chronic low back issues, but traditionally got spontaneous spasms in the toes not numbness. She had swelling in the left calf and burning through the left pelvis, hip and leg. She had some thoracic spasm. (EX-7, p. 15). On neurological examination, Claimant had an absent ankle reflex on the left side. She could not bear weight on her left toes. Robaxin and Norco were prescribed. It was recommended that she begin treatment with an orthopedist. (EX-7, p. 16).

Plano Presbyterian Hospital Medical Records

Claimant was admitted to the Plano Presbyterian Hospital Emergency Room on October 20, 2007, for wound care following arthroscopic right knee surgery. (EX-5).

Dr. Deborah Westergaard

Dr. Westergaard's credentials were not presented in evidence. She performed a pain consultation for Claimant on June 13, 2008. Claimant reported pain in both knees, both hips and lower back pain. Claimant indicated that her lower back pain began 30 years earlier. She related her pain to a 1983 motor vehicle accident. (EX-6, p. 3). A spinal cord simulator was not considered for pain management because Claimant had a history of thoracic spine surgery and a thoracic spine schwannoma. (EX-6, p. 6).

On November 10, 2008, Dr. Westergaard performed a saphenous nerve block on Claimant's left knee. (EX-6, pp. 7-12). She performed a second saphenous nerve block on Claimant's left knee on November 24, 2008. (EX-6, pp. 13-18). On December 15, 2008, Claimant reported an 80 percent relief in pain. She had not used her cane since the injection. (EX-6, p. 19).

Claimant presented for follow-up evaluations on March 5, 2009, June 9, 2009 and September 17, 2009. (EX-6, pp. 23-39). On September 17, 2009, Dr. Westergaard performed a saphenous nerve block on Claimant's left knee. (EX-6, pp. 38-39). On November 3, 2009, Dr. Westergaard performed piriformis, quadratus and psoas myoneural injections at L4-L5. (EX-6, pp. 40-42).

Claimant presented for follow-up evaluations on June 29, 2010, October 12, 2010 and April 18, 2011. (EX-6, pp. 43-62). On April 18, 2011, Dr. Westergaard noted that Claimant was deploying to Afghanistan for three months. She prescribed Claimant a 90-day supply of Robaxin and a one month supply of hydrocodone, noting that Claimant's children could pick up her hydrocodone prescription for the following two months. (EX-6, p. 58).²

² EX-6, pp. 63-85 are irrelevant records related to another patient of Dr. Westergaard.

Deployment Medical Records

Claimant presented to the medic on September 10, 2011, complaining of lower back pain on the left side after slipping down three stairs two days earlier. She indicated that she struck her lower back on the stair. She reported no pain initially, but later that day she felt pain in her left lower back radiating down to her left leg. She reported experiencing lumbar and sciatic pain previously. On physical examination, no obvious deformities were noted. Claimant was tender in the left lumbar paravertebral area. She reported pain on flexion and extension. No motor or sensory deficits were noted. Motrin and Flexeril were prescribed. (CX-1, p. 1).

On September 20, 2011, Claimant presented for a follow-up. She reported lower back pain and numbness in the second and third toes of her left foot. She reported some relief from her medication. On physical examination, no obvious deformities were noted. Claimant reported pain on flexion and extension. No motor deficits were noted. On sensory examination, Claimant was plus two to three distally. Examination revealed symptoms in the left lower extremity in an L4-L5 nerve root distribution. It was recommended that Claimant return to the U.S. for treatment. Mederol Dosepak was prescribed. (CX-1, p. 1).

Dr. James D. Cable

Dr. Cable's credentials were not presented in evidence. Claimant was evaluated by Dr. Cable on October 5, 2011. She indicated that she was injured in Iraq when she slipped on stairs and hit her back. She noted that her knee was bent during the fall. She reported previously experiencing pins and needles sensation and a new sensation of numbness in her left foot. She reported weakness in her foot. At times, it would not respond when she wanted to move it. She complained of pain down her posterior legs and pins and needles feeling in the anterior leg down into the knee on the left side. She rated her leg pain at an eight to nine out of ten and her back pain at a seven to eight out of ten. She reported difficulty emptying her bladder but no incontinence. She reported worsened pain when standing and walking. She used a cane at times. Solu-Medrol and a Mederol Dosepak were prescribed in Iraq, but Claimant reported they did not help. She indicated that she was treated by Dr. Westergaard for pain management of prior medical problems. Claimant gave her medical history to include multiple knee procedures, a left femoral tumor operation in 1996, a synovial cyst removal at L4-L5 in 1998, a spinal cord tumor

removal in the thoracic cord in 2007 and a thyroidectomy in 2010. (CX-1, p. 3).

On physical examination, Claimant pointed to the SI joints on the left and L5-S1 as the source of her pain. Extension increased her pain. Flexion gave her some relief. She had a decreased patellar reflex on the right and a decreased Achilles tendon reflex on the left. She had diffuse decreased sensation involving the left lower extremity to light touch. (CX-1, p. 3). Manual motor testing showed some decreased EHL strength on the left. (CX-1, pp. 3-4). All other muscle groups were intact. A sitting root test was positive bilaterally, both causing left lumbar pain. Supine straight leg raising on the right was to 60 degrees and caused left lumbar pain. Supine straight leg raising on the left was to 50 degrees and caused low back pain into the left hip. Hip motion on the left and a Patrick maneuver caused back and hip pain. Dr. Cable opined that Claimant may have herniated the L5-S1 disc and sprained the sacroiliac joint. He prescribed Ibuprofen and Norco. He recommended physical therapy. (CX-1, p. 4).

Claimant began physical therapy on October 18, 2011. She complained of stabbing pain in the left hip, left ankle and down the back of the left leg. She had burning in the lower left posterior hip and upper leg, an ache in the lower back and pins in her left knee and left ankle. (CX-1, p. 5).

On December 15, 2011, an MRI of Claimant's back was performed. It revealed grade I anterolisthesis of L4 upon L5, measuring approximately nine millimeters. No suspicious narrow signal abnormality was demonstrated. Disc desiccation was present at multiple levels, most significantly at L4-L5. (EX-1, p. 3). Claimant also underwent an MRI of her hip, which revealed early symmetric osteoarthritis without evidence of additional hip abnormality. (EX-1, p. 4).

On January 9, 2012, Claimant presented for a follow-up with Dr. Cable. He reviewed the MRI of her pelvis, which he noted showed some minor changes in her hips. He noted that the MRI of her back revealed neural foraminal narrowing at L4-L5 on the left, consistent with her symptoms. She had ligamentum flavum thickening and severe facet hyperarthropathy. She had a mild degree of anterolisthesis of L4 on L5. She had mild to moderate spinal canal stenosis. She had similar changes at L3-L4 with some displacement of the L4 nerve root on the left. She had similar changes at L5-S1, but to a lesser degree. Dr. Cable recommended a left L4-L5 transforaminal epidural steroid

injection ("ESI"). Claimant reported worsening pain. She also complained of knee pain. On physical examination, she had a significantly crepitant left knee. There was a click at terminal flexion. There was minimal effusion and no obvious instability. Dr. Cable recommended an opinion from an orthopedist specializing in knee conditions. (CX-1, p. 7).

Claimant presented for a follow-up with Dr. Cable on March 20, 2012. She had undergone a L4-L5 transforaminal ESI on February 14, 2012. Her pain level went from a six out of ten down to a zero during the anesthetic phase. She reported her pain levels were zero or one out of ten for three weeks after the procedure. Claimant reported a significant level of pain, but it was better than before. She reported increased back and knee pain from going to the grocery store. She reported anxiety, PTSD symptoms and depression related to chronic pain. Dr. Cable recommended that Claimant consult a psychologist. He prescribed Xanax. He also recommended a second ESI. (CX-1, p. 8).

On April 18, 2012, Claimant presented for a follow-up with Dr. Cable. Claimant reported the Norco and Xanax were helpful. She had a second ESI eight days earlier, but reported it was not very helpful. Dr. Cable recommended a surgical consultation. On physical examination, a sitting root test caused knee pain. Dr. Cable recommended that Claimant consult a psychologist and a knee doctor. He released Claimant to perform sedentary work. (CX-1, p. 10).

Claimant presented for a follow-up with Dr. Cable on August 2, 2012. Claimant reported worsened pain since her last appointment. She was experiencing pain in the lumbosacral, left buttock, left anterior thigh, left posterior thigh, left shin, left calf, top of the left foot and bottom of the left foot. The pain was persistent, with an average intensity of seven out of ten. She reported that the ESI helped her back and leg, but not her knee. Her back and leg pain had returned. Physical examination revealed tender paravertebral muscles bilaterally with spasms. (CX-1, p. 11). Straight leg raising was positive on the right and the left at 90 degrees. Left light touch was abnormal at L4 and L5. Dr. Cable diagnosed Claimant with lumbar radicular syndrome, degenerative joint disease of the left knee and major depressive disorder secondary to chronic pain. He referred Claimant to Dr. Cohen for depression and pain control. (CX-1, p. 12).

In August 2012, Dr. Cable opined that Claimant had not reached MMI. He expected Claimant to reach MMI in two to four months. He noted that Claimant was not depressed and was fully functional at the time of injury. (CX-1, pp. 14-15).

On September 27, 2012, Claimant presented for a follow-up with Dr. Cable. She complained of back pain and left leg pain. She reported feeling increased frustration and depression, to the point of suicidal ideation. (CX-1, p. 27). Her medications were helping. Dr. Cable prescribed Methocarbamol, Hydrocodone-acetaminophen, Ibuprofen and Synthroid. (CX-1, p. 28). He opined that Claimant could not return to work. (CX-1, p. 29).

Dr. Thomas Schott

Dr. Schott's credentials were not presented in evidence. On June 13, 2012, Dr. Schott evaluated Claimant's left knee. Claimant complained of constant, unrelenting left knee pain. She informed Dr. Schott of a long history of knee problems. She indicated that she hyperflexed her knee on September 8, 2011, when she fell down a set of stairs. She reported locking, swelling, catching and instability. She reported a history of knee surgeries in 1983, 1984, 1988, 1990 and 1992. She stated that she was able to walk up and down stairs before the work accident, but was unable to walk much since then. She was using a cane. (EX-2, p. 1). An x-ray of Claimant's knee showed end-stage arthrosis with some osteopenia. Dr. Schott opined that Claimant's September 2011 accident involved "an exacerbation" of her very severe underlying arthrosis. He recommended a knee replacement. He restricted Claimant to light duty work and limited weight bearing activity up to two hours per day. (EX-2, p. 2).

Dr. Tom Mayer

Dr. Mayer's credentials were not presented in evidence. Dr. Mayer examined Claimant on August 29, 2012, at the request of Dr. Cable. He took Claimant's medical history to include five left knee surgeries and a synovial cyst removal at L3. (CX-1, p. 16). Claimant reported extreme depression. She rated her pain at a seven out of ten made worse by bending, lifting, walking, standing and climbing, and made better by ice and rest. She lifted up to eight pounds, and reclined 18 hours a day. She reported sleep disturbances and a 35 pound weight gain since the injury. (CX-1, p. 17).

On physical examination, Claimant walked with a markedly antalgic gait on the left side. She used a cane. She could toe stand but could not heel stand due to perceived pain and weakness in the left leg. She did not show any specific muscle weakness in the L5 distribution. She had severe lumbar tenderness with segmental rigidity at L4-S1 bilaterally, somewhat worse on the right side. (CX-1, p. 17). The midline and left side were tender through the spine, and her left sciatic notch was tender. Her motion was severely restricted. (CX-1, p. 18).

Dr. Mayer diagnosed Claimant with chronic left lumbar radicular pain, non-compensable postoperative left knee pain, non-compensable deconditioning syndrome, non-compensable chronic pain syndrome with medical/psychological features. (CX-1, p. 18).

On September 6, 2012, Claimant presented for a follow-up with Dr. Mayer. Dr. Mayer noted that Claimant was eager to participate in a functional restoration program. He noted that Claimant had severely deficient mobility with extreme strength deficits and extreme lifting capacity deficits, which was consistent with physical problems and psychological fear-avoidance. (CX-1, p. 21). Claimant complained of severe pain, which always ranged between a seven and a ten out of ten. For material handling, Claimant performed in the below sedentary range. She was unable to lift at all and could only perform three pounds of occasional carrying. She failed to meet positional demands for balancing, bending, reaching overhead and below the waist, sitting, standing, walking and climbing. On her mental health evaluation, she had severe loss of function with definite social isolation. She had moderate stressors with an extreme level of depressive symptoms. She had thoughts of suicide, but denied intent or plan. Dr. Mayer recommended a progressive exercise program. (CX-1, p. 22). He requested authorization for a comprehensive pain management treatment plan, which would be completed in eighty hours. (CX-1, p. 24).

On September 21, 2012, Dr. Mayer wrote a letter to Carrier. He noted that programs of chronic pain management or functional restoration have traditionally been interdisciplinary and integrated, but sometimes doctors are asked to "strip out the component of treatment involved in psychological care." Dr. Mayer proposed a program that involved the physical and educational components of the treatment process along with case management to assist in planning of return to work. (CX-1, p. 25). He recommended a program that would focus on measurement-

driven training for the lumbar spine, measurement-driven functional training under an occupational therapist, education on physiology, pain/stress management, coping skills, work reintegration, medications and pathophysiology, and individual case management on work reintegration options. (CX-1, pp. 25-26).

Dr. Mayer issued a letter to Dr. Cable on October 23, 2012. He noted that he had been requesting treatment for three weeks, but Carrier sent a list of questions to Dr. Cable. He noted Dr. Cohen's medication management had helped somewhat in managing Claimant's extreme mood disorder and suicidality. Claimant was frustrated by Carrier's refusal to authorize treatment. (CX-1, p. 39).

Dr. Mayer issued a letter to Dr. Cable on December 19, 2012. He noted that it had been a month since he last saw Claimant. He noted that Claimant's care was segmented due to Carrier's concern about "any 'psych issues' being handled under this workers' compensation claim, despite the chronic pain syndrome related to physical and psychosocial problems that date back to" the September 8, 2011 injury. Claimant was paying for treatment of her depressive and anxiety symptoms with her health insurance. (CX-1, p. 41). Dr. Mayer noted there was no recent progress regarding authorization of the functional restoration program. He noted that he would taper Claimant's medication usage once she was participating in functional restoration. He encouraged stretching exercises and slow increases in repetitions of a progressive walking program. (CX-1, p. 42).

Dr. Mayer issued another letter to Dr. Cable on January 24, 2013. He noted that Claimant had not yet been authorized to participate in functional restoration. Claimant was receiving treatment for her depression from Dr. Cohen. Dr. Mayer opined that Claimant's depression was aggravated by her work injury. (CX-1, p. 46). Dr. Mayer refilled Claimant's hydrocodone prescription, noting he was unable to taper usage due to his inability to treat her. Claimant was ambulating with a cane and extremely stiff. Cognitively she was somewhat brighter but slowed by the depressive symptoms. (CX-1, p. 47).

Dr. Mayer issued a letter to Carrier on March 6, 2013. He noted the only treatment he was "specifically engaging in involves the lumbar spine injury" acknowledging that Employer/Carrier were not authorizing any individual psychological care or treatment for her knee condition. (CX-1, p. 48).

Dr. Mayer issued another letter to Carrier on March 20, 2013. He noted that Carrier had agreed to cover the functional restoration treatment, but would not authorize payment for the psychological treatment. (CX-1, p. 50).

On April 10, 2013, Dr. Mayer wrote a letter to Dr. Cable noting that Claimant had been participating in the functional restoration program for one month. Claimant was enthusiastic about the program. Dr. Mayer opined that Claimant's mood disorder was improving somewhat in conjunction with her physical training. Claimant continued to complain of high levels of pain and was highly variable in her exercise levels from day to day. Dr. Mayer noted that inconsistency was very common in the early stages of functional restoration programs, particularly with patients who have not done much physical activity for an extended period of time. Claimant was attending treatment three days per week, which Dr. Mayer found remarkable. He did not anticipate an increase in frequency of attendance. (CX-1, p. 51). Claimant's use of opioids had decreased. (CX-1, p. 52).

On May 1, 2013, Dr. Mayer wrote another letter to Dr. Cable noting that Claimant was halfway through her functional restoration program. Claimant had decided to pursue surgery. (CX-1, p. 53). Dr. Mayer referred Claimant back to Dr. Cable for evaluation of her candidacy for lumbar surgery. Her functional restoration program status was placed on medical hold until a surgery determination was made. Claimant's use of opioids had decreased. (CX-1, p. 54).

On July 23, 2013, Claimant informed Dr. Mayer that Dr. Bosita from the Texas Back Institute recommended a decompression at L3 and a fusion at L4. Dr. Mayer noted that Claimant would be scheduled to undergo a psychological evaluation as part of pre-surgical planning. He placed Claimant on medical hold until the surgical decision process was complete. (CX-1, p. 56).

Dr. Howard Cohen

Dr. Cohen's credentials were not presented in evidence. Dr. Cohen examined Claimant on August 29, 2012, at the request of Dr. Mayer. Claimant complained of a high level of pain in the low back, left lower extremity and knee. She described her pain as aching, throbbing, shooting and stabbing. She rated the pain at six to nine out of ten. She reported that ice, medication and deep breathing helped her pain and activity worsened her pain. She reported feeling depressed. (CX-1, p.

30). She did not go out of her house much and did "not function." (CX-1, p. 31).

During a mental status exam, Claimant's mood was depressed and her affect was blunted. Her memory and concentration were grossly intact. Her thought process showed no evidence of delusions or hallucinations. She denied homicidal or suicidal ideation. Her I.Q. is above average. Her insight and judgment were good. On physical examination, Claimant had right iliopsoas, bilateral gluteus minimus and biceps femoris trigger points. Dr. Cohen diagnosed Claimant with chronic left lumbar radicular pain, "noncompensable" left knee pain, deconditioning syndrome, chronic widespread pain and chronic pain syndrome with depression. He recommended that Claimant continue taking hydrocodone and baclofen. He noted that Claimant needed to be more stable to benefit from a functional restoration program. He noted that Claimant had clear myofascial tender points and most likely myofascial pain syndrome. He opined that Claimant could benefit from trigger point injections, massage and functional restoration. He noted that psychological stabilization would be important in improving her myofascial pain syndrome. He opined that Claimant was at a high risk for suicide. He prescribed Abilify and Pristiq. (CX-1, p. 32).

Claimant presented for a follow-up with Dr. Cohen on October 8, 2012. Dr. Cohen opined that Claimant's chronic pain would not be well controlled until she was able to perform the functional restoration program. Claimant's mood was depressed and her affect blunted. She denied homicidal or suicidal ideation. Her insight and judgment were good. (CX-1, p. 34). Dr. Cohen prescribed Hydrocodone, Robaxin, Xanax, Abilify and Pristiq. (CX-1, p. 35).

On May 31, 2013, Dr. Cohen noted that Claimant had lumbar postlaminectomy syndrome and non-compensable left knee pain. She had surgery scheduled for June 4, 2013. She had lost 30 pounds. She reported more anxiety and was taking more Xanax. She was stable on Wellbutrin and Abilify. She was alert and oriented. Her mood was euthymic and her affect was appropriate. Her memory and concentration were grossly intact. She showed no evidence of delusions or hallucinations. She denied homicidal or suicidal ideation. Her insight and judgment were good. Dr. Cohen prescribed Norco, Robaxin, Wellbutrin, Abilify and Xanax. (CX-1, p. 55).

In his July 23, 2013 report, Dr. Cohen noted that Claimant was planning a 360 degree fusion and was nervous about the procedure. She had stopped smoking but was socially isolated. Dr. Cohen recommended that Claimant find some new friends and do volunteer work or other activities where she could be sociable. Claimant was alert and oriented. Her mood was euthymic and her affect was appropriate. Her memory and concentration were grossly intact. She showed no evidence of delusions or hallucinations. She denied homicidal or suicidal ideation. Her insight and judgment were good. Dr. Cohen prescribed Norco, Robaxin, Wellbutrin, Abilify and Xanax. (CX-1, p. 58).

Dr. Gregory Powell

Dr. Powell's credentials were not presented in evidence. On October 12, 2012, Dr. Powell performed an injection consultation at the request of Dr. Mayer. Claimant reported central low back pain without radiation into the extremities. She had no weakness, numbness, tingling or paresthesias. (CX-1, p. 36). On physical examination, Claimant performed flexion to 40 degrees, extension to zero degrees and side bending to five degrees with absence of motion at the L4-L5 and L5-S1 segments. Exquisite tenderness was noted over the facet joints in each segment with positive quadrant load bilaterally. Prone straight leg raise was untestable as Claimant was unable to lay prone. Supine straight leg raise was negative for radicular symptomatology. Dr. Powell opined that Claimant would benefit from a trial of lumbar facet injections at L4-L5 and L5-S1 bilaterally. He opined that Claimant should begin the outpatient functional restoration program. (CX-1, p. 37).

Dr. John C. Milani

Dr. Milani's credentials were not presented in evidence. Dr. Milani performed a second opinion consultation of Claimant on January 30, 2013, at the request of Employer/Carrier. Claimant complained of back pain with referred pain into her left leg. She also complained of numbness in the left lateral and plantar surfaces of the foot, weakness in the left leg and of ambulation difficulty which lead to the use of a cane. Dr. Milani noted that Claimant had a history of back pain and decompression schwannoma surgery five years earlier. He noted that Claimant's current back treatment included medication management, epidural injections and physical therapy. He reviewed Claimant's December 5, 2011 MRI. (CX-1, p. 43; EX-3, p. 1).

Claimant admitted having joint pain, back pain, neck pain, joint swelling, muscle pain, limitation of motion, muscle cramps, ankle instability, depression and difficulty sleeping. Neurological testing revealed decreased sensation in the left lateral calf, anterior and lateral foot. (CX-1, p. 44; EX-3, p. 2). Straight leg testing was positive on the left and her lumbosacral range of motion was severely limited in each direction. She had an antalgic gait with a left-sided limp. She had paralumbar tenderness to palpation and her range of motion was severely limited in each direction. Dr. Milani diagnosed Claimant with grade I spondylolisthesis at L4-L5, lumbar radiculopathy and left L4-L5 lateral recess stenosis. (CX-1, p. 45; EX-3, p. 3).

Dr. Milani noted that Claimant's medication usage was not an inordinate amount. He strongly recommended that she participate in a functional restoration program which would place emphasis on both the physical and mental aspects of her work injury. He opined that Claimant's current injury had clearly aggravated her psychological condition and made treatment more difficult. He noted that she could consider the possibility of L4-L5 decompression and fusion surgery if progress was not made from the functional restoration program. He noted that Claimant's progress would be more difficult due to her left knee problems, which he opined were aggravated by the work injury. He found that Claimant had not reached MMI and was unable to work. (CX-1, p. 45; EX-3, p. 3).

Blue Star Imaging Medical Records

On June 20, 2013, Claimant underwent an MRI of the lumbar spine ordered by Dr. Renato Bosita.³ It revealed a circumferential 1.3 millimeter disc bulge at L3-L4 effacing the thecal sac. At L4-L5 there was uncovering of the posterior superior margin of the disc secondary to the anterolisthesis, evidence of Claimant's prior surgery and facet hypertrophic changes with ligamentum flavum hypertrophy on the left. A bulging annulus, facet hypertrophic changes and minor bilateral neural foraminal narrowing were found at L5-S1. The impression was grade I spondylolisthesis of L4 and L5, disc desiccation of L4-L5 and L5-S1 with minor disc space narrowing of L4-L5, a circumferential disc bulge with facet hypertrophic changes at L3-L4 and bulging annulus with facet hypertrophic changes at L5-S1. (EX-1, p. 1).

³ Dr. Bosita's medical records were not presented in evidence.

Dr. Robert Holladay

Dr. Holladay is a board-certified orthopedic surgeon. He performed a peer review of Claimant's medical records on July 24, 2013, at the request of Employer/Carrier. He did not examine Claimant. (EX-4, p. 1). He reviewed the medical records of Drs. Cable, Schott, Mayer, Cohen, Powell, Milani and Bosita. (EX-4, pp. 2-10).

Dr. Holladay reviewed a June 27, 2013 report from Dr. Bosita, an orthopedic surgeon, which was not presented in evidence. Dr. Bosita recommended surgery to include L4-L5 spinal fusion with L3-L4 decompression. Dr. Bosita's recommendation was based on Claimant's back pain, left leg pain, left leg weakness and lack of response to conservative care. Dr. Bosita opined that the work injury aggravated an underlying degenerative condition. (EX-4, p. 10).

Dr. Holladay opined that the medical records provided no objective evidence that the September 8, 2011 work-injury produced "new acute structural damage to the lumbar spine." He did not review any of Claimant's medical records predating September 8, 2011. He found no objective evidence of acute left L5 radiculopathy, but noted that Claimant had subjective left lower extremity symptoms. He opined that Claimant's left knee condition could correlate with these symptoms. He opined that the June 20, 2013 MRI revealed no acute structural damage, stating that the problems were all "disease of life findings, identified in up to 93% of asymptomatic subjects." (EX-4, p. 11). He opined, "In the absence of objective evidence of an acute L5 radiculopathy to the left, I am unable to identify that the work event on 9/8/11 aggravated or accelerated the pre-existing and postsurgical changes in this 60 year old female." He opined that "the work event did not aggravate or accelerate the pre-existing advanced conditions in the left knee in all medical probability, per the opinion of the claimant's own treating doctor on 6/13/12, and supported by the advanced degenerative changes on x-ray." He did not believe the lumbar fusion and decompression surgery was medically necessary because the grade I spondylolisthesis at L4-L5 and the mild central canal stenosis at L3-L4 were "disease of life findings." He recommended that Claimant be weaned off of opioids and muscle relaxants, lose weight and perform home exercise. He noted that Claimant needed a total knee replacement, which was not related to her work-injury. He did not believe Claimant could complete a functional restoration program due to her knee condition. He

opined that the effects of Claimant's lumbar sprain/strain should have resolved. (EX-4, p. 12).

Dr. Benzel MacMaster

Dr. MacMaster is an orthopedist, whose credentials were not presented in evidence. He evaluated Claimant on October 14, 2013, at the request of Employer/Carrier. Claimant presented with "a history of burning dull and stabbing pain in the lumbar region that occurs constantly." She reported pain going down the left leg to below her knee. She had numbness and tingling in her left foot, primarily in the lateral border of the foot, from the heel to the lateral three toes. She had spasms in the left groin area. Claimant noted that the onset of symptoms occurred suddenly on September 8, 2011, when she struck her back on stairs, twisting her back at the same time. She also reported injuring her left knee in the same fall. Her symptoms were aggravated by standing and walking. She noted that the epidural steroid injections provided her pain relief for approximately six months. She rated her pain at a five out of ten. She reported limited success from the functional rehabilitation program. (EX-8, p. 1).

Dr. MacMaster noted that surgery had been recommended for Claimant's lumbar spine and left knee. (EX-8, p. 1). He reviewed Claimant's medical records. (EX-8, pp. 1-2). On physical examination, Claimant displayed a left antalgic gait. Claimant's shoulders and iliac crests were level. She had a normal thoracic kyphosis, normal lumbar lordosis and no lateral curvature. Claimant was tender to palpation over the base of the cervical spine, through much of the thoracic spine and over a wide area of the lumbar spine extending into the left buttock. Her paraspinous muscle tone was increased, particularly to the left. She had a positive FABER test on the left. She performed lateral flexion to 25 degrees on the right and 20 degrees on the left. (EX-8, p. 3). Femoral stretching caused pain in the anterior thigh and back on the right and left. Straight leg raising was negative on the right and positive for posterior thigh pain on the left. Cross straight leg raise was positive for back pain on the right and negative on the left. (EX-8, p. 4).

Dr. MacMaster diagnosed Claimant with back pain, ACQ spondylolisthesis, lumbar/lumbosacral disc degeneration and osteoarthritis localized to the left leg. He opined that Claimant could have temporarily exacerbated her underlying degenerative condition during the work-accident, but "there was

no evidence on the original MRI done approximately 3 months after the accident of any specific condition that could be attributed to the single event as described." (EX-8, p. 4). He noted there was no evidence of a fracture or significant disc herniation. He opined that Claimant's history of a synovial cyst on the right side at L4-L5 was strongly suggestive that the arthritic conditions seen at that level had been longstanding problems. He found no reasonable basis to conclude that there was material aggravation or alteration of that degenerative condition. He opined that Claimant had reached maximum medical improvement for any condition arising from her slip and fall injury while at work on September 8, 2011. He opined that Carrier would not be responsible for any additional treatment for Claimant's condition. He opined that the decompression laminectomy and fusion at L4-L5 and decompression at L3-L4 were not clinically indicated based on Claimant's self-reported condition at the time of his examination. He noted that Claimant had no symptoms that were strongly suggestive of spinal stenosis and no motor deficit. He opined that her sensory deficits strongly suggested an S1 pattern of discomfort, which would not be explained by the findings of her MRI. (EX-8, p. 5).

The Contentions of the Parties

Claimant was a Human Resources manager in Iraq working for Employer when she slipped and fell down some stairs. She claims injuries to her back, left leg, left knee, left hip, left foot and neck. She also contends that her psychological condition worsened following the accident. She asserts that she is entitled to all reasonable and necessary medical care, including the recommended left knee replacement and recommended lumbar surgery. She seeks temporary total disability benefits from September 20, 2011, to present and continuing.

Employer/Carrier argue that Claimant's conditions, other than the lumbar problem, pre-existed her fall in Iraq. They contend Claimant's prior medical conditions are the basis for her current complaints and are unrelated to her work-related accident.

IV. DISCUSSION

It has been consistently held that the Act must be construed liberally in favor of the Claimant. Voris v. Eikel, 346 U.S. 328, 333 (1953); J. B. Vozzolo, Inc. v. Britton, 377 F.2d 144 (D.C. Cir. 1967). However, the United States Supreme

Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the Claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. Director, OWCP v. Greenwich Collieries, 512 U.S. 267, 114 S.Ct. 2251 (1994), aff'g. 990 F.2d 730 (3rd Cir. 1993).

A. Credibility

I have considered and evaluated the rationality and internal consistencies of the testimony of the witnesses, including the manner in which the testimony supports or detracts from the other record evidence. In so doing, I have taken into account all relevant, probative and available evidence, while analyzing and assessing its cumulative impact on the record. See Indiana Metal Products v. National Labor Relations Board, 442 F.2d 46, 52 (7th Cir. 1971). An administrative law judge is not bound to believe or disbelieve the entirety of a witness's testimony, but may choose to believe only certain portions of the testimony. Mijangos v. Avondale Shipyards, Inc., 948 F.2d 941 (5th Cir. 1991).

Moreover, in arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. Duhagon v. Metropolitan Stevedore Company, 31 BRBS 98, 101 (1997); Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce, 551 F.2d 898, 900 (5th Cir. 1981); Banks v. Chicago Grain Trimmers Association, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968).

It is also noted that the opinion of a treating physician may be entitled to greater weight than the opinion of a non-treating physician under certain circumstances. Black & Decker Disability Plan v. Nord, 538 U.S. 822, 830, 123 S.Ct. 1965, 1970 n.3 (2003)(in matters under the Act, courts have approved adherence to a rule similar to the Social Security treating physicians rule in which the opinions of treating physicians are accorded special deference)(citing Pietrunti v. Director, OWCP, 119 F.3d 1035 (2d Cir. 1997)(an administrative law judge is bound by the expert opinion of a treating physician as to the existence of a disability "unless contradicted by substantial

evidence to the contrary"); Rivera v. Harris, 623 F.2d 212, 216 (2d Cir. 1980) ("opinions of treating physicians are entitled to considerable weight"); Loza v. Apfel, 219 F.3d 378 (5th Cir. 2000) (in a Social Security matter, the opinions of a treating physician were entitled to greater weight than the opinions of non-treating physicians).

I found Claimant credible in her hearing testimony. She consistently presented the mechanism of her injury and her complaints to all treating and consultative physicians who evaluated her.

B. The Compensable Injury

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of or in the course of employment." 33 U.S.C. § 902(2). Section 20(a) of the Act provides a presumption that aids the Claimant in establishing that a harm constitutes a compensable injury under the Act. Section 20(a) of the Act provides in pertinent part:

In any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary—that the claim comes within the provisions of this Act.

33 U.S.C. § 920(a).

The Benefits Review Board (herein the Board) has explained that a claimant need not affirmatively establish a causal connection between his work and the harm he has suffered, but rather need only show that: (1) he sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. Kelaita v. Triple A Machine Shop, 13 BRBS 326 (1981), aff'd sub nom. Kelaita v. Director, OWCP, 799 F.2d 1308 (9th Cir. 1986); Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140 (1991); Stevens v. Tacoma Boat Building Co., 23 BRBS 191 (1990). These two elements establish a **prima facie** case of a compensable "injury" supporting a claim for compensation. Id.

Under the Defense Base Act, an employee need not establish a causal relationship between his actual employment duties and the event that occasioned his injury. O'Leary v. Brown-Pacific-Mason, Inc., 340 U.S. 504, 506-507 (1951). "All that is required is that the 'obligations or conditions' of employment create the 'zone of special danger' out of which the injury arose. Id.

The zone of special danger is well-suited to cases, like this one, arising under the Defense Base Act, since conditions of the employment place the employee in a foreign setting where he is exposed to dangerous conditions. See N. R. v. Halliburton Services, 42 BRBS 56 (June 30, 2008). An employer's direct involvement in the injury-causing incident is not necessary for any injury to fall within the zone of special danger. Id., p. 60. The specific purpose of the zone of special danger doctrine is to extend coverage in overseas employment such that considerations including time and space limits or whether the activity is related to the nature of the job do not remove an injury from the scope of employment. O'Leary, 340 U.S. at 506; see Cardillo v. Liberty Mutual Insurance Co., 330 U.S. 469, 481 (1947).

1. Claimant's Prima Facie Case

Based on the stipulations of the parties, injury to Claimant's back is undisputed. Claimant contends she has established a **prima facie** case with respect to her psychological condition based on her testimony and the opinion of Dr. Milani. She contends that her left leg, left knee, left hip, left foot and neck conditions are also compensable. Employer/Carrier contend Claimant has failed to establish a **prima facie** case with respect to her psychological, left leg, left knee, left hip, left foot and neck injuries. They argue these injuries are not compensable.

Claimant's **credible** subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a **prima facie** case and the invocation of the Section 20(a) presumption. See Sylvester v. Bethlehem Steel Corp., 14 BRBS 234, 236 (1981), aff'd sub nom. Sylvester v. Director, OWCP, 681 F.2d 359, 14 BRBS 984 (CRT) (5th Cir. 1982).

On the other hand, uncorroborated testimony by a discredited witness is insufficient to establish the second element of a **prima facie** case that the alleged injury occurred in the course and scope of employment, or conditions existed at work which could have caused the harm. Bonin v. Thames Valley Steel Corp., 173 F.3d 843 (2nd Cir. 1999) (unpub.) (upholding an ALJ ruling that the claimant did not produce credible evidence that a condition existed at work which could have caused his alleged injury); Alley v. Julius Garfinckel & Co., 3 BRBS 212, 214-215 (1976).

Neck Injury

Claimant contends she suffered a compensable neck injury as a result of her September 8, 2011 accident. However, the record is devoid of any complaints by Claimant regarding her neck. During the formal hearing, Claimant testified she has problems with her neck during physical therapy. However, she did not seek any medical treatment for her neck after her work accident. Accordingly, I find Claimant's uncorroborated testimony is insufficient to establish that the alleged neck injury occurred in the course and scope of employment, or conditions existed at work which could have caused the harm. Thus, Claimant has failed to establish a **prima facie** case sufficient to invoke the Section 20(a) presumption with respect to her alleged neck injury. Cairns v. Matson Terminals, Inc., 21 BRBS 252 (1988).

Left Hip Injury

Claimant underwent an MRI of her hip on December 15, 2011, which revealed early symmetric osteoarthritis without evidence of additional hip abnormality. No doctor ever related this condition to Claimant's work accident, and it appears to be degenerative in nature. Accordingly, I find Claimant's uncorroborated testimony is insufficient to establish that the alleged hip injury occurred in the course and scope of employment, or conditions existed at work which could have caused the harm. Thus, Claimant has failed to establish a **prima facie** case sufficient to invoke the Section 20(a) presumption with respect to her alleged hip injury.

Psychological Injury

The medical records indicate Claimant received treatment for depression and anxiety from Dr. Mary Welp, a primary care physician, on several occasions from November 29, 2005 through

April 29, 2011, several days before her deployment. After returning to the United States following her work-injury, the medical records show that Claimant did not report psychological complaints until March 20, 2012, when she reported anxiety, PTSD symptoms and depression related to chronic pain to Dr. Cable. On August 2, 2012, Dr. Cable referred Claimant to Dr. Cohen for depression and pain control. Dr. Cohen began treating Claimant on August 29, 2012. Dr. Cohen diagnosed Claimant with chronic left lumbar radicular pain, "noncompensable" left knee pain, deconditioning syndrome, chronic widespread pain and chronic pain syndrome with depression. On January 30, 2013, Dr. Milani, Employer/Carrier's choice of physician, opined that Claimant's current injury had clearly aggravated her psychological condition and made treatment more difficult.

Based on the foregoing, I find Claimant presented sufficient evidence to meet the threshold issue that she suffered an alleged harm and psychological injury as a result of her employment with Employer. Thus, Claimant has established a **prima facie** case of a psychological injury sufficient to invoke the Section 20(a) presumption.

Left Knee Injury

Claimant testified that her left knee was problematic before going to work for Employer, but she asserts that the work accident aggravated her pre-existing injury. The medical records indicate Claimant received treatment and saphenous nerve blocks for her left knee condition from Dr. Westergaard on several occasions from June 13, 2008 through April 18, 2011, several days before her deployment.

Claimant reported left knee pain to Dr. Cable on October 5, 2011. On June 13, 2012, Dr. Schott evaluated Claimant's left knee. An x-ray of Claimant's knee showed end-stage arthrosis with some osteopenia. Dr. Schott opined that Claimant's September 2011 accident involved "an exacerbation" of her very severe underlying arthrosis. He recommended a knee replacement. Dr. Milani opined that Claimant's left knee problems were aggravated by the work injury.

Based on the foregoing, I find Claimant presented sufficient evidence to meet the threshold issue that she suffered an alleged harm and left knee injury as a result of her employment with Employer. Thus, Claimant has established a **prima facie** case sufficient to invoke the Section 20(a) presumption.

Back, Left Leg and Left Foot Injuries

The parties stipulated that Claimant suffered a compensable back injury. However, the majority of the rebuttal medical evidence submitted by Employer/Carrier is related to Claimant's back condition. In order to comprehensively address Employer/Carrier's rebuttal medical evidence, I will address the compensability of Claimant's back injury.

Claimant testified that she had back problems before going to work for Employer, but she asserts that the work accident aggravated her pre-existing condition. Claimant testified she had surgery to repair of a synovial cyst of her spinal sheath and surgery to remove a benign tumor from her spinal canal. On December 13, 2006, an MRI of Claimant's thoracic spine was reviewed, which revealed a tumor at T11 and near total effacement of the spinal cord at that level. The tumor was removed in 2007. On November 3, 2009, Dr. Westergaard performed piriformis, quadratus and psoas myoneural injections at L4-L5.

On December 15, 2011, an MRI of Claimant's back was performed. It revealed grade I anterolisthesis of L4 upon L5, measuring approximately nine millimeters. No suspicious narrow signal abnormality was demonstrated. Disc desiccation was present at multiple levels, most significantly at L4-L5. Claimant underwent two rounds of ESI injections at L4-L5 and a functional rehabilitation program. Dr. Holladay's summary of Dr. Bosita's opinion indicates that Dr. Bosita opined that the work injury aggravated an underlying degenerative condition.

During the course of her treatment, Claimant continuously made complaints of radicular pain in her left leg and foot. During her first examination by Dr. Cable, Claimant reported weakness in her left foot, pain down her posterior legs and pins and needles feeling in the anterior leg down into the knee on the left side. On August 2, 2012, Dr. Cable diagnosed Claimant with lumbar radicular syndrome.

Based on the foregoing, I find Claimant presented sufficient evidence to meet the threshold issue that she suffered an alleged harm, a lumbar injury and left lumbar radicular pain as a result of her employment with Employer. Thus, Claimant has established a **prima facie** case sufficient to invoke the Section 20(a) presumption.

2. Employer's Rebuttal Evidence

Once Claimant's **prima facie** case is established, a presumption is invoked under Section 20(a) that supplies the causal nexus between the physical harm or pain and the working conditions which could have caused them.

The burden shifts to the employer to rebut the presumption with substantial evidence to the contrary that Claimant's condition was neither caused by his working conditions nor aggravated, accelerated or rendered symptomatic by such conditions. See Conoco, Inc. v. Director, OWCP [Prewitt], 194 F.3d 684, 33 BRBS 187 (CRT) (5th Cir. 1999); Gooden v. Director, OWCP, 135 F.3d 1066, 32 BRBS 59 (CRT) (5th Cir. 1998); Louisiana Ins. Guar. Ass'n v. Bunol, 211 F.3d 294, 34 BRBS 29 (CRT) (5th Cir. 1999); Lennon v. Waterfront Transport, 20 F.3d 658, 28 BRBS 22 (CRT) (5th Cir. 1994).

Substantial evidence is evidence that provides "a substantial basis of fact from which the fact in issue can be reasonably inferred," or such evidence that "a reasonable mind might accept as adequate to support a conclusion." New Thoughts Finishing Co. v. Chilton, 118 F.3d 1028, 1030 (5th Cir. 1997); Ortco Contractors, Inc. v. Charpentier, 332 F.3d 283 (5th Cir. 2003) (the evidentiary standard necessary to rebut the presumption under Section 20(a) of the Act is "less demanding than the ordinary civil requirement that a party prove a fact by a preponderance of evidence").

Employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). See Smith v. Sealand Terminal, 14 BRBS 844 (1982). The testimony of a physician that no relationship exists between an injury and a claimant's employment is sufficient to rebut the presumption. See Kier v. Bethlehem Steel Corp., 16 BRBS 128 (1984).

When aggravation of or contribution to a pre-existing condition is alleged, the presumption still applies, and in order to rebut it, Employer must establish that Claimant's work events neither directly caused the injury nor aggravated the pre-existing condition resulting in injury or pain. Rajotte v. General Dynamics Corp., 18 BRBS 85 (1986). A statutory employer is liable for consequences of a work-related injury which aggravates a pre-existing condition. See Bludworth Shipyard,

Inc. v. Lira, 700 F.2d 1046 (5th Cir. 1983); Fulks v. Avondale Shipyards, Inc., 637 F.2d 1008, 1012 (5th Cir. 1981). Although a pre-existing condition does not constitute an injury, aggravation of a pre-existing condition does. Volpe v. Northeast Marine Terminals, 671 F.2d 697, 701 (2d Cir. 1982). It has been repeatedly stated employers accept their employees with the frailties which predispose them to bodily hurt. J. B. Vozzolo, Inc. v. Britton, supra at 147-148.

Psychological Injury

Employer/Carrier failed to provide any evidence to rebut the presumption with respect to Claimant's psychological injury. Dr. Milani, who evaluated Claimant on January 30, 2013, at the request of Employer/Carrier, found Claimant's current injury had clearly aggravated her psychological condition and made treatment more difficult. Accordingly, I find Employer/Carrier failed to rebut the presumption with respect to Claimant's psychological condition.

Left Knee Injury

With respect to Claimant's left knee condition, Employer/Carrier rely on the opinion of Dr. Holladay, who performed a peer review of Claimant's medical records on July 24, 2013, at the request of Employer/Carrier. Dr. Holladay opined that "the work event did not aggravate or accelerate the pre-existing advanced conditions in the left knee in all medical probability, per the opinion of the claimant's own treating doctor on 6/13/12, and supported by the advanced degenerative changes on x-ray." Therefore, I find that Employer/Carrier have rebutted Claimant's **prima facie** case of compensability with respect to Claimant's left knee condition.

Back, Left Leg and Left Foot Injuries

With respect to Claimant's back condition and radicular pain, Employer/Carrier rely on the opinions of Dr. Holladay and Dr. MacMaster. Dr. Holladay opined that the medical records provided no objective evidence that the September 8, 2011 work-injury produced "new acute structural damage to the lumbar spine." He opined, "In the absence of objective evidence of an acute L5 radiculopathy to the left, I am unable to identify that the work event on 9/8/11 aggravated or accelerated the pre-existing and postsurgical changes." Dr. MacMaster found no reasonable basis to conclude that there was material aggravation or alteration of that degenerative condition. He opined that

Claimant could have temporarily exacerbated her underlying degenerative condition during the work-accident, but "there was no evidence on the original MRI done approximately 3 months after the accident of any specific condition that could be attributed to the single event as described." Based on the foregoing opinions, I find that Employer/Carrier have rebutted Claimant's **prima facie** case of compensability with respect to Claimant's back condition and left lumbar radicular pain.

3. Weighing All the Evidence

If an administrative law judge finds that the Section 20(a) presumption is rebutted, he must weigh all of the evidence and resolve the causation issue based on the record as a whole. Universal Maritime Corp. v. Moore, 126 F.3d 256, 31 BRBS 119(CRT)(4th Cir. 1997); Hughes v. Bethlehem Steel Corp., 17 BRBS 153 (1985); Director, OWCP v. Greenwich Collieries, supra.

Left Knee Injury

To rebut the presumption with respect to Claimant's left knee condition, Employer/Carrier rely only on the opinion of Dr. Holladay that the work accident did not aggravate or accelerate the pre-existing left knee condition. Dr. Holladay stated he relied on the opinion of Claimant's treating doctor. However, Dr. Holladay appears to misstate Dr. Schott's opinion. Dr. Schott opined that Claimant's September 2011 accident involved "an exacerbation" of her very severe underlying arthrosis. Dr. Milani also opined that Claimant's left knee problems were aggravated by the work injury. Accordingly, I find the preponderance of the medical evidence establishes that Claimant's pre-existing left knee condition was aggravated, accelerated or rendered symptomatic by her September 8, 2011 work-injury.

Back, Left Leg and Left Foot Injuries

Claimant's record testimony and statements to medical care providers are consistent in that back pain existed following her work-injury and never fully resolved. She complained of back pain during her initial evaluation in Afghanistan following the accident. Both Drs. Cable and Mayer found that Claimant suffered from degenerative disc disease superimposed on an injury to the lumbar spine. Dr. Bosita opined that the work injury aggravated an underlying degenerative condition.

I find the opinions of Drs. Cable, Mayer and Bosita, Claimant's treating physicians, should be afforded greater weight than the opinions of Dr. Holladay, who did not evaluate Claimant, and Dr. MacMaster, who only evaluated her one time.

Dr. Holladay did not review any of Claimant's medical records pre-dating the work-injury. Dr. Holladay based his opinion that Claimant did not aggravate her degenerative condition on his finding that there was no objective evidence of an acute L5 radiculopathy to the left. However, Dr. Holladay never evaluated Claimant, and the medical records of her treating physicians list findings of lumbar radicular pain on multiple occasions.

Dr. MacMaster found no reasonable basis to conclude that there was **material** aggravation or alteration of that degenerative condition. However, he also opined that the September 8, 2011 incident could have temporarily exacerbated her lumbar spine condition. The Act merely requires that Claimant show an aggravation of a pre-existing injury. It appears that Dr. MacMaster was imposing a higher standard of material aggravation.

Accordingly, I find the preponderance of the medical evidence establishes that Claimant's pre-existing lumbar condition was aggravated, accelerated or rendered symptomatic by her September 8, 2011 work-injury.

Given the foregoing, I find Claimant has shown after weighing the entire record that she suffers from compensable injuries to her left knee, back and radicular lumbar pain as a result of the work-related accident that occurred on September 8, 2011. Claimant has also shown that she suffered a compensable psychological injury.

C. Nature and Extent of Disability

Having found that Claimant suffers from compensable injuries, the burden of proving the nature and extent of his disability rests with the Claimant. Trask v. Lockheed Shipbuilding Construction Co., 17 BRBS 56, 59 (1980).

Disability is generally addressed in terms of its nature (permanent or temporary) and its extent (total or partial). The permanency of any disability is a medical rather than an economic concept.

Disability is defined under the Act as the "incapacity to earn the wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Therefore, for Claimant to receive a disability award, an economic loss coupled with a physical and/or psychological impairment must be shown. Sproull v. Stevedoring Servs. of America, 25 BRBS 100, 110 (1991). Thus, disability requires a causal connection between a worker's physical injury and his inability to obtain work. Under this standard, a claimant may be found to have either suffered no loss, a total loss or a partial loss of wage earning capacity.

Permanent disability is a disability that has continued for a lengthy period of time and appears to be of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. Watson v. Gulf Stevedore Corp., 400 F.2d 649, pet. for reh'g denied sub nom. Young & Co. v. Shea, 404 F.2d 1059 (5th Cir. 1968) (per curiam), cert. denied, 394 U.S. 876 (1969); SGS Control Services v. Director, OWCP, 86 F.3d 438, 444 (5th Cir. 1996). A claimant's disability is permanent in nature if he has any residual disability after reaching maximum medical improvement. Trask, supra, at 60. Any disability suffered by Claimant before reaching maximum medical improvement is considered temporary in nature. Berkstresser v. Washington Metropolitan Area Transit Authority, 16 BRBS 231 (1984); SGS Control Services v. Director, OWCP, supra, at 443.

The question of extent of disability is an economic as well as a medical concept. Quick v. Martin, 397 F.2d 644 (D.C. Cir. 1968); Eastern S.S. Lines v. Monahan, 110 F.2d 840 (1st Cir. 1940); Rinaldi v. General Dynamics Corporation, 25 BRBS 128, 131 (1991).

To establish a **prima facie** case of total disability, the claimant must show that he is unable to return to his regular or usual employment due to his work-related injury. Elliott v. C & P Telephone Co., 16 BRBS 89 (1984); Harrison v. Todd Pacific Shipyards Corp., 21 BRBS 339 (1988); Louisiana Insurance Guaranty Association v. Abbott, 40 F.3d 122, 125 (5th Cir. 1994).

Claimant's present medical restrictions must be compared with the specific requirements of his usual or former employment to determine whether the claim is for temporary total or permanent total disability. Curit v. Bath Iron Works Corp., 22 BRBS 100 (1988). Once Claimant is capable of performing his usual employment, he suffers no loss of wage earning capacity and is no longer disabled under the Act.

D. Maximum Medical Improvement (MMI)

The traditional method for determining whether an injury is permanent or temporary is the date of maximum medical improvement. See Turney v. Bethlehem Steel Corp., 17 BRBS 232, 235, n. 5 (1985); Trask v. Lockheed Shipbuilding Construction Co., *supra*; Stevens v. Lockheed Shipbuilding Company, 22 BRBS 155, 157 (1989). The date of maximum medical improvement is a question of fact based upon the medical evidence of record. Ballesteros v. Willamette Western Corp., 20 BRBS 184, 186 (1988); Williams v. General Dynamics Corp., 10 BRBS 915 (1979).

An employee reaches maximum medical improvement when his condition becomes stabilized. Cherry v. Newport News Shipbuilding & Dry Dock Co., 8 BRBS 857 (1978); Thompson v. Quinton Enterprises, Limited, 14 BRBS 395, 401 (1981).

In the present matter, nature and extent of disability and maximum medical improvement will be treated concurrently for purposes of explication.

Claimant contends that she has not reached maximum medical improvement, and she is entitled to temporary total disability benefits from September 20, 2011, to present and continuing.

None of Claimant's treating physicians ever found that she had reached maximum medical improvement with respect to her psychological, lumbar spine, lumbar radicular pain or left knee conditions. On April 18, 2012, Dr. Cable released Claimant to perform sedentary work. On June 13, 2012, Dr. Schott restricted Claimant to light duty work and limited weight bearing activity up to two hours per day with respect to her knee injury. He recommended a total knee replacement. In August 2012, Dr. Cable opined that Claimant had not reached maximum medical improvement. He expected Claimant to reach MMI in two to four months. On September 27, 2012, Dr. Cable opined that Claimant could not return to work. Dr. Bosita recommended surgery to include L4-L5 spinal fusion with L3-L4 decompression.

On January 30, 2013, Dr. Milani, Employer/Carrier's first choice of physician, found that Claimant had not reached MMI and was unable to work. On July 24, 2013, Dr. Holladay opined that the effects of Claimant's lumbar sprain/strain should have resolved. However, Dr. Holladay did not believe Claimant could complete a functional restoration program due to her knee condition. On October 14, 2013, Dr. MacMaster opined Claimant had reached maximum medical improvement. Dr. MacMaster's opinion regarding maximum medical improvement is based on his assertion that the work injury did not aggravate Claimant's degenerative back condition. As discussed above, I find Claimant's underlying back condition was aggravated by the work-accident. Based on the opinions of Drs. Cable, Schott, Bosita and Milani, I find the weight of the evidence supports a conclusion that Claimant has not reached maximum medical improvement.

The parties stipulated that Claimant received temporary total disability benefits from October 5, 2011 through present. Claimant contends she is entitled to temporary total disability benefits beginning on September 20, 2011. On September 20, 2011, a medic in Afghanistan recommended that Claimant be sent back to the United States. The medical records from the Medical Clinic of North Texas indicate that Claimant returned to the United States on September 23, 2011. Based on the foregoing, I find Claimant is entitled to temporary total disability benefits from September 23, 2011, to present and continuing.

E. Entitlement to Medical Care and Benefits

Section 7(a) of the Act provides that:

The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.

33 U.S.C. § 907(a).

The Employer is liable for all medical expenses which are the natural and unavoidable result of the work injury. For medical expenses to be assessed against the Employer, the expense must be both reasonable and necessary. Pernell v. Capitol Hill Masonry, 11 BRBS 532, 539 (1979). Medical care must also be appropriate for the injury. 20 C.F.R. § 702.402.

A claimant has established a **prima facie** case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. Turner v. Chesapeake & Potomac Tel. Co., 16 BRBS 255, 257-258 (1984).

Section 7 does not require that an injury be economically disabling for claimant to be entitled to medical benefits, but only that the injury be work-related and the medical treatment be appropriate for the injury. Ballesteros v. Willamette Western Corp., 20 BRBS 184, 187.

Entitlement to medical benefits is never time-barred where a disability is related to a compensable injury. Weber v. Seattle Crescent Container Corp., 19 BRBS 146 (1980); Wendler v. American National Red Cross, 23 BRBS 408, 414 (1990).

An employer is not liable for past medical expenses unless the claimant first requested authorization prior to obtaining medical treatment, except in the cases of emergency, neglect or refusal. Schoen v. U.S. Chamber of Commerce, 30 BRBS 103 (1997); Maryland Shipbuilding & Drydock Co. v. Jenkins, 594 F.2d 404, 10 BRBS 1 (4th Cir. 1979), rev'g 6 BRBS 550 (1977). Once an employer has refused treatment or neglected to act on claimant's request for a physician, the claimant is no longer obligated to seek authorization from employer and need only establish that the treatment subsequently procured on his own initiative was necessary for treatment of the injury. Pirozzi v. Todd Shipyards Corp., 21 BRBS 294 (1988); Rieche v. Tracor Marine, 16 BRBS 272, 275 (1984).

The employer's refusal need not be unreasonable for the employee to be released from the obligation of seeking his employer's authorization of medical treatment. See generally 33 U.S.C. § 907(d)(1)(A). Refusal to authorize treatment or neglecting to provide treatment can only take place after there is an opportunity to provide care, such as after the claimant requests such care. Mattox v. Sun Shipbuilding & Dry Dock Co., 15 BRBS 162 (1982). Furthermore, the mere knowledge of a claimant's injury does not establish neglect or refusal if the claimant never requested care. Id.

Having established compensable back, left knee and psychological injuries, Claimant is entitled to all reasonable and necessary medical expenses for such injuries pursuant to Section 7 of the Act. She is also entitled to reimbursement for medical expenses she incurred related to these injuries.

V. INTEREST

Although not specifically authorized in the Act, it has been an accepted practice that interest at the rate of six per cent per annum is assessed on all past due compensation payments. Avallone v. Todd Shipyards Corp., 10 BRBS 724 (1974). The Benefits Review Board and the Federal Courts have previously upheld interest awards on past due benefits to insure that the employee receives the full amount of compensation due. Watkins v. Newport News Shipbuilding & Dry Dock Co., aff'd in pertinent part and rev'd on other grounds, sub nom. Newport News v. Director, OWCP, 594 F.2d 986 (4th Cir. 1979). The Board concluded that inflationary trends in our economy have rendered a fixed six per cent rate no longer appropriate to further the purpose of making Claimant whole, and held that ". . . the fixed per cent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. § 1961 (1982). This rate is periodically changed to reflect the yield on United States Treasury Bills" Grant v. Portland Stevedoring Company, et al., 16 BRBS 267 (1984).

Effective February 27, 2001, this interest rate is based on a weekly average one-year constant maturity Treasury yield for the calendar week preceding the date of service of this Decision and Order by the District Director. This order incorporates by reference this statute and provides for its specific administrative application by the District Director.

VI. ATTORNEY'S FEES

No award of attorney's fees for services to the Claimant is made herein since no application for fees has been made by the Claimant's counsel. Counsel is hereby allowed thirty (30) days from the date of service of this decision by the District Director to submit an application for attorney's fees.⁴ A

⁴ Counsel for Claimant should be aware that an attorney's fee award approved by an administrative law judge compensates only the hours of work expended between the close of the informal conference proceedings and the issuance of the administrative law judge's Decision and Order. Revoir v. General

service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days following the receipt of such application within which to file any objections thereto. The Act prohibits the charging of a fee in the absence of an approved application.

VII. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon the entire record, I enter the following Order:

1. Employer/Carrier shall pay Claimant compensation for temporary total disability from September 23, 2011 to present and continuing, based on Claimant's average weekly wage of \$2,831.82, in accordance with the provisions of Section 8(b) of the Act. 33 U.S.C. § 908(b).

2. Employer/Carrier shall pay all reasonable, appropriate and necessary medical expenses arising from Claimant's September 8, 2011, work injuries to her back, left knee and psychological injury, pursuant to the provisions of Section 7 of the Act.

3. Employer/Carrier shall receive credit for all compensation heretofore paid, if any, as and when paid.

4. Employer/Carrier shall pay interest on any sums determined to be due and owing at the rate provided by 28 U.S.C. § 1961 (1982); Grant v. Portland Stevedoring Co., et al., 16 BRBS 267 (1984).

5. All computations of benefits and other calculations which may be provided for in this Order are subject to verification and adjustment by the District Director.

Dynamics Corp., 12 BRBS 524 (1980). The Board has determined that the letter of referral of the case from the District Director to the Office of the Administrative Law Judges provides the clearest indication of the date when informal proceedings terminate. Miller v. Prolerized New England Co., 14 BRBS 811, 813 (1981), aff'd, 691 F.2d 45 (1st Cir. 1982). Thus, Counsel for Claimant is entitled to a fee award for services rendered after **MARCH 8, 2013**, the date this matter was referred from the District Director.

6. Claimant's attorney shall have thirty (30) days from the date of service of this decision by the District Director to file a fully supported fee application with the Office of Administrative Law Judges; a copy must be served on Claimant and opposing counsel who shall then have twenty (20) days to file any objections thereto.

ORDERED this 10th day of June, 2014, at Covington, Louisiana.

LEE J. ROMERO, JR.
Administrative Law Judge